# Final Report

NSW Department of Communities and Justice
Targeted Earlier Intervention Program Evaluation

15 November 2024

Document classification: Client use

## Acknowledgement of Country

Taylor Fry, Social Ventures Australia (SVA) and Gamarada Universal Indigenous Resources Pty Ltd (G.U.I.R) acknowledge and pay respect to past, present and future traditional custodians and elders of this country on which this work was undertaken.

### About Taylor Fry, Social Ventures Australia and G.U.I.R

This evaluation is being delivered by a partnership between Taylor Fry, Social Ventures Australia and G.U.I.R:

**Taylor Fry** is a leading consultancy, providing actuarial, analytics, statistical and related policy advice to business and government in Australia and New Zealand. Taylor Fry helps their clients make data-informed, evidence-based decisions across a variety of specialist areas to enhance their financial health, and effect meaningful change for communities and society. This expertise spans insurance, accident compensation, health, welfare, education, justice, disability, environment and conservation, telecommunications, and loyalty programs.

**Social Ventures Australia** (SVA) is a not-for-profit organisation that works with partners to alleviate disadvantage – towards an Australia where people and communities thrive. We influence systems to deliver better social outcomes for people by learning about what works in communities, helping organisations be more effective, sharing our perspectives and advocating for change SVA Consulting is Australia's leading social purpose strategy consultancy firm, working with around 150 clients each year. For more information about SVA, please see: https://www.socialventures.org.au

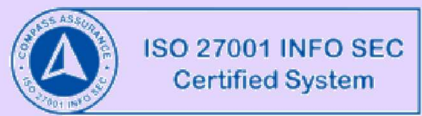
**Gamarada Universal Indigenous Resources Pty Ltd** (G.U.I.R) is a 100% Aboriginal owned and operated organisation that provides professional services to the private, government and community sectors. G.U.I.R works to influence and support research and evaluation, health care and mental health, education, justice, employment and defence sectors. It specialises in program co-design and delivery, research and evaluation, coaching and mentoring, staff training, organisational capacity building and community engagement.

The evaluation team wishes to acknowledge the view expressed by many Aboriginal Controlled TEI providers and other Aboriginal stakeholders that Aboriginal people are continuing to experience impact of colonialism, which can manifest as poverty, racism, disadvantage and institutionalisation for Aboriginal children and families.

### Professional disclosure statement

Taylor Fry, SVA and G.U.I.R have prepared this report in good faith on the basis of our research and information available to us at the date of publication, without any independent verification. Information has been obtained from sources that we believe to be reliable and up to date, but Taylor Fry, SVA and G.U.I.R do not guarantee the accuracy, completeness or currency of the information. The information in the report is general in nature and is not intended to and should not be used or relied upon by readers as the basis for any strategic, business, financial, tax or legal decisions.

This report was prepared by Taylor Fry, SVA and G.U.I.R for the use and benefit of our client only and for the purpose for which it was provided. SVA does not accept any liability if this report is used for an alternate purpose from which it was intended, nor to any third party in respect of this report.



# Table of Contents


**1 Executive Summary .... 9**
1.1 About the evaluation .... 9
1.2 Findings from the evaluation .... 10
1.3 Opportunities and recommendations .... 14
**2 Overview of the Targeted Earlier Intervention Program .... 15**
2.1 Background to the TEI program .... 15
2.2 TEI evidence base .... 17
2.3 TEI data collection and reporting by providers .... 20
**3 Approach for this evaluation .... 22**
3.1 Context for the evaluation and its purpose .... 22
3.2 Evaluation approach .... 22
3.3 Key methodologies .... 25
3.4 Limitations .... 30
**4 Summary of changes to Interim Report .... 33**
4.1 Overview of the Interim Report .... 33
4.2 Updates to findings in the Interim Report .... 33
**5 TEI service provision and demand .... 36**
5.1 Client numbers and service provision .... 36
5.2 Potential unmet demand .... 39
5.3 Program reach to priority groups .... 41
**6 Outcomes Evaluation .... 46**
6.1 Outcomes sought by the TEI program .... 47
6.2 Quantitative outcomes evaluation methodology .... 49
6.3 Summary of outcomes evaluation results from different methodologies .... 50
6.4 TEI program and its impact on safety outcomes .... 52
6.5 TEI program and its impact on other outcomes .... 58
6.6 Factors that influence outcomes .... 62
6.7 Unanticipated outcomes from the TEI program .... 72
6.8 Client satisfaction and community SCOREs .... 72
**7 SCORE relationship with observed client outcomes .... 76**
**8 Evaluation findings relating to Aboriginal children and families .... 80**
8.1 Background on the TEI program with Aboriginal children and families .... 80
8.2 Service delivery for Aboriginal children and families .... 82
8.3 TEI Outcomes for Aboriginal children and families .... 85
8.4 Costs and benefits of the program relating to Aboriginal children and families .... 99
**9 Economic Evaluation .... 102**
9.1 Benefits of the TEI program .... 102
9.2 Costs of the TEI program .... 104
9.3 Economic impact of the TEI program .... 108
9.4 Interpreting costs and benefits .... 109
**10 Opportunities and recommendations for the TEI program .... 110**
10.1 Potential opportunities to improve the TEI program .... 110
**Appendix A Case studies .... 115**

A.1 Gudjagang Ngara li-dhi (GNL) TEI Case Study ........ 116
A.2 Muloobinba Case Study ........ 123
A.3 Intereach Case Study ........ 129
A.4 Creating Links TEI Case Study ........ 137
A.5 Uniting South West Sydney ........ 143

**Appendix B TEI Service Types ........ 151**

**Appendix C Types of referrals to other services recorded in DEX ........ 158**

**Appendix D Full data analysis relating to SCORE collection ........ 159**

D.1 How SCOREs are collected ........ 159
D.2 Rate for SCORE collection ........ 161
D.3 Distribution of SCORE questions across services ........ 164
D.4 Community SCORE collection ........ 166

**Appendix E Full data analysis relating to service delivery ........ 168**

E.1 Program clients ........ 168
E.2 Sessions delivered ........ 172
E.3 Sessions per client ........ 173
E.4 Service delivery and funding ........ 174

**Appendix F Full data analysis relating to potential unmet demand ........ 178**

F.1 High-level regional level indicators of demand ........ 178
F.2 Entry rates into TEI using HSDS ........ 180
F.3 Coverage of outlets delivering TEI services ........ 183
F.4 Distance travelled by individual clients to receive services ........ 185
F.5 Local coverage of Community Strengthening supports ........ 188

**Appendix G Assessment of program reach to priority groups ........ 190**

G.1 Risk factors of individual clients in the program ........ 190
G.2 Client complexity ........ 197
G.3 Program reach to priority groups ........ 198

**Appendix H Outcomes results (full analysis) ........ 199**

H.1 Individual-level safety outcome modelling ........ 199
H.2 Propensity matched comparison for broader outcomes ........ 237
H.3 Aggregate analysis of child protection safety outcomes ........ 261
H.4 SCORE relationship with client outcomes ........ 269
H.5 Client satisfaction ........ 276

**Appendix I Service delivery for Aboriginal Children and Families (additional analysis) ........ 281**

I.1 TEI program reach to Aboriginal Children and Families ........ 281
I.2 Past government service interactions for Aborginal Children and Families in TEI ........ 282
I.3 TEI outcomes for Aboriginal children and families ........ 286

**Appendix J Economic/Cost benefit results (full analysis) ........ 290**

J.1 Methodology ........ 290
J.2 Full assumptions ........ 292

**Appendix K Detailed data for graphs used throughout this document ........ 295**

K.1 Section 5 ........ 295
K.2 Section 6 ........ 297
K.3 Section 8 ........ 301
K.4 Section 9 ........ 306
K.5 Appendix B ........ 309
K.6 Appendix D ........ 310
K.7 Appendix E ........ 312
K.8 Appendix F ........ 317

K.9 Appendix H ..... 320
K.10 Appendix I ..... 365

# Glossary of Terms

| Term | Definition |
|---|---|
| ACCO | Aboriginal and/or Torres Strait Islander Community-Controlled Organisation[(a)], as defined in the National Agreement on Closing the Gap. Some organisations funded to deliver services under the TEI Program are ACCOs. |
| CALD | Culturally and Linguistically Diverse. In DEX reporting this is defined based on questions on country of birth and the main language spoken at home. We recognise that the Diversity Council of Australia has recommended a switch to Culturally and racially marginalised (CARM), but we have retained CALD for this report since it best aligns with our data. |
| Case | A method in the Data Exchange system to capture one or more instances of service (sessions) received by a client or group of clients that is expected to lead to a distinct outcome. A case may contain between one and an unlimited number of sessions. A case record helps understand what funded activity is being delivered, the location it is being delivered from, the reason clients came to the service and the number of clients receiving a service. |
| Community Centres | One of the five program activities. It is designed to provide a community centre for people to meet, interact and volunteer, and also provide a soft entry point with supported referrals for people who need more targeted or intensive support. For a list of service types included in the program activity, see Appendix B. |
| Community Connections | One of the five program activities. It is designed to build social capital and local networks to promote tolerance and understanding, in turn, creating stronger communities. For a list of service types included in the program activity, see Appendix B. |
| Community Strengthening | One of the two program streams. It aims to connect more vulnerable members of a community with their broader community, while strengthening the community as a whole. The program stream is comprised of program activities Community Connections, Community Centres, and Community Support |
| Community Support | One of the five program activities. This activity is designed to increase the knowledge, skills, experience, confidence and wellbeing of community members to support their goals. For a list of service types included in the program activity, see Appendix B. |
| Concern report[(b)] | A child and young person concern report, which relates to the initial contact made at the Child Protection Helpline from mandatory or non-mandatory reporters who have reasonable grounds to suspect a child or young person is at risk of significant harm (ROSH) and has current concerns about the safety, welfare or wellbeing of the child/young person. |
| DEX | The Data Exchange platform. All TEI service providers are required to collect and report data through the Data Exchange in accordance with the Data Exchange Protocols[(c)]. |
| Group client | Also referred to as 'unidentified group client' or 'unidentified client' throughout this report. All clients other than individual clients who do not have any identifying information collected in DEX. Only the total number of clients who participated in the service or activity is recorded in DEX. |
| HSDS | The Human Services Dataset. This key data source for the evaluation was used to measure risk factors and outcomes information. It was created by combining data collected through the administration of NSW Government services and some Commonwealth Government supports. The version of the HSDS used for this report contains records up to 30 June 2022, for NSW residents born since 1 January 1990 and their family members (e.g. parents and siblings). |
| Individual client | Also referred to as 'identified client' throughout this report. A client who has a unique client record created for them in DEX, with their details and demographic information collected. |
| Intensive or Specialist Support | Also referred to as 'Intensive Support' throughout this report. One of the five program activities. Providing intensive and specialist support is designed to ensure the needs of people with high and/or complex needs are met, and their outcomes improved. For a list of service types included in the program activity, see Appendix B. |
| Organisation | An organisation funded to deliver services under the TEI Program. |
| Out of home care (OOHC)[(d)] | The Out of Home Care (OOHC) Program is provided to children and young people who are unable to live with their own families. Foster carers take on the responsibilities of a parent for a |

| Term | Definition |
|---|---|
| | period of time, to provide a safe, nurturing and secure family environment for children and young people needing care. |
| Outlet | An outlet is a location where a service took place or where staff travelled from to deliver a service, (TEI Data Collection and Reporting Guide, May 2023). An organisation may have multiple outlets. |
| pp | Percentage point |
| Program activity | Sessions are classified under five program activities. Activities comprise thematic groups of services. The activities are Develop Community Connections ('Community Connections'), Provide a Community Centre ('Community Centres'), Provide Community Support ('Community Support'), Provide Targeted Support ('Targeted Support') and Provide Intensive or Specialist Support ('Intensive Support'). For a list of service types under each program activity, see Appendix B. |
| P-value | A p-value is a statistical measure that helps determine the significance of your results in hypothesis testing (e.g. whether the treatment cohort has different outcomes to the control group). It represents the probability of obtaining test results at least as extreme as the observed results, assuming that the null hypothesis is true.<br>In simpler terms, a p-value helps you understand whether your data provides enough evidence to reject the null hypothesis. A low p-value (typically ≤0.05) indicates strong evidence against the null hypothesis, suggesting that the observed effect is statistically significant. Conversely, a high p-value (> 0.05) suggests that the observed effect is not statistically significant, and is more likely to have arisen by chance. |
| ROSH report[b] | A concern report that meets the statutory threshold of risk of significant harm (ROSH). In assessing a child/young person concern report to determine if it meets the statutory threshold of significant harm, caseworkers in Child Protection Helpline apply the Structured Decision Making (SDM) Screening and Response Priority (SCRPT) tools to reports to determine the level of response category. A child or young person is at ROSH if the circumstances that are causing concern for their safety, welfare or wellbeing 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. |
| SCORE | Standard Client/Community Outcomes Reporting (SCORE) reporting tool (see Section 2.3 for more details). |
| SEIFA | Socio-Economic Indexes for Areas, a scoring method developed by the Australian Bureau of Statistics (ABS) to indicate the socioeconomic level of a region. |
| Service type | The primary focus of a session. Activities comprise relevant groups of services. For instance, the Community Centres activity includes the service types community engagement, Education and Skills Training, Information/Advice/Referral, and social participation. See Appendix B for further detail and the complete list of service types. |
| Session | An individual instance or episode of service in the Data Exchange system, such as a home visit or a counselling session. |
| Stream | There are two streams comprising groups of activities. The Community Strengthening stream includes activities that facilitate greater community cohesion, inclusion and wellbeing, and empowerment of Aboriginal communities. The Wellbeing and Safety stream includes activities that strengthen protective factors and respond to known risk factors, ensuring parents and caregivers are able to meet their personal wellbeing and safety outcomes, and are able to provide their children and young people with a safe and nurturing home. |
| Substantiated ROSH report[e] | A determination made after DCJ's legally mandated field assessment (the Safety and Risk Assessment, or SARA, part of the NSW Structured Decision Making suite of tools, or SDM) of whether a child is at risk of 'actual harm' following a ROSH report, to classify the report as either 'substantiated' or 'not substantiated'. A substantiation indicates there is sufficient reason to believe the child has been, is being, or is likely to be abused, neglected or otherwise harmed. |
| Targeted Support | One of the five program activities. This activity is designed to ensure that the needs of people with known vulnerabilities are met and their outcomes improved. For a list of service types included in the program activity, see Appendix B. |

| Term | Definition |
|---|---|
| Wellbeing and Safety | One of the two program streams. This stream aims to ensure young people, parents and caregivers are able to meet their personal wellbeing and safety outcomes, and that parents are able to provide their children and young people with a safe and nurturing home. The stream is comprised of the program activities Targeted Support and Intensive or Specialist Support. |

Sources and further information

(a) https://www.facs.nsw.gov.au/providers/working-with-us/working-with-you/aboriginal-community-controlled-organisations

(b) https://www.facs.nsw.gov.au/resources/statistics/services/metadata/chapters/responding-to-concerns

(c) https://dex.dss.gov.au/wp-content/uploads/2017/03/data_exchange_protocols.pdf

(d) https://www.facs.nsw.gov.au/families/out-of-home-care/about-out-of-home-care/care-types

(e) https://dcj.nsw.gov.au/service-providers/deliver-services-to-children-and-families/nsw-interagency-guidelines-for-practitioners/assessing-wellbeing-safety-and-risk/assessment-of-safety-and-risk.html

# 1 Executive Summary

## 1.1 About the evaluation

### About this report

This final evaluation report for the Targeted Earlier Intervention (TEI) program builds upon our Interim Report, which provided an update on the progress of the evaluation of the NSW Department of Communities and Justice (DCJ) TEI program and outlined initial findings. The Interim Report focused primarily on the process evaluation questions, while this report places greater emphasis on the outcomes and economic evaluation components.

### About the Targeted Earlier Intervention program

The TEI program is one of DCJ's key initiatives to strengthen families and communities across NSW. It prioritises children, young people and families who are experiencing or at risk of vulnerabilities and aims to prevent the escalation of risks associated with child abuse and neglect and ensures that issues are addressed early on. It does this by increasing access to services at the point where they can have the most impact – early in life and early in need. In doing so, it aims to also reduce the number of children coming into contact with the child protection system.

The TEI program, which is delivered by close to 500 service providers, includes a diverse range of services. These vary in duration and intensity, from community engagement in the Community Strengthening stream, to case management and specialist support within the Wellbeing and Safety stream.

### Data sources used for the evaluation

For this Final Report, the evaluation has drawn on an in-depth online survey of TEI providers, case study interviews with five TEI providers, including 20 staff members and 47 clients, and a review of data captured on the Data Exchange (DEX) between 1 July 2020 to 30 June 2023, including client numbers, service sessions and service providers. For the identified individual clients[1] (primarily recorded from Wellbeing and Safety Stream sessions), their demographics and client outcomes recorded using the Standard Client/Community Outcomes Reporting (SCORE) tool[2] are also examined.

In addition, the evaluation includes an analysis of individual TEI clients using the Human Services Dataset (HSDS). The HSDS contains data on government service interactions and supplements what can be observed from the DEX data to provide a better understanding of the impact of TEI on the outcomes for the individual TEI clients. This is then examined in conjunction with TEI funding information to form the economic evaluation of the TEI program.

Importantly, the linked data allows us to test how the TEI program impacts on safety outcomes over the subsequent two years for the individual clients.

### Limitations of the evaluation

We recognise a range of limitations to the evaluation and results should be interpreted with these limitations in mind. Some key limitations:

---

[1] A client who has a unique client record created for them in DEX, with their details and demographic information collected. See Section 2.3 for details.

[2] See Section 2.3 for more details on SCORE collection

- The breadth and diversity of TEI services mean our case studies and provider survey may not prove representative. Relatedly, while we assess overall program outcomes using the HSDS and program data these are likely to vary by activity, service and provider in ways that are difficult to estimate.
- DEX reporting was implemented in 2020-21, with mandatory reporting taking effect from 1 January 2021 and reporting in the first year impacted by COVID and natural disasters. There are some coverage and quality issues, particularly early in the program.
- Our ability to assess outcomes is strongest for individually identified clients (who can be linked anonymously to the HSDS) – this skews towards the Wellbeing and Safety stream services where 59% of clients are individually identified, with less evidence found for the Community Strengthening stream where only 8% of clients are identified[3].
- While the HSDS is a rich data source covering a broad range of key government services, there remain many elements of wellbeing and vulnerabilities that are not included in the data asset. This affects risk adjustment (TEI clients tend to have higher vulnerabilities than those from the general population with similar historical service use that we can observe from the data) and outcome measurement (some benefits from TEI supports will not be readily visible in HSDS collections). We have highlighted where these limitations are relevant to our results and analysis throughout this report.
- The economic evaluation only includes benefits associated with reduction in child protection outcomes. Benefits from other areas where TEI may have an impact have not been quantified.

## 1.2 Findings from the evaluation

### Process evaluation findings

The Interim Report provides a detailed analysis of TEI delivery, drawing on feedback from NSW Government stakeholders, sector representative bodies and TEI providers. In this Final Report, we provide an update on the process evaluation findings, which include:

- **Additional progress has been made towards implementing TEI reforms, including need-based commissioning.** In recent months, DCJ has made progress toward some of the remaining TEI reform areas, including an updated approach to commissioning for TEI services.
- **Additional qualitative analysis reinforces the need for a review of funding allocations.** The Interim Report contained feedback from providers noting challenges presented by funding allocations. Some felt that additional funding was needed to achieve outcomes for participants. This was reinforced through the case studies conducted in the second part of the evaluation. This analysis indicates that a review of funding allocations could identify where client outcomes would stand to be improved the most.
- **Further quantitative research highlights areas of relatively lower reach and funding.** There is significant variation in the share of funding in a region going to Wellbeing and Safety stream without an obvious relationship to risk factors or needs. There is a likely future need in Western Sydney, South Western Sydney and Illawarra Shoalhaven districts where some LGAs are forecast to see strong general population growth. Providers interviewed in the case studies noted that this forecast population growth may be a key driver of future TEI demand.
- **While funding targets for investment in ACCO-led service delivery have not been met, DCJ has renewed its commitment to this investment.** As part of the recommissioning process, DCJ has renewed its commitment to investment in early intervention programs delivered by Aboriginal Community Controlled Organisations (ACCOs) and to embed Aboriginal led commissioning principles

[3] Using data from DEX. Numbers might be slightly understated due to double counting of unidentified group clients.

in the TEI program. This includes an investment target of 30% of funding in NSW for early intervention services and programs directed towards ACCOs.

## Outcomes achieved

**The evaluation found evidence for improvements in child protection outcomes following TEI support**

Our analysis concludes that TEI has had a positive impact on safety outcomes for individual clients. Key findings include:

- **Participation in TEI was measured to reduce the likelihood of concern reports, ROSH, and of remaining in OOHC.** The model estimates that at the sixth quarter (i.e. 16-18 months)[4] after entering TEI, the rate of having a concern report is reduced by 6.6% in relative terms. This means that for every 100 TEI children who would have ended up with a concern report in the quarter there were 7 children who avoided having a concern report due to participation in the program. While the measured reduction in ROSH was not statistically significant, we believe that it is more likely that this is due to not having a sufficiently large sample size for analysis rather than TEI genuinely having no impact on reducing ROSH reports. This is because the measured reduction in ROSH is similar in magnitude to the reduction in concern report (which is statistically significant), and fewer concern reports should logically result in fewer cases being screened in at ROSH. Additionally, the likelihood of remaining in OOHC is reduced by 4.8% in relative terms at the sixth quarter.
- **TEI was measured to have a more substantial absolute impact on the likelihood of concern reports and ROSH for children already known to child protection compared to children with no prior contact to the system, but its relative effectiveness is comparable across the two groups.**
- **Participation in TEI led to increased referrals to key service areas, such as housing, which shows that TEI services are connecting clients to services they need.** In particular, Specialist Homelessness Service and mental health service presentations increase after TEI entry, which suggests that providers are making referrals in response to client needs.

While TEI aims to influence a broad range of outcome domains (linked to the Human Services Outcomes Framework) the evaluation was not able to quantify the impact of TEI on additional outcomes such as education and employment due to changes in data or lack of data. Provider feedback suggested that TEI influences a wide range of outcomes, particularly related to sense of belonging in the community, participation in community events, empowerment and self-determination and health of children and young people.

## Factors that influence outcomes

Our data analysis showed that the characteristics of the TEI clients, and the type and quantity of services they engage with, can make a difference to outcomes. As discussed, the program was measured to have a stronger absolute impact on the likelihood of concern report and ROSH for children already known to the child protection system prior to entering TEI, compared to child clients with no prior contact with the system. From the same analysis, Counselling services and Specialist Support services were estimated to provide larger improvements for clients. There also appears to be a dose effect, with greater reductions in child protection interactions observed for clients with a larger number of sessions.

Providers believe that delivering flexible and adaptable services, which are based on strong relationships and connections with clients and community, is key to achieving outcomes. Providers also note that

---

[4] We have chosen to focus on presenting the estimated impact of TEI at six quarters (i.e. 16-18 months) after program entry since we do not have many observations beyond six quarters (TEI was introduced in the September 2020 quarter and our data ends at the June 2022 quarter, see data sources section below for details)

external social factors have a significant impact on client outcomes and these are outside of their control (for example, the impacts of the Covid-19 pandemic, multiple natural disasters and rising cost of living). Providers emphasised that flexibility in the TEI program and adequate funding were crucial to their ability to achieve outcomes with clients.

### Results from DEX Satisfaction and Community SCORE data

Satisfaction SCOREs assessments collected by providers in DEX show that individual TEI clients are generally satisfied with the TEI services that they have received, and believe the program has listened to their needs and helped them to better deal with the issues that they sought help with[5]. This is a positive outcome for the program and reinforces the positive feedback collected from provider and client interviews.

Similarly, results from Community SCOREs are closely tied to themes of community and empowerment that aligned strongly with evidence collected from providers and clients. This provides valuable insight regarding community outcomes that is not easily captured in the government administrative datasets.

### Using DEX SCORE data as an indicator for client outcomes

**Circumstances and Goals SCOREs are useful indicators of client outcomes, both when looking at values at a point in time as well as change over time.**

In this evaluation, we have not used the Circumstances and Goals SCORE results to measure program impact on client outcomes as client outcomes can be directly observed from the HSDS data and tied to quantifiable program benefits. However, our analysis of the Circumstances and Goals SCOREs[6] has shown that these are still useful indicators of client outcomes, which makes them helpful monitoring tools and can help to inform service provision for the TEI provider. Clients with higher SCOREs recorded at a point in time have lower observed likelihood of experiencing adverse outcomes[7] in the quarter following the SCORE assessment, while improved SCOREs for an individual over time is also indicative of improved outcomes, especially when the nature of the SCORE domain is closely linked with the underlying outcome (e.g. the Personal and family safety SCORE domain is highly predictive of the safety outcomes).

### Findings related to Aboriginal children and families

Our evaluation included a targeted focus on results for Aboriginal participants, with key findings including:

- **The proportion of Aboriginal clients who have received services from ACCO providers has increased over time since 2020-21.** This is the case across the majority of districts. However, the proportion of funding provided to ACCO providers in 2022-23 was 7.7% which is below DCJ's target of 30% in Aboriginal-led early intervention programs first articulated in DCJ's Aboriginal Outcomes Strategy 2017-2021. As noted earlier, DCJ has committed to investing in ACCO led service delivery options for Aboriginal participants.
- **Aboriginal children and families who participated in TEI were measured to have experienced a larger absolute reduction in concern report and ROSH than non-Aboriginal children, although**

[5] In 2022-23, Satisfaction SCOREs were collected from ~30% of individual clients (compared to a target of 10%). There may be biases in how the SCOREs are collected and who they are collect from which impacts the result.

[6] SCOREs from each Circumstance SCORE domain (e.g. Personal and family safety, mental health) and Goal SCORE domain (e.g. Increasing Skills, Changing behaviours) were analysed and compared.

[7] Concern report and ROSH outcomes were examined for clients under 18 years old; Victim of domestic violence and at risk of homelessness were examined for adult clients.

**noting that Aboriginal children have higher rates of interaction with the child protection system even before accessing TEI.** The estimated relative reduction in concern reports due to TEI was similar between Aboriginal and non-Aboriginal children.

- **As is the case for non-Aboriginal clients, participation in TEI did not appear to reduce the rate of children entering OOHC.**

TEI also appears to be increasing relevant referrals for Aboriginal clients as observed from the linked HSDS data.

Provider feedback and case studies provided meaningful insights about how and why outcomes occur for Aboriginal clients. ACCO providers we spoke to as part of the case study process emphasised the importance of ACCO led services, which could apply culturally-specific understanding to their programs and activities. Aboriginal clients we spoke to also directly commented on the importance of, and high satisfaction with, Aboriginal service delivery. To this extent ACCO providers we spoke to emphasised that current TEI data capture does not include the attainment of cultural outcomes, which from their perspective are critical pre-requisites for Aboriginal clients and community in achieving TEI outcomes such as safety and empowerment.

Satisfaction SCORE assessments collected by ACCO providers also reported high satisfaction from individual Aboriginal clients for the services received. However, we cannot draw firm conclusions from the provider feedback regarding the impact of ACCO service delivery on client outcomes given the small sample sizes and the inability to identify ACCO providers in the corresponding HSDS data.

### Economic benefits

We have attached economic benefits to improvements in outcomes. Improvements in Safety outcomes (reduction in concern and ROSH reports, and exits from OOHC) translate to $92 million in annual benefits at a minimum. Where possible, we have identified the economic benefit of safety outcomes generated by TEI.

- **Over 2022-23, the estimated total value of these quantifiable benefits is $92 million**, with $79 million being avoided costs to government and $13 million being benefits accruing to the individual. This compares to a total cost of $181 million.
- **This translates to 51 cents of quantifiable safety benefit for each dollar cost of the TEI program in 2022-2023.** Other potential benefits remain unquantified – the benefits calculation only includes safety benefits for individuals identified in the HSDS data as these were the only improvements found by the outcome evaluation with strong evidence that the improvements can be attributed to TEI. There is an unknown quantum of additional economic benefits from:
  - other outcomes that are not necessarily well reflected in administrative data (such as domestic and family violence victimisation).
  - participants who are only identified as group clients (and thus not individually represented in the data). This means that there are potentially unknown benefits for approximately 40% of the funding that goes to community strengthening. Considering only funding to individual sessions, 66 cents of safety benefit was found for each dollar spent.
  - navigation and service access, which have consistently been a key benefit cited but cannot be reliably quantified via administrative data. A simple analysis of service usage would capture only the increased cost of service provision, but not the benefits of meeting previously unserved needs of clients.

We believe the economic evaluation is supportive of the TEI program impacts, even with a cost benefit ratio less than one:

- We have found relatively few comparable public cost-benefit analyses to benchmark against. Many government projects would likely struggle to prove positive benefits if focusing on future avoided cost to government.
- Concrete downstream improvement in outcomes are often difficult to establish for early intervention services, so the fact that safety benefits were quantifiable is significant.

Beyond this, we have adopted a conservative methodology, only recognising benefits where robust evidence exists through statistical analysis. This necessitates that the outcome be well-reflected in administrative service datasets, that there is sufficient signal (i.e. a large enough sample size and low enough natural volatility in the outcome) and that there is a relatively simple translation of service usage to outcomes (some services are more nuanced and increased/decreased usage can often both relate to 'positive' outcomes).

Given the low volume of individual clients especially for the Community Strengthening Stream, statistical analysis of benefit brought by each program activity was not conclusive and hence we have not compared cost benefit ratios by activity type.

## 1.3 Opportunities and recommendations

Drawing on the evidence and feedback collected during the evaluation, we provide the following recommendations for DCJ in administering TEI:

1. **Increase funding and capacity of ACCOs to deliver TEI services.** To support the achievement of its stated investment targets, DCJ will also need to invest in building the capacity of new and emerging ACCOs to be able to deliver TEI successfully.
2. **Focus on increasing TEI access in high population-growth and remote areas.** This will include supporting new and emerging providers in new suburban growth areas. The evaluation found a lack of outlets delivering Counselling services and Specialist Support services in the more remote districts even though these services were measured to be relatively effective in reducing the likelihood of child protection outcomes.
3. **Greater opportunity for interim contract and funding reviews during a contract period.** While increased contract durations should be continued, there should be more frequent opportunities for contract and funding reviews in response to changing circumstances.
4. **Increased flexibility in service provision and provider awareness.** Simplification of the overall TEI program design, to have fewer distinct service types and greater allowance for providers to deliver a wider range of activities within a district, and adapt the target cohorts based on local need.
5. **Support for community engagement and partnership development.** DCJ should look to provide sufficient facilitation or funding for providers to participate local forums and to undertake outreach to build partnerships in their local communities which enables effective referrals.
6. **Update outcomes measurement approaches.** In particular, to reflect cultural outcomes and consider principles of Indigenous Data Sovereignty. Better recording of individual clients will facilitate better outcomes measurement and allows for a better understanding of program reach.
7. **Define the focus of future evaluations.** While this evaluation has played an important role in confirming the impact created by TEI overall, it would be useful for future evaluations to focus on understanding what service provision factors led to these kinds of outcomes. For example, investigating as part of the quantitative analysis whether program effectiveness varies between ACCO and non-ACCO providers, to support the qualitative results in this evaluation. Similarly, another area of potential enquiry is the investigation of how specific program activities and service types impact on the outcomes sought by TEI, and whether certain activities or service types lead to greater outcomes, or a broader range of outcomes.

# 2 Overview of the Targeted Earlier Intervention Program

## 2.1 Background to the TEI program

The Targeted Earlier Intervention (TEI) Program commenced in July 2020. It is one of the key early intervention initiatives for the NSW Department of Communities and Justice (DCJ), which aims to strengthen families and communities and reduce the number of children coming into contact with the child protection system. The target population for TEI is children, young people, families, and communities within NSW who are experiencing or at risk of vulnerability. This population may experience challenges and/or barriers to identifying and accessing the services they need to live independent and self-determining lives.

