100 LIVES IN WESTERN SYDNEY: Presentation of Findings

For:

Department of Premier and Cabinet
Department of Family and Community Services, Western Sydney and Nepean Blue Mountains Districts
Department of Education, Macquarie Park Operational Directorate
The Sydney Children’s Hospitals Network
WentWest Ltd, the Western Sydney Primary Health Network
Western Sydney Local Health District
NSW Police Force
Juvenile Justice NSW
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Executive Summary

Service Delivery Reform (SDR) is a collaborative partnership among the Human Services agencies in the Western Sydney LHD region. SDR is a NSW Government initiative which aims to improve the coordination of, and communication among, government agencies to improve service delivery to vulnerable people. A multidisciplinary team of researchers at Western Sydney University was commissioned to evaluate SDR in Western Sydney, with particular reference to Making a Safe Home (MaSH), Vulnerable Families (VF), and the Middle Years Project (MYP), as well as the governance processes themselves. MaSH supports families where there is neglect of children and a risk of their removal to Out of Home Care (OOHC). VF aligns resources across and within WSLHD and FACS to improve health outcomes by responding to the needs of children and families in a timely way. MYP supports children from two primary schools in the region in their transition to high school. Western Sydney SDR was evaluated using realist evaluation.

The SDR Management Group comprises two tiers. Senior managers have authority to execute decisions; they have maintained commitment to SDR throughout the whole process. Communication has been clear and correspondence is trusting and collegial. The effectiveness of the Group can be attributed to shared understandings of context, vision, and purpose. The Group has also provided an authorising environment for group members to act innovatively and collaboratively for the benefit of service users and in pursuit of their shared vision. The Department of Premier and Cabinet has played a crucial role in holding partners to account and facilitating this environment.

The research project highlighted a number of lessons that can be learned from the experience of SDR to date. To be effective, referral criteria need to be both clear and widely understood, but also flexible. Achieving both of these objectives can be a challenge, as they can be in tension with each other. The success of the programs can be supported both by the use of timeframe standards and the provision of direct funding to programs. Relationships are also crucial to success: both relationships with children, families and caregivers and relationships within and between agencies. The role of a coordinator is particularly vital in bringing focus and momentum to the programs.

The expected outcomes from the interventions, processes and programs need to be clearly understood, both for the effective implementation of the projects themselves and for the purposes of any future research. The innovative and important practices in SDR can bring great benefit in the future, both in Western Sydney and beyond, so it is important that they are properly evaluated and then disseminated. Protocols and practices both for recording data and for appropriately sharing it among agencies are vital both for the projects themselves and for any future evaluation.

The success of SDR will benefit many, but will bring particular benefit to Aboriginal and Torres Strait Islander children, young people, and families. These groups are highly represented in all the programs. Greater inclusion of Aboriginal representatives in all planning and decision making bodies in SDR would be beneficial.

An economic evaluation was carried out as part of the research project and it is recommended that it would be worthwhile to continue to invest in both MaSH and VF, particularly if the systems and processes of both programs could be strengthened. The MYP’s early stage of development means that there is an excellent opportunity to plan for a comprehensive evaluation, including economic evaluation. It is strongly recommended that there be renewed efforts to align interagency datasets as a way of contributing to future evaluation and informing ongoing improvement.
The intention, the idea and the purpose of SDR

Service Delivery Reform (SDR) is a collaborative partnership among the Human Services agencies in the Western Sydney LHD region. SDR is a NSW Government initiative aiming to improve the coordination of, and communication among, government agencies, to improve service delivery to vulnerable people. Mandated by the Social Services subcommittee of Cabinet, SDR ‘aims to give local decision makers and frontline workers a clear mandate to work differently across agency boundaries ... to innovate and deliver what is needed at the local level’ (NSW Government, 2015, p.4). Four demonstration sites were selected to launch the initiative, one of which is Western Sydney.

The vision of Western Sydney SDR is that through coordinated, purposeful, and integrated prevention and early intervention service delivery, the children and young people of Western Sydney will grow up and develop within healthy, safe and well functioning families. Through the design and practice of cross agency team and project work, it is expected that the focus on prevention and early intervention will help alleviate reactive crisis intervention by each agency, strengthen collegial co-operation and promote joint decision making and client centred solutions. Another focus of this work is embedding the culture and processes of working together across all levels of the various agencies when benefit for shared clients can be realised.

A multidisciplinary team of researchers at Western Sydney University was commissioned to evaluate SDR in Western Sydney, with particular reference to Making a Safe Home (MaSH), Vulnerable Families (VF), and the Middle Years Project (MYP), as well as the governance processes themselves. Western Sydney SDR was evaluated using realist evaluation. Realist evaluation is increasingly used in health and human services research when stakeholders wish to learn about the mechanics of complex program delivery, and where programs might operate in multiple contexts and/or are required to adapt to changing needs and opportunities. In realist evaluation, the underlying idea is that change is generated, rather than caused, by a new program or intervention in a certain context. The concept of the generative mechanism focuses on how activities and processes operate to generate particular outcomes in particular contexts. This helps to account for variation within and among organisations, personnel, and/or clients, to determine not only what works, but also when, for whom and in what circumstances.

Guided by realist evaluation, the aim of the evaluation was to determine whether and, if so, how Western Sydney SDR works, and to identify lessons to guide its development and translation into different contexts. Extending the remit of this evaluation, an economic analysis was included to gauge the value proposition of Western Sydney SDR. Investment in time and resources was compared with outcomes to date. The economic analysis determined the investment costs required and whether the outcomes to date represent value for money. However, given the aim of realist evaluation, the economic analysis was not applied to MYP, due to its early stage of development at the time of this evaluation.
Who was involved and how they went about it

The Service Delivery Reform (SDR) Management Group comprises members who collectively represent the eight agencies involved in Western Sydney SDR, namely: Department of Premier and Cabinet (DPC); Department of Family and Community Services (FACS), Western Sydney and Nepean Blue Mountains Districts; Department of Education, Macquarie Park Operational Directorate; Sydney Children’s Hospitals Network; WentWest Ltd, the Western Sydney Primary Health Network (WS PHN); Western Sydney Local Health District (WSLHD); NSW Police Force; and Juvenile Justice NSW.

Within the Management Group are two tiers that might be referred to, respectively, as managerial and operational. The managerial tier includes senior managers who have authority to execute decisions, including those pertaining to resource allocation, on behalf of the agency they represent; those in the operational tier are responsible for planning and implementing SDR within the agency they represent, and for informing their senior colleague(s) of progress and emerging issues. Senior managers, at CEO level, have maintained their commitment to this process throughout the more than three years since the commencement of SDR. The Management Group convenes bimonthly, in person. Additionally, those with operational responsibilities convene fortnightly as the Project Team, in person or via teleconference. Within the Management Group, the position of chair has been shared, initially among FACS, WSLHD, and the Department of Education, and, subsequently, between the NSW Police Force and Sydney Children’s Hospitals Network, with a six-month rotation as agreed in mid-2015. Since the inception of this Group, the DPC has served as secretariat.

The research into the workings of the governance group found that there was an expectation amongst members that communication would be clear and that commitments that were made would be honoured. Analysis of the correspondence among members found that correspondence was carried out in a manner that was warm, collegial and respectful, with a high level of trust. Preliminary and draft documents were shared openly and regularly amongst members. Members supported each other in negotiating the complex bureaucracies of host agencies.

The perceived effectiveness of the Management Group is partly attributed to shared understandings, both of each other’s contexts and of the vision and purpose of SDR. These shared understandings have been developed in a variety of ways, including in previous appointments with some partner organisations and in a shared history of working together across a number of partnerships and initiatives, leading to well established trusting relationships, particularly amongst the most senior members of the group. The inclusion of newer members, with more junior roles in organisations, did bring some challenges, and did lead to a sometimes unequal division of power and influence within meetings and in decision making. Some newer members reported that they found it difficult to make contributions and to further decision making. The sense of shared understanding and shared purpose was facilitated by discussion of individual cases and a focus on outcomes for service users. The presentation of individual cases and stories also promoted understanding of the organisational complexities inherent in each agency.

The Management Group was seen as effective also because it provided an authorising environment for the group members to act innovatively and collaboratively for the benefit of service users and in pursuit of their shared vision. The mandate from the NSW Social Policy Cabinet Committee set the tone for this authorising environment. The role of the DPC was also seen as crucial. The DPC was considered impartial; it could hold other partners to account, and could provide the Management Group with information that it would otherwise not have been able to access. The authorising environment did not, however, apply to all agencies equally. The seniority of the representative from each agency was also a key factor in whether objectives could be achieved. Some agencies found it easier than others to send senior representatives to meetings, partly because of the juxtaposition of their geographical boundaries to the Western Sydney LHD area.
What SDR did: the three initiatives evaluated

The WSU research team was contracted to evaluate three initiatives, so other SDR initiatives, including ‘Child and Youth Mental Health in Western Sydney’ and ‘No Antenatal Care’ are not discussed in this report.

**Making a Safe Home (MaSH)** is designed to support families in which there is neglect of children and a high-risk of their removal to out of home care (OOHC). Where there is parental motivation to change, families are provided with targeted support through the purchase of goods and services (from public, private, and/or not-for-profit organisations), referral, and casework strategies to keep their children at home. Intended outcomes include improved wellbeing for children, and economic benefits if family support is a less costly option than OOHC. MaSH is delivered by FACS and has been operating for over two years. Although MaSH slowly engaged families during the trial and early implementation phase, intake has increased over the past 12 months. At the time of the client review in September 2017, 28 families with 64 children had been accepted into MaSH since its inception in 2015; 18 families remained in the program (64%).

Initially, MaSH was implemented only in the Western Sydney district of FACS, in response to the collaborative partnership with Western Sydney Local Health District (LHD), supported by the Service Delivery Reform (SDR) process. Over the past year, MaSH has been extended to the Nepean Blue Mountains district of FACS. This extension entailed engagement with Nepean Blue Mountains LHD, which is outside the Western Sydney SDR process.

The MaSH service model was developed from an interagency co-design process initiated by FACS and incorporated into the SDR process. In the MaSH program logic model, the referral criteria are: child/ren aged 0–5 years in the family; a high risk of child/ren’s removal due to neglect (not physical or sexual violence); and a capacity and willingness for parental change. With the implementation of MaSH, both the eligibility criteria and the intervention components have broadened to include families with older children, restoration cases, and families without Parental Responsibility Contracts. Exceptions to the criteria can also be approved by the Intake Panel.

The MaSH service model comprises a number of intervention components, including responsive, flexible, individualised services, practical home support, and interagency responsibility for cases. Parental Responsibility Contracts were initially part of the program but are no longer a prominent feature.

The MaSH service model relies on three key processes. First, cases are considered by interagency intake and case review panels. Second, FACS purchases external goods and services on the recommendation of panels. Third, caseworkers play a key role in identifying and referring potentially suitable families and following through on case plans recommended by panels.

**Vulnerable Families (VF)** aims to align resources across and within WSLHD and FACS, governed by a Memorandum of Understanding (MoU) between the two agencies, to respond to the health concerns of vulnerable children and families in a timely way, and so improve health outcomes. Towards this aim, a full-time coordinator was appointed by WSLHD, supported by a Working Party with members from WSLHD, FACS, and WS PHN. The role of this coordinator is to serve as a nexus between FACS and WSLHD to enable personnel within both departments to negotiate client access to health and community services, respectively. From April 2016 to December 2017 (inclusive), 244 families had been referred to the coordinator.

One of the strategic aims of VF is a shift towards having a single point of contact in Health, in order to coordinate a swift response to identified unmet health needs among FACS families, thus ensuring that appropriate intervention is initiated. The target population for referral to the VF project is families who have unmet health needs relevant to determinants of child and family health (including developmental delay and/or disability, substance misuse, mental illness, significant challenges with parenting), and where the children remain living in the family home.

The project was designed in response to certain interdepartmental conditions which were perceived as ineffective or inefficient, including FACS caseworkers not having direct access to WSLHD, and variance among FACS caseworkers in identifying and responding to unmet health needs in their caseloads. The
VF initiative offers FACS five new key benefits. First, there is a new referral pathway involving a single point of contact within Health. Second, FACS can access advice in matching identified health needs with the appropriate range of health services. Third, funding is provided for families to receive a needed service from a private health provider. Fourth, case advocacy within WSLHD will increase the chances that VF families will be prioritised on existing waiting lists or that a pre-existing Health response can be coordinated. Fifth, FACS will receive feedback about health related activity.

The Middle Years Project (MYP), led by the Department of Education, aims to support students from Yellow Sand and Green River Primary Schools as they transition to Blue Sky High School (all school names are pseudonyms). Towards this aim are targeted initiatives for particular cohorts of students, as well as initiatives for all students in Years 5 and 6. A teacher was employed to support this program, while WSLHD offers youth health screening to a particular cohort of students.

The intention of the MYP was to provide an initiative for children who face the challenges of Emotional Disturbance and Behavioural Disorder but who do not go to a specialist school, either through choice or due to circumstances. It was generally understood that children from the two feeder schools (Yellow Sand and Green River Primary Schools) who face these academic, behavioral and emotional challenges achieve poor outcomes when they go to Blue Sky High School. Children who are able to cope within the supportive environment of primary school find that they struggle when going into high school in Year 7. The challenges that they face can be manifested in poor attendance, poor educational attainment, undesirable behaviour, and a total disengagement from school in early high school.