The TEI program is designed to provide targeted services at the point where they can have the most impact – early in life and early in need - ensuring the best investment for communities and government. By delivering support to children, young people, families and communities experiencing, or at risk of, vulnerability, the TEI program seeks to prevent risks associated with child abuse and neglect from escalating and ensure issues are addressed early. This includes a focus on supporting the following priority groups, which are recognised as particularly important in the early intervention space:

- Aboriginal children, young people, families and communities
- 0–5 year olds
- Children and young people at risk of disengagement from school, family and community
- Young parents with known vulnerabilities or who are experiencing hardships.

Investment in the TEI program has increased each year from $161 million in the first year in 2020-21 to $172 million in 2022-23. In 2021-22 financial year, it was delivered by 472 service providers, in 1,440 outlet[8] locations. For 2022-23, the TEI program was delivered by 468 service providers in 1,518 outlet locations. In 2022-23, a total of 161,602 unique individual clients[9] and 1,133,760 group clients[10] received services from the TEI program – both these figures are over 15% higher than 2021-22.

[8] An outlet is a location where a service took place or where staff travelled from to deliver a service, (TEI Data Collection and Reporting Guide, May 2023). The figures represent the number of service providers and outlets with session records in DEX – the actual number of service providers and outlets would likely be higher as there are outlets that have not submitted data in DEX.

[9] This client figure is lower than the 170,229 reported in the 2022-23 TEI dashboard due to slightly different counting rules. The evaluation counted records with the same Statistical Linkage Key (SLK) as the same client, while the TEI dashboard treats each record with different client ID as different clients.

[10] Number of unidentified group clients for 2021-22 is likely to be inflated due to known reporting issues. Steps have been taken to ensure the issues are resolved for subsequent periods, however the data was not able to be remediated for the period already submitted and some of the issues may have persisted in the data for 2022-23. See Appendix E.1 for details.

Figure 2.1 – TEI two Program Streams and five Program Activities

Source: TEI Annual Report 2020-21

The TEI program has been centred around two streams of support (see Figure 2.1 above):

- **Community Strengthening**: which aims to connect members of a community experiencing, or at risk of experiencing, vulnerability with their broader community, as well as aiming to strengthen the community as a whole. This includes activities that facilitate greater community cohesion, inclusion and wellbeing, and empowerment of Aboriginal communities. Services include neighbourhood and community centres.
- **Wellbeing and Safety:** which aims to support children, young people and families with targeted or intensive support where they are experiencing identified vulnerabilities. This includes activities that strengthen protective factors and respond to known risk factors, ensuring parents and caregivers are able to meet their personal wellbeing and safety outcomes, and are able to provide their children and young people with a safe and nurturing home, such as, parenting programs, supported playgroups, counselling, peer support and mentoring.

Within each stream, there are a diverse range of program activities and service types that are implemented according to local community need. A full listing of services is provided in Appendix B but some common ones for each activity are:

- **Community Connections** – Information/Advice/Referral, Social Participation, Community Engagement.
- **Community Centres** – Information/Advice/Referral, Social Participation (with a greater emphasis on group meetings)
- **Community Support** – Advocacy and Support, Education and Skills training, Information/Advice/Referral, Social Participation
- **Targeted Support** – Family Capacity Building, Counselling, Information/Advice/Referral, Parenting Programs, Supported Playgroups
- **Intensive and Specialist Support** – Family Capacity Building, Counselling, Information/Advice/Referral, Specialist Support.

Appendix B. People may access services across both program streams at the same time. Vulnerabilities may increase or decrease over time for people and therefore their access to program activity options will change depending on their level of need for more or less intensive support. The TEI Program structure provides the flexibility for providers to deliver services across any or all of the program activity options. Service providers are contracted to deliver particular program activity options (either in combination or

individually). These options will be negotiated locally through District commissioning processes that determine local priorities for TEI service provision.

The TEI program supports the following practice principles across TEI service delivery:

- Person centred with the child, young person and/or family at the centre and leading decision making
- Strengths based using a strengths based approach to service design and implementation, which support people to build their capacity for change
- Evidence-informed across the life course, using natural development phases and transition points as 'triggers' for service delivery
- Holistic and collaborative working in partnership with other relevant services and/or organisations to achieve better outcomes
- Capability building to build social capital within communities
- Trauma informed to recognise the impact of trauma on those accessing services, and develop and implement trauma informed policies and practices
- Flexible and responsive in working with families, recognising that families' needs are not static, and that families may be transitioning in and out of hardship and disadvantage over time.

TEI services do not operate in isolation, but sit within a complex and diverse human service system. The willingness of services to collaborate, co-design and co-ordinate with other services, both government and non-government, universal and targeted, is vital for the TEI Program to achieve outcomes for its target group. For all service types in the TEI program see Appendix B.

The TEI program is currently beginning the recommissioning process, with new contracts expected from July 2025. Some driving principles for commissioning are[11]:

- Embedding Indigenous Data Sovereignty and self-determination into program design
- Ensuring the system delivers flexible and holistic services
- Continuing to use evidence to inform practice
- Continuous improvement in workforce, data and evidence.

The 2025 program will incorporate some streamlining, including the integration with Family Connect and Support (FCS), and consolidation of some of the existing TEI activities.

## 2.2 TEI evidence base

The current TEI program was designed in response to the TEI reform process which commenced in 2015. That reform was based on extensive consultation as well as reviews of available evidence, which led to five key reform aims:

1. Improve outcomes for clients of TEI services.
2. Create a service system continuum grounded in evidence-informed practice.
3. Target resources to those with the greatest needs.
4. Facilitate district decision making on the design and delivery of local services.
5. Increase flexibility so that clients are the centre of the system.

[11] https://dcj.nsw.gov.au/service-providers/deliver-services-to-children-and-families/targeted-earlier-intervention-program/tei-recommissioning-2025.html

To achieve the reform aims, DCJ committed to commission local service providers to deliver services, focussing on key priority groups. In addition, DCJ committed to monitor and review client outcomes, including through regular program evaluations.

### 2.2.1 TEI consultation process

As part of the TEI reform process, over 500 written submissions were received, DCJ held 26 district consultation forums with over 1,100 participants, and 11 Aboriginal stakeholder forums were conducted. In addition, over 1,800 clients of TEI services provided feedback via an online survey, with 85 clients participating in focus groups and/or one-on-one interviews.

A consultation report was released in 2016, which summarised eight themes from the consultation. These included:

- Greater service flexibility;
- Improved accessibility for 'at risk' groups;
- Services designed to reflect Aboriginal needs and priorities;
- Strengthened partnership and networks;
- Increased overall funding and reach;
- Improved information systems and sharing;
- Increased capability building; and
- Changes to funding arrangements.[12]

### 2.2.2 Evidence base informing TEI program design

In addition to consultations, the TEI reform was informed by research into effective approaches to early intervention.[13] In 2015, the Australian Research Alliance for Children and Youth, in partnership with the NSW Government, released the report *Better systems, better chances – A review of research and practice for prevention and early intervention.*

The report provided a strong evidence base for the TEI program and reforms. For example, it shows that protective and risk factors at the individual, family and community levels are highly predictive of life outcomes, and effective prevention and early intervention can dramatically change life trajectories.[14]

The TEI program has a strong focus on evidence-based programming. Since the program implementation of TEI in 2020, DCJ has commissioned a range of evidence reviews to inform program design as well as aspects of service delivery. DCJ also built and maintains an evidence portal on its website, which provides access to a broad range of research and evidence from Australia and overseas, which can be used by providers to design evidence-informed services.[15]

---

[12] NSW Family and Community Services (2016). "Targeted Earlier Intervention Program Reform Consultation Summary Report: What you told us", https://www.facs.nsw.gov.au/__data/assets/file/0008/371996/Executive-Summary.pdf

[13] NSW Family and Community Services (2016). "Targeted Earlier Intervention Program Reform: Reform directions – local and client centred, https://www.facs.nsw.gov.au/__data/assets/file/0007/379366/TEI-Program-Reform-Directions-local-and-client-centred.pdf

[14] Fox, S., Southwell, A., Stafford, N., Goodhue, R., Jackson, D. and Smith, C. (2015). *Better Systems, Better Chances: A Review of Research and Practice for Prevention and Early Intervention.* Canberra: Australian Research Alliance for Children and Youth (ARACY). http://www.community.nsw.gov.au/__data/assets/pdf_file/0008/335168/better_systems_better_chances_review.pdf

[15] Department of Communities and Justice, Evidence Portal, https://evidenceportal.dcj.nsw.gov.au/

The design of the TEI program focuses on protective factors related to community wellbeing and child, youth and family wellbeing. Community wellbeing relies on conditions that enable individuals to flourish and fulfil their potential such as connectedness (social connections, social groups and community organisations). TEI's Community Strengthening stream focuses on strengthening connectedness, particularly for vulnerable groups within the community, and contributing to improvements in other community conditions where possible.

Child, youth and family wellbeing can be affected by a combination of risk and protective factors, which can collectively either build resilience or escalate vulnerabilities. TEI aims to support child, youth and family wellbeing through targeted supports at the points where the evidence suggests they will have most impact – early in life and early in need. TEI prioritises supports for specific target groups as described below.

### 2.2.3 Evidence supporting TEI priority groups

The TEI program prioritises supports to four key groups of clients, based on evidence of need and evidence of the points in a person's life where intervention can be most effective.[16]

The TEI program prioritises **children aged 0-5 years old,** as well as **young parents with known vulnerabilities or who are experiencing a number of hardships**. This is in response to evidence that intervention can be most effective in early childhood, while the brain is rapidly developing. Negative experiences in early childhood can have a greater impact on outcomes later in life. Environmental stresses experienced early in life, such as poor nutrition, abuse, neglect and poverty, can lead to increased risks of mental and physical illness throughout the individual's life. Young parents can benefit from parenting, practical, advocacy and other support to help them build a nurturing and stimulating home environment for their child, and connect with the services they need to raise their child, secure independence and support themselves and their family.[17] .

The TEI program also prioritises **children and young people at risk of disengagement from school, family and community**. Family and community connections can be central to the development of positive self-identity. A child or young person's experiences and support during transition periods can have a significant impact on school engagement, school completion and later employment.

**Aboriginal children, young people, families and communities** are a TEI priority. The cumulative effect of historical and intergenerational trauma has led to widespread disadvantage among Aboriginal people in Australia. In NSW, Aboriginal children make up 45% of the out of home care population as at Jun 2023 despite being just 5% of the population.[18] DCJ has a strategic commitment to improve the outcomes of Aboriginal families and communities, and to ensure that all Aboriginal people in NSW have the opportunity to achieve their aspirations.

TEI key groups align with priorities highlighted by the Stronger Communities Investment Unit – 2018 Insights Report.

---

[16] See: Department of Communities and Justice TEI Program Specifications (2019) https://facs-web.squiz.cloud/__data/assets/pdf_file/0009/679896/TEI-Program-Specifications.pdf citing the above ARACY report.

[17] This aligns with NSW Health's First 2000 Days Framework, reflecting the lifelong impact of adverse experiences during this period, as well as the opportunities to build resilience, mitigate against vulnerability and influence positive life course outcomes during this period.

[18] The Department has a strategic commitment to improve the outcomes of Aboriginal families and communities, and to ensure that all Aboriginal people in NSW have the opportunity to achieve their aspirations. The impact of adverse experiences during this period, as well as the opportunities to build resilience, mitigate against vulnerability and influence positive life course outcomes during this period See Productivity Commission information repository: https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area12/out-of-home-care

### 2.2.4 Evidence around Aboriginal programming

It is recognised that there are continuing challenges faced by Aboriginal people in a system that does not fully empower and resource them to design and implement their own strategies. In 2022/23, Gamarada Universal Indigenous Resources (G.U.I.R) undertook a review of evidence around Aboriginal-led early support programming. This focus was on Aboriginal-led initiatives beyond the DCJ funded programs. The review was conducted in the context of recent criticism of the Government's approach to the oversight and implementation of the Aboriginal Outcomes Strategy (AOS) in reducing the overrepresentation of Aboriginal children and young people in out-of-home care (OOHC).

We believe the findings of the review are relevant to this report. G.U.I.R recommended community co-designed, community-led, culturally safe, strengths-based, culturally-affirming, trauma-informed, healing-based, holistic, coordinated, and flexible early support programs for Aboriginal children, youth, families and communities in order to maximise outcomes. G.U.I.R also recommended sustained government funding to health literacy programs, preventative and restorative community-led programs, Aboriginal health and support workers, culturally safe spaces and skill-building programs, as well as service components such as transport support to programs and food in waiting rooms, in order to strengthen gains in social and health indices for vulnerable community members.

The report also concluded that 'the evidence base for Aboriginal-led early support programs revealed the complexities of seeking 'standards of evidence' for Aboriginal programs that do not operate in isolation from contextual factors.'[19]

Moreover, the review suggested that the conceptual framing of 'standards of evidence' may also require deeper inquiry within Aboriginal communities to ascertain its meanings and applications. Within the context of TEI, this means the need for future research to fully understand the extent to which Western epistemological and statistical approaches are valid within Aboriginal communities.

## 2.3 TEI data collection and reporting by providers

As part of the TEI reform, the TEI program defined a core set of client outcomes in the TEI Program Outcomes Framework. TEI providers are required to collect data to demonstrate that they are working towards these TEI outcomes. To implement the TEI Outcomes Framework, new data collection processes were introduced, which rely on the Data Exchange (DEX), a web-based platform hosted by the Commonwealth Department of Social Services. All TEI services must report data through DEX. Service providers commenced collecting data in DEX 1 July 2020, and this has been mandatory since 1 January 2021.

Programs in the Wellbeing and Safety Stream are required to create individual client records for each client. For Community Strengthening services, individual client records are not required for each client (often it would not be practical or possible to collect this information). Instead, providers are expected to create unidentified group records which contain the numbers of participants at an event / session, but do not have identifiable information about individuals and/or create individual client records for a random sample of clients.

Providers are required to capture data about client satisfaction and short-term outcomes up to 12 months after completing a program activity. It is expected that providers ensure a satisfaction SCORE is recorded for at least 10% of individual clients in every reporting period, and an initial SCORE and at least one subsequent Circumstances/Goals SCORE recorded for at least 50% of individual clients.

[19] See: Zulumovski, K (2023) "Aboriginal-led early support programs for Aboriginal children, young people, families, and communities:_A Review of the Evidence Base"

They can do this via their choice of validated outcomes tools, but most use the ‘Standard Client/Community Outcomes Reporting’ (SCORE) reporting tool, for which DEX is configured. Providers may also conduct SCORE assessments in a variety of ways – clients conduct self-assessments, workers conduct the assessment, and/or have workers conduct the assessment together with the client.

For individual clients, SCOREs should be recorded at the beginning of service delivery (initial SCORE) and then at regular intervals during service delivery (subsequent SCORE) for ongoing services, or before the session begins (initial SCORE) and then at the end of the session (subsequent SCORE). Three types of SCOREs are recorded for individual clients (in all cases they are rated in a scale of 1 to 5 and higher rating represents better client outcomes):

- Circumstances SCORE – measures if clients’ circumstances are adequate and stable across a range of domains such as health, family safety, material wellbeing, employment, education and housing.
- Goals SCORE – measures clients’ progress towards achieving their goals across domains such as increasing access to information and knowledge, changing behaviours, ability to respond to crisis and having choice and control in making decisions.
- Satisfaction SCORE – measures clients’ satisfaction in the services they received and whether they think the support was client centred and helpful. Note that Satisfaction SCORE should only be recorded after service delivery unlike the other two types of SCOREs.

For sessions where it is not practical to record SCOREs for individual clients, a Community SCORE may be captured for groups of unidentified clients in DEX. Methods of collecting a Community SCORE vary. Where appropriate, clients may be surveyed at the start and end of a program (e.g. a multi-session activity) or there may be just one survey at the end of a program (e.g. a community-wide event). In these cases, results are collated and a single Community SCORE assigned. Providers can also use observations and professional judgement to assign a Community SCORE rather than conducting surveys.

# 3 Approach for this evaluation

## 3.1 Context for the evaluation and its purpose

The purpose of this evaluation is to understand the overall impact of the Targeted Earlier Intervention (TEI) Program, which commenced in July 2020. It includes a process, outcome, and economic evaluation, examining Program Activities, Service Types, target groups and service regions, using existing quantitative data and research as well as additional surveys and interviews. Results from the evaluation will inform future design of the program.

This evaluation focuses on the TEI program from mid-2020 (when current TEI program contracts were commissioned) through to June 2023 (the latest available reporting data), subject to any limitations in data availability for that time frame.

Both DCJ and the evaluation team are committed to achieving the highest standards of ethical research. The evaluation plan has been reviewed and approved by the Aboriginal Health and Medical Research Council (AH&MRC) (AH&MRC Reference: 2115/23).

## 3.2 Evaluation approach

### 3.2.1 Evaluation questions

We have worked with Department of Communities and Justice (DCJ) to refine a set of evaluation questions to guide the evaluation.[20] This Final Report focuses on the questions related to the outcomes and economic evaluation, which are described in the table below.

Table 3.1 – Outcomes evaluation questions

| **Outcomes Evaluation: Is the TEI program making a difference?** |
|---|
| ▪ Where/when did TEI achieve better outcomes for clients (especially fewer children entering the child protection system)?<br>▪ Where/when did TEI achieve poorer outcomes?<br>▪ What were the factors that contributed to better (or poorer) outcomes (if any)?<br>▪ What unanticipated outcomes (positive or negative) did the program produce (if any)?<br>▪ Which of the service types worked, for whom, where and why? Should there not be enough data available the question should look at program activities.<br>▪ Did the TEI program have any influence in supporting and hindering client and service system outcomes, and if so, what was the influence?<br>▪ Have there been improvements in outcomes for Aboriginal children and families, particularly any reduction in the rate of over-representation of Aboriginal children in out-of-home care? How do these improvements compare to non-Aboriginal children and families?<br>▪ What factors influenced any change in outcomes for Aboriginal children and families and what adaptation, if any, was required to better meet the needs of Aboriginal children and families |

[20] These evaluation questions were first designed by DCJ prior to project commencement.

Table 3.2 – Economic evaluation questions

| Economic Evaluation: To what extent did the TEI program represent value for money and deliver economic benefits to the community and government? |
|---|
| ▪ What are the quantifiable benefits of the overall TEI program and/or at a program stream level (for example, what that the longer-term out-of-home care savings associated with the TEI program)? And are there benefits that cannot be quantified?<br>▪ What are the costs of delivering the TEI program, and do the quantifiable benefits of the program outweigh its costs?<br>▪ For which program stream/program activities did benefits outweigh costs?<br>▪ What is the cost to provide culturally safe services to Aboriginal families?<br>▪ Is there a greater benefit for Aboriginal children and families' relative to cost compared with non-Aboriginal children and families? |

The other evaluation questions (detailed in the table below) relate to the process evaluation and were included in the interim evaluation report.

Table 3.3 – Process evaluation questions and sub-questions

| Process Evaluation: How well has the TEI program been implemented? | |
|---|---|
| **1a) Has the TEI program been implemented as planned?** | ▪ Did the TEI program commission the anticipated level and type of services/activities in the areas planned? If not, has there been improvement and is it expected to do so in the future?<br>▪ How well did the program reach the target populations and priority cohorts and in what locations?<br>▪ Has the TEI program been appropriate for Aboriginal families and communities? What adaptations have been/are still required to better meet their needs?<br>▪ What were the barriers and facilitators of implementation?<br>▪ Have there been any unexpected circumstances that affected program implementation (e.g. the COVID-19 Pandemic, natural disasters, etc)? |
| **1b) Have there been effective processes in place to ensure that the services were well designed and implemented by providers?** | ▪ To what extent has the program been able to ensure that services are client-centred, flexible, and responsive to client and community needs?<br>▪ To what extent has the program been able to ensure that services are culturally safe and appropriate? Do current reporting systems adequately reflect cultural outcomes, values and considerations, especially for people of Aboriginal or CALD background?<br>▪ To what extent has the program been able to encourage/ensure that clear referral/client pathways were developed and effective partnerships between services formed?<br>▪ Are new services and service features being designed and delivered by community for community? |

| Process Evaluation: How well has the TEI program been implemented? | |
|---|---|
| **1c) What opportunities are there to improve or expand the TEI program?** | ▪ Are there opportunities to improve the program design and its two program streams?<br>▪ Are there opportunities to improve implementation of the program and commissioning of services?<br>▪ What factors should be considered in scaling up or expanding the program?<br>▪ Are there opportunities to make the program more culturally safe, especially for Aboriginal people?<br>▪ Are there opportunities to improve the data collection and reporting of the TEI program? |

### 3.2.2 Data sources

The findings contained in this Final Report are informed by multiple sources of evidence. These include:

- **Online Survey of TEI providers:** An in-depth, two-part survey was issued to all 472 TEI providers to understand perspectives on TEI process and effectiveness. The second part of the survey focussed specifically on TEI data reporting processes including the Data Exchange (DEX) platform. Providers were asked to nominate the most appropriate person in their organisation to complete each survey. 371 individual service provider responses were received for Part 1 and 225 responses were received for Part 2.
- **Data Exchange data (DEX):** Analysis of data reported by TEI service providers through DEX in the three-year period between 1 July 2020 to 30 June 2023, including client numbers, demographics, service sessions[21] and outcomes (SCORE) assessments[22]. Reporting into DEX was voluntary in the first six months of the period analysed and became compulsory from 1 January 2021. Clients may either be recorded in DEX as individual clients, where client details and demographic information are recorded, or as unidentified group clients when it is not practical to collect client details. Only the number of people who participate in a service/activity is recorded for unidentified group clients. Most of the individual clients are recorded from Wellbeing and Safety stream sessions while most of the unidentified group clients are from the Community Strengthening stream sessions. Note that when reporting individual client numbers from DEX, we have counted records with the same Statistical Linkage Key (SLK) as the same client. This results in the cited numbers in this report being slightly lower than those published in the TEI annual report and TEI dashboard which counts using ClientID in DEX.
- **Human Services Dataset (HSDS):** The HSDS brings together 27 years of data from across government and over seven million records about children, young people and families. The records contain de-identified information from all NSW residents born on or after 1 January 1990 (the Primary Cohort) and their relatives (i.e. family members, guardians and carers – the Secondary Cohort). The HSDS was created by de-identifying and combining data collected through the administration of different NSW Government services including child protection, health, education and justice.[23] The HSDS supplements what can be observed from the DEX TEI program data to provide a better understanding of who are using TEI services as individual clients and what outcomes have been achieved for these individual clients (only individuals clients can be linked to the HSDS). Data linkage

---

[21] A session is an individual instance or episode of service, such as a home visit or a counselling session

[22] Standard Client/Community Outcomes Reporting tool from DEX. See Section 2.3 for more details on SCORE collection

[23] https://www.facs.nsw.gov.au/resources/research/human-services-dataset-hsds/about-the-human-services-dataset

timelines mean that the HSDS data (including TEI linkage) includes data up to June 2022 (rather than 2023), so results from the HSDS are based on a two-year window.

- **Case Study interviews**: Case studies were conducted across five separate provider locations. The case studies included interviews with both key staff members of providers, as well as clients accessing TEI services at each location. In total, we conducted interviews with around 20 TEI provider staff members, as well as 47 clients. The case studies have helped provide further context to the evaluation findings to better understand differences in TEI results, and results have been included throughout this report. The methodology adopted for conducting the case studies has been included in Section 3.3.2.
- **Funding data:** The funding commitment to each TEI provider at the beginning of each of the 2020-2021 to 2023-24 years, split by program activity. We were also provided with provider funding commitments for the 2019-2020 (pre-TEI) year.

### 3.2.3 Evaluation Governance

The evaluation has had input from a number of governance bodies:

- **DCJ internal working group**: The internal working group is comprised of DCJ staff from TEI, FACSIAR (Family and Community Services Insights, Analysis and Research), district Commissioning and Planning, and Transforming Aboriginal Outcomes. The internal working group met with the evaluation team once a month to discuss governance topics such as key findings, approach to methodologies and research timelines.
- **DCJ Internal Aboriginal Advisory Group**: A group comprised of Aboriginal DCJ staff. This advisory group provided guidance over the evaluation's research methodology, and approach to cultural appropriateness and safety.
- **Aboriginal Reference group**: A group consisting of nine external ACCO representatives. See below section 3.3.4.
- **HSDS Governance Advisory Committee**: A cross-agency group that monitors the HSDS to ensure appropriate use and that results are correctly interpreted.
- **NSW Artificial Intelligence Assessment Framework:** Aspects of the evaluation (specifically the use of machine learning models in parts of the quantitative analysis) were subject to assessment under the NSW AI Assessment Framework, including committee review.
- **Aboriginal Health and Medical Research Council (AH&MRC):** A group that ensures cultural sensitivity for all aspects of research that involve Aboriginal people.

These governance bodies ensured the evaluation was conducted with rigorous oversight, cultural sensitivity, and methodological integrity.

## 3.3 Key methodologies

### 3.3.1 Provider survey

#### Survey delivery

An in-depth, two-part survey was issued to all 472 TEI providers to understand perspectives on TEI process and effectiveness. The survey was split into two parts, with part one focusing on implementation, process and outcomes, and part two focussed specifically on TEI data reporting processes including the Data Exchange (DEX) platform. Only findings relating to outcomes have been included within this Final Report, with the remaining having been included within the Interim Report.

Providers were asked to nominate the most appropriate person in their organisation to complete each survey. There were 371 individual service provider responses received for Part 1 and 225 responses were received for Part 2. Analysis of multi-choice questions has been included throughout both reports, with analysis often broken down by provider type (e.g. ACCO vs non ACCO).

#### Approach to categorising open-text survey responses

As part of the provider survey, respondents were provided with several open-text questions. These were included to allow for a greater diversity of responses and were particularly important in collecting recommendations and suggestions in relation to the implementation of TEI, and insight on the types of outcomes achieved by TEI.

Open text responses were categorised based on a thematic analysis. The categorisation is based upon the total number of responses containing the same sentiment/suggestion.

Where appropriate, we provide a percentage of respondents who responded to a particular theme. However, in many cases a percentage would be misleading, as provider comments were not always a direct response to a question. As such, we cannot know the proportion of respondents who would agree or disagree with that sentiment if a direct question had been raised. In these cases, the proportion of responses have been categorised into three ranges and these terms have been used in the report:

- **A small number:** An isolated subset of responses only. In most situations limited to one or two similar responses.
- **Several:** A noticeable subset of responses. In most situations around five responses and up to one quarter of responses.
- **Many:** A significant subset of responses. More than one quarter of responses.

### 3.3.2 Case studies

#### Approach to case study site selection

The case study methodology was developed alongside close consultation with the DCJ internal evaluation working group, the independent Aboriginal Reference Group (see below 3.3.4) as well as DCJ's internal Aboriginal Advisory Group comprised of Aboriginal DCJ staff. The methodology was also informed by the results relating to outcomes available to us at the time of writing the Interim Report (June 2023). The methodology also factored in feedback and perspectives received from providers (via the survey) and stakeholder interviews.[24] From these sources, it was agreed that the case studies should cover:

- two ACCOs out of the five proposed case studies. This would give appropriate representation to the number of TEI clients that identify as Aboriginal, as well as reflect TEI's intended ACCO investment target.
- districts with a large proportion of Aboriginal clients.
- an ACCO provider with an example of Aboriginal led co-design or co-commissioning.
- a regional district.
- both large and smaller providers.

[24] Stakeholder interviews included conversations with Sector Peak bodies, DCJ Executives, and TEI commissioning and planning teams.

- South Western Sydney and Hunter Central Coast districts, given interim findings that these districts had proportionally stronger performance on outcomes. South Western Sydney was also prioritised as a district with a large number of CALD clients.

We then worked with the DCJ internal evaluation working group to identify a short list of potential providers using the above criteria. This list was then further refined based on the following factors:

- Availability and willingness to participate in process.
- Ability and capacity to host up to 10 clients for in person interviews.
- Availability of staff for interviews.

This methodology resulted in the following five selections for case studies.

- **Muloobinba** – a medium sized ACCO TEI provider based in the Hunter region. Muloobinba was identified as a provider who had supported community led co-design of a TEI service.
- **Gudjagang Ngara li-dhi** (GNL) – a small ACCO TEI provider based in the Central Coast. The Hunter Central Coast district was prioritised given its status as the region with fastest growing Aboriginal population.
- **Intereach –** a large provider primarily based out of the Murrumbidgee district, with services extending to regional offices such as Deniliquin, Albury and Corowa.
- **Creating Links –** a small provider based out of Bankstown in the South Western Sydney district. Creating Links has strong links with the local Bankstown community and services a large proportion of CALD TEI clients.
- **Uniting** (South Western Sydney) – a large provider of TEI services. Conversation was focused on Uniting's provision of TEI services in South Western Sydney, which includes a mix of urban, rural and regional LGA's such as Campbelltown, Cabramatta, Camden, Wollondilly and Wingecarribee.

For each case study site, we worked with the providers to identify suitable staff and clients to interview. Staff were chosen at the provider's discretion based upon their knowledge and experience of TEI service delivery. Clients were chosen by providers largely based upon availability and willingness, with considerable effort required of providers in explaining to clients the reason and merits of the case study interviews. Clients were provided a $50 voucher for their participation.[25]

Provider feedback and case studies also provided perspectives on how and why outcomes are achieved for clients. This feedback encompasses a large body of provider feedback[26], as well numerous in-depth case study conversations with a range of TEI provider staff members. Our view is that considering the perspectives of TEI providers furnishes the evaluation with important context around outcomes and research findings, which may be particularly pertinent to consider given the limitations of quantitative analysis as set out in Section 3.4.

### Limitations of Case Study methodology

There are several limitations to the case study methodology that should be considered when evaluating case study findings.

- Sample size - while we were able to speak to a large sample of clients, the overall TEI cohort is large. There is a risk that the clients we have spoken to are not fully representative of the broader cohort, particularly given that we did not cover all TEI districts across the case studies. Similarly, staff at the

[25] Clients were informed beforehand that the vouchers were sourced from DCJ funding.

[26] The provider survey was split into two parts, with part 1 receiving 371 responses out of a total of 472 TEI providers that received the survey, and part 2 receiving 225 responses. Part 1 was aimed at understanding provider perspectives on implementation and outcomes of TEI, with part 2 focused on DEX and HSDS.

providers we interviewed may not form a representative sample of providers across TEI given the specific criteria used to select providers.

- Sampling bias – to address sample size concerns, the methodology we adopted prioritised high client numbers over prescriptive criteria. This meant providers had discretion over client selection, largely based upon willingness. This means there is a risk that clients we interviewed were relatively more positive about the TEI services they received, or alternatively that providers may have selected clients with more positive views of TEI.
- Attribution to TEI – Providers of TEI services often provide other services that are not funded through TEI. For clients, the distinction between TEI and non TEI services is likely not clear, and in many cases would not be actively communicated by providers. As a result, client feedback about impact and outcomes may not be fully attributable to TEI.

### 3.3.3 Analysis using DEX and HSDS datasets

As introduced in Section 3.2.2, the DEX and HSDS datasets provide a wealth of data for TEI program evaluation. Analyses such as descriptive statistics and model results from these datasets provide evidence throughout this report regarding many aspects of the program including its provision and reach, achieved outcomes and economic impact.

Estimating changes in client outcomes that are attributable to TEI support is a key part of this evaluation. To facilitate this, we have employed different analyses techniques using the HSDS and DEX data, each able to provide insights from a different perspective and with differing limitations as introduced in Table 3.4 below and further detailed in Section 3.4. The quantitative component of the outcomes evaluation goes beyond looking at improvements in client SCOREs, which can suggest improvements in client outcomes but don't provide evidence to whether the improvement is due to participating in the program. Nonetheless, we compared SCORE survey results of individual clients to their outcomes in HSDS to assess whether SCORE is predictive of client outcomes.

Using results from the outcomes evaluation, we estimated the economic benefits associated with the improvement in client outcomes from the TEI support provided, both in terms of avoided cost to the government and quality of life benefit to the individual. This is compared with the total amount of funding for the TEI program to inform the economic evaluation of the program.

Table 3.4 - Summary of HSDS data analysis methodologies

| Method | Description | Limitations |
|---|---|---|
| Individual-level safety outcome modelling using regression models (DEX program data linked to HSDS) | ▪ Using quarterly individual-level regression models to conduct targeted measurement and statistical significance testing of the impact of TEI support delivered to a child (and/or their parents) in reducing the child's concern reports, ROSH and OOHC outcomes<br>▪ The regression setup controls for the difference in risk profile between the TEI clients and the general population and allows all children of individual clients in TEI to be included in the analysis<br>See Section 6.2, Section 6.4.1 and Appendix H.1 | ▪ Can only measure the impact for children who are individual TEI clients (or their parents are) and are linked to the HSDS. Impact of group sessions must be estimated separately in aggregate analysis using DEX data<br>▪ Separate models are required for each outcome and they are time consuming to build – hence we have prioritised three key outcomes to be modelled<br>▪ TEI clients may have risk factors and vulnerabilities that cannot be observed in government service data. This influences conclusions from HSDS analysis and what baseline outcomes can be expected for TEI clients. |
| Aggregate analysis of child protection safety outcomes (DEX and funding data) | ▪ Analysis of key safety outcomes at an LGA level to test whether LGAs with more intense TEI service provision have seen more outcomes improvement since TEI inception compared to others<br>▪ Allows broader support factors, including the number of group sessions/clients and the level of funding, to be tested against outcomes<br>See Section 6.2, Section 6.4.1 and Appendix H.3 | ▪ The aggregate approach is expected to be less sensitive than individual-level impacts – TEI would need to reach a sizeable fraction of at-risk children and see a substantial decrease in outcomes rate at the LGA level |
| Individual-level propensity matched comparison for broader outcomes (DEX program data linked to HSDS) | ▪ A large set of outcomes across different domains can be tested quickly for the TEI group and the comparison group to determine the impact of the TEI support on the outcomes<br>▪ A risk-matched comparison group is established from those who do not interact with TEI but otherwise have similar characteristics<br>See Section 6.2, Section 6.5.1 and Appendix H.2 | ▪ Can only measure the impact for individual TEI clients in the HSDS who can also be risk-matched to someone who have similar characteristics but is not a TEI client<br>▪ TEI clients may have risk factors and vulnerabilities that cannot be observed in government service data. This influences conclusions from HSDS analysis and what baseline outcomes can be expected for TEI clients. |

| Method | Description | Limitations |
| --- | --- | --- |
| Usefulness of SCORE result in understanding client outcomes (DEX program data linked to HSDS) | ▪ Assessed the usefulness of SCORE results as an indicator of client outcomes by:<br>– Testing the direct correlation between SCOREs and subsequent client outcome<br>– Testing the predictiveness of change in SCORE at different points in time on the change in client outcome in the same period<br>▪ Outcomes tested include concern report and ROSH for children, and being victim of domestic violence and at risk of homelessness for adults<br>See Section 7 and Appendix H.4 | ▪ Only tests linear relationship (e.g. higher ROSH always means more negative outcome). Outcomes such as health services usage is not tested as high usage rate could an indication of bad client circumstance but can also be a positive outcome that the client is receiving the support they need. |

### 3.3.4 Aboriginal research component of TEI evaluation

Aboriginal research has formed a major component of this evaluation. While questions relating to Aboriginal providers and clients have always featured as a core element of the evaluation questions,[27] in the early stages of the evaluation, we worked with DCJ to increase the scope of Aboriginal research within this evaluation. This broadened scope has encompassed:

- Incorporating Gamarada Universal Indigenous Resources (G.U.I.R) as part of the evaluation team as a dedicated Aboriginal researcher.
- Committing to achieving the highest standards of ethical research. The evaluation plan has been reviewed and approved by the Aboriginal Health and Medical Research Council (AH&MRC) (AH&MRC Reference: 2115/23).
- Working with G.U.I.R to establish an independent Aboriginal Reference Group[28] who have provided input to the evaluation process and interpretation of findings. The Aboriginal Reference Group has also been supplemented by advice of an Aboriginal Advisory Group comprised of Aboriginal DCJ staff.
- Undertaking dedicated analysis of provider survey responses submitted by providers identifying as Aboriginal controlled, as well as committing to two case studies with ACCO providers and clients.

The results of the Aboriginal research component have played a key role in understanding and interpreting both qualitative and quantitative findings. These findings are set out in Section 8 of this report.

## 3.4 Limitations

We recognise limitations facing the evaluation (in addition to those related to the case study and quantitative research methodologies, (Sections 3.3.2 and 3.3.3). Results from the evaluation should be interpreted with these limitations in mind. The currently known limitations are outlined below:

- **The TEI program is broad and heterogeneous.** Insights into variation by program activity, district and service provider will depend on the volume, granularity, and quality of the quantitative program data. Relatedly, it is not feasible to conduct in-depth qualitative research with all TEI providers. Instead, this evaluation draws on qualitative data provided in the survey of providers, and a limited

---

[27] See Section 3.2.1.

[28] The Aboriginal Reference Group is made up of provider representatives from Aboriginal Community Controlled Organisations and AbSec.

number of case study reviews that focused on specific identified themes in greater depth to draw program-level insights.

- **Outcome impacts are most robust for clients who are individually identified.** For the whole of program analysis using individual client data from HSDS, the insights are predominantly based on clients who have received Wellbeing and Safety stream services. These clients make up around two-thirds of individual clients identified in the HSDS. For client analysis at the program activity or a service type level, the insights for the Community Strengthening stream are based on individual clients which only makes up a small proportion of the total clients in the stream. In 2022-23, the proportion of clients with individual records out of total individual and unidentified group clients is 8% for Community Strengthening activities and 59% for Wellbeing and Safety activities.[29]
- **Recording practices vary by provider and region.** Any insights at the district level would be affected by differences in the quality of client data collection. This limits some of our commentary on impacts and reach for different geographies.
- **There are some inconsistencies in DEX reporting, particularly for early stages of the program.** Reporting through DEX was implemented in 2020-21 and reporting in the first year was also impacted by COVID and natural disasters. Data collection only became mandatory from 1 January 2021, six months after the commencement of the program.
- **Not all individuals are identifiable when assessing the program's reach and demand, especially for the Community Strengthening stream.** Due to the potential double counting that exists in the count of group clients and the inconsistencies identified in the recording of group clients, it is difficult to estimate the true number of clients that have received support and the true proportion of identified clients, especially for the Community Strengthening stream which is mostly comprised of group clients. Therefore, to supplement the individual client analysis the evaluation also examines the number of sessions and funding provided to assess program reach and potential unmet demand.
- **While a valuable data asset, there are some natural limitations to the use of HSDS data:**
  - **Service use is sometimes a proxy for underlying outcomes.** While we do not formally make a distinction between indicators and outcomes in our report, we note that measures we can track in the HSDS (for example, the number of children with concern reports) are sometimes a proxy for the underlying outcome we seek (for example, whether children are safe with their families). Interpretation of change in service use must also be made carefully, as increases or decreases in service usage do not necessarily translate to negative or positive outcomes. For example, housing support can be considered as a positive outcome for the client if the underlying need was already there.
  - **Relatedly, the HSDS provides an incomplete picture of vulnerability and resilience factors**. The understanding of the risk profile of TEI clients and the broader population from the perspective of the HSDS is based on how they have interacted with key government services including child protection, health, justice, housing, and education. TEI clients may have risk factors and vulnerabilities that cannot be observed in government service data. Additionally, families who are in need of support but aren't interacting with government services are not visible in the data. This influences conclusions from HSDS analysis of potential unmet demand and what baseline outcomes can be expected for TEI clients.
  - **The HSDS population definition create some skews.** People born before 1990 are less likely to be captured in the data. This is because by construction of the HSDS, records of people born before 1990 are only included if there is evidence from key datasets (e.g. NSW birth data) that the person is related to someone born after 1990. Despite this, it is expected that the relative

[29] Using data from DEX. Numbers might be slightly understated due to double counting of unidentified group clients.

comparison of rates between districts and cohorts remains valid. The skew implications are less significant for TEI than some other programs, given the focus on children, young people, and their families.

- **Incomplete linkage of TEI to the HSDS and small inconsistencies between DEX and HSDS.** Only individually-identified clients are linkable, but even within this group linkage will be incomplete, since people with insufficient or low-quality data recorded may not be able to be linked to other datasets or provided with a unique identifier. About 40,000 (over 20%) of 180,000 individual clients who directly attended TEI sessions were unable to be linked to the HSDS. Even amongst those linked, linkage remains imperfect (a very small proportion of PPNs do not map one-to-one to unique DEX client identifiers). Linkage rates by DCJ District were relatively consistent, with the exception of the Sydney district, for which good linkage was found around half as often compared to other districts. It is not clear whether the variance is due to difference in record keeping processes or a consequence of the linkage process. Nevertheless, this suggests that HSDS analysis is likely representative of most of the TEI population. Additionally, information from DEX and the HSDS is sometimes inconsistent (for example, whether a client is Aboriginal). This report presents findings from the HSDS as well as DEX. Where analysis uses the HSDS or HSDS combined with DEX, HSDS information has been prioritised. Where analysis relies on the DEX, DEX information has been used exclusively.
- **No ability to differentiate linked outcomes for ACCO providers.** Linkage of TEI information to the HSDS does not include information related to the provider such as ACCO status, making it impossible to provide a good estimation of the impact of ACCOs specifically.
- **Data quality is imperfect for a range of HSDS datasets.** The HSDS contains administrative datasets relating to different services, some higher quality than others. Quality issues include smaller issues which affect a negligible proportion of records (e.g. start dates being after end dates, negative ages, imperfect linkage between HSDS datasets evidenced by non-one-to-one mappings of PPNs to other unique identifiers on datasets) and these have been corrected by imputation where possible. Issues for some datasets affect a broader or unknown proportion of records and where necessary, data has been excluded from analysis (for example, student attendance through the pandemic and more recent temporary accommodation data). It is expected that observations from the HSDS are still accurate. Notes have been added where a potentially material data issue may affect the interpretation of a statistic. Further, datasets sometimes provide inconsistent information and decisions have been made to prioritise information from certain datasets.

- **Provider feedback may not be representative of all perspectives.** Where the report references feedback from TEI providers, this is referring to responses to the TEI Evaluation Survey issued to all TEI providers in July and August 2023. The survey had 371 responses and coverage across all TEI districts, thus comprising a large majority of all TEI providers.[30] However there remains the possibility that the collective dataset may not be representative of all TEI providers and staff members delivering services.

[30] The provider survey was split into two parts, with part 1 receiving 371 responses out of a total of 472 TEI providers that received the survey, and part 2 receiving 225 responses. Part 1 was aimed at understanding provider perspectives on implementation and outcomes of TEI, with part 2 focused on DEX and HSDS.

# 4 Summary of changes to Interim Report

## 4.1 Overview of the Interim Report

In late 2023, we prepared an Interim Report with initial findings of the evaluation. The Interim Report focussed primarily on the process evaluation component, as the findings of the outcomes and economic evaluation components were not yet available at that time.

The Interim Report drew on sources including program documentation, interviews with DCJ staff and sector representatives, an in-depth survey of TEI providers and an initial review of data captured on the Data Exchange (DEX) between 1 July 2020 and 30 June 2022, including client numbers, demographics and service sessions. In addition, the Interim Report captured initial analysis of the Human Services Dataset (HSDS), which was used to supplement what can be observed from the DEX data to provide a better understanding of TEI clients. For the Interim Report, only data up to 30 June 2021 was available for the HSDS and hence relevant findings were limited to the first year of TEI only. For this reason, the HSDS was used to explore program reach but not outcomes.

In the Final Report, we draw on additional data sources, including an expanded DEX and HSDS dataset and additional qualitative interviews with service providers and clients, to provide an update on some of the key findings from the Interim Report.

## 4.2 Updates to findings in the Interim Report

### 4.2.1 Findings related to program design and implementation

**Since the Interim Report was written, additional work has been undertaken towards implementing TEI reforms**

The Interim Report outlined the work that has been undertaken towards achieving the TEI reform aims which were articulated at the program's inception. Since the Interim Report was written, DCJ has made additional progress towards the reform aims, including progress towards a revamped recommissioning approach which is expected to see the re-allocation of existing funding based on local need, rather than historical contracts. The re-commissioning process was in its early stages at the time this report was written, so the full implementation of this process was not assessed as part of this evaluation.

**Additional qualitative analysis reinforces the need for a review of funding allocations**

The Interim Report contained feedback from the TEI providers survey in which providers emphasised shortages in funding and a perceived mismatch between funding allocations and the true cost of delivering TEI services. Additional qualitative data collected as part of the case study analysis reinforces this concern, with providers describing that the current funding allocations are not reviewed frequently enough to account for changes in demand or complexity. Limitations in funding are also causing provider to limit the types or duration of services and supports they can offer to clients, as well as their ability to invest in organisational capacity and partnership development.

**Further quantitative research highlights areas of relatively lower reach and funding**

Section 5 and Appendix F contain additional analysis of reach and potential unmet demand. Some of this extends the work of the Interim Report to address specific questions that arose subsequently. Appendix E.2 shows that there is significant variation in the share of funding in a region going to Wellbeing and Safety streams, without an obvious relationship to other factors such as socioeconomic status. It also points to likely future needs in Western Sydney, South Western Sydney and Illawarra Shoalhaven districts, where some LGAs are forecast to see strong total population growth, which will affect the population that may require TEI support.

**Since the Interim Report was written, DCJ has renewed its commitment to investing in ACCO-led earlier intervention programs**

As part of the recommissioning process, DCJ has renewed its commitment to investment in early intervention programs delivered by Aboriginal Community Controlled Organisations (ACCOs) and to embed Aboriginal led commissioning in the TEI program. This includes a statewide investment target of 30% of funding for early intervention programs directed towards ACCOs. As mentioned above, the re-commissioning process was in its early stages at the time this report was written, so the full implementation of this process was not assessed as part of this evaluation.

Additional qualitative analysis undertaken since the Interim Report reinforces the importance of culturally appropriate and Aboriginal led programming, as well as the need for flexibility for ACCOs to deliver TEI in ways that incorporate culture and reflect the local community context.

### 4.2.2 Findings related to SCORE collection and reporting

***SCORE[31] is an intentionally flexible tool to make it easier for providers to use, however flexibility in how the SCORE is collected and differences in completion rates between client groups means that care needs to be taken when drawing conclusions from these results***

The Interim Report introduced the SCORE tool for assessing client outcomes which is intentionally flexible for organisations to complete, but at the cost of potentially making comparative data analysis more complex, as data is not collected in the same way. Specifically, organisations can:

- Adopt the standardised client surveys from SCORE directly, or use translated SCORE ratings from other validated tools
- Decide whether the assessment is completed by the client themselves, by the workers and/or joint assessment based on what makes the most sense for their service and client.

Goals and Circumstances SCORE ratings appear comparable whether they are direct entries or mapped from other provider validated outcome tools. Satisfaction SCOREs from other validated outcomes tools tend to be higher (average rating 4.8 compared to 4.4), though almost all satisfaction SCOREs recorded from other validated outcomes tools were collected by providers in the Sydney district and therefore is more likely driven by regional variation.

On the other hand, SCOREs assessed by practitioners tend to have lower ratings across all three types of SCOREs, while SCORE ratings assessed by clients, jointly between a client and practitioner, or a support person, were relatively similar across districts, outcome type and outcome domain. It is possible that practitioners adopt slightly different standards when making assessments and assess lower ratings than others for the same scenario. This impacts how the SCORE results should be interpreted, especially when tracking outcomes for the same client. It is also possible that practitioner assessments are more common when the client's situations are genuinely worse, rather than there being a difference in the standards adopted. This could not be verified through the HSDS as the information regarding who completed the assessment is not available in the HSDS. There is also variation across districts regarding the proportion of SCOREs completed by practitioners / translated from other validated tools. For example, less than 15% of satisfaction SCOREs in Northern NSW and South Eastern Sydney are practitioner assessed, compared with 45% in Central Coast. Additional analysis on how SCOREs are collected can be found in Appendix D.1.

[31] SCOREs are rated in a scale of 1 to 5 and higher rating represents better client outcomes. The three types of SCOREs collected for individual clients are Circumstances (measures changes in client circumstances), Goals (measures progress in achieving specific goals) and Satisfaction (measures client satisfaction). See Section 2.3 for more details on SCORE collection and the types of SCOREs.

The proportion of clients with at least one SCORE result recorded has continued to trend upwards in 2022-23 across all three types of SCOREs. However, for Goals and Circumstances SCOREs, the completion rate in 2022-23 was around 35% which is still less than the target of 50% for each. The proportion of clients with SCORE results recorded in the same domain (E.g. Personal and family safety, housing) from at least two different sessions (as a proportion of all clients who have attended two or more sessions) is even lower at around 25%. Later in Section 7 we show that clients' changes in Circumstances and Goals SCOREs are useful in monitoring client outcomes over time.

In the Interim Report we also identified that factors such as age and location of the client have an impact on the likelihood of having a SCORE collected, which affects the interpretation of SCORE results. Clients in metropolitan districts tend to be more likely to have a SCORE recorded, while Aboriginal clients have a lower likelihood of having a SCORE recorded after all other factors are controlled for. This is consistent with the challenge emphasised by ACCO providers with clients being unwilling or reluctant to provide personal information or data and believed that their data could be misused, especially before a relationship and trust can be developed. Further analysis using an additional year of HSDS data confirms these trends still hold and are true for all three types of SCORE outcomes. Detailed results regarding SCORE collection rates can be found in Appendix D.2 and D.3.

In addition to assessing outcomes for individual clients, outcomes for groups or communities can be reported via the Community SCORE tool. This is typically used when it is not possible or practical to record SCOREs for individual clients (e.g. one-off event, drop-in centre). As such, it is most commonly used in recording the outcome of Community Strengthening stream activities. It can be collected in a variety of ways, including practitioner assessments from observing clients' interactions during a session and how they responded to the session, as well as collecting short questionnaires from the clients at the session.

Overall, around 6% of Community Strengthening sessions conducted in 2022-23 had a Community SCORE assessment. There has been a slight reduction in the rate of collection in the last two years despite an increase in the number of assessments, as the total number of sessions conducted has grown at a faster rate. Further details regarding the collection of Community SCOREs can be found in Appendix D.4.

# 5 TEI service provision and demand

This Section of the report considers the following evaluation questions:

- Did the TEI program commission the anticipated level and type of services/activities in the areas planned?
- How well did the program reach the target populations and priority cohorts and in what locations?

To answer these questions, the evaluation draws on multiple sources of evidence, including analysis of data submitted by providers in the Data Exchange (DEX) platform, population data captured in the Human Services Dataset (HSDS), and a survey of TEI providers. As noted in the limitations Section, reporting into the DEX platform is a relatively new process that only became mandatory from 1 January 2021 and the quality of the data has evolved over time. Insights from the analysis are subject to the quality of data in DEX and assumes that the client and service provision data submitted to DEX is a representative sample of all clients and services delivered in each district. Initial results regarding program reach and demand were presented in the Interim Report, with results from additional quantitative research presented below.

## 5.1 Client numbers and service provision

***Recorded TEI client numbers are increasing at rates higher than population growth***

Recorded client numbers for the TEI program have been increasing in each of the last two years to over 160,000 individual clients and over 1.1 million unidentified group clients[32] in 2022-23. South-Western Sydney continues to be the largest district by number of individual clients, sessions[33], and outlets, reaching just over 38,000 individual clients in 2022-23. Western Sydney is the second largest district in terms of individual client numbers. Over the period since reporting commenced, statewide recorded client numbers were:

- 127,831 clients in 2021-22 and 161,602 individual clients in 2022-23. This represents a 26% increase and higher than the 13% increase from 2020-21 to 2021-22. Around 110,000 of the clients from 2022-23 were new to TEI.[34]
- 977,815 unidentified clients (clients who do not have any individual information recorded, predominantly from Community Strengthening stream sessions) in 2021-22 and 1,133,760 in 2022-23. This represents a 16% increase and lower than the 37% increase from 2020-21 to 2021-22[35]. Note that a client could be counted multiple times in these figures.

The number of individual and unidentified group clients recorded had increased across all program activities. In particular, the number of individual clients from the two program activities in the Wellbeing

[32] Unidentified group clients describe the number of clients who participate in a service/activity, where no identifying information is collected. Clients are recorded as unidentified group clients when it is not practical or possible to collect client details. For an example, a large community event.

[33] A session is an individual instance or episode of service, (Data Exchange Protocols), April 2023.

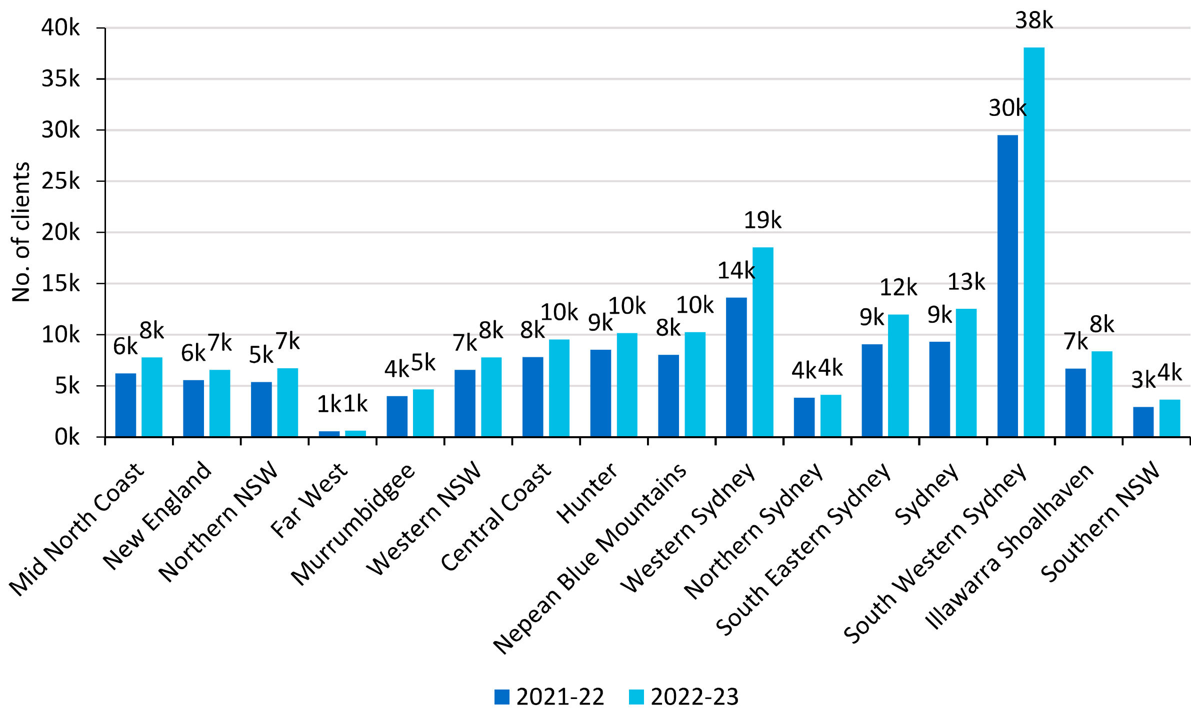
[34] These client figures are slightly lower than those reported in the TEI annual report / TEI dashboard. The evaluation counted records with the same Statistical Linkage Key (SLK) as the same client, while the annual report treats each record with different client ID as different clients.

[35] Number of unidentified group clients for 2021-22 is likely to be inflated due to data reporting issues identified in South Eastern Sydney and Sydney districts, with the issue from South Eastern Sydney persisting in 2022-23.

and Safety Stream had increased by 20% in 2022-23, compared to only 3% increase observed in the previous year.

All DCJ districts experienced an increase in the number of individual clients recorded as shown in Figure 5.1 below, with Western Sydney and South Western Sydney recording the largest proportional increase. These were already the largest districts in terms of individual clients recorded in the previous year and also had the highest population growth rates observed in 2022-23. There is a clear correlation between the population growth rate and the growth in individual clients recorded in each district, with the growth rate in individual clients greater than the population growth rate in each district.

Figure 5.1 – Number of individual clients by DCJ district (DEX)

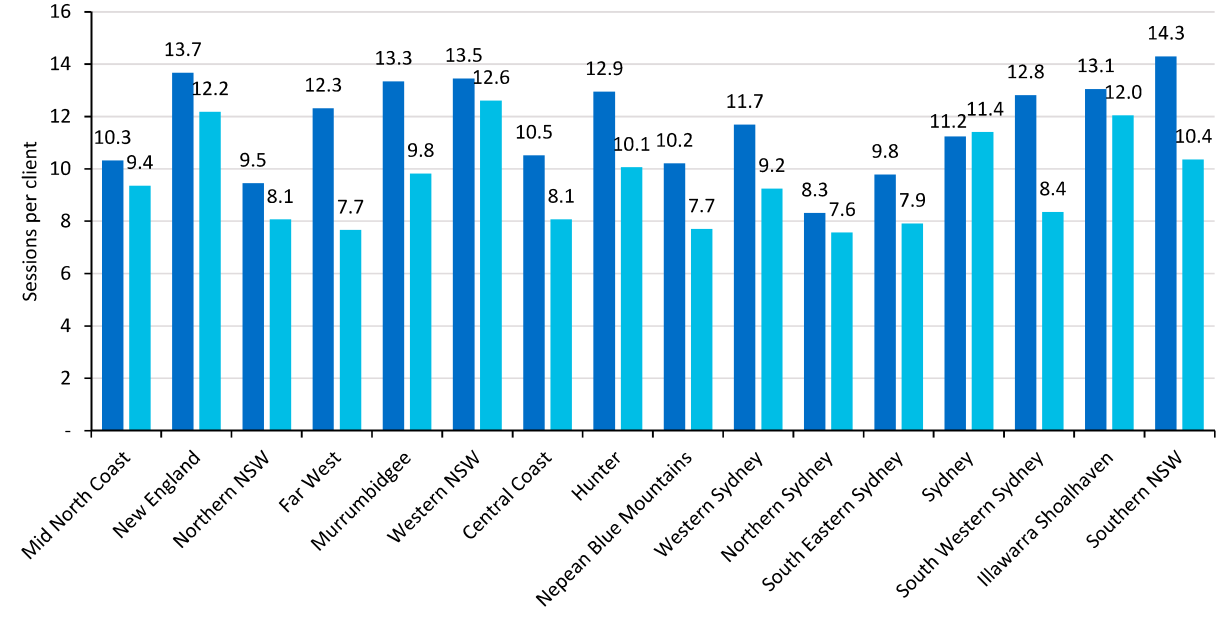



All districts except Sydney and South Western Sydney had an increase in unidentified group clients recorded, with Nepean Blue Mountains recording the highest proportionate increase at 75%. Detailed client breakdowns by program activity type and by DCJ district can be found in Appendix E.1.

There continues to be significant variation in the mix of sessions by program activity that are delivered to clients in each district. Over 50% of sessions conducted in Murrumbidgee and Northern NSW in 2022-23 were Community Strengthening stream sessions, compared to around 20% for Sydney, Northern Sydney and Hunter. The number of Intensive Support sessions delivered in the more remote districts also remains low. See Appendix E.2 for further details on the mix of sessions delivered.

Along with the increase in the total number of clients, Figure 5.2 below shows a reduction in the average number of sessions recorded for individual clients across all districts except Sydney, with the largest decrease again observed in the two largest districts, Western Sydney and South Western Sydney. There is also a general decrease in the funding per session for organisations across all districts. These observations suggest that organisations may be reducing the intensity of services for clients in order to cope with supporting increasing number of clients with the resources that they have. See Appendix E.3 and E.4 for further breakdowns of sessions per client and funding.

Figure 5.2 – Average number of sessions per client by client's year of entry (DEX)




*Note: Includes sessions from the year of entry and the year after year of entry, so a two-year period is captured for both cohorts to ensure a fair comparison.

***The increase in recorded TEI client numbers in 2022-23 is likely to be from a combination of genuine increases in number of clients receiving TEI services and improvements in data recording***

By comparing the client and session data in DEX, we make the following observations which suggest that there have been **genuine increases in the number of clients who received TEI services**:

- The growth in individual clients who received TEI services is correlated with the population growth in a district, suggesting there are natural increases in client base from the population growth.
- The increase in individual clients is mainly driven by an increase in average number of clients attending each session from the Wellbeing and Safety Stream, which accounts for most of the individual clients. This increase is observed for both identified and unidentified clients and the proportion of sessions with identified clients has also been stable at around 98.5% in each of the last two years. Hence there is likely to be a genuine increase in the average number of clients attending each session rather than there being an improved identification of clients.
- The increase in unidentified group clients is mainly driven by a proportionately similar increase in the number of Community Strengthening stream sessions, which accounts for most group clients. Overall, the average number of group clients per session is in line with the previous year. For two of the districts that observed the highest proportionate growth in unidentified group clients, Nepean Blue Mountains and Illawarra Shoalhaven, the increase in client numbers is contributed to by numerous different outlets, indicating a genuine increase in overall service delivery for the districts.

There is also evidence that **data recording has improved**, which impacts the recorded client number beyond the genuine increases in clients who received TEI services:

- For the other two districts with a large proportionate increase in number of unidentified group clients, Western Sydney and Central Coast, the increase was concentrated in a small number of providers, with 3 outlets make up ~40% and ~50% of total increases in the districts respectively. Some of the outlets that recorded a large increase in number of clients did not have a corresponding increase in the number of sessions and/or funding, which means it is more likely driven by an

improvement or change in data recording. In the Interim Report, we had also identified potential data issues for 2021-22 in Sydney and South Eastern Sydney. The issue appears to be mostly resolved for the Sydney district, with providers that had a large increase in number of group clients in 2021-22 recording a decrease in 2022-23 to levels more consistent with what was observed two years ago. This also affects how the change in client numbers should be interpreted for the district.

- Across most districts, we see organisations with a very high funding per session in the prior year increasing the number of sessions delivered in the year after and thus significantly reducing the amount of funding per session. Part of this is likely due to an improvement in data recording and it is especially apparent from 2020-21 to 2021-22 as data recording in DEX was not compulsory for half of 2020-21.

Lastly, there may be a small degree of under-reporting of client numbers in DEX as no session records were found for some of the organisations appearing in the funding data. Overall, we did not find DEX records for sessions conducted in 2022-23 from organisations that accounted for 2.2% of total funding in the year. Further details of the analysis in this Section can be found in Appendix E.

## 5.2 Potential unmet demand

***Despite rising TEI client numbers, there are signs of potential unmet demand in some districts.***

It would be useful to be able to identify unmet demand in regions to support future funding arrangements. Our data can only partially answer this question; there are no official numbers for people suitable for TEI who do not interact with services, so unmet demand is therefore proxied. Analysis of expected level of demand versus the actual level of TEI services provided, after adjusting for regional observable differences, suggests some disparities that indicate areas of unmet demand.