The project has gone through a variety of iterations before settling into the program that is currently being delivered. A part-time Middle Years Teacher has now been appointed, funded directly by Education, and the services offered are now coordinated by him. He is described as an ‘adult ally’ for the children, particularly in Yellow Sand, as he builds a relationship with them in Year 6 that then endures into their commencement of Year 7 in Blue Sky HS. The Middle Years Teacher’s role involves mentoring these children, advocating on their behalf, providing case planning and assessments, and designing and delivering programs. Participants in the MYP are engaged in a group work program. Boys undertake the ResponseAbility program, a resilience and wellbeing program based on Russian martial arts. Girls undertake an equivalent program, called the 3D group – Dogs, Drums and Driving. This program incorporates mindfulness, CBT, trauma informed practice, emotional learning, and goal setting, and is delivered within a strengths-based framework. The Middle Years Teacher provides additional support in literacy work, both to the targeted children and to the whole Year 6 cohort. The targeted young people also receive additional support in developing social skills.
What have been the lessons learned?

The research project and partnership with the SDR Management Group highlighted a number of lessons that can be learned from the experience of SDR to date.

**Referral criteria are most effective when they are clear and widely understood**

In both MaSH and VF, those who referred to the services had a positive view of both the process and the service offered. MaSH is most successful when managers and caseworkers are familiar with the program and with the referral criteria. However, some workers expressed uncertainty and cited a lack of clarity as to what the referral criteria were and whether individual cases that they had linked to MaSH were considered to be good or bad referrals. In VF, there was an inconsistent pattern of take-up of the program from across the Western Sydney region, with some areas accessing the program much more frequently than others.

**Referral criteria are most effective when they are flexible and subject to review**

In all three programs, but most notably in MaSH and MYP, the referral criteria changed and evolved. This was a positive development and was implemented for understandable reasons. For example, in MaSH, Parental Responsibility Contracts were a prominent feature at the co-design stage but are now rarely, if ever, used in practice, due to the poor perception of them by client groups; they therefore no longer feature in referral criteria. In MYP, the referral criteria for the core group of children were not stated definitively and the process relied on the knowledge and experience of school principals, teachers, and other staff. Flexibility and the broadening and modifying of criteria have allowed the benefits of the programs to be experienced more widely and ensure that those who are most likely to receive benefit from a program are connected to it.

The two lessons, that referral criteria need to be clear and widely understood and that they need to be flexible may appear to be incompatible with each other. This is a reflection of the nature and evolution of the programs. The programs have broadened their criteria to bring in new clients and new client groups but this has not always been widely communicated, leading to some uncertainty. In all programs, a balance needs to be found between the positives of flexibility and responsiveness and the need for clarity in referral criteria.

**Practitioners should be widely and systematically informed about SDR programs**

Not all the programs in SDR were well known and well understood by the key people involved in the relevant agencies. MYP was clearly understood by the principals of the schools involved and by the teachers and other workers closest to the program. The core group of children received the key interventions from MYP and the benefits of the program were experienced by all Year 6 children and some from Year 5. Not all of those children or their families will have fully understood that the interventions were part of the Middle Years Project and the multi-agency Service Delivery Reform initiative, but it is difficult to see how this is crucial. VF was widely understood by workers in relevant agencies. MaSH was regarded positively by those who were closest to the program, but some other caseworkers were not familiar with it. This may not have impacted directly on children and families, but, as managers are the key link to the referral process, a wider understanding of MaSH, facilitated by an efficient communication strategy would allow the program’s benefits to be more widely distributed. Any communication strategy will need to ensure that provision of information is regularly reviewed and repeated to take account of the regular turnover of staff.

**Time frame standards can bring focus and accountability**

In MaSH, in particular, delays were found to occur in some cases between assessment by the Intake Panel and provision of additional MaSH services. FACS services continued to be provided in the interim. Delay in commencing MaSH services was most often for understandable and justifiable reasons and was connected to the challenges presented by the particular client group at whom the services were targeted. However, in a very small number of cases the reasons for the delay in service provision were not readily apparent. Setting a standard time frame for this service provision would allow closer monitoring and hence management of these processes. This would apply also to VF and MYP; time frame standards would help to ensure effective, timely, and targeted service provision.

**Success in the Service Delivery Reform initiatives will bring particular benefit to children from Aboriginal and Torres Strait Islander backgrounds**
Around 2% of the population of Western Sydney identify as Aboriginal or Torres Strait Islander, but this population is disproportionately represented in the OOHC system and has disproportionately poor health outcomes. Aboriginal children and families are highly represented in MaSH, MYP and VF programs and will receive particular benefit from successful SDR projects. Mechanisms for consultation with Aboriginal communities are available in MaSH and VF. Bringing in specific Aboriginal expertise has been a successful approach in MYP and could be replicated elsewhere, including in the Management Group. It would be helpful to include an Aboriginal representative on the MaSH Intake and Review Panels as an important step towards provision of culturally appropriate services.

**Funding directly associated with programs helps them to develop and demonstrates their value to partners and to potential referral agents**

Having access to their own funding is one factor that allows initiatives to achieve what they set out to do and demonstrates their value and importance. The initial selection of projects was at least partly determined by funding, with initial projects proceeding because agencies, notably FACS and Health, were able to find seed funding.

In MaSH there was sometimes a lack of understanding from practitioners as to whether a family would be funded, whether MaSH had its own funding, or whether MaSH could recommend funding from FACS. However, availability of funding associated with a MaSH intervention could make a significant positive difference to those families receiving the intervention, for example in the provision of mentors or childcare. Availability of funding also contributed to MaSH being regarded positively by practitioners – those who had most experience of MaSH regarded it most positively.

VF funding has facilitated the provision of services outside the core statutory agencies, bringing identifiable added value to the children and families included in the project. The pool of funding from which to purchase health services outside the LHD was an important factor in the success of VF.

MYP, in its first year of initiation, has been successful in achieving targeted funding. The MY Teacher was directly funded by Education and that funding is continuing in 2018. More recently, MYP has also been successful in receiving Health funding for a speech pathologist.

Funding of SDR interventions is discussed further in the latter two sections of this report.

**Quality worker–family relationships are vital to helping families and to supporting caseworkers in their role**

In all projects and initiatives, the relationship between workers and families has been crucial to the success of the interventions. In MYP, the individual work of the MY Teacher, along with the relationships established within the groups have been at the heart of the positive start to that project. In MaSH, honest, genuine, empathic, and reliable professional relationships were associated with success and positive responses.

**Coordinator, partnership and networking roles are vitally important**

The most prominent of the coordinator roles in the SDR initiatives is that of the ‘single point of contact’ in VF. This is a high profile role and very well regarded, both by those working within VF and those involved in other initiatives. The VF project is embodied in this coordinator role and confidence in the individual is translated into confidence in the program. Other projects have different characteristics and objectives but the coordinator role can bring significant value. The appointment of the Middle Years Teacher to MYP brought renewed focus, energy, and direction to the project. The governance of the whole SDR project is facilitated by the coordinating role played by the DPC. Progress in all projects was faster and more successful when resourcing enabled the appointment of a coordinator.