We have performed a **high-level regional analysis** where we have examined how aggregate TEI services and funding are distributed relative to population and socio-economic status. The number of sessions per 100,000 children vary by a factor of five from highest district (Far West) to lowest (Northern Sydney). Most of this variation appears consistent with providing more per capita support to lower socioeconomic regions. Districts with higher SEIFA[36] had lower TEI funding and session volume. The analysis suggests that the South Western Sydney and Western Sydney districts have fewer sessions and resourcing compared to levels expected based on SEIFA. Note that while SEIFA does provide an indication of risk, it is a broader metric and not necessarily reflective of demand for TEI services. For example, while South Western Sydney has one of the lower SEIFAs, it also has a rate of ROSH reports below the state-wide average[37]. Moreover, regions with a higher proportion of Aboriginal people could represent additional need for early intervention beyond socioeconomic factors, given over-representation of Aboriginal people in child protection systems.

Additionally, we have refreshed our Interim Report analysis of **actual versus expected TEI entry rates, after risk-adjustment**. This compares entry rates of individual TEI clients against what might be expected based on the risk profiles[38] of each DCJ District as observed in the HSDS. This allows for a more detailed risk-controlled analysis, at the expense of only being able to include identified clients in the HSDS, and

[36] Socio-Economic Indexes for Areas, an ABS measure combining a range of socioeconomic indicators

[37] https://public.tableau.com/app/profile/facs.statistics/viz/DistrictProfile-SouthWesternSydneyDistrict/SouthWesternSydneyDistrict

[38] The Risk profile is of each District is calibrated from a combination of demographic factors (e.g. age and SEIFA scores) and historical risk factors (e.g. Child protection history, hospital admissions) that impact the likelihood of entry into TEI. Further details of the method and the full list of factors used is provided in Appendix F)

their linkable children[39]. From this analysis, the Murrumbidgee, Hunter and Far West districts had the lowest rates of entry relative to their risk profiles. This indicates that the reach or capacity of providers in those districts are potentially not equal to the demand. When looking specifically at rate of entry to the Wellbeing and Safety stream, the results are similar, with movements consistent with distribution of funding. For example, the Hunter district's entry rate moves considerably upwards and the Nepean Blue Mountains district shows a much lower rate of relative entry, in line with the former having the highest proportion of funding to Wellbeing and Safety services and the latter having the lowest.

The differences seen between the two analyses above can be explained by differences in data quality between districts. The individual-level risk adjustment should be more accurate, but is limited to individual-level clients that are linked to the HSDS; reporting differences between districts therefore distort the picture. For example, the South Western Sydney District has the highest identified client rate, and this would be artificially increasing its entry rate relative to other districts in the HSDS data. Additionally, the HSDS analysis does not account for the number of sessions provided per client, of which there is some variation between districts (refer to Section 5.1).

A related consideration is the **implications of forecast population growth**. NSW Planning issues regular population forecasts, with strong growth expected in some LGAs in Western Sydney, South Western Sydney, Hunter and Illawarra Shoalhaven. This reflects recent trends and planning around new housing developments. All else equal, we would expect greater need for TEI services to grow in these areas over time.

Overall, while it is possible to compare how districts are meeting demand on a few measures, there is no single perfect indicator of unmet demand. We tend to favour the higher-level regional analysis plus population growth figures, given they align and are less affected by reporting patterns, but recognise it is relatively coarse analysis.

Full details of these analyses are provided in Appendix F.1 and F.2. Other unmet demand analysis conducted in the Interim Report have also been refreshed, with mostly the same conclusions. These are:

- Coverage of outlets delivering TEI services (see Appendix F.3)
- Distance travelled by clients to receive services (see Appendix F.4)
- Local coverage of Community Strengthening stream sessions (see Appendix F.5)

Two additional insights from the analyses are:

- There is a lack of outlets delivering Counselling services and Specialist Support services in the more remote districts, which have resulted in very few clients from remote areas receiving these services. As shown later in Section 6.6.2, there is some initial evidence that these two service types have improved outcomes for clients in higher risk situations (though the volume of data is still low for the evidence to be conclusive).
- There are some areas (at an LGA level) where clients are travelling a long distance to attend TEI sessions but the proportion of clients receiving support virtually is considerably less than other districts. This shows that there is potential scope to increase the availability for supports to be conducted virtually in these areas, as travelling long distances could be a deterrent to clients getting the support they need.

[39] Note that for HSDS analysis, we have defined TEI entrants as any clients in the TEI data, plus their children. This roughly doubles the amount of entrants included in the analysis compared to just those in the TEI linkage.

## 5.3 Program reach to priority groups

This Section presents findings from linked government administrative data, the Human Services dataset (HSDS). In this Subsection (as with all analysis in this Final Report using the HSDS), clients are defined as those who were recorded in DEX as individual clients and were able to be linked to the HSDS (direct clients), as well as children who are not direct clients themselves but have a parent identified through the HSDS who is a direct client (indirect clients). Altogether, there were 176,214 such clients, 57% of which were direct clients and 43% of which were indirect clients. Analysis is more robust for the Wellbeing and Safety stream due to greater recording of individual clients in this stream (see limitations in Section 3.4).

***The TEI program appears to have been effective in targeting and prioritising clients with known risk factors and vulnerabilities and in reaching the four priority groups. Many providers, however, highlighted that the level of client complexity is beyond what was expected and what they are resourced to respond to.***

### 5.3.1 Reaching clients with risk factors and vulnerabilities

Analysis of linked government service datasets in the HSDS showed that the risk profile of individual clients entering TEI in the first two years was higher than that of the general population. That is, TEI clients had higher levels of service history (risk factors) than the general population. A broad range of risk factors spanning multiple domains was examined. Appendix G contains the full analysis of all risk factors.

Figure 5.3 depicts risk factor rates based on service use for TEI clients who first attended each program activity. Risk factors shown are concern reports, being a victim of domestic violence, criminal justice interactions, homelessness presentations and mental health (ambulatory) services. TEI clients were at least twice as likely to have each of the risk factors examined and more likely to have risk factors spanning multiple domains. This is consistent with the TEI program expectation that clients will have known risk factors, vulnerabilities, or will already be receiving a crisis response. It is also consistent with stakeholder feedback and provider commentary indicating that sometimes TEI was used as a step-down response following successful casework with families, noting these families would be expected to have a significant risk profile.

Figure 5.3 – Risk profile of individual clients in 2021-22 and 2022-23 by first program activity (HSDS)

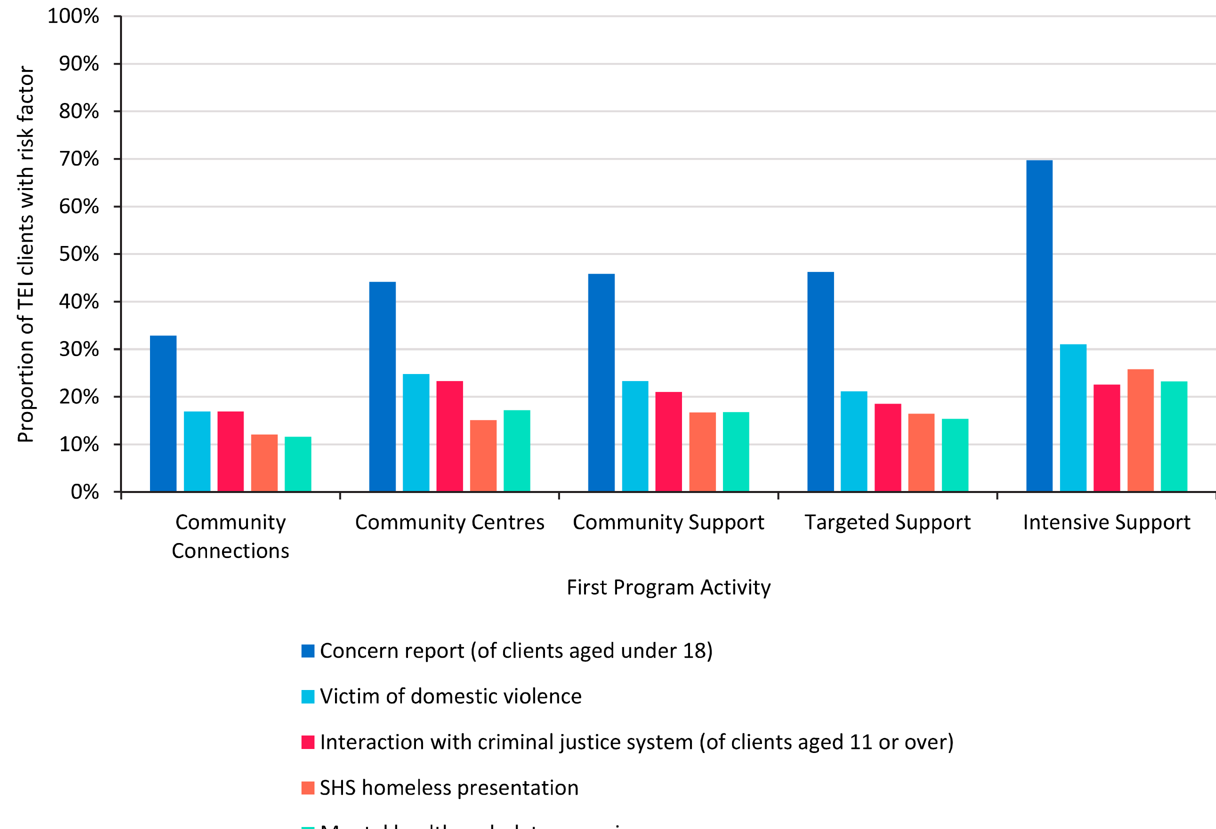


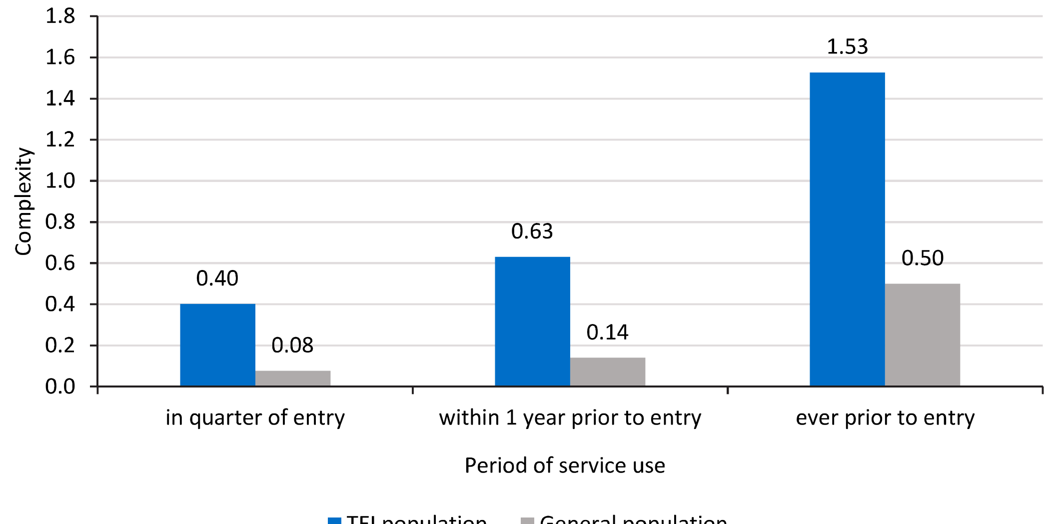

Figure 5.3 shows that the Wellbeing and Safety stream has the highest proportion of individual clients already known to the child protection system (i.e. had a previous concern report), and most other risk factors. 70% of children in Intensive or Specialist Support had a history of interacting with child protection prior to entering these programs compared to about 35% for children in Community Connections. Individual clients only represent a small proportion of clients accessing the Community Strengthening stream and so the results may not be representative of the stream overall. However, these results are consistent with the design of the streams. The Wellbeing and Safety stream aims to provide early and/or preventative support to people with known risk factors or vulnerabilities, which is evident in the data.

A common theme throughout provider surveys and interviews was that the risk profile of clients presenting to TEI does not necessarily align with the premise of “early intervention”, with clients often presenting to TEI with complex and intersectional challenges that early intervention aims to prevent (see Section 6.4 with provider feedback). This is consistent with risk profiles seen in the HSDS, given a large proportion (42%) of participants are already known to the child protection system and participants’ service use prior to TEI spanned multiple domains.

As a proxy measure of client complexity, Figure 5.4 shows the average number of domains out of 9 selected domains a TEI client used services in, over different time periods prior to entering TEI. The domains reflect services related to drug/alcohol use, mental health, justice, domestic violence, custody, public housing, homelessness services, child protection and school suspensions. Appendix G provides formal definition for these. For each TEI client, five people were randomly selected in the general NSW

population with the same age and sex to form the general population group for comparison purposes [40]. The figure shows that TEI clients used services across three to five times as many domains as the general population prior to their entry into the TEI program.

Figure 5.4 – Average count of 9 domains utilised prior to TEI entry for TEI individual clients (n=176,214) and the general population (n=878,743) (HSDS)




Further analysis shows that even amongst the subset of people who have used services in at least one domain, TEI clients are more complex; with 65% of service-using TEI clients having service history in at least two domains, compared to 42% of the service-using general population. Of TEI clients using those services in the quarter of TEI entry, 28% of TEI clients used services in at least two domains, compared to 14% of the general population.

While there was a perception among stakeholders interviewed that clients are presenting with more complex risk profiles, we do not have a long enough time series of linked data to compare current TEI complexity with earlier equivalent programs to validate this perception.

For this analysis, note that unidentified clients make up most records in the Community Strengthening stream, and including unidentified clients into the analysis (if their service history was observable) would potentially change the relative prevalence of service history. We expect that service use rates would remain similar or slightly decrease if a greater proportion of Community Strengthening Stream clients were individually recorded.

### 5.3.2 Reaching priority groups

The Department recognises four key TEI groups (priority groups) that are particularly important in the context of early intervention, and who are crucial considerations for its strategic planning:

- Aboriginal children, young people, families and communities
- 0–5 year olds
- Children and young people at risk of disengagement from school, family and community

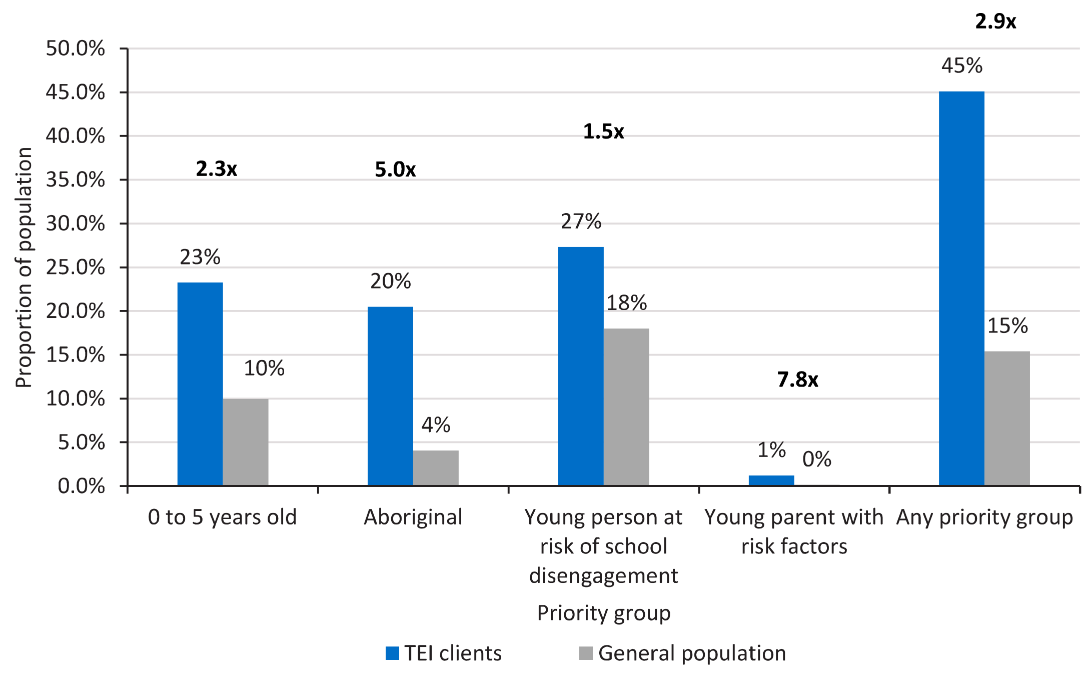
[40] Additionally, to remove differences between TEI clients and the comparison group owing to visibility of individual service use in the data, time trends in the data and data processing changes or issues, TEI client service use in a given quarter was compared to general population service use in the same quarter. Further, those born in NSW were matched to those born in NSW and those born outside NSW were matched to those born outside NSW.

- Young parents with known vulnerabilities or who are experiencing hardships.

Analysis of reach for these groups requires formal definition that is feasible within the linked data[41]. Service providers have successfully been targeting the four priority groups of the TEI program for program entry. People in the priority groups were more prevalent in the TEI population[42] compared to the general population, with 45% of TEI individual clients being in a priority group.

Figure 5.5 shows as bars the proportions of the TEI population and general population of NSW that are in each of the four priority groups. For young people at risk of disengagement from school, the proportions reported are of those who were enrolled in school at any point in the last year. The figure also shows multipliers above each priority group. This multiplier is the ratio of TEI priority group prevalence to general population prevalence graphed in bars (relativity). The relativity indicates how much more likely a TEI client is to be in a priority group compared to the general population. The figure shows that targeting was most effective for the young parent with risk factors (8 times more prevalent in the TEI population) and Aboriginal (5 times more prevalent in the TEI population) priority groups. Further details about the analysis and results are included in Appendix G.

Figure 5.5 – Proportion of TEI individual clients and general population in priority groups (HSDS)



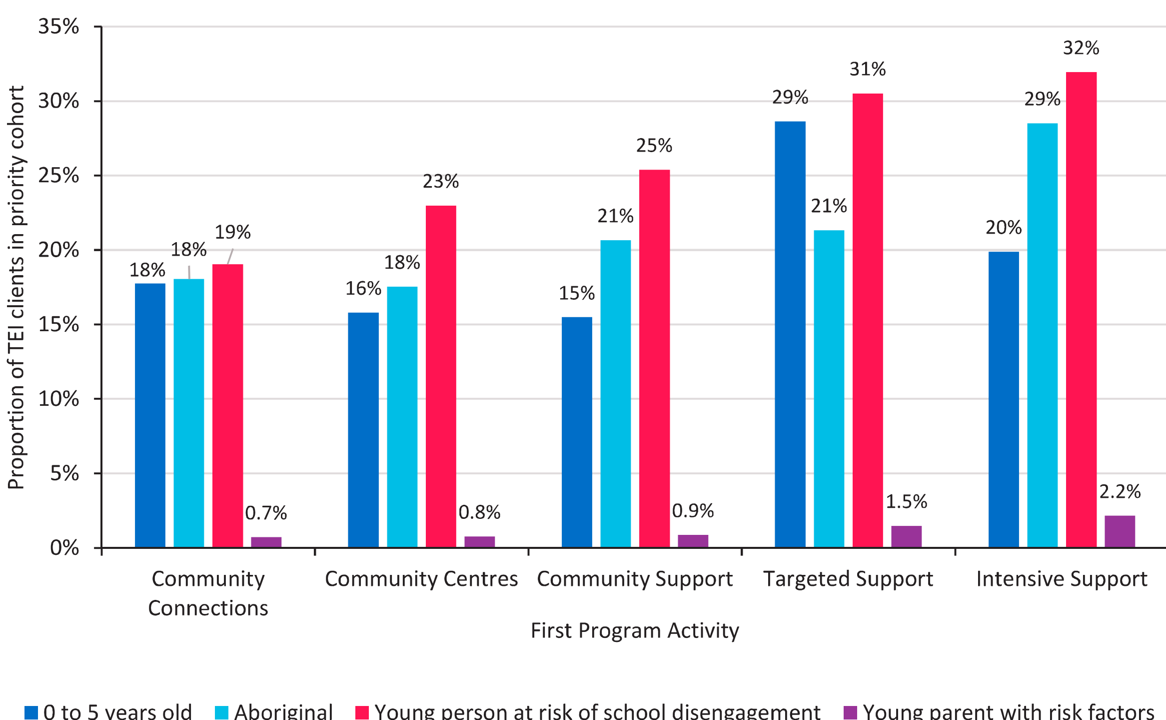

Note: Relativity (multipliers displayed above bars) is calculated as proportion of TEI in priority groups divided by proportion of general population in priority groups. Results are rounded.

The Wellbeing and Safety stream had larger proportions of priority clients as would be expected given it is intended to provide service to more complex clients. There is also more uncertainty around the result for the Community Strengthening stream since the vast majority of Community Strengthening clients are unidentified clients who aren't captured by this analysis. Figure 5.6 shows the proportion of clients in each priority group by first program activity. For young people at risk of disengagement from school, the proportions reported are of those who were enrolled in school at any point in the last year.

[41] Refer to Appendix G for the definitions adopted for this evaluation.

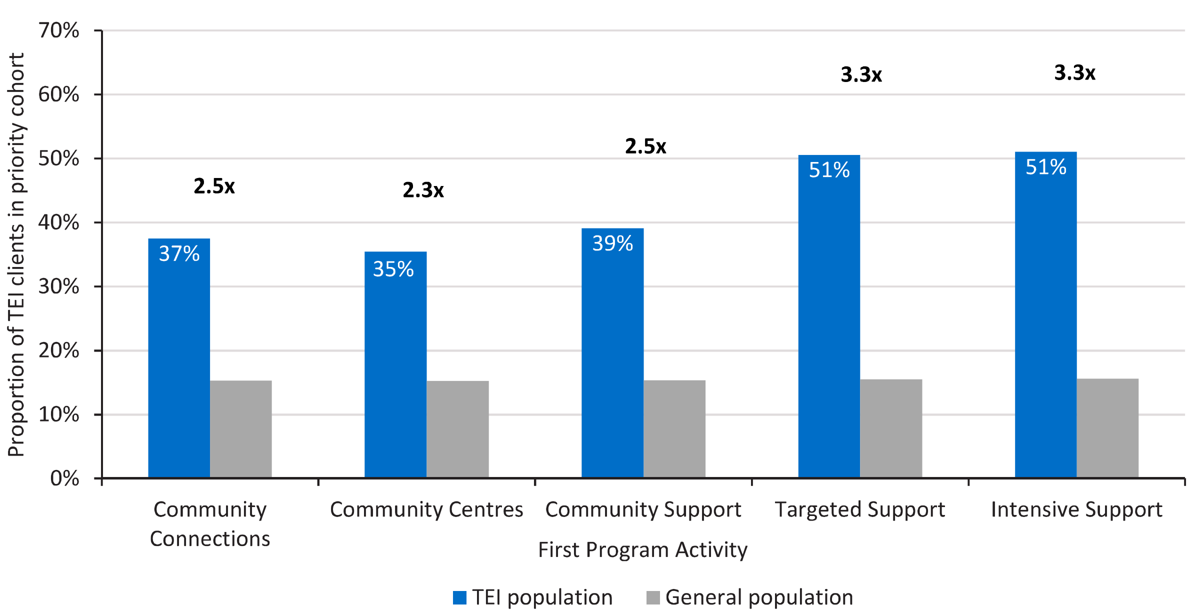
[42] Note that for HSDS analysis, we have defined the TEI population as any clients in the TEI data, plus their children. This roughly doubles the amount of entrants included in the analysis.

Figure 5.6 – Proportion of TEI individual clients in priority groups by first program activity (HSDS)




Targeting of priority groups was more effective for the Wellbeing and Safety stream, consistent with the intent that this stream works with more vulnerable clients. Figure 5.7 reveals that over 50% of individual clients who first accessed Wellbeing and Safety stream activities belonged to a priority group, a prevalence over 3 times that of the general population, compared to 35-40% of individual clients who first accessed Community Strengthening stream activities, a prevalence 2 times that of the general population.

Figure 5.7 – Proportion of TEI individual clients in any priority group and relativity to general population (HSDS)




Note: Relativity (multipliers displayed above bars) is calculated as proportion of TEI in priority groups divided by proportion of general population in priority groups. Results are rounded.

# 6 Outcomes Evaluation

This Section of the report considers the following evaluation questions:

- Where/when did TEI achieve better outcomes for clients (especially fewer children entering the child protection system)?
- Where/when did TEI achieve poorer outcomes?
- What were the factors that contributed to better (or poorer) outcomes?
- What unanticipated outcomes (positive or negative) did the program produce?
- Which of the service types worked, for whom, where and why? Should there not be enough data available the question should look at program activities.
- What was the influence of the TEI program in supporting and hindering client and service system outcomes?

To answer these questions, the evaluation draws on multiple sources, including analysis of data submitted by providers in the Data Exchange (DEX) platform, population and government service usage data captured in the Human Services Dataset (HSDS), a survey of TEI providers and finally case study interviews with TEI providers and their clients.

## 6.1 Outcomes sought by the TEI program

***The TEI outcomes framework outlines a core set of client outcomes that the program aims to achieve***

The core set of client outcomes sought by TEI fall under the seven domains set out in Table 6.1.

Table 6.1 - TEI outcomes framework

| Domain | | Outcome |
|---|---|---|
| | Social and Community | ▪ Increased participation in community events<br>▪ Increased sense of belonging in the community |
| | Empowerment | ▪ Increased self-determination |
| | Education and Skills | ▪ Increased school attendance and achievement |
| | Economic | ▪ Sustained participation in employment |
| | Safety | ▪ Reduced risk of entry into the child protection system |
| | Health (physical and mental) | ▪ Improved health of children and young people<br>▪ Improved parent health |
| | Home | ▪ Sustained safe and stable housing |

The framework is designed to enable monitoring and reporting on outcomes over time for all program activities and its domains are aligned with the Human Services Outcome Framework, which was adopted and progressed by the Social Innovation Council in early 2016.

To measure how each service provider is working towards the outcomes, client information is recorded systematically through the Data Exchange (DEX). Specifically, short-term client outcomes data that is structured to align with the overarching TEI client outcomes is collected through the Standard Client/Community Outcomes Reporting (SCORE) Framework.

This evaluation goes beyond these SCOREs by conducting analysis with qualitative surveys and interviews as well as linked government administrative data analysis. The linked data analyses aim to examine how outcomes of clients have changed over time and determine whether these changes can be attributed to the program. It also assesses the usefulness of SCOREs as an indicator of client outcomes.

Subsections 6.4.1 and 6.5.1 in this Section present findings from linked government data in the Human Services dataset (HSDS). Table 6.2 lists outcomes captured by the HSDS that were examined as part of the outcome evaluation along with the TEI outcome domain they belong to. While all these outcomes were examined, it was not expected that the TEI program would necessarily have a direct measurable

impact on each one of these. The focus of analysis was child protection outcomes in line with TEI's long-term objectives.

Table 6.2 – List of outcomes captured by the Human Services Dataset (HSDS) to be examined

| Outcome domain | Outcomes | |
|---|---|---|
| **Primary outcome area** | | |
| Safety | ▪ Child protection concern reports<br>▪ Risk of Significant Harm (ROSH) reports | ▪ Out of home care (OOHC) episodes – both starting an episode and exit from OOHC |
| **Secondary outcome areas** | | |
| Education and skills | ▪ School attendance*<br>▪ School suspension* | ▪ NAPLAN results*<br>▪ Year 12 completion |
| Safety | ▪ Substantiated ROSH report[43]<br>▪ Court presentations<br>▪ Domestic violence incidents<br>▪ Time in custody | ▪ Proven offences<br>▪ Youth cautions<br>▪ Youth justice conferencing |
| Health | ▪ Mental health support<br>▪ Hospital admissions for mental health | ▪ Hospital admissions for drug and alcohol<br>▪ Drug and alcohol support |
| Home | ▪ Homelessness support – rough sleeping<br>▪ Homelessness support - homeless | ▪ Homelessness support – at risk |

* System changes and COVID-19 have limited our use and reporting on these outcomes. Notes with further detail on data limitations have been added wherever school attendance data has been used. NAPLAN did not proceed in 2020 due to COVID-19 and the latest NAPLAN included in the HSDS was conducted in June 2021.

We examine safety outcomes in the primary outcome area in Section 6.4 and broader outcomes in Section 6.5. An overview of the different approaches used to quantify the impact of TEI on client outcomes can be found in Section 3.3.3, with a summary of results provided in Section 6.3.

In section 6.8 we examine the results from the Satisfaction and Community SCORE assessments. While Satisfaction SCOREs are not a direct reflection of the client outcomes achieved in any specific outcome domain, they are still useful indicators of the client's perception of the delivery of TEI program and program's usefulness in addressing the client's needs. The Community SCOREs provide an indication of the Community outcomes achieved by the program, which are not captured by the HSDS data.

[43] A determination made after DCJ's legally mandated field assessment (the Safety and Risk Assessment, or SARA, part of the NSW Structured Decision Making suite of tools, or SDM) of whether a child is at risk of 'actual harm' following a ROSH report. Refer to the Glossary for detailed definition of ROSH and substantiated ROSH.

## 6.2 Quantitative outcomes evaluation methodology

Section 3.3.3 outlined three key quantitative analyses that form the quantitative component of the outcomes evaluation (full details of all analyses are included in Appendix H):

1. **Individual-level safety outcome modelling using regression** – for child protection outcomes, we used difference-in-difference (DiD) regression models to directly estimate the impact of the TEI program and whether this estimated impact is statistically significant (likelihood of being a genuine difference rather than by chance). We tested outcomes for both children directly interacting with TEI and the children of parents interacting with TEI. The regression models compare the outcomes of TEI children with those in the general population at different quarterly time points since TEI participation after controlling for differences in their risk characteristics.
2. **Individual-level propensity matched comparison for broader outcomes** – rather than building a bespoke regression model for each outcome across every domain of interest, secondary outcomes were examined using a propensity matching approach. By building a model to understand the risk profile of TEI clients, we attempted to construct a comparison group from the broader population who share similar characteristics but had no interaction with TEI. We then calculated and compared the outcomes of TEI clients against this comparison group. In this way, secondary outcomes could quickly be benchmarked against those of the comparison cohort.
3. **Aggregate analysis of child protection safety outcomes** – the first two analyses rely on individual client data that is better populated for the Wellbeing and Safety stream. This means these analyses offer less insight into the effectiveness of the Community Strengthening stream. We attempted to make use of unidentified client data aggregated at the LGA level by examining whether the total number of TEI sessions could explain any regional differences in concern report rates or differences over time.

The analysis goes beyond looking at paired SCOREs in DEX, which can provide insight on how the outcomes of clients have changed over time but not whether the change can be attributed to the program.

### 6.2.1 Structure of DiD regression models

The regression approach used compares the outcomes of TEI children with those in the general population at different quarterly time points since TEI participation after controlling for differences in their risk characteristics. To achieve this:

- For each safety outcome (e.g. concern report), a Generalised Linear Model (GLM) is used to predict the probability of a child having the outcome for each subsequent quarter since program entry.
- Observations for the TEI cohort from the first quarter after program entry were included. This can either be the first quarter that the child themselves was recorded as an individual client of a session, or the first quarter that one of their parents was recorded as an individual client if the child did not directly participate in TEI.
- Children from the general population who had no interaction with TEI were used for comparison by randomly assigning them to quarters between September 2020 (first quarter of TEI) and March 2022 (last quarter in data) and including their observations from that quarter. This assigned quarter is used to determine which cohort of TEI children they will be compared against by the model.
- Standardising variables from a wide range of domains were tested for the model to control for the difference in risk profile as at the time the children enter TEI. This includes the child's demographic factors (e.g. age, indigenous status), service use history for the child and of the parent from domains including safety, justice, health, housing and education (e.g. time since last concern report as at quarter of TEI entry). We have also assumed that the TEI cohort have greater prevalence of

additional risk factors that are not observed in the data due to the selection effect associated with TEI (e.g. in the client interviews we identified parents who suffered from postpartum depression but have not accessed mental health services).

- The statistical significance of the TEI support is determined using a hypothesis test where the null hypothesis is that children with TEI support have outcomes that are no different than those without TEI support. In the regression framework this corresponds to a hypothesis test on a treatment parameter variable. In our case, this is an interaction term between TEI entry flag and quarter since TEI entry terms (duration) as we are examining differences at different quarters post program entry.

Our approach to the regression modelling is a form of difference-in-difference (DiD) estimation. The DiD portion is due to us asking the question of whether the change for the TEI group is more or less than the general population after standardising for differences in risk profile.

DiD regression is widespread in the literature, particularly economics (e.g. Angrist and Pischke 2009). Examples of logistic regression setups (as ours is) include Carlo et al. (2010) and King et al. (2013). The Columbia Mailman School of Public Health has a high-level introduction[44] of the approach. Further details of the methodology that we have adopted, the full list of control variables used for each model and the justification for specific aspects of our methodology can be found in Appendix H.1.2.

## 6.3 Summary of outcomes evaluation results from different methodologies

Table 6.3 summarises the results from each of the methods applied to estimate the impact of TEI on client outcomes. The subsections that follow present these results in detail. We have focussed mainly on the regression results in the body of this report as it was able to consider all linked individual TEI participants in a detailed risk-controlling framework. The need to analyse a large number of outcomes necessitated a more efficient methodology. The propensity-matching method allows the treatment effect on numerous different outcomes to be examined simultaneously, but we found that in our case the established match was not sufficient to draw meaningful conclusions. This was primarily due to the inability to match a significant proportion of TEI clients, especially for clients with higher risk profile and have a greater need of support services (thus having potential for more substantial improvement in outcomes).

Table 6.3 - Summary of results using different methodologies

| Method | Description | Result | Uncertainties and Limitations |
|---|---|---|---|
| Individual-level safety outcome modelling using regression | Quarterly individual-level regression models to conduct targeted measurement and statistical significance testing of the impact of TEI support in reducing child protection outcomes. The individual TEI clients are compared to the | There is evidence that the TEI program is having a positive impact in reducing interactions with the child protection system. At the sixth quarter (i.e. 16-18 months) after TEI entry:<br>▪ The rate of having a concern report is reduced by 6.6% and the rate of remaining in OOHC is reduced by 4.8% in relative terms. Both of these results | ▪ While differences between subgroups were observed, the results were not statistically significant. This could either be due to there being genuinely no difference between client groups or that the sample sizes in the analysis were too |

[44] https://www.publichealth.columbia.edu/research/population-health-methods/difference-difference-estimation

| Method | Description | Result | Uncertainties and Limitations |
|---|---|---|---|
| | general population, controlling for differences in risk characteristics. | were statistically significant (i.e. the improvement is likely to be genuine rather than due to chance).<br>▪ The rate of being screened at ROSH is reduced by 5.0% in relative terms. While this result was not statistically significant given the sample size, it is logical to expect that a reduction in concern reports would also lead to a reduction in ROSH. | small for the model to be confident that the differences observed are unlikely to be due to chance.<br>▪ Difference in the impact of unobserved risk factors between TEI and non-TEI cohorts is uncertain. |
| Aggregate analysis of child protection safety outcomes | Analysis of key outcomes at an LGA level to test whether LGAs with more intense TEI service provision have seen more improvement compared to others | No significant differences by TEI service intensity | ▪ Analysis is at a high level, so a lack of data points makes it hard to establish trends from volatility.<br>▪ There was a lack of variation in TEI intensity, which made it difficult to establish correlation between changing TEI intensity and outcomes. |
| Individual-level propensity matched comparison for the primary and secondary outcome areas (as listed in Table 6.2) | Testing of difference in outcomes across different domains for the TEI group and the comparison group who do not interact with TEI but otherwise have similar characteristics | No evidence of program effect across the outcome areas examined, including the child protection outcomes, as the comparison group outcomes followed similar trends to the TEI group, even in the absence of TEI intervention. | A satisfactory risk match was not able to be established for 20-25% of TEI participants. These unmatched participants are mostly the more complex entrants with more risk factors (and higher rates of poor outcomes). The comparison thus does not reflect holistically on the TEI program. |
| Case studies and surveys | Interviews with staff and clients of five TEI service provider organisations | Various qualitative insights | Small and non-representative sample. The case studies provide supplementary insights to the quantitative analysis rather than conclusive findings. Cannot be used to determine outcomes attributable to or |

| Method | Description | Result | Uncertainties and Limitations |
|---|---|---|---|
| | | | associated with the TEI program. |

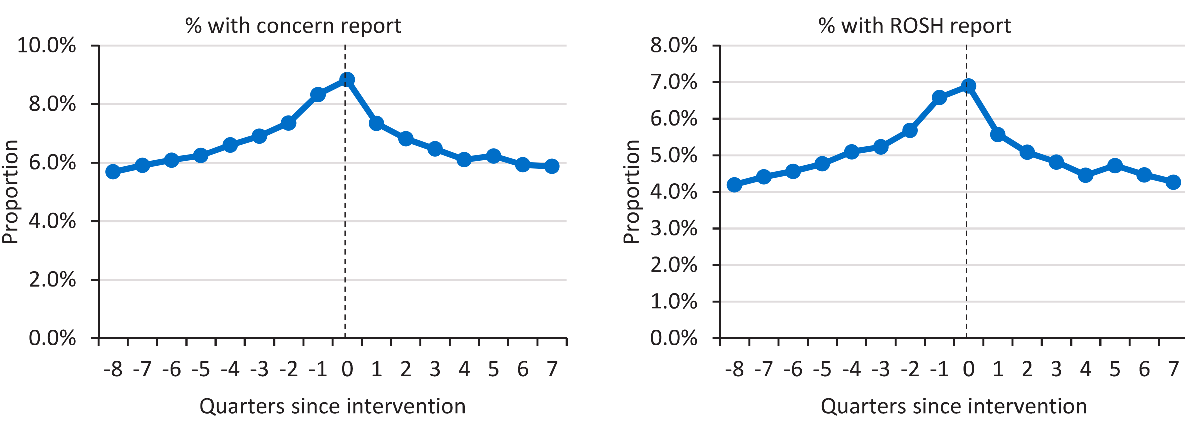
## 6.4 TEI program and its impact on safety outcomes

### 6.4.1 What the data tells us about the impact of TEI on safety outcomes

***Analysis of HSDS data shows that individual clients are seeing improvements in safety outcomes post intervention.***

Through linked cross-sectoral service usage data, we were able to track the rate at which individual TEI participants interact with government services after they enter TEI, including elements of the child protection system. Figure 6.1 shows the proportion of individual TEI clients[45] aged under 18 who had concern reports or ROSH reports in each of the 8 quarters pre- and post-TEI entry, as a measure of safety outcomes. In all outcomes analysis, quarter 0 is defined as the calendar quarter of intervention. All other quarters are calendar quarters relative to the intervention calendar quarter.

Figure 6.1 - Proportion of TEI participants under 18 with concern reports (left) and ROSH reports (right) (HSDS)




The concern reports figure shows that the rates of reports trend upwards towards the point of intervention, before trending downwards afterwards, reaching a level similar to two years pre-intervention, after about a year. This aligns with provider feedback (refer to Section 6.4.2) that participants often enter TEI at crisis points in their lives (often via referral) and that participants do see improvements in their situation afterwards. The regression modelling aims to estimate how much of this observed improvement in outcomes is attributable to the program itself. Appendix H.2.4 includes outcomes charts over time for all outcomes.

***There is evidence that the TEI program is having a positive impact in reducing interactions with the child protection system***

The descriptive analysis above does not attempt to separate the incremental impact of TEI intervention on participants. That is, some of the improvements observed may have eventuated even in absence of TEI. We relied on regression modelling to help attribute part of the change to TEI.

There were four key regression models to separately examine different outcomes for different cohorts:

[45] TEI clients are defined the same way as in Section 5.3, which includes both direct clients and children of the direct clients who are parents. The count of clients included in both analysis are identical.

- **Concern report** – concern report rates amongst those not in OOHC
- **ROSH** – risk of significant harm amongst those not in OOHC
- **OOHC (not in OOHC at entry)** – risk of entering OOHC amongst those not in OOHC
- **OOHC (in OOHC at entry)** – rate of remaining in OOHC amongst those already in OOHC.

Table 6.4 below summarises the model results for the TEI cohort as at six quarters after entry. The estimated impact of participation in TEI is shown as the percentage point (pp.) absolute change in the rate of the modelled child protection outcome. The change relative to the expected rate without TEI support is also shown. The p-value corresponds to the result from a hypothesis test with the null assumption that there is no difference in the modelled outcome due to TEI participation – a smaller p-value means that there is a stronger evidence that those participating in TEI genuinely have changed outcome trajectories. For our analysis we have assumed a p-value of less than 0.05 (5% significance) means there is sufficient evidence to conclude that the difference observed is genuine rather than by chance.

We have chosen to focus on presenting the estimated impact of TEI at six quarters (i.e. 16-18 months) after program entry since we do not have many observations beyond six quarters (TEI was introduced in the September 2020 quarter and our data ends at the June 2022 quarter). A complete summary of the modelled TEI impact for each quarter after entry can be found in Appendix H.1.3.

Table 6.4 – Summary of modelled TEI impact on each child protection outcome, at six quarters after TEI entry

| Model | With TEI support | Expected rate without TEI support | Estimated impact (absolute)[a] | Estimated impact (relative)[b] | 95% confidence interval | p-value (two-sided) | No. of individuals with the outcome in model data |
|---|---|---|---|---|---|---|---|
| Concern report | 9.85% | 10.55% | -0.70pp | -6.6% | (-1.20pp, -0.24pp) | 0.01 | 2,501 |
| ROSH | 7.45% | 7.85% | -0.39pp | -5.0% | (-0.88pp, +0.08pp) | 0.11 | 1,891 |
| OOHC – not in OOHC at entry | 0.82% | 0.69% | +0.13pp | +19.4% | (-0.10pp, +0.34pp) | 0.18 | 208 |
| OOHC – in OOHC at entry | 79.72% | 83.67% | -3.95pp | -4.8% | (-7.15pp, -0.82pp) | 0.01 | 976 |

Notes

(a) Calculated as With TEI support minus Expected rate without TEI support, however differences may occur due to rounding.

(b) Calculated as Estimated impact (absolute), divided by Expected rate without TEI support, however differences may occur due to rounding.

From the table we observe that:

- The relative rates of concern report (9.9%), ROSH (7.5%) and OOHC (0.8%) observed for children not already in OOHC is in line with the intensity of the interactions, with OOHC being the most intensive and infrequent form of child protection interaction.
- The rate of remaining in OOHC for children already in OOHC is relatively high (about 80%) – this is also expected as restoration rates tend to be low and OOHC episodes tend to last longer than a quarter.

- Participation in TEI led to an overall reduction in the likelihood of concern reports, ROSH, and of remaining in OOHC. The model estimates that at six quarters after entering TEI:
  - The rate of having a concern report is reduced by 6.6% in relative terms. This means that for every 100 TEI children who would have ended up with a concern report in the quarter there were 7 children who avoided having a concern report due to participation in the program.
  - The rate of being screened at ROSH is reduced by 5.0% in relative terms. This means that for every 100 TEI children who would have ended up being at ROSH in the quarter there were 5 children who avoided ROSH due to participation in the program.
  - The rate of remaining in OOHC is reduced by 4.8% in relative terms. This means that for every 100 TEI children who would have ended up remaining in OOHC in the quarter there were 5 children who left OOHC due to participation in the program.
- For the rate of concern report and remaining in OOHC, the estimated reductions were statistically significant (at a 5% significance level). This means the decrease in risk measured is likely to be genuine and unlikely to be due to random chance.
- For ROSH, the estimated reduction was not statistically significant (at a 5% significance level). This means given the sample size of the ROSH data, we are not confident that the reduction observed is genuine rather than due to random chance. However, we note that the measured reduction in concern report and ROSH is similar in magnitude and the reduction in concern reports is statistically significant. It's reasonable to expect that a reduction in concern reports would lead to a reduction in ROSH, as fewer concern reports should logically result in fewer cases being screened in at ROSH. The alternative argument is that TEI has only reduced concern reports that are not ROSH reports, which seems less plausible.
- The model estimates that the rate of entering OOHC is increased by 19.4% in relative terms at six quarters after entering TEI. However, the estimated increase is not statistically significant (at a 5% significance level), hence we do not have conclusive evidence of TEI affecting the rate of entering OOHC. This measured difference is in contrast to the results of the provider survey (see section 6.4.2), where 77% of providers believe that the program has been moderately effective, very effective or extremely effective in preventing children from entering OOHC.

The primary uncertainty of retrospective outcome evaluations using linked data is that we can only control for risk factors that are observable from the available data. Further discussions of the model limitations can be found in Appendix H.1.7.

***This measured positive impact on Safety outcomes is larger for children and families that have already been in contact with the child protection system when looking at improvement in absolute terms, but the relative reduction is comparable.***

The regression model set up also allows to test the size of the TEI impact for children with different characteristics (by including interaction terms). This helps us to understand if the program is providing different outcomes for children who are already in contact with the child protection system. From the linked data, 46% of children accessing TEI were already known to child protection as indicated by having least 1 prior concern report upon TEI entry.

Table 6.5 illustrates the modelled impact of TEI on concern report rates six quarters after entry, categorised by whether the child had prior concern reports at the time of program entry. The data show that children with past interactions with child protection are much more likely to have future concern reports. It is estimated that without TEI, 19.6% of children already known to child protection will have concern reports, compared to only 1.9% of those not previously known. TEI support had a greater absolute impact on reducing concern report rates for children already known to child protection, with a 1.3 percentage point reduction versus a 0.1 percentage point reduction, a statistically significant difference. However, the relative impact of TEI was similar for both groups, with a 6.8% reduction for

those known to child protection and a 5.6% reduction for those not known, a difference that was not statistically significant. This indicates that while TEI has a more substantial absolute impact on higher-risk children, its relative effectiveness is comparable across both groups.

Table 6.5 – Impact of TEI at six quarters after entry on concern report rates by whether the child had prior concern reports

**Impact on concern report rate**

| Had prior concern report? | With TEI support | Expected rate without TEI support | Estimated impact (absolute)[(a)] | Estimated impact (relative)[(b)] | 95% confidence interval | No. of clients with the outcome in model data |
|---|---|---|---|---|---|---|
| Yes | 18.22% | 19.55% | -1.34pp | -6.8% | (-2.33pp, -0.39pp) | 2,263 |
| No | 1.83% | 1.94% | -0.11pp | -5.6% | (-0.34pp, 0.13pp) | 237 |

**Impact on ROSH report rate**

| Had prior concern report? | With TEI support | Expected rate without TEI support | Estimated impact (absolute)[(a)] | Estimated impact (relative)[(b)] | 95% confidence interval | No. of clients with the outcome in model data |
|---|---|---|---|---|---|---|
| Yes | 13.83% | 14.55% | -0.72pp | -4.9% | (-1.71pp, 0.18pp) | 1,719 |
| No | 1.33% | 1.42% | -0.09pp | -6.0% | (-0.31pp, 0.16pp) | 173 |

Notes

(a) Calculated as With TEI support minus Expected rate without TEI support, however differences may occur due to rounding.

(b) Calculated as Estimated impact (absolute), divided by Expected rate without TEI support, however differences may occur due to rounding.

***Analysis at an LGA level did not find any relationship between other measures of TEI service provision and safety outcomes***

As discussed, one limitation of the regression analysis is that it only accounts for TEI clients identifiable and linked in the HSDS, which is skewed heavily towards the Wellbeing and Safety stream. We have performed additional analysis of safety outcomes aggregated at an LGA level that tests whether LGAs with more intense TEI service provision (e.g. more group clients/sessions, higher total funding) have seen more improvement compared to others. This is to leverage more of the aggregate data available. There was no evidence that LGAs with more TEI service provision had better safety outcomes than other LGAs, noting that this aggregate level analysis has less data points making it more difficult to isolate real differences.

Full details of the analysis are included in Appendix H.3.4.

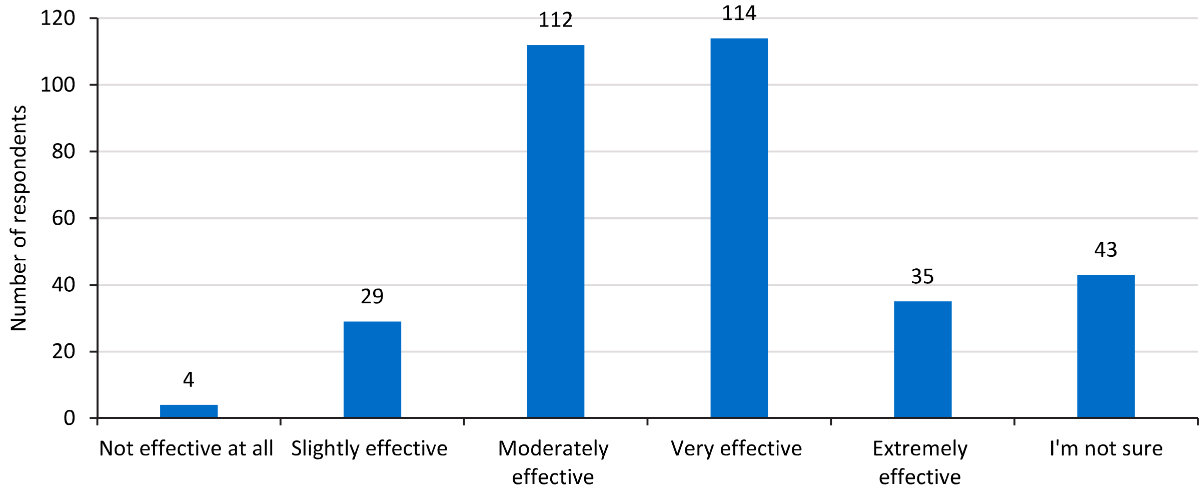
### 6.4.2 Provider feedback about TEI impact on safety outcomes

***Providers are positive about the impacts of TEI services on safety outcomes***

It is important to supplement quantitative data analysis with perspectives from providers and clients about whether they *believe* that TEI is having an impact, based on their own observations. The evaluation found that, overall, providers were largely positive about the outcomes they had observed for TEI services.

When surveyed about child protection outcomes, over 77% of providers indicated that they believed TEI was either moderately effective, very effective or extremely effective (Figure 6.2). This compared to a response rate of less than 10% who believed that TEI was slightly effective or not effective at all.

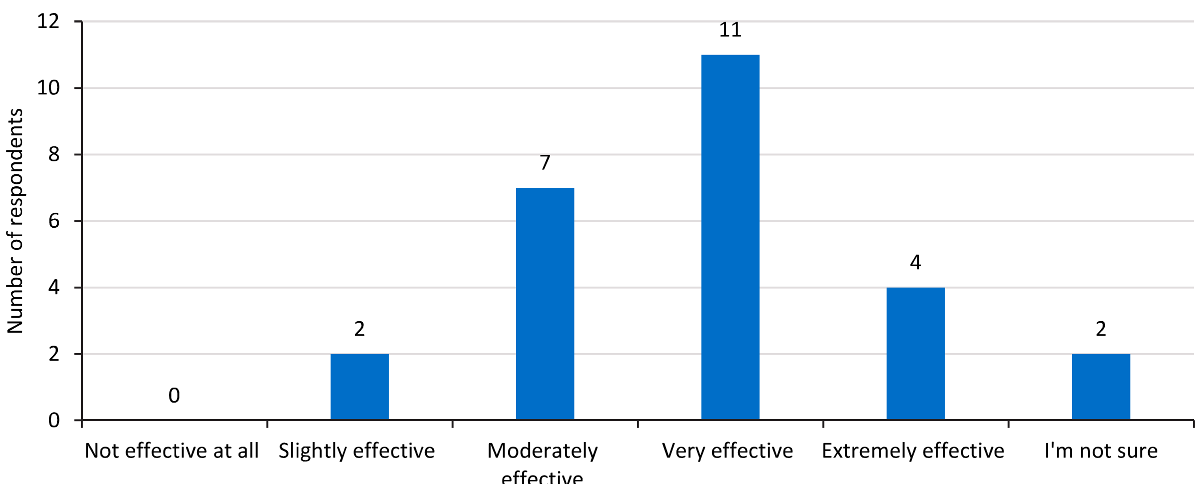
Figure 6.2 – Provider survey results: "From your perspective, how effective is the Targeted Earlier Intervention (TEI) in reducing the risk of children entering into the child protection system over the short term (i.e. over the first 12 months)?", n = 337




For ACCO providers, the results were stronger,[46] with over 85% of providers indicating that they believed TEI was either moderately, very or extremely effective in improving child protection outcomes. Again, this compared to a response rate of less than 10% who believed that TEI was slightly effective or not effective at all.

[46] Noting the smaller sample size of 26 providers.

Figure 6.3 – Provider survey results: "From your perspective, how effective is the Targeted Earlier Intervention (TEI) in reducing the risk of children entering into the child protection system over the short term (i.e. over the first 12 months)?", n = 26 (Providers identifying as Aboriginal Controlled)




In the case studies, the majority of providers indicated that their TEI services have a direct impact on safety outcomes. While caution should be taken in drawing overarching conclusions from a limited number of case studies, these stories provide detail about the ways that TEI can lead to positive safety outcomes.

For example, one provider commented that:

*"I think if you took away what we are doing for parents and their parenting skills, there would be a big toll on families. This directly flows through to Child Protection (outcomes)".*

ACCO providers interviewed in the case studies generally felt that TEI was able to achieve strong safety outcomes for their clients. However, both ACCO case study providers highlighted that the way they delivered TEI required substantial adjustments to meet the needs and requirements of their communities and clients, which corroborates with feedback received from the provider survey. This is further explored in Section 8.

These findings support the findings of the quantitative analysis, which showed there are positive signs of the impact of the TEI program on some safety outcomes for clients.

***Clients interviewed were optimistic about the impact of TEI on safety outcomes.***

The case studies provided important insights into client perceptions about the impacts of TEI. Clients interviewed tended to be enthusiastic about the impact of TEI for their families, describing a broad range of outcomes, including outcomes not included within the TEI Outcomes Framework.[47] Around one quarter of the 47 clients interviewed described positive safety related outcomes occurring as a result of TEI services.

Clients found TEI a vital service for their families in times of great need or heightened vulnerability. For instance, one client prior to accessing TEI services (Family Capacity Building) was in a state of high emotional distress, which in turn was significantly impairing her ability to capably parent. She told us:

> *"My life was in chaos. It meant a lot to me to receive (provider's TEI) support - to go from where we were. We hit rock bottom. I was suicidal...*

[47] Many Aboriginal clients described outcomes that were not included in the TEI Outcomes Framework, particularly cultural outcomes. The importance of these outcomes are discussed in Section 8.3.2.

*I couldn't say where I would be without them. I probably wouldn't have my kids. I would have had to give them up."*

Another client accessed support from a TEI parenting program. The TEI parenting program was able to help put in place essential parenting strategies for the client:

*"(Without Provider's TEI service) I probably would have put my daughter up for adoption. I really felt isolated, and I don't think I would have been able to handle the ups and downs of my child. My family is judgemental, [TEI Provider] listens and helps, they provide me strategies and ways of dealing with my daughter. My family doesn't do that, they just judge me for being a bad parent. I would have been lost."*

Another client highlighted the importance of TEI counselling:

*"The counselling support they provided me has helped me get to a much better place for myself and my kids. In the past, I wasn't doing a good job with my kids. They weren't going to school, and I wasn't really taking them to their medical appointments... it has helped provide me the confidence to not give up on life, that I didn't have to give up on the kids. They make me feel like I could actually do this".*

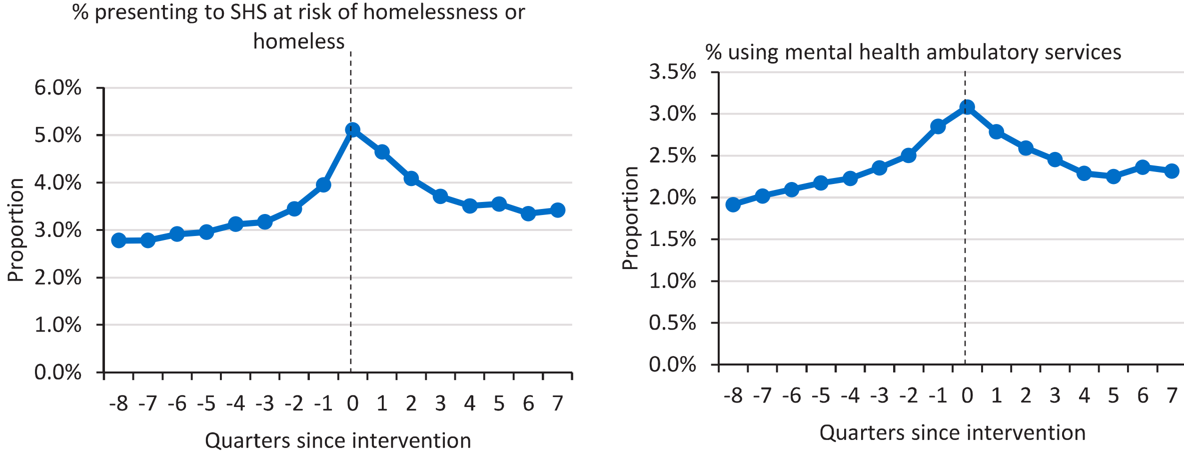
## 6.5 TEI program and its impact on other outcomes

### 6.5.1 What the HSDS tells us about the impact of TEI on other outcomes

***There is evidence of increased referrals to key service areas, such as housing, which shows that TEI services are having an impact in connecting clients to services they need***

In addition to analysis of safety outcomes in Section 6.4.1, we were able to observe the changes in TEI clients' (and their children's)[48] other service usage behaviour before and after intervention. For instance, Figure 6.4 tracks homelessness, as measured by Specialist Homelessness Services (SHS), and mental health ambulatory service usage over time. Tracked outcomes for a broader range of services are included in Appendix H.2.4.

Figure 6.4 - Proportion of TEI participants presenting to Specialist Homelessness Services as homeless or at risk of homelessness (left) or using mental health services (right) (HSDS)




Specialist Homelessness Service presentations in particular increase dramatically (even in comparison to the safety outcomes behaviour in Figure 6.1) in the quarter of TEI intervention and never return to the

[48] Specifically, those identifiable in the HSDS, which is approximately 78% of individual clients from the DEX.

same rate as 8 quarter prior to intervention. Noting that around 15% of TEI providers also provide SHS (as measured by our provider survey), this could be considered a positive outcome of participants being referred to services that they need, rather than a decrease in housing stability following intervention. A similar comment can be made with regards to ambulatory mental health service usage, although the spike is not as pronounced.

This is consistent with responses from provider surveys and interviews, where a commonly praised characteristic of TEI providers' services were their holistic nature and the fact that clients were able to be referred to additional support services as required without having to establish entirely new relationships. This is supported by the client outcomes observed in the HSDS outcomes analysis whereby some services usage increased after the client entered TEI.

Similar comments can be made for other outcomes where interacting with TEI may have increased service usage. As a result, interpreting the results becomes difficult as increases or decreases in service usage do not necessarily indicate an improvement or deterioration in outcomes. Appendix H.2.4 includes outcomes charts for all outcomes.

***The impact of TEI on a range of outcomes was not able to be quantified through the data analysis***

In order to attempt to quantify the TEI impact on a wider range of outcomes, we constructed a comparison cohort by matching each TEI client to a non-TEI person with similar risk characteristics via a propensity score matching methodology. This was to ensure the control and treatment groups are similar and changes in outcomes can be attributed to program participation.

After several attempts, we selected a methodology in which a reasonable match could be found for 80% of TEI clients[49]. However, this means that around 1 in 5 are excluded from the analysis; these were skewed towards the higher risk clients. The inability to compare this high-risk cohort of clients was a significant limitation of the analysis. Additionally, the complexity of interpreting increases and decreases (introduced above) made the results less useful because TEI clients often saw increased service usage after intervention.

A number of the data limitations discussed in Section 3.4 also limited the ability to quantify the impact of TEI on certain outcomes. In particular:

- Some outcomes may not be well recorded in the linked administrative data. For example, underreporting of domestic violence incidence is a well-known issue. Less acute service usage such as non-admitted patient medical services are also not in the dataset (although the data does include mental health ambulatory services).
- Data to test employment outcomes were not available
- Education data were heavily impacted by COVID-19 and system changes.

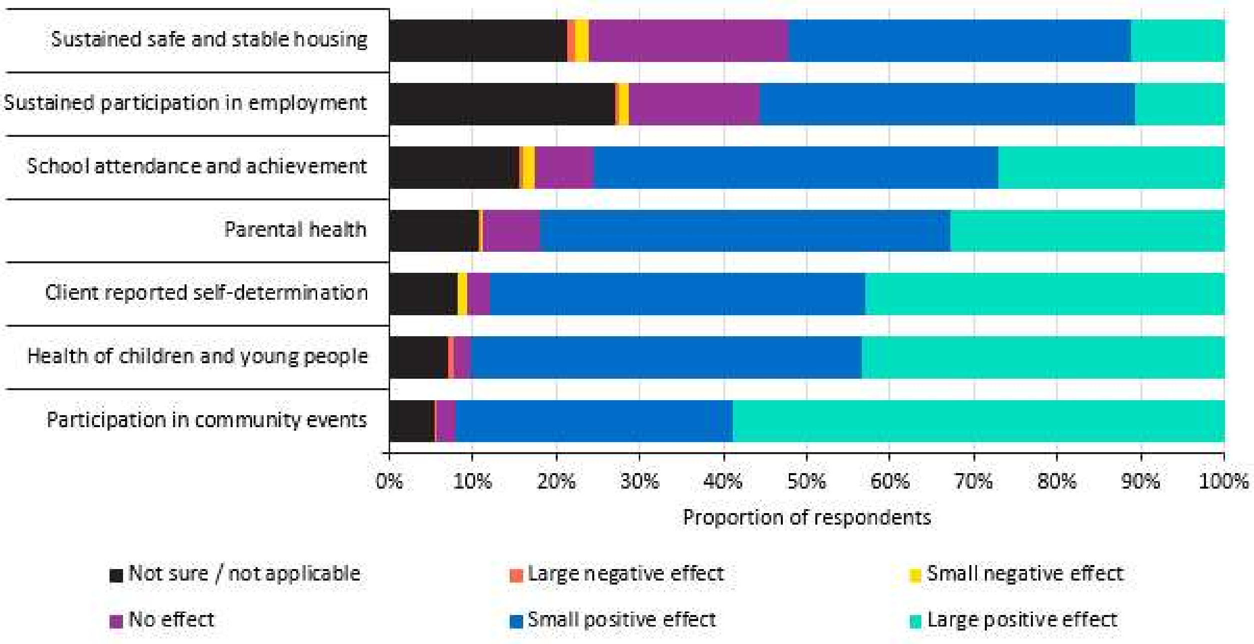
Notwithstanding the above limitations and considerations, we have compared the outcomes pathways for the lower risk matched comparison groups and found that none provided clear evidence of TEI impact. Full details are provided in Appendix H.2

[49] Multiple propensity modelling and matching methodologies were used, including gradient boosted models (GBM) of varying complexity, stratified matching and one-to-many matching. Overall, we found that no methodology was able to find an appropriate matched comparison cohort for all TEI clients. For methods that were able to provide matches for all clients (for example those with looser matching conditions), the matched risk factor distributions were not aligned with the TEI cohort and important behaviours were lost such as the spike of service usage during quarter of intervention.

### 6.5.2 Provider feedback about TEI impact on other outcomes

From the survey, providers generally reported positive perceptions about TEI helping individual clients achieve other outcomes. However, providers did not believe that TEI was equally effective in supporting all outcomes.

Figure 6.5 – Provider survey results – "The TEI program is designed around the TEI Outcomes Framework, which includes the following long term client outcomes. For each outcome, how much of an effect do you believe that the overall TEI program is having on individual clients?", n = 339




As shown in Figure 6.5, providers were surveyed on how well TEI can achieve long term outcomes for clients based upon the TEI Outcomes Framework. The responses indicated the most support for 'sense of belonging to their communities' and 'participation in community events', with over 92% of providers indicating a small or large positive effect for each outcome. The next highest level of support was for 'health of children and young people', and 'client reported self-determination', with 88% and 90% of providers indicating a small or large positive effect for each outcome respectively.