**Outcome measures should be clearly understood and expressed**

For the future development of projects, including potential roll-out to other areas, it is important to have clarity as to what are desirable outcomes, particularly regarding actual impact on the lives of children and families. In MaSH, the aim of keeping children at home, rather than in Out of Home Care (OOHC), is not a universal or ultimate goal; in some circumstances it will be the correct decision for a child to go into OOHC. The key outcome measures will relate to the longer term wellbeing of children and families, and that will need to measured over time. In VF, it was possible to track referrals but not the outcome of those referrals, that is, whether the referrals were taken up and, if so, whether the desired health improvements were achieved. Again, clarity is needed about outcomes beyond just tracking
referrals, so that outcomes are directly related to positive changes in the lives of the children and families. The research framework for MYP should be clear about what changes are expected, both in the core group and in the wider cohort of Year 6 children.

The promotion and support of a culture of research and evaluation should accompany the introduction of new and innovative interventions

It is not a criticism of the programs in SDR to say that they were not initiated with research directly in mind. Agencies respond to immediate needs, to deliver services on the basis of their current knowledge, experience, and available resources. They don’t always spend time and precious resources in seeking to prove what is already well understood. There were, however, challenges for the research team in developing a research framework in a practice context. These challenges were apparent from the start of the project, with the process of gaining ethics approval in a multi-agency, iterative project proving to be burdensome and time consuming. There were further challenges in gathering data, both in relation to SDR projects themselves and in being able to measure change against a baseline or some other counterfactual.

The projects in SDR are innovative and show evidence of positive impact on children and families. If this is to be demonstrated more widely, then it is important that a research culture and ethos accompanies the roll-out of programs. At this stage, this is particularly important with regard to MYP, where useful and important research into this program’s impact on children and families can be carried out in the next year.
Economic appraisal: investment costs and outcomes

Investment costs

The investment costs of SDR relate to the overall governance and to the individual programs evaluated. The initial co-design workshops and prototyping clinic, although led by FACS, were important to the development of SDR in Western Sydney. These workshops involved multiple agencies, Government and NGOs, with up to 46 participants per workshop, and, overall, convened for a total of 8 days. A consultancy company was hired to guide these workshops. In total, the time spent by all participants was 2,752 hours, at an in-kind time cost of $301,131. Consultancy costs totaled $250,000, and so the overall ‘one-off’ costs that prompted the SDR process were $551,131.

Recurrent time costs refer to the time spent by organisations at the Management Group and the Project Team meetings, pivotal in liaising with program teams. SDR has been driven largely by the goodwill of staff and organisations in offering time, which is generally beyond their usual activities. It is important to value this time, as there is an opportunity cost to individuals and agencies, and to recognise the investment made. The intensity of SDR working has varied over the 3 years, settling into a regular pattern of work from 2016 onwards. The total time spent after 3 years has been 2,063 hours, at a cost of $238,400.

MaSH developed out an of co-design process that involved a series of workshops and these are costed under the governance scheme. Table 1 provides a summary of MaSH activity since its inception in 2015. Clients are aggregated to preserve anonymity. The overall cost of staff time and services procured was $1,165,914, with health-related expenditure. The intake to MaSH has increased over time, with 75% of families admitted in the 2017 calendar year.

Table 1. MaSH activity, costs, and client status

<table>
<thead>
<tr>
<th></th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Clients</td>
<td></td>
<td></td>
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<tr>
<td>Families</td>
<td>3</td>
<td>4</td>
<td>21</td>
<td>28</td>
</tr>
<tr>
<td>Children</td>
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<tr>
<td>Costs incurred $</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Health</td>
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<td>232,824</td>
<td>35,948</td>
<td>573,644</td>
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<tr>
<td>Other</td>
<td>118,663</td>
<td>73,654</td>
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<tr>
<td>Total</td>
<td>423,536</td>
<td>306,478</td>
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<tr>
<td>Costs saved $</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>OOHCP plus associated</td>
<td>728,808</td>
<td>732,908</td>
<td>740,905</td>
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<td>Net $ Saving minus costs</td>
<td>305,272</td>
<td>426,430</td>
<td>305,005</td>
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The economic analysis estimated the cost in implementing the VF program, including the salary of VF personnel, the in-kind time costs of the VF working group, and the full private sector expenditure. There was not enough information to fully cost the use of public services. While public services may be considered ‘usual business’, the VF initiative is intended to increase activity levels. This adds to the workload of existing services, which may result in unintended consequences for non-VF clients if waiting times increase due to priority being given to VF clients. Ideally, all such activity resulting from VF should be tracked and costed, consistent with best practice in economic evaluation, and aligned with the MoU.

In total, there have been 257 referrals to VF. The referral activity was lower in 2017, with a focus on prioritising non-OOHC children, as the residual funding from the $0.9m available to the program decreases. Overall, since VF began in April 2016, a total of $832,000 has been spent from the $0.9m, inclusive of $63,000 on private invoices, the Vulnerable Families Coordinator position, and a range of other expenditures, including an Alternate Care clinic position, a youth group, and training for staff. These expenditures were consistent with the MoU, and were overseen by the Director of Community Services. Finally, the VF working group has met 12 times, for 2 hours each time, over the period considered by the evaluation, and with an average of 6 people attending. The in-kind time cost was approximately $13,200. These costs were aggregated to preserve anonymity of individuals’ salaries.
Table 2. Vulnerable Families: referral activity and expenditure

<table>
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<th>2016 Referrals</th>
<th>2017 Referrals</th>
<th>Total Referrals</th>
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<td></td>
<td>%</td>
<td>%</td>
<td>%</td>
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<tr>
<td>Auburn</td>
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<tr>
<td>Blacktown</td>
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<td>15</td>
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<td>Parramatta</td>
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<td>16</td>
</tr>
<tr>
<td>Other</td>
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<td>7%</td>
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<tr>
<td>Total</td>
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<td>100%</td>
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</tbody>
</table>

MYP is at an early stage of development, and so indicative costs are provided, as opposed to a definitive costing of what the program will cost going forward. These indicative costs are: (i) salary costs of the MY Teacher who is contracted at 2 days a week; (ii) the time cost of a class teacher running specific sessions; (iii) 2 police officers participating in group programs, over 7 weeks, at 1.5 hours per week; (iii) in-kind support of the Network Specialist Centre Facilitator (NSCF) of approximately 1 day per week; (iv) the MYP working group, who met 9 times, for 2 hours each time, over the period considered by the evaluation, with 11 attendees on average; (v) 3 meetings with Health and Education; (vi) 6 health screens and health plans, at $650 per person, inclusive of screening, and travel time for health staff; (vii) the in-kind time cost of the NSCF, who over the course of the development of MYP has spent approximately 45 days to date. Overall, the associated costs in developing and operating MYP have been approximately $94,000. These were aggregated to preserve anonymity of individuals’ salaries.

Outcomes

The purpose here is to report on and assess the value proposition of the SDR Management Group. There were already established working relationships among many of the agencies, especially between FACS and Western Sydney Local Health District (WSLHD), which have led and supported the development and continuity of the Management Group. Multi-agency working is not new. The remit of the evaluation was to assess the impact of SDR, and so the focus here is on outcomes produced from the Management Group itself, rather than multi-agency output produced previously. Table 3, below, reproduces the key statements from the Terms of Reference (ToRs). As outlined in the document, these reflect a set of general purpose statements rather than a set of specific objectives with associated timelines or key performance indicators. The table indicates whether a purpose has been achieved, is in progress towards achievement, or whether this is unclear.

Table 3. Progress of Management Group relative to Terms of Reference at the time of the research

<table>
<thead>
<tr>
<th>Purpose statements</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Driving the development, implementation, and operation of SDR</td>
<td>√</td>
</tr>
<tr>
<td>2. Making decisions about service delivery, funding, and governance reform</td>
<td>√</td>
</tr>
<tr>
<td>3. Identifying, agreeing on, and sharing accountability for the achievement of</td>
<td>?</td>
</tr>
<tr>
<td>shared outcomes</td>
<td></td>
</tr>
<tr>
<td>4. Reconfiguring agency service delivery and resources to support SDR</td>
<td>?</td>
</tr>
<tr>
<td>5. Ensuring consistency with reform principles/objectives</td>
<td>√√</td>
</tr>
<tr>
<td>6. Approving and overseeing the implementation of a project plan which identifies</td>
<td>?</td>
</tr>
<tr>
<td>vision and shared outcomes, management, reporting, and evaluation requirements</td>
<td></td>
</tr>
<tr>
<td>7. Liaising with relevant agencies and Ministers to get required approvals</td>
<td>√√</td>
</tr>
<tr>
<td>8. Ensuring appropriate resource sharing mechanisms e.g. pooled funding</td>
<td>?</td>
</tr>
<tr>
<td>9. Assisting with data sharing protocols and processes to expedite reform</td>
<td>√</td>
</tr>
</tbody>
</table>
10. Identifying and managing risks and systemic and strategic level issues and operational issues

11. Reporting, recommending, and/or escalating issues to the SPCC or other relevant governance structures

12. Identifying further opportunities for reform

Key: ✓✓ = achievements; ✓ = activity; ? = unclear

Given the understanding that MaSH has prevented children from being removed from home, this leads to an immediate cost saving by avoiding OOHC, equivalent to a minimum of $41,000 per child per annum. Further, there may be additional costs saved by avoiding the need to remove children, including those associated with the legal process, contact visits, and hotel stays.

Overall, from the 28 families with 64 children that have entered the MaSH program, 22 families with 48 children remained together or were successfully restored. From a purely financial perspective, MaSH appears to have saved FACS approximately $2,202,621 by avoiding OOHC costs. Therefore, over the period of the evaluation, MaSH has generated a positive return on investment, with a net saving of $1,036,707 – a ROI ratio of 0.89. On average, for every dollar invested in MaSH there has been a return of $0.89 to FACS. These findings are caveated by the necessary limitations of the research.

Within MaSH documentation regarding intended outcomes there is a mix of both service level and client level outcomes. There appear to be general improvements in service level outcomes; however, it is difficult to measure the extent to which this has occurred. There was considerable variation among clients regarding the time elapsed between their entering the MaSH program and their receiving service supports. What has not been achieved is the stated objective of improving data linkages between service providers.

With regard to client outcomes, child safety and wellbeing may legitimately be proxied by whether children remained at home, but cannot be assumed, and this is more a measure of the absence of serious problems, rather than of progress towards positive outcomes. There is a process of monitoring and evaluation through MaSH that has led to the removal of children. However, the extent to which wellbeing has improved in children who remain at home is not known; neither is there a systematic collection of data on other outcomes.

The MoU made explicit a list of KPIs in VF for FACS and WSLHD to monitor and report against. These KPIs differed between organisations, in that for FACS they were client outcome focused and for WSLHD they were mainly at service level. In general, there has been achievement against these KPIs, with the operation of the VF program and development of a common referral protocol for VF and other related services. However, without a comparison group, it is difficult to assess the costs saved by reducing referral times and avoiding the duplication that may result if certain caseworkers assisted clients to access the health system.

The overriding rationale for VF, as stated in the MoU, is to ‘assist or achieve improved life outcomes for children and young people with health issues’. The MoU provided a number of KPIs by which to track progress and measure successful outcomes, specific to FACS and WSLHD, respectively. It is unclear if these particular KPIs have been achieved. There is no internal recording of progress, and the 100 Lives evaluation was not able to draw inferences regarding this, given data limitations. Overall, it is reasonable to say that VF has supported all of these objectives, and, on balance, has led to improvements, but to what extent is unknown.

For FACS, it is more likely than not, that VF has increased the proportion of children and young people in safe and stable homes. But it is impossible to say more than this, such as, what was the increase in proportion. For WSLHD, it is more straightforward to say that KPIs are likely to have been met. The establishment of VF has led to improvements in the identification of need and in the number of early interventions, and there is more integrated healthcare – in many cases, clients have transferred between pilot initiatives, including VF and MaSH and other related programs, such as the Whole Family Team.

The ‘added value’ of the working group is difficult to quantify, which is not unusual, as support can often be intangible rather than directly measurable. A working group seems important. There are regular
discussions of VF activities and about integrating VF with other initiatives and programs. Further, the group does provide general support and guidance to the VF Coordinator when needed. There was also one instance where the working group has been crucial in helping to alleviate blockages in the public system.

**MYP** is at an early stage of development and implementation. It has been a significant achievement of the MYP working group, and the governance of SDR as a whole, that MYP has been implemented. It will take time for service level and client outcomes to emerge. At present, there is not an explicit set of expectations, associated key performance indicators, or indications that the latter are desired. A focus group provided a series of suggestions as to possible changes that could be seen in a year or two's time that would indicate that MYP had been a success:

(i) A reduction in the rate of suspension from school for children in the program progressing into Year 7 and Year 8;
(ii) Increased attendance at school by children progressing into Year 7 and Year 8;
(iii) Increased engagement in lessons and in school in general.

There were also some suggestions as to what might be possible successful outcomes that may be less directly measurable, such as children having a greater sense of belonging and feeling connected.
What do we need to further invest in?

From an economic perspective, it would be worthwhile to continue to invest in MaSH and VF if the system and processes of both programs were strengthened to enable clarity regarding, for instance, eligibility, assessments, referrals processes, service use, and client outcomes, including health and wellbeing.

It is recommended that the following be considered with regard to strengthening processes and enhancing the efficiency and effectiveness of Making a Safe Home (MaSH).

1. **Improve awareness of MaSH across Community Service Centres (CSCs), with updated documentation regarding eligibility, guidelines for case referral to the Intake Panel, and clarity on the assessment of risk and parental capacity:** The purpose of such measures would be to help support access so that MaSH can reach all clients that can benefit, and also avoid inappropriate referrals and the associated time costs. It may also be helpful to consider appointing an Aboriginal representative on the Intake and Review Panels. Clarity on the measurement of risk and parental capacity would also create a baseline against which the success of services could be measured. This may also be important from the perspective of risk management. MaSH is taking risks in working with cases that would otherwise lead to the removal of children. Therefore, there is the possibility of unintended negative consequences if a case goes wrong. It may then be important to demonstrate that due process was followed, as expected.