By contrast, providers were sceptical of outcomes achieved by their specific TEI services in 'sustained safe and stable housing', and 'sustained participation in employment', with a corresponding response rate of only 52% and 56% respectively. For each of these outcomes, 24% and 26% of providers respectively instead believed that the TEI services they provided had no effect whatsoever.

Through open text responses and case study interviews, providers provided a range of insights explaining their perspectives on why TEI is unable to achieve full impact in certain outcome domains. This is explored in Section 6.6.1.

***TEI's impact on Social and Community, and Empowerment outcomes***

The case study interviews suggest that TEI can have a positive impact on Social and Community and Empowerment outcome domains.

In the case studies, multiple providers emphasised the importance of advocacy support as a critical component of TEI. Providers explained that the goal of advocacy support was to 'help clients stand on their own two feet', and to help clients feel capable and confident to interact with social services on their own.

One case study provider explained that advocacy was important in helping clients get the services they need, while also helping to alleviate stress from clients who might feel overwhelmed by various applications, assessments and processes involved in the wider social services system.

> *"(Advocacy) is about helping clients to understand what other services might be there, and how to actually engage with those services… you're linking them for support and as a result … they feel less stress."*

Case study providers also explained the wider impact of advocacy support:

> *"Without TEI, we would be placing pressure on every other service… it's helping to prevent clients from being escalated to higher risk and support needs. TEI is very much needed as a touch point that can be accessed by any parent, to help them navigate other services and eventually advocate for themselves. By doing this, TEI is helping to ensure that those families with extreme need don't need to wait as much. I can't even imagine how bad things would be [without TEI]."* Clients interviewed highlighted that advocacy support was particularly beneficial during periods of vulnerability or heightened distress. For example, one client who had very recently escaped domestic violence commented: *"It's really hard to get government paperwork done. And having someone to help - it might sound small but it's a very, very big help.*
>
> *… After [TEI Provider] had helped me a few times, I started to feel confident calling up Centrelink myself, and getting things done for myself and my family. The dread started to fade."*

This support was significant for families coming from CALD backgrounds. One client explained that:

> *"Lots of families need [TEI Provider]. We are all relying on them to get through. Families like mine who are new to Australia; we just don't know where to go for support.*

*… Australia is very different than my country. For example, my mum tells me to listen to my husband, but here (provider) helps me understand I have rights [if my husband mistreats me], and where and how I should go for help."*

***Reduced isolation, particularly for CALD and regional clients***

The case studies noted that TEI can be an important contributor to social connection and reduced isolation. For example, the staff of one provider emphasised how TEI services ensure that clients can access community and support networks in circumstances where they would otherwise feel isolated – leading to social participation and improved mental health. There were examples from clients of how isolation after childbirth drives anxiety and depression. For these clients, the ability to interact with TEI services was a key factor in their ability to maintain their mental wellbeing. For example, one client commented that:

> *"It was important that [TEI Provider] helped me get into a (supported) playgroup. I was going nowhere, and staying home with the kids was making me incredibly stressed. It's been a place I can relax and the kids love it too."*
>
> *"For CALD clients, there's an especially important role for TEI to play. We find that CALD parents are often extremely isolated. Our TEI service helps get them out of the shell. Only once they trust us, are we able to get them to properly engage with other services".*

A caseworker from one provider spoke about the importance of TEI in regional areas, where service coverage is limited for clients requiring more intensive support.

> *"Because of the regional context, our TEI service is especially critical. The communities that we cover just don't have much other services offered there."*
>
> *"There are no services out here that cover those more complex cases. There is a big gap between TEI and statutory removal. For example, Brighter Futures struggles to get out here. [TEI Provider] can*

> *handle it through TEI because we have caseworkers that have backgrounds in child protection. We cover a lot of ground."*

Another caseworker from the same provider explained how the wide range of TEI services help reduce isolation for clients living in remote locations:

> *"… our services do a lot for ensuring our community is more connected - we know that early parenthood is a stressful time. A lot of the parents we see just won't have the outlet or ability to meet others due to sheer distance."*

> *"Often families don't have their own family and community around them. We find a lot of parents struggling alone, or without the knowledge of what to do in certain situations. We can really help provide them that support network and familiarity and help them see parenting strategies in a different light."*

## 6.6 Factors that influence outcomes

We sought to understand the factors that may influence positive outcomes from TEI services. While there is some insight by examining characteristics of the clients and the types of services they received (see Section 6.6.2), results were limited from the linked HSDS analysis. Feedback from providers and clients through survey and interviews, provides information to more deeply understand why and how TEI contributes to positive outcomes (see Section 6.6.1 below).

### 6.6.1 Provider and client feedback on factors that influence outcomes

***Providers believe that external social factors have a strong influence on client outcomes***

In both the provider survey and the case studies, providers discussed a range of environmental factors that may influence outcomes TEI is able to achieve. For example, providers described increased social isolation and delays in accessing services as a result of COVID-19, increased demand services following natural disasters and complexities experienced by families due to cost of living pressures. Without additional resources, providers reported that they were unable to address rising demand for services and thus achieve outcomes.

Several providers suggested that clients are presenting to TEI services with increasing levels of risk and complexity. These providers commented that the ability to achieve positive outcomes is challenged when working with clients who are near crisis point. For instance, one provider commented in the survey:

> *"We are seeing factors such as cost of living, domestic violence, homelessness becoming a key factor in changing demand. We feel that they are driving increasing family dysfunction and reduced parenting capability. This in turn is making clients more and more resource intensive to work with".*

Another surveyed provider commented:

> *"Since COVID, there has been what we consider a tidal wave of young people disengaged from schooling, and those that are presenting with (often undiagnosed) mental illness."*

Several providers commented on the tension they experience between supporting families with early intervention compared to the provision of more concentrated support for children and families experiencing significant crisis or vulnerabilities.

ACCO providers in both the provider survey and case study interviews also commented on the increase in client complexity. Several ACCO providers felt that TEI was experiencing changing demand, with clients presenting with increasingly intensive cases, in turn creating funding and resourcing pressure.

For example, staff at one ACCO commented that they are seeing an increase in the proportion of clients who are presenting with significant and complex support needs, which cannot always be addressed through early intervention focussed supports:

> *"We try not to take families who have an open case with DCJ as it's simply too intense – we are meant to be providing an early intervention service. But it's hard to say no, because we want to be able to support the families."*

The organisation also commented that COVID-19 appeared to be a driver of changing demand:

> *"Ever since COVID, we've noticed a big shift in our clients. It seems like much more support is needed for parenting."*

***Providers and clients emphasised the importance of relationships and connection for outcomes to be achieved***

TEI providers and clients spoke of the importance of trusting relationships between the client and provider, as an important enabler for outcomes to be achieved. In interviews, clients explained that the provider's staff genuinely cared about them and their families. For ACCO providers, there was particular emphasis on the importance of organisations that can have culturally specific understanding and connection.

Providers also felt that having strong connections with the local community and local organisations (such as schools and other community organisations) was also an important enabler which could help to ensure people were aware of the services and how to engage with them.

For example, staff from one provider highlighted that being integrated in the community can mean that TEI provides a soft entry point into the broader social services system, where needed. This was a critical factor in ensuring that clients' wider needs were met and addressed. They see TEI as playing an important role in addressing unmet need in the community, which could otherwise escalate and require more intensive support from other services and providers.

***Providers and clients believe TEI program design elements can influence outcomes***

Providers described multiple ways that TEI program design can affect outcomes for clients. Most frequently mentioned was flexibility. Providers value the flexibility of the TEI program that allows them to adapt services to the needs of their local community. For one organisation, TEI's open and flexible service delivery is important to adapt to clients.

> "*There is no formulated structure in terms of how we achieve engagement with clients. This has created a strong synergy with our ethos of flexibility. It's important as it allows us to prioritise adaptability in meeting the specific needs and goals of the clients*."

This includes meeting clients outside of normal working hours, meeting clients at home, adjusting the intensity or duration of supports provided (as much as possible), and matching clients with the most appropriate case worker based on their cultural or language background. Clients described the benefits of this flexibility:

> *"Dealing with [TEI Provider] is easy. They come to my house which is very convenient, especially for a single mum. They are dealing with me on a personal level. I trust them. It was an easy process."*

***Providers believe that funding levels have an important influence on client outcomes***

Providers value the longer duration of TEI contracts (as compared to previous programs) which helped to increase organisational stability and certainty. However, in survey and interviews, providers explained how funding limitations can impact their ability to create outcomes with clients. For example, providers have had to limit the intensity or duration of supports to clients (even if there are no official time limits within TEI contracts).

Staff from another provider explained that the reality of current funding means that clients cannot be provided individualised supports for longer than six months. They believe that this timeframe is simply too short, relative to the developmental timeline for children, to achieve lasting and deeper outcomes:

> *"We're not sure if we're having the greatest impact, because we must move those kids through in a six-month timeframe and there is usually a long way to go for where they need to be. We can miss some key transition points in a family's lives - like being ready for school, starting school, accessing key services like NDIS".*

At other times, providers weren't able to invest time and resources in 'early' intervention activities because they had to prioritise their limited resources toward people with higher levels of risk. As we saw from the data on safety outcomes (in Section 6.4.1), the TEI support had a greater impact in improving safety outcomes for the higher risk children (indicated by previous interactions with the child protection system / recent OOHC episode). Providers reported the level of funding also affects their ability to invest in organisational capacity and partnership development.

### 6.6.2 Influence of client characteristics and services received on modelled TEI impact

***The modelled impact of TEI for children in the priority cohorts is mixed compared to other children, with a slightly more favourable impact for Aboriginal children and slightly less favourable impact for those at risk of school disengagement or who have a young parent with risk factors. There is also variation observed between DCJ districts.***

We analysed the outcomes from the HSDS data to further understand whether TEI support had a greater impact for certain cohorts of clients than others, such as those with more complex situations or backgrounds mentioned in the provider interviews. This is done using the same set up as the quarterly individual-level regression models introduced in Section 6.4.1 to estimate the impact of TEI in reducing child protection outcomes for specific cohorts of clients. In Section 6.4.1 we have already looked at results for children with and without previous interactions with the child protection system. In this section, we investigate the impact of TEI for children in each of the four priority cohorts[50] as well as by various client characteristics and service use factors.

The tables in this section display the estimated absolute impact of TEI in percentage points as well as the relative impact of TEI (absolute impact as a proportion of the outcome rate without TEI). The corresponding p-values are shown in brackets. Refer to charts in Appendix H.1.5 and H.1.6, and tables in Appendix K.9 for full tabular results including confidence intervals and observed outcome rates.

Table 6.6 presents the modelled impact of TEI for children in each of the four priority cohorts (with the result for all clients as seen in Section 6.4.1 included for reference).

Table 6.6 – Estimated impact of TEI program at 6 quarters after TEI entry, for each priority cohort (absolute impact, relative impact and two-sided p-value)

| Cohort (not mutually exclusive) | % of total child TEI clients | Concern report | ROSH | OOHC – not in OOHC initially (entry rate) | OOHC – in OOHC initially (rate of remaining) |
|---|---|---|---|---|---|
| Aboriginal children | 22% (n=5,621) | -1.13pp -5.6% (p=0.16) | -1.24pp -7.9% (p=0.13) | +0.50pp +34.8% (p=0.20) | -2.78pp -3.3% (p=0.18) |

[50] Separate models are built for each cohort. Detailed definitions for each priority cohort can be found in Appendix G.3. Note that as this section focuses on the child protection outcomes, we examine the outcomes of the children of young parents with risk factors, rather than the outcome of the young parents themselves.

| **Cohort (not mutually exclusive)** | **% of total child TEI clients** | **Concern report** | **ROSH** | **OOHC – not in OOHC initially (entry rate)** | **OOHC – in OOHC initially (rate of remaining)** |
|---|---|---|---|---|---|
| 0 to 5 year olds | 43% (n=11,306) | -0.48pp -5.8% (p=0.19) | -0.19pp -3.2% (p=0.57) | +0.24pp +27.4% (p=0.19) | -4.85pp -5.7% (p=0.06) |
| Children at risk of school disengagement | 13% (n=4,745) | -0.56pp -3.1% (0.49) | +0.18pp +1.4% (0.82) | +0.08pp +9.7% (0.69) | -2.26pp -2.9% (0.51) |
| Have young parent with risk factors | 2% (n=492) | +1.53pp +13.4% (0.52) | +1.51pp +20.3% (0.47) | +2.97pp +202.9% (0.01) | +7.28pp +10.8% (0.52) |
| **All TEI clients (from Section 6.4.1)** | **100% (n=25,391)** | **-0.70pp -6.6% (0.01)** | **-0.39pp -5.0% (0.11)** | **+0.13pp +19.4% (0.18)** | **-3.95pp -4.8% (0.01)** |

The values in each cell of the right four columns are, in order of appearance: the absolute impact of TEI (calculated as Expected rate With TEI support minus without TEI support); the relative impact of TEI (calculated as Estimated impact (absolute), divided by Expected rate without TEI support); and the two-sided p-value from the hypothesis test that the impact of TEI is zero. Results are rounded.

The table shows that for children who have young parents with risk factors, TEI appears to have contributed to a higher rate of entry into OOHC, where the rate with TEI support is about two times higher than what is expected without TEI support and the difference is statistically significant (p=0.01). TEI is also measured to have increased the other child protection outcomes although these results are not statistically significant. The explanation behind these results is unclear. Rather than that the circumstances for these children have deteriorated as a result of TEI, it is possible that the increased interaction with the child protection system is because of better awareness of their existing circumstances due to TEI. In addition, it could be that this cohort tends to have risk factors that were unable to be observed and controlled for using the available data.

Looking at all other priority cohorts in isolation, there is no statistically significant evidence that TEI had an impact on any of the child protection outcomes. We note that conducting analysis at the priority cohort level means working with a smaller sample size. Therefore, there is greater statistical uncertainty in observed results and the corresponding p-values are generally higher. Alternatively, there is also no statistically significant evidence[51] that the relative impact of TEI for clients in each priority cohort is different to clients not in the priority cohort (except for OOHC entry rate for children who have young parents with risk factors compared to children who do not). This means there is no conclusive evidence that TEI was more or less effective for children who were in a priority cohort than those who were not.

In addition to the priority cohorts, we have compared the effectiveness of TEI by clients' age upon entry (banded 0 to 5, 6 to 11 and 12 to 17 years) and their residential DCJ district[52]. The full results as at six quarters after TEI entry are shown in Table 6.7 and Table 6.8 below:

[51] P-value > 0.05 where the p-value corresponds to a hypothesis test with the null hypothesis that the size of the impact of TEI for children in a given priority cohort is the same as children not in the priority cohort.

[52] Comparison by DCJ district is not done for OOHC entry rate due to very low volume of data in some districts.

- By age band, we observe the greatest reduction in concern report and ROSH rate from TEI support for primary school age (age 6 to 11) clients, with around 1pp absolute reduction or 9% relative reduction from TEI. For OOHC rate, the observed impacts between age bands were similar.
- Clients in Northern Sydney had a statistically significant reduction across concern report, ROSH and remaining in OOHC rates at the 5% threshold level. The relative reduction in concern report and ROSH rate from TEI support is the highest among all districts with over 35% relative reduction in both outcomes. This is also the district with the lowest rate of child protection outcomes in general.
- Results for other districts were also mixed, with no districts having unfavourable impact from TEI across all three child protection outcomes. For example, in Central Coast, TEI support have contributed to a 16.6% relative reduction in the in the rate of remaining in OOHC (p<0.01), but with a measured increase in concern report and ROSH rate from TEI support that was not statistically significant.

Table 6.7 – Estimated impact of TEI program on safety outcomes at 6 quarters after TEI entry by age at TEI entry (absolute impact, relative impact and two-sided p-value)

| Age band | % of total child TEI clients | Concern report | ROSH | OOHC – not in OOHC at TEI entry quarter (entry rate) | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|---|
| 0 to 5 years old | 45% (n=11,306) | -0.53pp -6.3% (p=0.16) | -0.22pp -3.6% (p=0.53) | +0.21pp +23.8% (p=0.24) | -4.45pp -5.2% (p=0.09) |
| 6 to 11 years old | 31% (n=7,828) | -1.16pp -9.3% (p=0.02) | -0.89pp -9.3% (p=0.04) | +0.07pp +10.4% (p=0.59) | -3.58pp -4.3% (p=0.19) |
| 12 to 17 years old | 25% (n=6,257) | -0.63pp -5.1% (p=0.22) | -0.01pp -0.2% (p=0.98) | -0.03pp -7.2% (p=0.85) | -3.61pp -4.4% (p=0.16) |

Table 6.8 – Estimated impact of TEI program on safety outcomes at 6 quarters after TEI entry by DCJ district (absolute impact, relative impact and two-sided p-value)

| DCJ district | % of total child TEI clients | Concern report | ROSH | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|
| Mid North Coast | 5% (n=1,353) | -2.65pp -14.9% (p=0.04) | -0.97pp -7.1% (p=0.47) | -14.95pp -18.9% (p=0.01) |

| DCJ district | % of total child TEI clients | Concern report | ROSH | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|
| New England | 5% (n=1,175) | -1.69pp -10.6% (p=0.18) | -0.36pp -3.2% (p=0.83) | +10.11pp +15.2% (p=0.19) |
| Northern NSW | 5% (n=1,209) | +1.33pp +15.1% (p=0.21) | +0.21pp +4.1% (p=0.82) | -0.76pp -0.9% (p=0.88) |
| Murrumbidgee | 3% (n=694) | -1.98pp -10.4% (p=0.26) | -1.09pp -7.5% (p=0.52) | -8.64pp -10.7% (p=0.25) |
| Western NSW | 8% (n=2,034) | -0.93pp -5.3% (p=0.49) | -0.36pp -2.7% (p=0.75) | +1.03pp +1.3% (p=0.84) |
| Central Coast | 4% (n=1,012) | +0.62pp +5.8% (p=0.57) | +0.10pp +1.2% (p=0.92) | -15.63pp -16.6% (p=0.00) |
| Hunter | 8% (n=1,874) | -2.23pp -13.1% (p=0.03) | -0.19pp -1.6% (p=0.85) | +9.67pp +12.6% (p=0.02) |
| Nepean Blue Mountains | 7% (n=1,641) | -1.48pp -15.7% (p=0.09) | -1.76pp -21.6% (p=0.03) | -2.90pp -3.4% (p=0.56) |
| Western Sydney | 11% (n=2,867) | +0.08pp +1.2% (p=0.92) | +0.56pp +10.9% (p=0.26) | -11.07pp -12.2% (p=0.00) |
| Northern Sydney | 4% (n=908) | -2.23pp -37.0% (p=0.01) | -1.69pp -38.1% (p=0.01) | -6.65pp -6.6% (p=0.02) |
| South Eastern Sydney | 6% (n=1,587) | -1.44pp -22.0% (p=0.04) | -0.88pp -18.2% (p=0.17) | -6.15pp -7.3% (p=0.44) |
| Sydney | 6% (n=1,389) | -0.80pp -11.6% (p=0.35) | -1.18pp -20.1% (p=0.18) | -12.24pp -14.0% (p=0.12) |

| DCJ district | % of total child TEI clients | Concern report | ROSH | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|
| South Western Sydney | 23% (n=5,618) | +0.64pp +9.3% (p=0.21) | +0.01pp +0.2% (p=0.94) | -4.86pp -5.2% (p=0.10) |
| Illawarra Shoalhaven | 4% (n=1,119) | -1.13pp -8.5% (p=0.34) | +0.14pp +1.9% (p=0.87) | +3.52pp +4.9% (p=0.60) |
| Southern NSW | 2% (n=464) | -3.26pp -25.4% (p=0.05) | -2.86pp -27.8% (p=0.09) | -11.28pp -12.6% (p=0.22) |

Note: the impact of TEI on the OOHC rate for children not in OOHC upon entry is not presented as the volume of the target is very low in some districts, failing to satisfy data privacy requirements. Results for Far West are not shown for the same reason.

***The type of program activity and service types that the clients receive seem to have an impact on the effectiveness of the TEI support, as well as the total number of sessions received***

As discussed in the previous section, providers have raised program design elements and the intensity/duration of support as factors that influence outcomes. We test this in the outcomes data by comparing the modelled impact of TEI for clients by the program activity, service type and number of sessions they have received, again using the same regression model and testing structure. The list of service types within each program activity and their definitions are included in Appendix B.

We observed that clients who received Intensive or Specialist Support have the highest rate of interacting with the child protection system post program, followed by those receiving Targeted Support and then Community Support. However, this is expected given the design and nature of these program activities and consistent with our observation in Section 5.3.1 where we see that clients receiving Intensive or Specialist Support are the most at risk.

Looking at the estimated impact of the TEI program on clients by program activity shown in Table 6.9 below:

- From the Community Strengthening stream, clients who accessed services from Community Centres had a reduction in all three of the child protection outcomes modelled compared to the expected rate based on their risk profile. The results for the other two program activity types are more mixed. However, the results for the Community Strengthening stream are more uncertain as they only have a small proportion of individual clients recorded and able to be linked to the HSDS. Overall, none of the results were statistically significant at the 5% significance threshold meaning there was insufficient evidence to conclude that any of these results did not occur by chance. However, the results for Community Centres is consistent with what providers have flagged to be effective design factors in their feedback. Community Centres provide a place for people in the community to meet and connect and is also a soft entry point for referral to other supports.
- From the Wellbeing and Safety stream, clients who received Targeted Support had larger measured relative reductions across all child protection outcomes than those who received Intensive or Specialist Support (note for rate of entry into OOHC it is a smaller relative increase). However, again these results were not statistically significant. The uncertainty in the results for Intensive or Specialist

Support is higher, as the volume of clients who have received the support is less, which contributed to higher p-values.

Table 6.9 – Estimated impact of TEI program on safety outcomes at 6 quarters after TEI entry by program activity (absolute impact, relative impact and two-sided p-value)

| **Program activity** | **% of total child TEI clients** | **Concern report** | **ROSH** | **OOHC – not in OOHC at TEI entry quarter (entry rate)** | **OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC)** |
|---|---|---|---|---|---|
| Community Connections | 5% (n=1,148) | -0.33pp -4.2% (p=0.40) | +0.06pp +1.0% (p=0.84) | +0.01pp +2.6% (p=0.98) | -2.02pp -2.5% (p=0.62) |
| Community Centres | 8% (n=1,927) | -0.34pp -3.6% (p=0.42) | -0.18pp -2.6% (p=0.70) | -0.09pp -14.8% (p=0.50) | -5.57pp -6.4% (p=0.08) |
| Community Support | 13% (n=3,416) | -0.35pp -3.5% (p=0.36) | +0.10pp +1.4% (p=0.78) | +0.31pp +64.6% (p=0.05) | -5.24pp -6.4% (p=0.10) |
| Targeted Support | 70% (n=17,669) | -1.04pp -8.9% (p=0.00) | -0.53pp -6.1% (p=0.06) | +0.22pp +30.6% (p=0.08) | -3.19pp -3.8% (p=0.08) |
| Intensive or Specialist Support | 5% (n=1,231) | -1.07pp -5.5% (p=0.30) | -0.05pp -0.4% (p=0.94) | +0.85pp +74.6% (p=0.06) | -1.47pp -1.8% (p=0.66) |

We then compared the impact of TEI by the service types that clients have received. The uncertainty in these results is even greater as the number of clients receiving each individual service type is less (especially for Community Strengthening stream services). However, we do note that clients who have received Specialist Support and Counselling services stood out as having the largest modelled reduction in concern report and ROSH outcomes as shown in Table 6.10 below, with relative reduction measured at 10-20% for both outcomes. Due to the lower volume of clients who have received these services the p-value associated with these measured reductions are also higher, where only the reduction in concern report for counselling services is below the significance threshold of 5%.

Counselling services can fall under both Targeted Support and Intensive or Specialist Support program activity types, while Specialist Support is only delivered under the latter activity type. As discussed in the Interim Report and again in Section 5.2, Intensive or Specialist Support activities are less readily available in the more remote regions.

Table 6.10 – Estimated impact of TEI program on safety outcomes at 6 quarters after TEI entry by service type (absolute impact, relative impact and two-sided p-value)

| Service type | % of total child TEI clients | Concern report | ROSH | OOHC – not in OOHC at TEI entry quarter (entry rate) | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|---|
| Indigenous services | 3% (n=1,436) | +0.28pp +2.0% (p=0.8) | +0.90pp +8.7% (p=0.17) | +0.33pp +42.7% (p=0.23) | -2.83pp -3.4% (p=0.58) |
| Social Participation | 9% (n=4,867) | -0.11pp -1.4% (p=0.82) | +0.19pp +3.2% (p=0.55) | -0.02pp -4.4% (p=0.94) | -9.07pp -10.5% (p=0.01) |
| Community Engagement | 5% (n=2,596) | -0.24pp -3.1% (p=0.64) | -0.01pp -0.2% (p=0.99) | *Not enough data* | +5.06pp +6.3% (p=0.43) |
| Education and Skills Training | 9% (n=4,657) | -0.76pp -8.3% (p=0.1) | -0.11pp -1.6% (p=0.71) | +0.12pp +28.0% (p=0.29) | -2.18pp -2.6% (p=0.51) |
| Information/Advice/Referral | 22% (n=11,335) | -1.06pp -7.4% (p=0.01) | -0.47pp -4.5% (p=0.19) | +0.30pp +34.5% (p=0.07) | -3.29pp -4.0% (p=0.15) |
| Advocacy and Support | 4% (n=2,050) | +0.30pp +2.4% (p=0.7) | +0.29pp +3.3% (p=0.58) | +0.04pp +6.3% (p=0.85) | -6.11pp -7.5% (p=0.16) |
| Counselling | 4% (n=1,992) | -2.39pp -14.3% (p=0.01) | -1.13pp -9.5% (p=0.1) | +0.14pp +22.0% (p=0.51) | +2.33pp +2.9% (p=0.61) |
| Family Capacity Building | 18% (n=9,009) | -1.17pp -7.1% (p=0.02) | -0.40pp -3.3% (p=0.25) | +0.28pp +25.8% (p=0.16) | -0.12pp -0.1% (p=0.98) |
| Material Aid | 5% (n=2,822) | -0.61pp -4.2% (p=0.39) | +0.24pp +2.2% (p=0.65) | +0.43pp +49.0% (p=0.08) | -1.09pp -1.3% (p=0.81) |
| Mentoring/Peer Support | 3% (n=1,692) | -0.99pp -6.9% (p=0.2) | -0.08pp -0.7% (p=0.92) | +0.47pp +47.0% (p=0.15) | -6.20pp -7.1% (p=0.2) |
| Parenting Programs | 7% (n=3,422) | -0.28pp -2.5% (p=0.6) | -0.18pp -2.0% (p=0.68) | +0.61pp +53.0% (p=0.03) | -6.02pp -7.0% (p=0.04) |

| Service type | % of total child TEI clients | Concern report | ROSH | OOHC – not in OOHC at TEI entry quarter (entry rate) | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|---|
| Supported Playgroups | 10% (n=5,185) | -0.04pp -0.7% (p=0.91) | +0.33pp +8.4% (p=0.21) | +0.43pp +329.0% (p=0.00) | +0.75pp +1.0% (p=0.9) |
| Specialist Support | 1% (n=373) | -2.61pp -13.2% (p=0.17) | -3.04pp -21.3% (p=0.07) | *Not enough data* | -4.49pp -5.4% (p=0.44) |

Note: Service types that can fall under multiple program activity (e.g. Information/Advice/Referral) are grouped and analysed as one category. Indigenous specific service types are also grouped into one broad category as the number of clients who have received the services are small, failing to satisfy data privacy requirements. The service type Facilitating Employment Pathways is excluded from all models, while Community Engagement and Specialist Support are excluded from the OOHC model for children not initially in OOHC, again due to small data volumes.

Lastly, we compared the impact of TEI by the number of sessions the clients have received in Table 6.11 below. Greater reductions in child protection interactions are observed for clients with a larger number of sessions. The results reflect the feedback from providers – where clients with more sessions received are also those in a more intensive situation as indicated by higher rate of past child protection outcomes. The support these clients received from TEI helped them to achieve a greater percentage point (absolute) reduction in the outcomes rate as well as a greater relative reduction.

Table 6.11 – Estimated impact of TEI program on safety outcomes at 6 quarters after TEI entry by number of sessions attended (absolute impact, relative impact and two-sided p-value)

| Number of sessions attended | % of total child TEI clients | Concern report | ROSH | OOHC – not in OOHC at TEI entry quarter (entry rate) | OOHC – in OOHC at TEI entry quarter (rate of remaining in OOHC) |
|---|---|---|---|---|---|
| 1 to 5 | 45% (n=11,414) | -0.56pp -5.9% (p=0.04) | -0.40pp -5.8% (p=0.13) | +0.11pp +16.9% (p=0.38) | -2.30pp -2.8% (p=0.31) |
| 6 to 15 | 28% (n=7,006) | -0.59pp -5.5% (p=0.13) | -0.12pp -1.5% (p=0.71) | +0.15pp +22.8% (p=0.31) | -4.75pp -5.6% (p=0.06) |
| 16 to 30 | 14% (n=3,569) | -1.77pp -15.7% (p=0) | -1.32pp -15.8% (p=0.00) | +0.33pp +57.7% (p=0.08) | -10.67pp -12.0% (p=0.00) |
| Over 30 | 13% (n=3,402) | -1.81pp -12.0% (p=0.01) | -1.18pp -10.3% (p=0.03) | -0.01pp -1.5% (p=0.98) | -4.03pp -4.7% (p=0.26) |

## 6.7 Unanticipated outcomes from the TEI program

***Aboriginal clients spoke of cultural outcomes which aren't being captured through TEI reporting***

Across the ACCO case studies, we heard numerous examples of Aboriginal clients achieving cultural outcomes as a result of receiving TEI service from ACCO providers. These are discussed within Section 8.3.2.

***From the HSDS linked data, there is an unanticipated increase for rate of entry into OOHC after receiving TEI support***

As shown earlier in Section 6.4.1, there is an unexpected increase in the OOHC entry rate after receiving TEI (or having a parent who received TEI), compared to the rate we expect to see given their risk profile. However, this result wasn't statistically significant so there is insufficient evidence to conclude it did not occur by chance rather than being a genuine effect of the program. If the effect is genuine, it is unclear whether it is explained by a genuine deterioration in circumstances due to TEI or that TEI has led to better awareness of their existing circumstances.

## 6.8 Client satisfaction and community SCOREs

Providers are required to collect satisfaction SCORE assessments for at least 10% of individual clients per reporting period. When it is not feasible to collect SCOREs from individual clients at a session, Community SCOREs should be collected (See Section 2.3 for details on SCORE collection). The satisfaction SCORE reflects clients' attitudes toward the program and the services they received, while the Community SCORE is aimed at measuring group and Community outcomes, both of which are not directly captured in the HSDS. In the sections below, we examine the results from these SCORE assessments captured in DEX to supplement the analysis of the observable client outcomes from HSDS. Satisfaction and community scores can be considered among indicators of program effectiveness.