2. **Consider whether the Intake Panel should meet according to need:** If cases are considered urgent, then perhaps panels should convene accordingly, so as not to miss the opportunity to best support children to remain at home, since there is considerable variation among the circumstances of clients.

3. **Consider the development of operational standards, such as the speed of service provision, and transition of the payment of services from FACS to other organisations:** This initiative would help ensure the equality of responses to clients, and that FACS is not paying unnecessarily for expenditures, such as 24-hour in-home support that Centrelink should pay for, or acute health care.

4. **Consider whether MaSH should have its own budget and accountability structure:** If MaSH is to be embedded as routine practice, then perhaps having a dedicated resource could lead to the sustainability of the program, especially if the program was made more available across FACS CSCs. This may, in turn, create the conditions in which MaSH can improve its system and processes to support effectiveness and efficiency.

5. **Invest in data systems to track clients, measure wellbeing, and assess risks over time; such data would feed back into ‘continuous quality improvement’:** This may facilitate the full demonstration of overall program impacts, enable continuous quality improvements, and permit more robust and comprehensive evaluations. It would also be important in demonstrating to other agencies, particularly Health, the value of MaSH in avoiding acute service use, and its value to the wider economy/society as more clients are taken up.

Similarly, the following recommendations are offered for consideration to improve the efficiency and effectiveness of Vulnerable Families (VF).

1. **Raising awareness of VF across all CSCs:** This would enable all eligible CSCs and clients to benefit, whereas at present there is a heavy focus on Blacktown.

2. **Training of caseworkers to identify health needs, and clarity regarding eligibility:** If the VF model is to be implemented, then caseworkers may benefit from basic health training in order to identify needs and to case manage clients with health concerns. It is unclear whether eligibility for VF is restricted, as is stated in the MoU, to clients with scores of ‘high’ or ‘very high’ risk, as measured by the SARA tool.

3. **Consideration of an alternative, or enhanced, VF model:** It may be useful to consider whether clients should be given a primary health screen or assessment, similar to that given to children on entering OOHC. Further, the client group in question is often the hardest to engage, and to encourage to sustain engagement. Perhaps VF has spread itself too thinly in maximising referrals, whereas a more focused use of resources, concentrated on boosting case management, may support engagement and achieve better client outcomes.
4. **Strategic discussion between senior FACS/Health staff and those implementing the program to develop a shared understanding of VF:** There is a difference between how VF was designed and how it has been implemented. A strategic discussion could consider whether VF is a referral program only, or whether clients can be supported regarding their sustained engagement. It may then be important to revisit its objectives, and develop specific and measurable KPIs. It is also important to develop a realistic expectation of success, given that the target population is challenging to engage with, and that the health sector can only do so much in this regard.

5. **Integrated data collection from FACS to VF to public and private health services:** For continuous quality improvement and evaluation it is important to track clients, and so understand if the VF model is effective and efficient. It would also be important to have a mechanism in place for tracking clients if recommendation 3 were considered. WSLHD has first class IT support, with experience in working with researchers, developing protocols, and with appropriate e-forms, which could be accessed, making the process of data collation straightforward (Plant et al. 2013). It may be necessary to seek data sharing agreements with the private sector also.

At present the **Middle Years Project (MYP)** is in an early phase, and therefore an economic evaluation is premature. However, this situation provides an excellent opportunity to plan for a comprehensive evaluation, including economic evaluation, and collect the necessary data alongside the implementation of MYP. If considered useful, to manage that process it is recommended that a research protocol be developed, jointly, between researchers and the working group. It is imperative that the design and implementation of MYP should lead the research, rather than vice versa, so that an evaluation is calibrated on the needs of the Industry and addressing the questions MYP wishes to answer. In turn, researchers can provide input into those discussions with advice – for instance, that particular approaches to implementation (e.g. developing comparison groups) can most robustly answer particular questions. The key elements of such a protocol could include the following:

1. **Theory of MYP:** Develop a clear and specific program theory of MYP that can then be empirically tested.

2. **Baseline data:** Gather the appropriate data that evidences key risk factors in Years 5 and 6 that predict problems in making the transition to Year 7, and the onset of problems thereafter.

3. **Model of Support – defining intervention and costing:** This has largely already been done from the current evaluation. However, MYP may further evolve (for instance, with the intended addition of a speech pathologist), which has implications for baseline data collection and follow-up.

4. **Service level outcomes:** The theory of change can inform the implementation process and the way agencies are expected to optimally work together to identify issues, respond quickly, and provide follow-up for children. Further, interventions are ‘events in systems’ and interact with existing services. There is a need to carefully develop realistic key performance indicators regarding intended service activity levels. However, activity is a means to an end. The key issue regarding value is whether client outcomes have been improved.

5. **Client outcomes and realistic expectations of impact:** It is then important to develop client outcome measures that MYP can aspire to achieve. These should align with the baseline measures of what the issues were, in order to assess whether MYP is reducing risk factors in transition, and if it is leading to improvement in children’s lives, for instance, in their education, health, and contact (or lack of contact) with the justice system.

6. **Value – defining success:** Ultimately, the judgement as to whether MYP will return value for the investment is a normative question, and informed by equity considerations of the need to attempt to support such children as those targeted.

7. **Comparison groups/control groups:** The previous steps would describe change; however, a fundamental consideration is whether MYP caused that change, as opposed to external influences. The key issue is ‘attribution’. It would be very important to carefully consider the possibility of developing comparison/control groups.

**Investment in the governance structure**

There is not enough evidence at present to suggest that the SDR programs are ready to be scaled and implemented across Greater Western Sydney. The economic evidence is not strong enough, as a result of the insufficiency of available data. As part of strengthening systems and processes, it would be
important to greatly improve the management of client data so as to follow trajectories, and align the outcomes collected with the NSW Client Outcomes Framework. This would be consistent with the vision of SDR as expressed by the Social Policy Cabinet Committee, and ‘Their Futures Matter: A New Approach’.

Further, it is strongly recommended that there should be renewed efforts to align interagency datasets. Client focused programs, if effective, have the potential to have significant and sustained interagency impacts. However, there is a need to demonstrate these impacts, to support sustained momentum in SDR, and to generate data frameworks that can be used in evaluation, and also inform continuous quality improvement.

SDR provides a mandate to test different governance and program delivery models. It is recommended that the WS SDR consider innovative approaches where, for example, different versions of a program are piloted in different areas, alongside an evaluation strategy. There are other steps that could be taken by the Management Group to support further investment in SDR programs, as follows:

1. **Strategic meetings to reaffirm the role and purpose of SDR and the Management Group:** It may be important to revisit the Terms of Reference, and define roles and responsibilities, intended outputs, and how success of the Management Group might be demonstrated.