### 6.8.1 Client satisfaction

***Across different service types and provider districts, clients have reported high level of satisfaction with the services they have received and believe the service was helpful in addressing their needs***

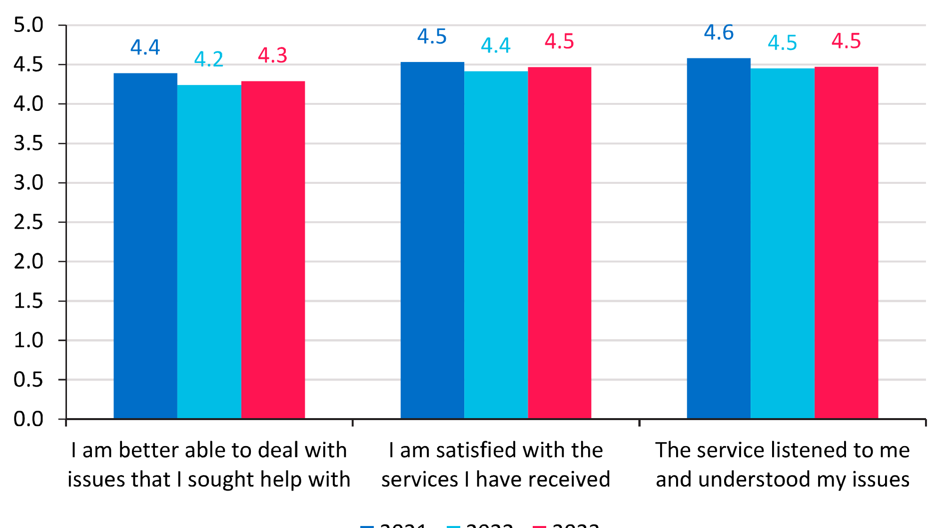
The satisfaction SCORE relates to three key questions about a client's perceptions of the responsiveness and value of the service received:

- The service listened to me and understood my issues
- I am satisfied with the services I have received
- I am better able to deal with issues that I sought help with.

The Satisfaction SCOREs are reported on the same five-point rating scale as the other outcome types (Goals and Circumstances SCOREs), which ranges from 1 (the client disagrees with the statement) to 5 (the client agrees with the statement), with 3 indicating neutrality (the client neither disagrees nor agrees). The average SCORE for each of the three questions by year is shown in Figure 6.6. Most clients either agree or strongly agree with the statements above regarding the services they received. This reaffirms the positive feedback received from providers client interviews.

When interpreting these SCORE results, it is important to note that satisfaction SCOREs are collected from less than one-third of individual clients and collection biases may exist (see Section 4.2.2 and Appendix D.2 for details).

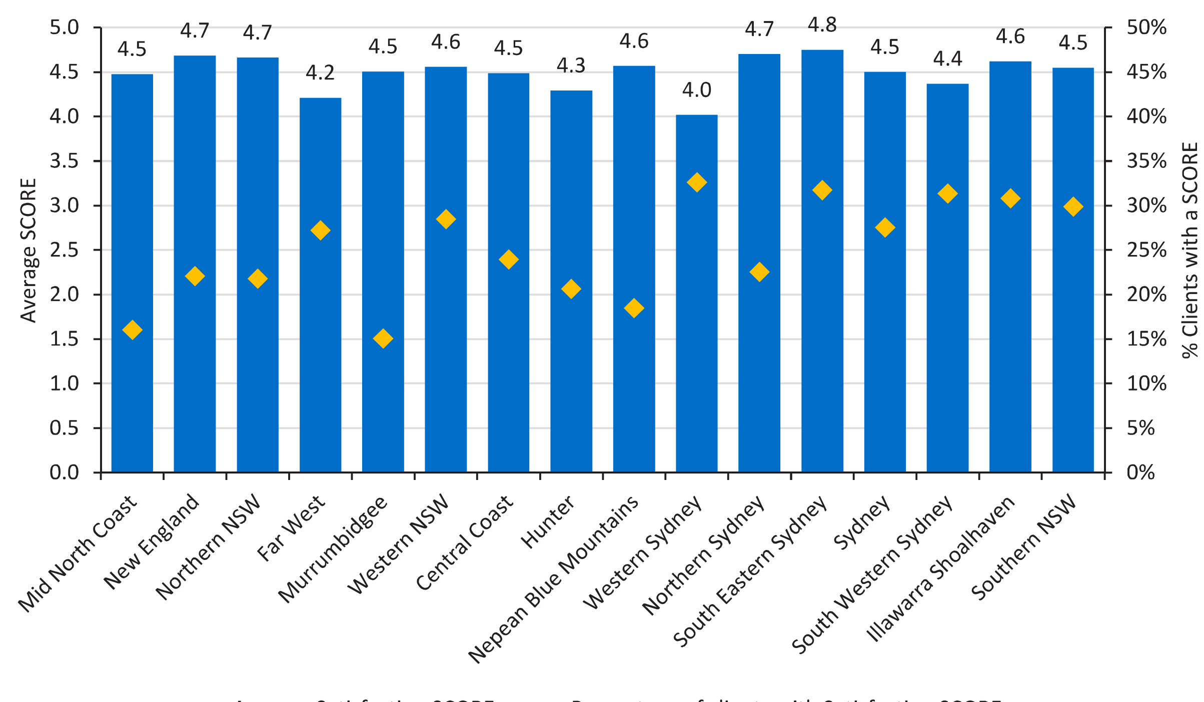
Figure 6.6 – Average satisfaction SCORE for each outcome domain by year (DEX)




Across most service types, clients have generally agreed or strongly agreed with the "I am better able to deal with issues that I sought help with" statement or SCORE domain. The average ratings for all service types are greater than four except for the service types Indigenous Advocacy/Support and Advocacy/Support. This is driven by one provider in Nepean Blue Mountains with very low average ratings for these services (almost all ratings were a one in 2021-22 and 2022-23) and which accounts for a significant proportion of surveys conducted in relation to these services, a possible data issue. Excluding this outlet, all service types have average ratings greater than four. The average SCORE and the volume of clients assessed for each service type can be found in Appendix H.5.

There were some differences between districts in terms of reported client satisfaction based the average of the three Satisfaction SCORE domains, as shown in Figure 6.7 below. This could be due to genuine differences in service quality, but it may also be due to differences in client mix and/or data recording. We have excluded from the chart the outlet from Nepean Blue Mountains with the potential data issue, which results in a higher average SCORE for the region. In addition, the SCORE rating is impacted by how it was collected and who it was completed by, and some cohorts of clients were more likely than others to have SCOREs recorded. SCOREs may therefore not be representative of the overall TEI population, and some caution should be applied in drawing conclusions at a program-wide level.

Figure 6.7 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district (DEX, all years)




*Note: To avoid distorting the broader trend, we have excluded SCORE results from the one outlet in Nepean Blue Mountains due to the potential data issue described in Section 6.8.1.

A breakdown of Satisfaction SCORE results by district for each individual domain can be found in Appendix H.5. For an analysis of Satisfaction SCOREs amongst Aboriginal clients, see Section 8.3.3.

### 6.8.2 Community outcomes (from Community SCORE assessments)

In this Section we focus on two of the Community SCORE domains that are primarily aimed at measuring outcomes for the client attending the sessions:

- Group/community knowledge, skills, attitudes and behaviours (e.g. clients have a better understanding of what services are available in their community / feel they have learnt parenting tips which they can apply at home)
- Social cohesion (e.g. clients feel more connected to their community after the event)

The outcomes are measured on the same 5-point scale as the individual SCOREs, with 1 representing no change and 5 representing significant change. Figure 6.8 below shows that the sessions assessed have generally led to a positive change in clients' knowledge/skills and helping them to feel more socially connected. A gradual increase is also seen over time.

Figure 6.8 – Average Community SCORE rating by year and domain (DEX, all years)

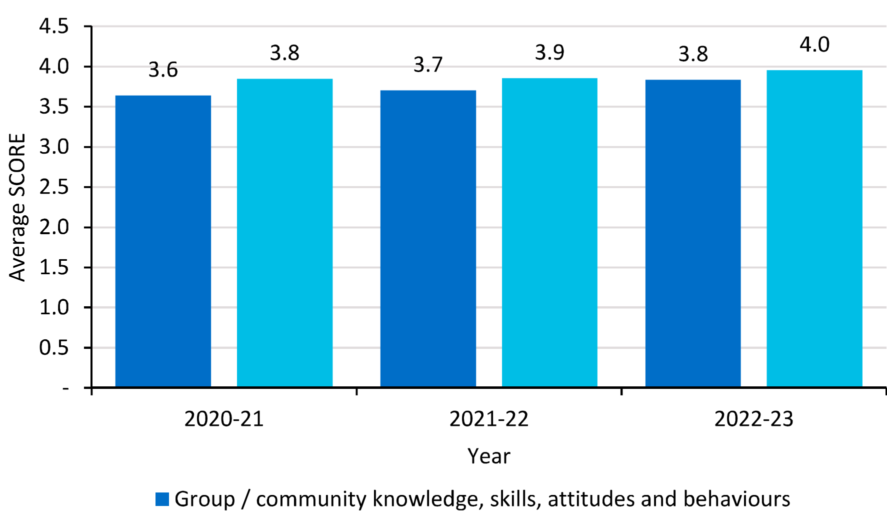
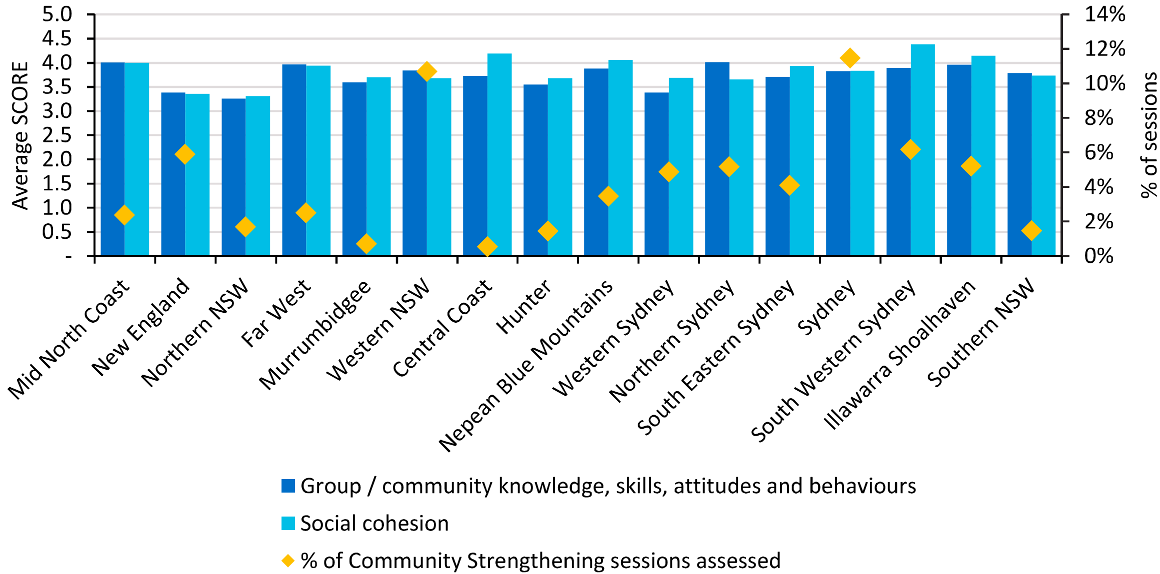



Figure 6.9 below shows that the positive change as measured by community SCOREs is observed across all districts, with some variations. When interpreting these results, it is important to note that the underlying number of clients present at these sessions can be vastly different as shown in Section 4.2.2 which may affect the robustness of the results. Variation in the proportion of sessions assessed as shown in the chart below as well as how the SCOREs are collected may also limit the comparability of results.

Figure 6.9 – Average Community SCORE rating by domain and overall proportion of Community Strengthening sessions assessed for each district (DEX, all years)




While we have not attempted to assess Community SCORE ratings (due to the lack of community outcomes being recorded in HSDS), we recognise the importance of their subject matter, particularly for Community Strengthening streams. They directly measure outcomes related to the *Empowerment* and *Social and Community* domains of the NSW Human Services Outcomes Framework, which are not easily measured in government administrative datasets.

# 7 SCORE relationship with observed client outcomes

In addition to the Satisfaction SCOREs, providers are also required to collect Circumstances and Goals SCOREs from individual clients to measure their outcomes across a range of domains including the clients' family safety, housing, education and health situations (See Section 2.3 for details on SCORE collection). These are recorded on a five-point scale:

- Circumstances SCOREs – a score of five represents the client's circumstance for the domain is adequate and stable over the medium term, while a score of one represents the client's circumstance is having a negative impact on independence, participation and wellbeing.
- Goals SCOREs – a score of five represents the client's goals in the domain are fully achieved, while a score of one represents no progress.

The full list of Circumstances and Goals domains can be found in Appendix H.4.1.

In this evaluation, we have not used the Circumstances and Goals SCORE results to directly measure client outcomes. This is because the outcomes from the primary outcome area (child protection outcomes) and the secondary outcome areas (Education and skills, Safety, Health, Home outcomes) of the evaluation can be directly observed in the HSDS data for linked individual clients. The data from HSDS is more robust and improvement in HSDS outcomes can be directly tied to quantifiable program benefits, while the SCORE assessments are regarded as more of a secondary source of client outcomes and are also subject to collection biases.

In spite of this, there remains an important question of whether the SCORE is a useful indicator of client outcomes given how it is currently collected and the rate of collection[53]. This would make it useful in understanding client outcomes when the underlying service use data of the client in the various domains are not readily available and to inform service provision for the TEI provider. For individual clients who can be linked in the HSDS and have Circumstances or Goals SCORE recorded, we have tested the relationship of clients' SCORE rating from each of the Circumstances domains (e.g. Personal and family safety, mental health) and Goals domains (e.g. Increasing Skills, Changing behaviours) with their observed outcomes. This was done to answer the questions of whether individual SCORE results are useful indicators of client outcomes following the session, and whether change in SCORE results over time reflects the measured change in their outcomes over the same period. Specifically, outcomes from three safety domains and one housing domain have been tested:

- Concern report
- ROSH
- Being victim of domestic violence
- At risk of homelessness.

Only children aged 0-17 are included in the analysis of concern report and ROSH outcomes, however the recorded SCORE survey result is taken from both the child's own client record as well as their parent's client record. For the analysis of domestic violence and at risk of homelessness, only adults aged 18+ are included in the analysis. This is because in administrative data records of domestic violence incidents and homelessness support tend to be under the parents in the household.

***Results from client Circumstances and Goals SCOREs are a direct indication of expected client outcomes in the quarter following the session.***

[53] Current collection rate of Circumstances and Goal SCOREs are below the target of 50% and biases exist in who the SCOREs are collected from (see Section 4.2.2 for details)

We first tested the direct correlation between a client's latest SCORE recorded in a given quarter and whether they will have a given observed outcome in the following quarter. This was done separately for each of the SCORE domains and we observed that there is a statistically significant negative correlation[54] across most domains for each outcome. A negative correlation means that higher SCORE results in the domain correspond to a lower likelihood of having an adverse outcome, hence providers can use the SCORE result as an indicator of the client's risk level after the session and tailor subsequent service provision to the client.

Table 7.1 and Table 7.2 below show the Circumstances and Goals domains with the most negative correlations (as determined by the correlation coefficient $\rho$) for each outcome, along with the relative probability in having the given outcome for clients with a SCORE of 1 or 2 (negative outcome) compared to clients with a SCORE of 4 or 5 (positive outcome). For example, 27% of clients (or children of clients) with a SCORE rating of 1 or 2 in the Personal and Family safety domain had a concern report recorded in the quarter following the SCORE assessment. This was 2.6 times more likely than clients with a SCORE rating of 4 or 5 in the same domain, where only 10% of the clients had a concern report recorded in the following quarter.

Table 7.1 – Circumstances SCORE domain with the most negative correlation with each outcome

| Outcome | Circumstances SCORE domain | Correlation coefficient $\rho$ | Prob. of outcome amongst clients with SCORE of 1 or 2 (A) | Prob. of outcome amongst clients with SCORE of 4 or 5 (B) | Relativity (A) / (B) |
|---|---|---|---|---|---|
| Concern report | Personal and Family safety | -0.18 | 27% | 10% | 2.6x |
| ROSH | Personal and Family safety | -0.17 | 22% | 8% | 2.8x |
| Victim of D.V. | Personal and Family safety | -0.10 | 11% | 4% | 2.4x |
| At risk of homelessness | Housing | -0.12 | 15% | 7% | 2.3x |

Table 7.2 – Goals SCORE domain with the most negative correlation with each outcome

| Outcome | Goals SCORE domain | Correlation coefficient $\rho$ | Prob. of outcome amongst clients with SCORE of 1 or 2 (A) | Prob. of outcome amongst clients with SCORE of 4 or 5 (B) | Relativity (A) / (B) |
|---|---|---|---|---|---|
| Concern report | Empowerment, choice and control | -0.12 | 20% | 10% | 2.1x |
| ROSH | Reducing Impact of immediate crisis | -0.10 | 19% | 11% | 2.1x |

[54] P-value < 0.0001 from a hypothesis test with no correlation between SCORE and observed outcome as the null hypothesis

| Outcome | Goals SCORE domain | Correlation coefficient $\rho$ | Prob. of outcome amongst clients with SCORE of 1 or 2 (A) | Prob. of outcome amongst clients with SCORE of 4 or 5 (B) | Relativity (A) / (B) |
|---|---|---|---|---|---|
| Victim of D.V. | Reducing Impact of immediate crisis | -0.07 | 9% | 5% | 1.7x |
| At risk of homelessness | Increasing skills | -0.05 | 6% | 3% | 1.9x |

Additional results for each outcome can be found in Appendix H.4. From the results we can also observe that:

- The measured outcomes generally have a stronger relationship with Circumstances SCOREs than with Goals SCOREs (as indicated by higher $\rho$ values).
- The SCORE domains with the strongest correlation with a given outcome are the ones that we would expect to be the most relevant based on what it measures – the "personal and family safety" and the "family functioning" domains have the strongest relationship with the safety outcomes while the "housing" domain have the strongest relationship with the at risk of homelessness outcome. The "reducing impact of immediate crisis" domain is also the Goals domain type that have the strongest relationship with the more severe safety outcomes of ROSH and being victim of domestic violence.
- Clients who have completed assessments in these domains also tend to have higher overall probability of experiencing the relevant outcome than the rest of the clients. Those who completed "personal and family safety" and "impact of immediate crisis" SCOREs have the highest overall probability of experiencing the safety outcomes in the following quarter, while those who completed "housing" SCOREs have by far the highest overall probability of being at risk of homelessness in the following quarter compared to clients who have completed assessments in other domains. This shows that there is some selection done by providers to assess clients in domains that are the most applicable to their situations.

The relationship between SCOREs and client outcomes is also observed across DCJ districts, and for SCOREs both recorded for the child and for the parent. Full analysis can be found in Appendix H.4.

***Changes in client Circumstances and Goals SCOREs over time are predictive of changes in client outcomes***

For clients with at least two assessments completed in the same domain, we use their characteristics as at the quarter of initial assessment to predict their outcomes in the quarter after their last assessment, using a regression setup similar to the analysis in Section 6.4.1. We built separate models for each of the four outcomes and selected three Circumstances SCORE domains and two Goals SCORE domains to be the focus in each model, to reduce model complexity. The domains are selected based on the volume of SCOREs collected, the magnitude of the direct correlation with the modelled outcome as discussed in the previous section, as well as some judgement with regards to which domains are most relevant. The list of predictors used and the number of clients included in each model can be found in Appendix H.4.3.

For each model, we then added the change in SCORE result between the initial and last assessment from each of the SCORE domains selected as a variable to the model and found it to be a statistically significant predictor of client outcomes. Clients with increase in SCOREs have lower chance of experiencing the modelled outcome following the assessment compared to clients with similar starting risk profile at the initial assessment but with a decrease in SCOREs. This demonstrates that SCORE is a useful tool for tracking client outcomes over time and identifying clients who have achieved greater improvement in outcomes than others. The SCORE domains used in each model and the corresponding

p-values[55] for the change in SCORE parameter are summarised in the table below. It is also worth noting that this does not tell us how much of the change in client outcomes is attributable to the TEI support they have received.

Table 7.3 – Summary of SCORE domains included in each model and the p-value for change in SCORE variable

| SCORE domain (C = Circumstance, G = Goal) | Concern report | ROSH | Victim of domestic violence | At risk of homelessness |
|---|---|---|---|---|
| Personal and Family safety (C) | ✓ | ✓ | ✓ | ✓ |
| Family Functioning (C) | ✓ | ✓ | ✓ | |
| Mental health (C) | ✓ | ✓ | ✓ | ✓ |
| Housing (C) | | | | ✓ |
| Empowerment, choice and control (G) | ✓ | ✓ | ✓ | |
| Impact of immediate crisis (G) | ✓ | ✓ | ✓ | ✓ |
| Increasing Skills (G) | | | | ✓ |
| **P-value for overall change in SCORE** | **<0.0001** | **<0.0001** | **<0.0001** | **0.0006** |

In addition, we have investigated the significance of a change in SCORE in predicting client outcomes for each individual domain listed above. For safety outcomes, we see strong evidence for change in Circumstances SCOREs being predictive. The predictiveness of change in Goals SCOREs is slightly weaker but still significant with a p-value less than 0.05. For being at risk of homelessness, we only found results Personal and Family safety and Housing domains to be significant predictors at the 5% significance level[56]. The full list of p-values can be found in Appendix H.4.3.

[55] P-value from a hypothesis test with the null hypothesis that there is no relationship between the change in SCORE variable and client outcome. A low p-value means there is a strong evidence of the SCORE result being predictive.

[56] For the domains that were not significant linear predictors, we have also fitted saturated models and confirmed that no monotonic relationship exists between the change SCORE rating and client outcome.

# 8 Evaluation findings relating to Aboriginal children and families

This Section outlines the findings from the evaluation as they relate to Aboriginal children, young people and families, with reference to the following evaluation questions:

- Have there been improvements in outcomes for Aboriginal children and families, particularly any reduction in the rate of over-representation of Aboriginal children in out-of-home care? How do these improvements compare to non-Aboriginal children and families?
- What factors influenced change in outcomes for Aboriginal children and families and what adaptation, if any, was required to better meet the needs of Aboriginal children and families?
- What is the cost to provide culturally safe services to Aboriginal families?
- Is there a greater benefit for Aboriginal children and families' relative to cost compared with non-Aboriginal children and families?

To answer the above questions, the evaluation draws on multiple sources, including analysis of data submitted by providers in the DEX platform, population data captured in the HSDS, a survey of TEI providers and finally case study interviews with ACCO providers and their clients.

As set out in Section 3.3.4, our evaluation was guided by an independent Aboriginal Reference Group,[57] DCJ's internal evaluation Aboriginal Advisory Group, and the research experience of Gamarada Universal Indigenous Resources.

## 8.1 Background on the TEI program with Aboriginal children and families

***Aboriginal children, young people, families and communities in NSW are a priority group in TEI.***

Aboriginal children, young people, families and communities are a priority group for the TEI program. In NSW, Aboriginal children make up 45% of the out of home care population despite representing just 8% of the children population.[58] In 2022-23, 25,056 or 16% of all individual clients and 19% of individual clients aged 0-17 identified as Aboriginal and or Torres Strait Islander. The TEI program is one of the NSW Government's key initiatives aiming to reduce entries into out of home care.

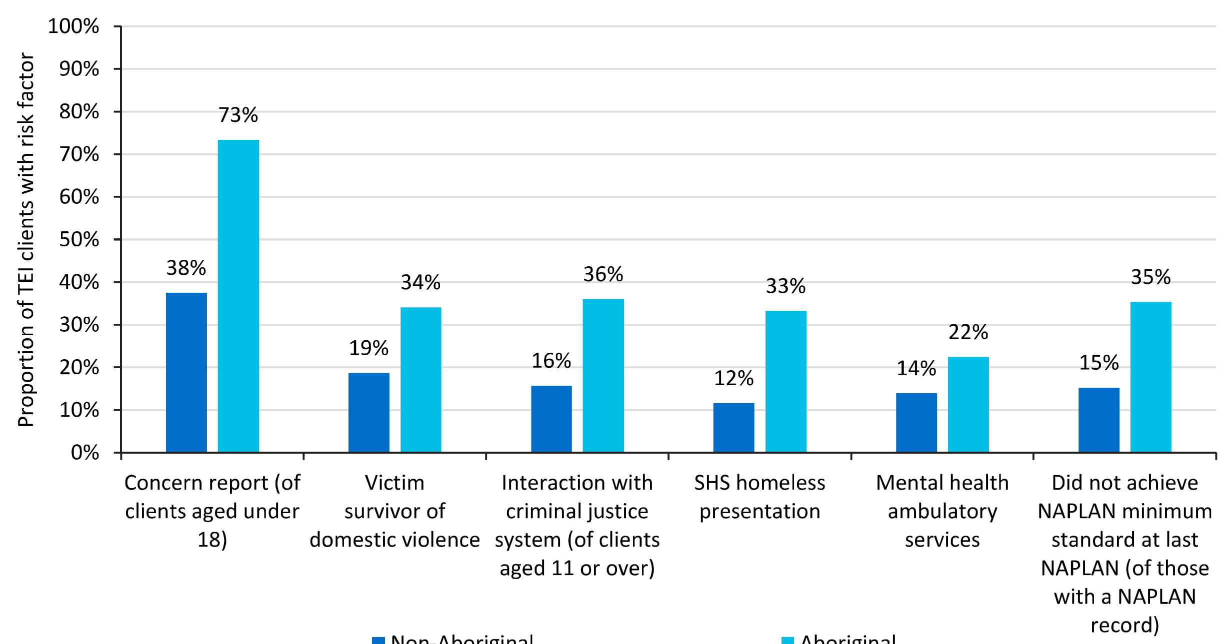
As introduced in Section 5.3.1, TEI clients have heightened historical service usage compared to the general population. Even amongst TEI clients, Aboriginal clients tended to have more complex circumstances than non-Aboriginal clients, a reflection of many contributing factors, including historical injustices experienced.

---

[57] The Aboriginal Reference Group is made up of provider representatives from Aboriginal Community Controlled Organisations, some of whomdeliver TEI services as well as AbSec.

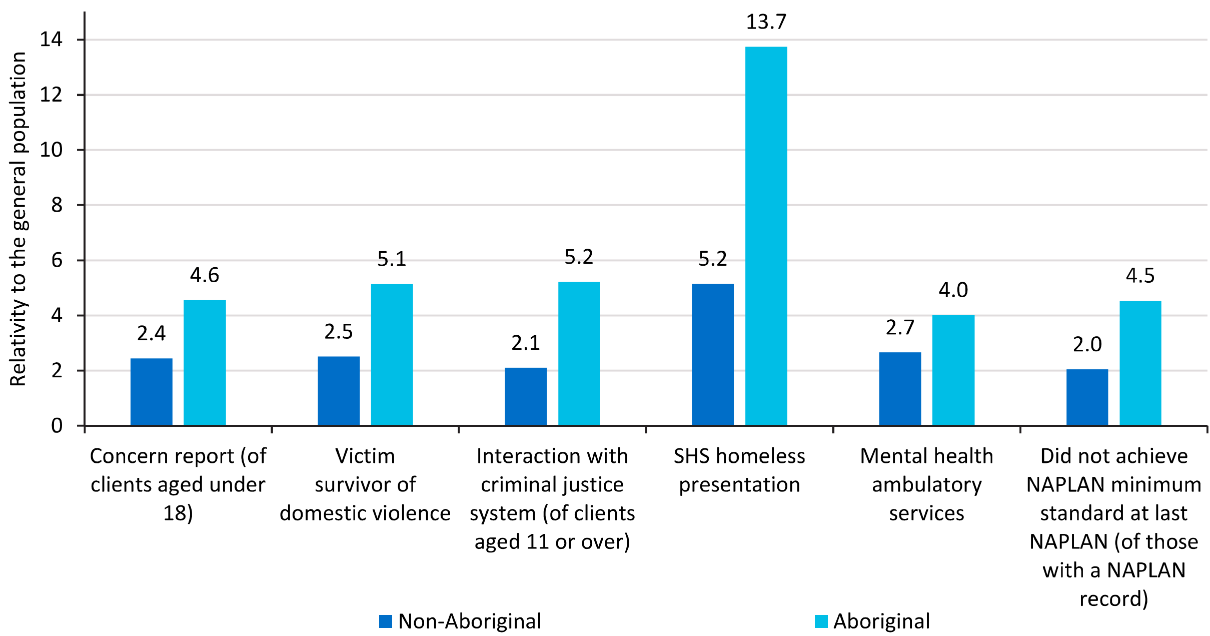
[58] See Productivity Commission information repository: https://www.pc.gov.au/closing-the-gap-data/dashboard/se/outcome-area12.

Figure 8.1 – Service interaction history of Aboriginal and non-Aboriginal TEI clients prior to TEI entry (HSDS)




As we see from Figure 8.1, Aboriginal TEI clients (including indirect clients)[59] are twice as likely to experience risk factors across safety, justice, education, housing and health domains.

Figure 8.2 – Relativity of service interaction compared to the general population prior to TEI entry, for Aboriginal TEI clients and non-Aboriginal TEI clients (HSDS)




Note: Relativity is calculated as proportion of clients with service interaction history divided by proportion of the general population with service interaction history.

[59] A total of 36,121 direct and indirect Aboriginal clients identified in the HSDS, 49% of which are indirect clients.

Figure 8.2 shows that there is a greater prevalence of service interaction amongst Aboriginal TEI clients compared to the general population (for instance, 73% of Aboriginal clients under 18 had a concern report prior to entry, 4.6 times greater than 16% in the general population).

***Targets for funding to Aboriginal Community Controlled Organisations have not been met.***

At the time of TEI commissioning in 2020, it was envisaged that the TEI program would provide *access to effective and culturally safe support and services for Aboriginal children, young people and families*.[60] The goal was to implement a prioritisation of the needs of Aboriginal children, young people and families to achieve better outcomes. To this end, the TEI reform envisaged:[61]

- Increased opportunity for Aboriginal involvement in program and service design and delivery (i.e. co-design)
- The improved capturing of outcomes delivered by Aboriginal services
- Improvement in funding equity, particularly for more disadvantaged LGAs.

The TEI reform was also intended to assist with the growth in capacity of Aboriginal organisations, as well as supporting these organisations to play a more active role in developing and implementing the TEI program. DCJ's Aboriginal Outcomes Strategy 2017-2021 set a target of 30% investment in Aboriginal-led early intervention providers by 2021, however these targets for investment in Aboriginal-led providers have not been met.

The proportion of funding provided to ACCO providers in 2022-23 was 7.7%. No new investment in TEI and the requirement to negotiate with existing TEI providers at the same funding level in the 2020 re-commissioning cycle, significantly reduced the opportunity to shift investment towards Aboriginal organisations. As noted in Section 4.2.1, DCJ has renewed its commitment to investment in early intervention services delivered by ACCOs and to embed Aboriginal-led commissioning in the TEI program. The re-commissioning process for 2025-2030 was in its early stages at the time this report was written, so the full implementation of this process was not assessed as part of this evaluation.

## 8.2 Service delivery for Aboriginal children and families

In 2022-23, 25,056 or 15.5% of all individual TEI clients identified as Aboriginal, having increased from 14.5% in 2020-21. Figure 8.3 shows the TEI clients identified as Aboriginal and the share of funding received by ACCO providers for each district. Aboriginal people make up a greater proportion of individual TEI clients in more remote areas, with over 40% of individual clients identified as Aboriginal in Western NSW and Far West districts. Murrumbidgee is the only district where the share of funding for ACCO providers is at or above the share of Aboriginal clients.[62] In contrast, no funding was provided to ACCO providers based in Southern NSW and only 6% of funding was provided to ACCO providers based in Western NSW, while Aboriginal clients make up 14% and 45% of the total clients in these districts respectively. A comparison of the proportion of program clients who are Aboriginal to the proportion of Aboriginal people in the general population is included in Appendix I.1.