2. **Further support for the Middle Years Project (MYP):** The successful implementation of MYP would be a major success story for WS SDR, and the governance function. Momentum is building, and it will be important to maintain this. The Education lead had been devoting a significant amount of personal time, and resources without additional budget. There could be a key role for SDR to meet its existing terms of reference regarding resource support. This may be justified on the basis of meeting shared outcomes. The support from WSLHD, in particular, is impressive.

3. **Clarity on the Management Group’s role in Making a Safe Home (MaSH) and Vulnerable Families (VF):** It may be useful to consider what the Management Group is bringing to the implementation and sustainability of these programs. These programs have considerable merit but there have been implementation limitations, including lack of follow-up to assess client outcomes, which has mainly affected VF. Recommendations could be made to help support the implementation of these programs, and demonstrate value to clients. If relevant, there may be a role for the Management Group in providing strategic oversight for continuous quality improvement, and learning lessons to apply to future programs.

4. **Revival of the WS SDR Data and Evaluation Working Group:** This group has been disbanded and it is recommended that consideration be given to reviving and resourcing it. The objectives of the group were to ‘develop, implement and oversee an evaluation plan to support the provision of evidence necessary for informed decision making’. This task requires investment of time and resources, especially to align multi-agency data around client trajectories – given the expectation that early prevention and intervention in vulnerable lives, if effective, can be transformational, and also lead to interagency benefits and cost savings. The potential benefits of such investment could be considerable, both in demonstrating the value of SDR and in supporting data driven continuous quality improvement.

5. **Development of shared learning with other SDR areas in NSW:** The process of SDR is also occurring in other areas outside of Western Sydney. It is recommended that joint forums could usefully be created to share learnings at both the strategic governance and the programmatic levels.
## Where to from here? Next steps

### 1. What works for whom? How? In what circumstances?

<table>
<thead>
<tr>
<th>What works for whom?</th>
<th>How?</th>
<th>In what circumstances?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MaSH</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake criteria work for caseworkers, panel members, parents, children</td>
<td>More likely to refer when clear on criteria Better able to assess suitability for program Program targeted to families who will benefit most and children who would otherwise be in OOHC</td>
<td>Criteria informed by research on risk factors for OOHC Criteria included on referral form Assessment and cumulative risk tools used by caseworkers and panel members Attention to each criterion in Intake Panels System to flag families in FACS with indicators of risk for consideration by MaSH</td>
</tr>
<tr>
<td>Timeframe standards for referral, intake, and service implementation works for children at high risk of removal</td>
<td>Avoids delay Support is secured quickly Gives children best chance of avoiding OOHC</td>
<td>For example, 2-week standard from referral to intake and intake to service delivery</td>
</tr>
<tr>
<td>Safety and wellbeing directed change goals for families in case plans works for parents with the willingness and capacity to achieve these goals</td>
<td>Collaborative Support is targeted and goal directed Progress can be tracked and evaluated</td>
<td>Goals and strategies are negotiated with parents/carers Goals and strategies documented and reviewed to track progress as part of review panels</td>
</tr>
<tr>
<td>Family support is recommended for payment through MaSH panel, helping families with complex and costly services</td>
<td>Provides rationale and reassurance that money is well spent on appropriate support for suitable families</td>
<td>Small, straightforward or discrete payments might be dealt with more efficiently through a standardised payment approval process Recommendations for the purchase of goods and services are detailed and monitored</td>
</tr>
<tr>
<td>Caseworkers are informed about MaSH providing help to caseworkers and families</td>
<td>Clearer understanding of role and expectations promotes job satisfaction Families have prompt, streamlined access to support, giving children the best chance of avoiding OOHC</td>
<td>Program guidelines in place Education for casework managers who share information with caseworkers Cases discussed in supervision and practice/case meetings</td>
</tr>
<tr>
<td>Quality worker–client relationship helps both families and caseworkers</td>
<td>Goals and circumstances can be communicated Client feels supported and able to ask for help Assessment is more thorough Greater job satisfaction</td>
<td>Attention given to the development of honest, genuine, empathic, reliable, and professional relationships</td>
</tr>
<tr>
<td>Regular interagency reviews help both the coordinator and families</td>
<td>Case plans and support are responsive to client circumstances Family progress can be tracked and evaluated</td>
<td>Interagency and interdisciplinary perspectives on case plans are developed through reflective discussions Efficient and thorough documentation and communication Progress is monitored and evaluated against change goals to inform case plans Caseworkers prepare relevant information for reviews</td>
</tr>
<tr>
<td>Outcome measures are important for FACS</td>
<td>Monitor progress in child development and parenting for case planning and compare MaSH families with comparison groups for evaluation purposes</td>
<td>Selection of reliable, validated, suitable, and practical measures SDR facilitates expert and organisational input into the selection of outcome measures</td>
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<tr>
<td>What works for whom?</td>
<td>How?</td>
<td>In what circumstances?</td>
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<tr>
<td><strong>Vulnerable Families</strong></td>
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<tr>
<td><strong>Having flexible referral criteria works for workers</strong></td>
<td>Families’ complex health needs are accommodated, as are the needs of adults, young people, and children</td>
<td>Goals and strategies are negotiated with healthcare providers</td>
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<td></td>
<td>There are standard exclusion criteria for health or wellbeing in the processes of advocacy and referral</td>
<td>There is minimal evidence that VF can change WSLHD practices</td>
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<tr>
<td></td>
<td>Referrals are made to healthcare, early intervention, and welfare/community service providers</td>
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<tr>
<td><strong>Funding to purchase health or social interventions external to WSLHD helps both FACS and families</strong></td>
<td>Coordinator has direct access to personnel who can authorise payment, and so can directly explain the rationale for the funding request</td>
<td>Payment approvals are efficiently processed when VF can access FACS Executive</td>
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<td></td>
<td>Swift approval for payment to external healthcare providers improves the likelihood of caseworker follow-up on families’ health needs, where demands on FACS are significant</td>
<td>Approvals are typically determined in circumstances where services justifiably address an unmet health need, provide early intervention, or promote child safety</td>
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<tr>
<td></td>
<td>There are standard exclusion criteria for health or wellbeing in the processes of advocacy and referral</td>
<td>Dedicated funds enable caseworkers to refer clients to VF</td>
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<tr>
<td><strong>Single, dependable point of contact within WSLHD</strong></td>
<td>VF provides caseworkers with a dedicated pathway to refer into the health system</td>
<td>Repeated use of VF pathways increases the likelihood a FACS caseworker will continue to make referrals</td>
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<tr>
<td></td>
<td>To optimise quality, caseworker managers approve referrals before sending information to the coordinator</td>
<td>A dedicated, single point of contact promotes learning within the health system</td>
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<tr>
<td></td>
<td>Avoids inconsistency</td>
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<td></td>
<td>Coordinator provides feedback to referring caseworkers</td>
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<tr>
<td></td>
<td>Actions are completed by the same person, building on past lessons and maintaining networks</td>
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</tr>
<tr>
<td><strong>Coordinator’s partnership and networking roles are important for both agencies</strong></td>
<td>Coordinator involvement in complementary initiatives with the WSLHD and FACS informs VF</td>
<td>There is an unchanged core stakeholder group since program inception</td>
</tr>
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<td></td>
<td>Coordinator directly communicates with executives within the WSLHD and FACS, with casework managers, and with WSLHD stakeholders</td>
<td>Trust and easy communications among core stakeholders optimises the capacity to deliver services in a timely way</td>
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<td></td>
<td>Coordinator networks within the WSLHD, which helps in designing appropriate, coordinated responses</td>
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<td></td>
<td>Permission to share client information across the WSLHD and FACS improves communications</td>
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Recommendations and future directions

The SDR Management Group is founded on established relationships among some members. These relationships contribute to shared decisions, but can also inhibit the group dynamic, as not all members experience the relationships in the same way. It takes time to build up respectful, trusting relationships. Regular strategic planning, as well as deliberation on activities, would help the Management Group to reflect on their understandings and to set and achieve shared goals.

MaSH is most successful when caseworkers are familiar with the program and the referral criteria. An education program for caseworkers and managers is likely to promote engagement with MaSH, as well as a clearer understanding of the MaSH program. The education program should clearly articulate MaSH and its place within FACS.

VF effectively enabled an innovative and responsive partnership between FACS and WSLHD aimed at addressing clients’ unmet health needs. VF has been able to organise swift and appropriate referrals for the target group and to purchase health and social interventions. The referral processes are working effectively, but the research team was not able to establish either whether referral appointments were taken up or whether interventions had a positive impact on the health and wellbeing of children and families. In future evaluation, it is recommended that the VF Working Party reach consensus as to what is meant by ‘what works’, and take steps to measure intervention effects post VF referrals.

MYP demonstrated strong interagency commitment. It was supported by interagency resources to ease student transition from primary to high school, which has been typically the sole responsibility of the Department of Education. More recently, the Management Group agreed to fund a speech pathologist for this program, and the Department of Education has agreed to extend the position of the MY Teacher. Such interagency commitment suggests MYP is well placed to support students in Years 5 and 6 as they transition into high school.

There was insufficient information to conduct a comprehensive economic evaluation of the three initiatives; there was a lack of follow-up data on client outcomes, and there were no comparison groups. It is likely that MaSH provides FACS with a positive return-on-investment, with the amount saved from avoiding OOHC being greater than expenditure on client services. The effectiveness and efficiency of MaSH may be improved with a more explicit referral process. VF may be an effective referral initiative, but it is not known if clients used the services referred to or whether client outcomes improved. Continued investment in MaSH and VF is worthwhile if client outcomes can be recorded over time to more fully assess effectiveness going forward. Similarly, resources committed to MYP, alongside an evaluation framework to assess impact, would be a wise investment. Overall, it is recommended that WS SDR consider investment in better client data collection, and also data sharing between agencies, in order to develop the economic case that programs should be scaled up with appropriate levels of investment.

An evaluation of MYP would be a worthwhile priority. There is also an opportunity to extend the evaluation of MaSH and VF by obtaining different forms of data from different sources.

If clear outcomes can be established and longitudinal client outcome data systematically collected for clients of both programs, as well as for comparable cohorts, robust research can be conducted. For example, research might consider the impact of referral processes on (prospective) clients and how these impacts shape lifestyle choices, service use, and wellbeing. There is also opportunity to further examine the governance of Western Sydney SDR.

A longitudinal study could determine the conditions that helpfully contributed to program achievements and ensured value for money. Business models that inform systemic change and help to translate SDR into different contexts could be tested to compare top-down, bottom-up, and mixed approaches.

Further economic analysis would require improved data management and data comparability. Collectively, these opportunities suggest there is considerable opportunity to better understand Western Sydney SDR, promote its achievements, and inform comparable initiatives further afield.

Service Delivery Reform is ultimately about bringing change to people’s lives in Western Sydney. It is undoubtedly the case that the programs are having this positive impact, and more consistent data
collection and linkage would allow this achievement to be more effectively demonstrated, recorded and, ultimately, replicated. A more regular and consistent use of strategic planning meetings by the Management Group would facilitate greater strategic involvement and oversight. The research team observed the commitment of agencies and individual practitioners and managers and the impact of SDR in more than 100 lives in Western Sydney, across the three programs evaluated. It is appropriate to end the report with two, anonymised, case studies of families whose lives were changed by MaSH and VF, respectively.
**MaSH case study: Jade and her baby**

Jade lives in a Department of Housing home with her baby son, who is seven months old. Jade’s ex-partner, the father of the baby, left the family home two months previously. Jade has two older children to different fathers. Her ten-year-old daughter lives with her father and grandparents and visits her mother every weekend. Jade’s three-year-old daughter, whom she sees once or twice per month, was removed 12 months prior, due to neglect associated with Jade’s substance abuse. The child lives with her father.

This history led to Jade’s unborn child being identified as at high risk of removal at birth, and FACS became involved during the pregnancy. During her pregnancy, Jade had stopped using drugs, had clean urinalysis results and had attended a parenting program, demonstrating motivation to parent her baby well. A decision was made that the baby was safe to go home with Jade with 24 hour monitoring and parenting support. An around the clock nanny service was engaged through MaSH and workers provided support and monitored progress. After a week of positive reports the nanny service was reduced. MaSH also facilitated the purchase of a washing machine and a baby car seat for the family.

The FACS caseworker has linked Jade in with community support services. The family was referred to a family preservation service, which involves a worker visiting in the home twice a week. The service has provided support and counselling for Jade’s past drug use, and relationship, emotional, and parenting issues. This service is time limited and will soon cease, so a referral has been made to a peer mentoring service. Jade also attends a local family support service where she sees a counsellor and participates in a parenting program. Jade enjoys the opportunity to talk with other mothers and has made friends at the centre.

**VF case Study: Alan**

Alan is a 12-year-old boy in a placement with his parental grandparents, where he has been since he suffered significant injuries at age four months while in the care of his parents. Alan has significant disability and functions at the level of a six-month-old child. He has severe cerebral palsy, seizures, and cortical vision impairment as a result of a brain injury. He remains non-verbal and uses a wheelchair. His carers are aging and are struggling to provide ongoing care, including pushing him in a wheelchair.

The VF coordinator liaised with an occupational therapist at Cerebral Palsy Alliance and discussed arrangements for Alan to trial power wheelchairs at home and at school, with a view to purchasing one through VF. The VF coordinator was able to obtain approval to draw on VF funds to purchase a power wheelchair and an electric positioning chair for Alan.

A service maintenance contract for each chair was pre-purchased, to ensure the ongoing use that this equipment was provided for, and the VF coordinator arranged for the equipment to be serviced as part of Alan’s NDIS plan. Cerebral Palsy Alliance agreed to support the family in the development of this plan, and ensure that this was included in the planning discussions.

VF funds were also used to purchase an iPad for Alan, which would enable new communication avenues.