---

[60] See: NSW Family and Community Services (2016). "Targeted Earlier Intervention Program Reform: Reform directions – local and client centred, https://www.facs.nsw.gov.au/__data/assets/file/0007/379366/TEI-Program-Reform-Directions-local-and-client-centred.pdf

[61] NSW Family and Community Services (2016). "Targeted Earlier Intervention Program Reform: Reform directions – local and client centred, https://www.facs.nsw.gov.au/__data/assets/file/0007/379366/TEI-Program-Reform-Directions-local-and-client-centred.pdf

[62] Although we note that on a total Aboriginal population (rather than TEI clients) basis other regions appear more in line. See Figure 8.15.

Figure 8.3 – Proportion of individual clients who are Aboriginal and Proportion of funding for ACCO providers in each DCJ District (DEX, 2022-23)

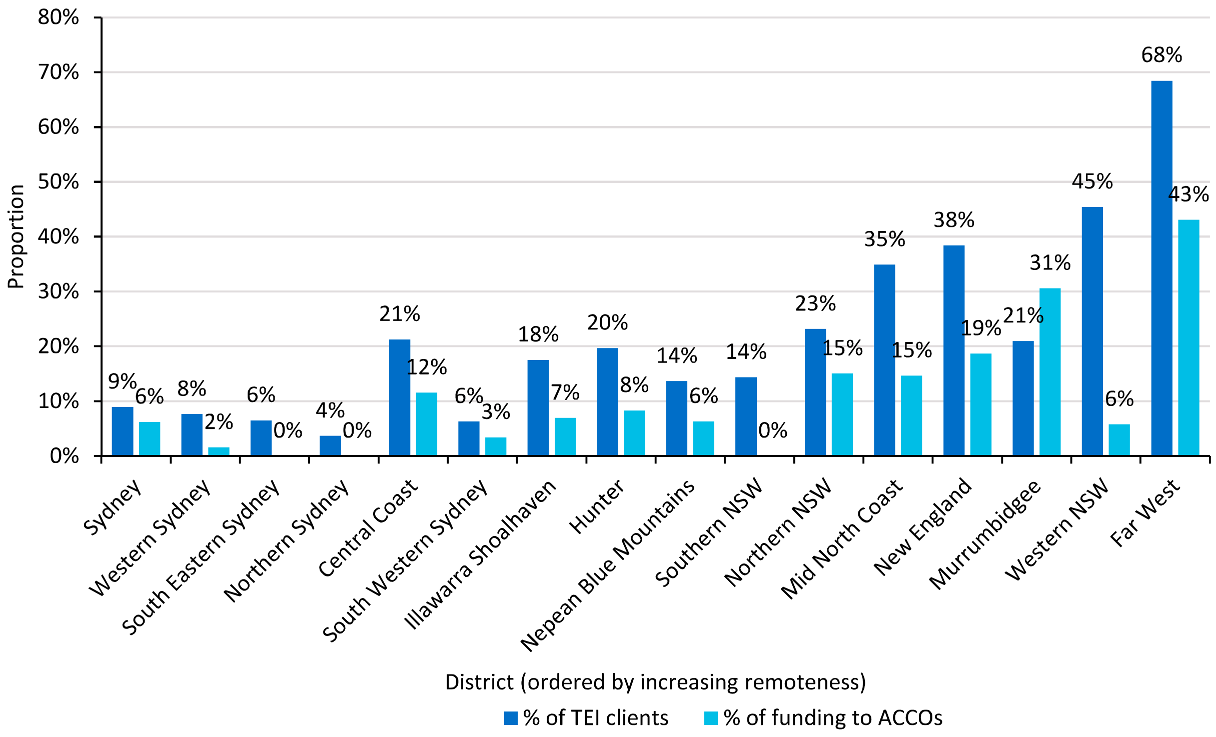
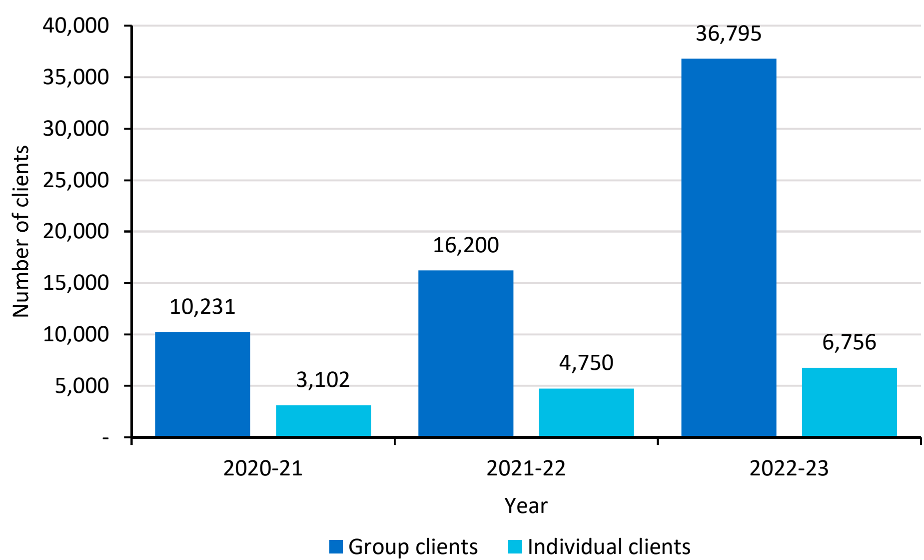



Figure 8.4 below shows that there has been a steady increase in the number of both group and individual clients served by ACCO providers. The number of group clients reached had doubled from 2021-22 to 2022-23 – this was mainly driven by increases in demand for ACCO providers in Central Coast, Illawarra Shoalhaven and Nepean Blue Mountains. This growth is markedly faster than the overall growth in TEI clients served for both individual and group clients.

Figure 8.4 – Number of individual and group clients served by ACCO providers (DEX)

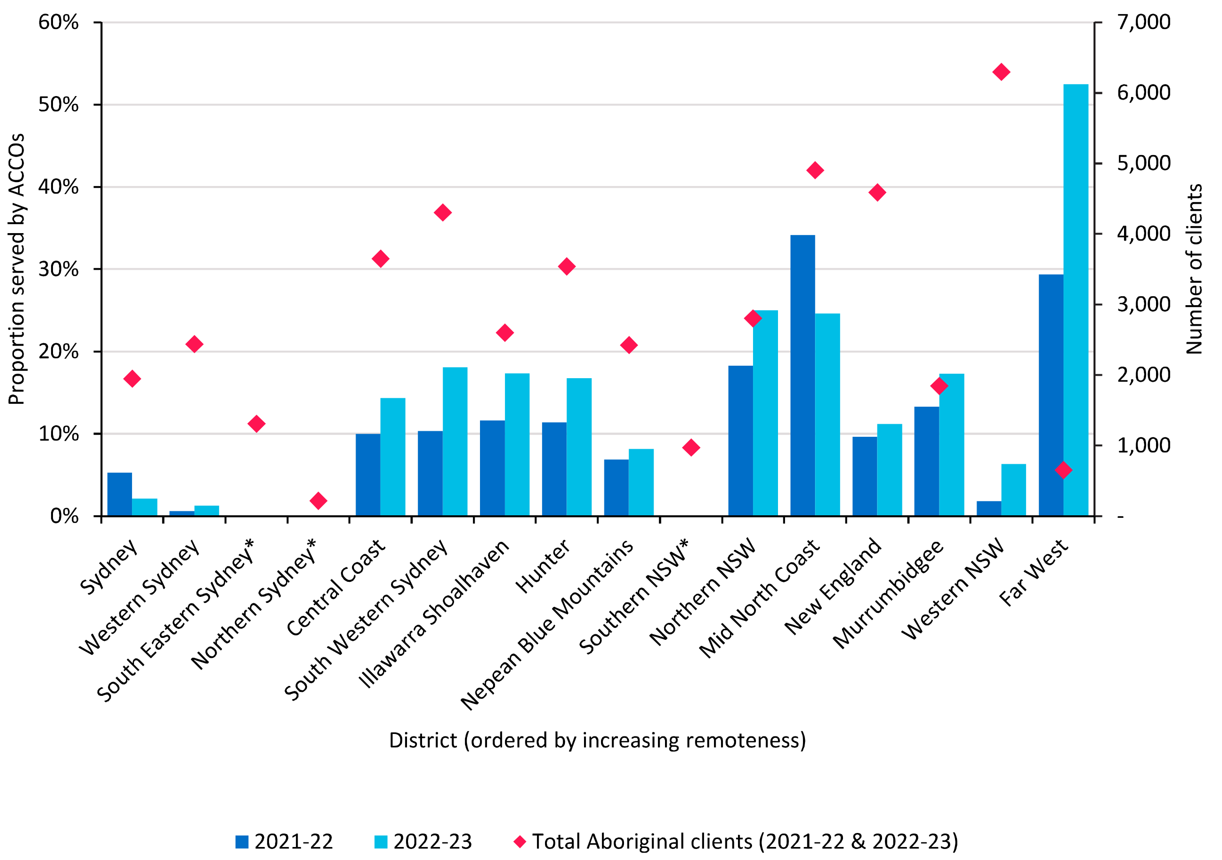



Note: Client numbers may be understated due to no client data submitted by some ACCO providers. In 2022-23, ACCOs without any client or session data submitted in the year accounted for 10% of total ACCO funding for the year.

At a district level, Figure 8.5 below shows that the proportion of Aboriginal clients who have received TEI services from ACCO providers increased from 2021-22 to 2022-23 across all districts except Sydney and Mid-North Coast. However, both districts have some ACCO providers who are yet to submit client data

into DEX for 2022-23 which results in the figures being understated. Aboriginal clients in Northern NSW, Mid-North Coast and Far West have the highest likelihood of receiving services from an ACCO provider. Western NSW have the highest number of Aboriginal clients accessing TEI in the last two years with only a small proportion of these clients receiving support from an ACCO provider. This is consistent with the funding provided to ACCO providers as observed in Figure 8.3.

Figure 8.5 – Proportion of Aboriginal clients who have received TEI services from ACCO providers compared to total number of Aboriginal clients in the district (DEX)




Note: There is a very small number of clients based in South Eastern Sydney, Northern Sydney and Southern NSW who received services from ACCO providers in other districts. These figures have been excluded from the analysis for data privacy reasons.

## 8.3 TEI Outcomes for Aboriginal children and families

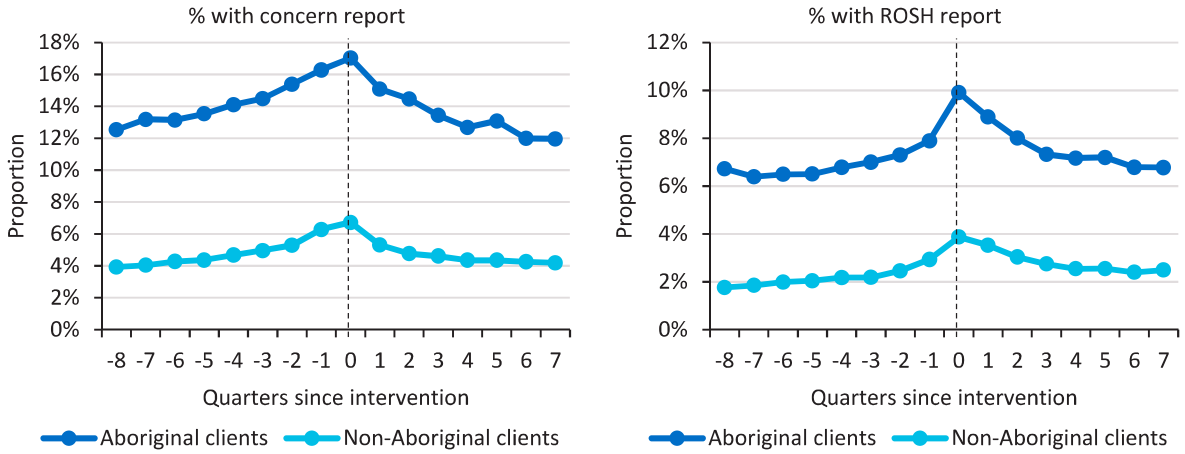
The outcome analysis presented in Section 6 using linked HSDS data was extended to examine results for Aboriginal children and families in this section. The focus of the analysis was on safety, examining child protection outcomes.

### 8.3.1 Safety outcomes

***Aboriginal children connected to TEI programs have higher rates of interaction with the child protection system, even before accessing TEI. Relative improvements due to TEI appear similar to the broader population, which translates to a larger absolute improvement in outcomes. However, we could not conclude that these differences in estimated impact isn't just due to chance given the smaller sample size.***

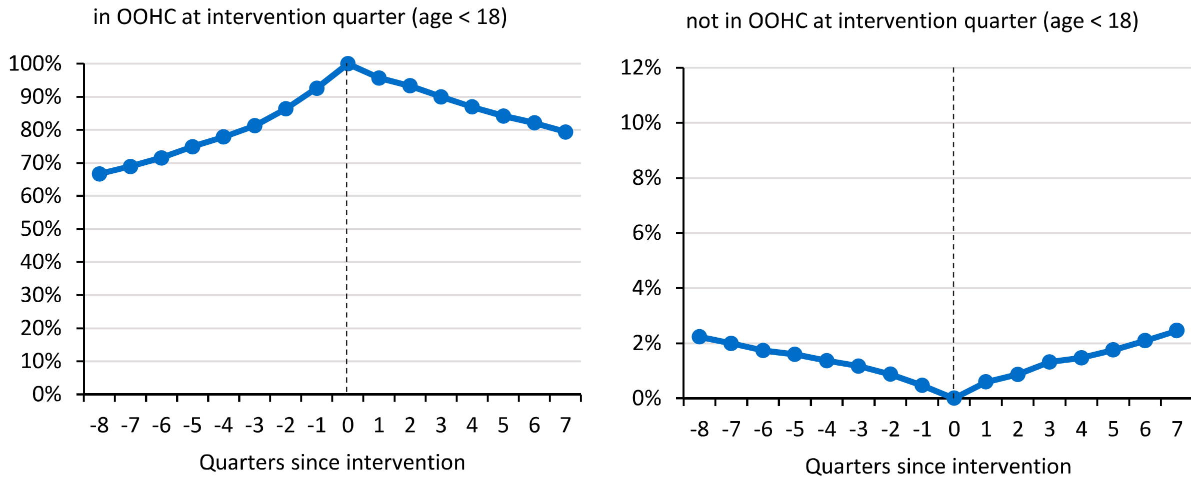
The pattern of child protection interactions for identified Aboriginal children in TEI are similar to that of the broader TEI population, albeit at an overall higher rate. Figure 8.6 shows the similar peak in service usage at the time of entry, followed by a decrease to pre-TEI levels as observed in 6.4.1.

Figure 8.6 - Proportion of Aboriginal TEI participants under 18 with concern reports (left) and ROSH reports (right) (HSDS)




Of particular interest for Aboriginal TEI clients are outcomes relating to OOHC, in which Aboriginal children are over-represented. The rate of being in OOHC for Aboriginal TEI clients under 18 is about four times that of non-Aboriginal TEI clients under 18. Figure 8.7 separately displays the OOHC rates over time for Aboriginal clients who were in OOHC in the quarter of entry to TEI and for Aboriginal clients who were not in OOHC in the quarter of entry to TEI. The shapes are unsurprising (as they are conditioned on status at time zero) but the regression setup allows testing of whether these trends are better than we would expect without TEI.

Figure 8.7 - Proportion of Aboriginal TEI clients under 18 in OOHC in quarters before and after entry to TEI, split by whether or not clients were in OOHC in quarter of intervention (HSDS)




We use the same quarterly individual-level regression model set up presented in Section 6 to estimate what proportion of the observed change in safety outcomes for Aboriginal clients is attributable to TEI support[63]. In Table 8.1 below, we provide detailed results for the estimated impact of TEI for Aboriginal clients, and compare against the estimated TEI impact for non-Aboriginal clients. The confidence intervals and p-values of the estimated impact are also included.

Table 8.1 – Estimated impact of TEI on safety outcomes for Aboriginal and non-Aboriginal clients

**Concern reports**

| Aborigi-nal Client? | With TEI support | Expected without TEI support | Estimated impact (absolute)[(a)] | Estimated impact (relative)[(b)] | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 19.09% | 20.22% | -1.13pp | -5.6% | (-2.8pp, 0.4pp) | 0.07 | 1,073 |
| No | 7.25% | 7.86% | -0.62pp | -7.8% | (-1.1pp, -0.1pp) | <0.01 | 1,433 |

**ROSH reports**

| Aborigi-nal Client? | With TEI support | Expected without TEI support | Estimated impact (absolute) | Estimated impact (relative) | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 14.52% | 15.76% | -1.24pp | -7.9% | (-2.8pp, 0.4pp) | 0.06 | 816 |
| No | 5.43% | 5.65% | -0.22pp | -3.9% | (-0.6pp, 0.2pp) | 0.15 | 1,074 |

[63] See Section 6.4.1 for details of the individual-level regression model used

**Out of home care (entry rate - children *not in* OOHC at quarter of entry into TEI)**

| Aborigi-nal Client? | With TEI support | Expected without TEI support | Estimated impact (absolute) | Estimated impact (relative) | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 1.94% | 1.44% | 0.50pp | 34.8% | (-0.3pp, 1.1pp) | 0.90 | 109 |
| No | 0.50% | 0.45% | 0.05pp | 11.1% | (-0.1pp, 0.2pp) | 0.72 | 99 |

**Out of home care (rate of remaining - children *in* OOHC at quarter of entry into TEI)**

| Aborigi-nal Client? | With TEI support | Expected without TEI support | Estimated impact (absolute) | Estimated impact (relative) | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 82.11% | 84.89% | -2.78pp | -3.3% | (-6.3pp, 1.8pp) | 0.09 | 526 |
| No | 76.97% | 82.39% | -5.42pp | -6.6% | (-9.8pp, -0.1pp) | 0.02 | 449 |

Notes

(a) Calculated as With TEI support minus Expected rate without TEI support, however differences may occur due to rounding.

(b) Calculated as Estimated impact (absolute), divided by Expected rate without TEI support, however differences may occur due to rounding.

From the table we observe that TEI support has contributed to a greater percentage point (absolute) reduction in the rate of concern reports and ROSH for Aboriginal clients than non-Aboriginal clients. For Aboriginal clients, the measured absolute reduction in both concern report and ROSH from TEI support is higher than 1pp, while for non-Aboriginal clients the measured reduction is smaller at 0.6pp and 0.2pp respectively for concern report and ROSH. For the rate of exiting OOHC, TEI support had a less favourable impact for Aboriginal clients. For Aboriginal clients, the measured absolute reduction in the rate of remaining in OOHC is 2.8pp compared to 5.4pp for non-Aboriginal clients.

Despite variations in modelled TEI impact for Aboriginal clients relative to non-Aboriginal clients, there is again no statistically significant evidence that the proportionate impact of TEI between the two groups of clients are different[64], i.e. it is not conclusive whether TEI support is genuinely more effective for one group than the other or the results observed could be due to random chance. This is consistent with the results presented in Section 6.6.2.

There is greater uncertainty surrounding the measured impact for Aboriginal clients due to lower data volume. There are also challenges in collecting data within Aboriginal clients and communities (as set out in the Interim Report, Section 6.3). This includes providers trying to collect DEX data prior to the establishment of relationships, and the preference for qualitative data and storytelling by Aboriginal clients and communities.

As explained in provider surveys and interviews, cultural safety is deemed an important factor in achieving better outcomes for Aboriginal clients, and ACCO providers are more positive about the impact

[64] P-value > 0.1 where the p-value corresponds to a hypothesis test with the null hypothesis that the size of the impact of TEI for Aboriginal children is the same as non-Aboriginal children.

of TEI than non-ACCO providers. Therefore, whether Aboriginal clients had received services from ACCO providers could be an important contributor to the size of the TEI impact. However, this could not be tested in the data as provider information (and corresponding ACCO status) is not available in the HSDS.

As an alternative, we have tested from the data whether the size of the TEI impact is different for Aboriginal children who have attended (or their parents have attended) sessions that were specifically designed for Aboriginal clients[65]. The estimates in the table below show that in both absolute and relative terms, these clients saw a greater reduction in the rate of OOHC, but less of a reduction in the rate of Concern Report and ROSH compared to Aboriginal clients who did not receive services designed for Aboriginal clients. However, the differences were not statistically significant. Detailed results for each outcome can be found in Appendix H.1.6.

Table 8.2 – Estimated impact of TEI on safety outcomes for Aboriginal clients by whether they have attended Aboriginal service type sessions

**Concern reports**

| Received Aboriginal specific services? | With TEI support | Expected without TEI support | Estimated impact (absolute)[(a)] | Estimated impact (relative)[(b)] | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 16.9% | 17.5% | -0.6pp | -3.6% | (-2.4pp, 1.2pp) | 0.5 | 162 |
| No | 19.5% | 20.7% | -1.2pp | -5.7% | (-2.9pp, 0.6pp) | 0.15 | 910 |

**ROSH reports**

| Received Aboriginal specific services? | With TEI support | Expected without TEI support | Estimated impact | Estimated impact (relative) | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 12.9% | 13.7% | -0.8pp | -5.8% | (-2.7pp, 1.1pp) | 0.42 | 124 |
| No | 14.8% | 16.1% | -1.3pp | -7.9% | (-2.8pp, 0.3pp) | 0.11 | 692 |

**Out of home care (children *not in* OOHC at quarter of entry into TEI)**

| Received Aboriginal specific services? | With TEI support | Expected without TEI support | Estimated impact | Estimated impact (relative) | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 1.4% | 1.2% | 0.2pp | 16.9% | (-0.5pp, 0.9pp) | 0.55 | 13 |
| No | 2.1% | 1.5% | 0.5pp | 35.0% | (-0.3pp, 1.2pp) | 0.17 | 96 |

**Out of home care (children *in* OOHC at quarter of entry into TEI)**

[65] Includes service types Indigenous community engagement, Indigenous social participation, Indigenous Advocacy/Support, Indigenous Healing Workshops, Indigenous supported playgroups. More detailed definition of each can be found in Appendix B.

| Received Aboriginal specific services? | With TEI support | Expected without TEI support | Estimated impact | Estimated impact (relative) | 95% confidence interval | p-value | No. of clients with the outcome |
|---|---|---|---|---|---|---|---|
| Yes | 78.9% | 85.9% | -7.0pp | -8.2% | (-13.5pp, 0pp) | 0.06 | 50 |
| No | 82.5% | 84.9% | -2.4pp | -2.8% | (-6.3pp, 1.6pp) | 0.24 | 477 |

Notes

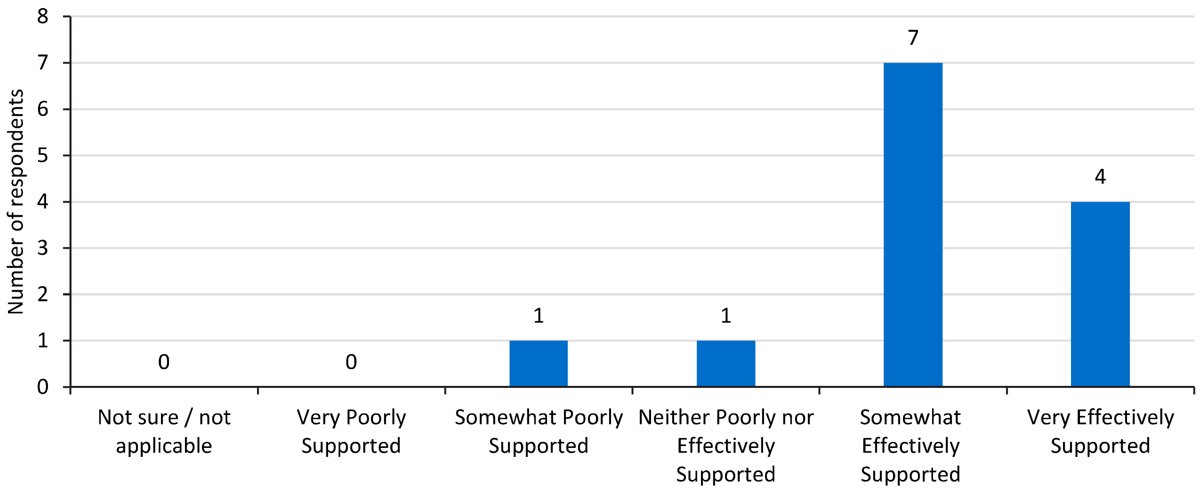
(a) Calculated as With TEI support minus Expected rate without TEI support, however differences may occur due to rounding.

(b) Calculated as Estimated impact (absolute), divided by Expected rate without TEI support, however differences may occur due to rounding.

***ACCO provider and client feedback is positive regarding safety outcomes for Aboriginal Children and Families.***

ACCO providers were positive about the overall impact of TEI for Aboriginal Children and Families. From the provider survey, these providers were proportionally more positive than the overall main cohort (noting the small sample size of 13), with 85% indicating that they believed Aboriginal Children and Families were either Somewhat Effectively, or Very Effectively supported by TEI.

Figure 8.8 – Provider survey results – "From your perspective, how effectively do you think (Aboriginal Children, Young People, Families and Communities) are being supported by the TEI services you provide under this contract?", n = 13 (Providers identifying as Aboriginal Controlled)




This aligns with provider survey results set out within Section 6.4.2, where 85% of ACCO providers indicated that they believed TEI was either moderately, very or extremely effective in improving child protection outcomes.

In open text responses, many ACCO providers emphasised the importance of early, culturally relevant, and safe interventions in achieving outcomes for Aboriginal clients. Several other providers also highlighted the importance of Trauma Informed care and practice. Many of these providers highlighted that ACCOs (and other Aboriginal controlled organisations) were best placed to provide this type of intervention, given their connection to, and understanding of culture and local communities.

On the other hand, there were concerns around the ability for TEI to support clients in other outcomes. As explained by one ACCO:

> *"We think that TEI does a good job in supporting our local communities and in reducing risks for families in the short term, but we don't think it works to solve the other big issues that impact*

*child protection. Things like violence, housing, justice. These issues are very complex and TEI can only do so much as an early intervention service".*

The limitations of TEI for Aboriginal children and families are explored further in our case study conversations with ACCO providers. These ACCOs believe that TEI is effective at generating safety outcomes for Aboriginal clients. However, this effectiveness was only possible through the specific cultural and community expertise and knowledge available to an ACCO. Without specific changes made by providers to improve cultural relevance and safety, these providers believed that TEI would not be able to achieve safety outcomes.

One ACCO emphasised that TEI requires additional organisational efforts to truly impact upon outcomes. The ACCO termed this as going 'the extra mile' to develop community-led approaches for clients, typically leveraging links to both culture and local communities.

They explained that ACCOs rely upon in-depth and expert understanding of culture and local links to deliver programs that evolve organically. One ACCO staff member noted that:

*"We build stronger connections with clients. We can give them a safe space where they feel culturally safe and build interaction and engagement from there. Allowing a client to feel free and comfortable - that's what keeps them come back...."* Another staff member commented that:

*"TEI is working, but in our opinion, it needs to be adjusted to benefit Aboriginal families - we make it our own, we make it work for our families and make it work for the community."*

*"TEI forces ACCOs to deliver in a linear rigid way, that doesn't work for the community."*

***Client testimony relating to Safety Outcomes***

Aboriginal clients we spoke to provided strong feedback about their experiences of TEI and the outcomes they had achieved, providing strong support for the ACCO's approach.

Clients provided a wider range of anecdotal evidence of the outcomes they achieved through the TEI services they received.

*"If [ACCO] weren't around - I really think I would have had to give the kids up. I just wouldn't be able to handle it by myself. They provide the community to help me raise the kids together."*

*Another client commented that:*

*"If [ACCO] wasn't here, our families would have suffered. If my kids had been taken, I would have considered self-harm. But I had [ACCO]s support - and kept my kid in my care."*

*Clients were also particularly enthusiastic when discussing the impacts of TEI supported playgroups provided by these two ACCO's. One client commented:*

*"[ACCO] has guided my parenting journey. I think it's been quite holistic, they've made me a stronger mum, a stronger person. Before the playgroup, I was barely surviving. You can't be a good parent like that..."*

*Another client noted that:*

*"In the end, without [ACCO], I wouldn't have gotten the help I needed to keep my family together. Without [ACCO], there would be more Aboriginal children in care, because that's what [ACCO] cares the most about - keeping families together."*

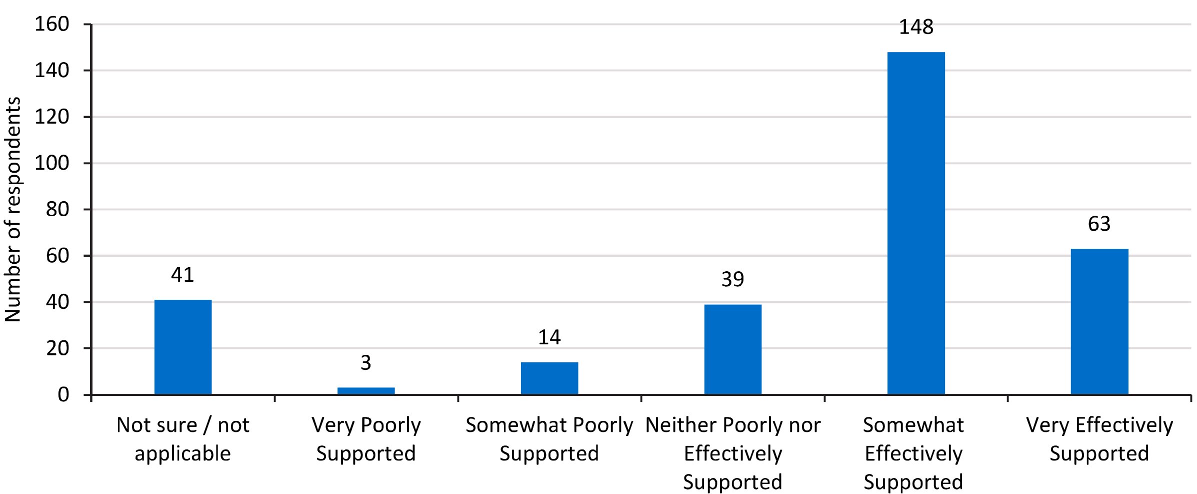
However, it is difficult to determine how much of this client feedback should be attributed to the ACCO as compared to TEI overall.[66]

**Service delivery by non-Aboriginal controlled providers**

For TEI providers generally, they were again largely optimistic about the impact of TEI specifically for Aboriginal Children and Families, indicating broad support for its effectiveness. When asked directly about the effectiveness of TEI for this client group, 69% of providers indicated that they believed Aboriginal Children and Families were either Somewhat Effectively, or Very Effectively supported by TEI, with less than five percent of providers indicating they were Very Poorly or Somewhat Poorly Supported by TEI.

It is also important to acknowledge that within open text responses, a small number of providers (including ACCO and non-ACCO providers), explained that they were highly sceptical of the actual impact of TEI. Some noted limitations due to factors beyond the program's control, including a broader system that is not culturally appropriate, such as the rates of Aboriginal children entering the child protection system, which are steadily increasing. These providers emphasised that over-representation of Aboriginal children in OOHC is systemic – encompassing factors such as poverty, racism, historical disadvantage and the legacy of colonialism and institutionalisation – factors that cannot be meaningfully addressed by an early intervention program alone.

Figure 8.9 – Provider survey results – "From your perspective, how effectively do you think (Aboriginal Children, Young People, Families and Communities) are being supported by the TEI services you provide under this contract?", n = 308




In open text responses, many non-ACCO providers were optimistic about their ability to achieve outcomes for Aboriginal clients. These providers reflected on efforts to incorporate local cultural knowledge and activities within their programs and drawing on strengths of Aboriginal communities and culture.

Another theme from provider responses was the importance of reducing isolation, stress, and providing supportive relationships and networks in contributing to safety outcomes for Aboriginal children and families. To this extent, non- ACCO providers highlighted the value of promoting cultural identity, increasing empowerment and awareness and the breaking down of barriers to engaging with services.

[66] The ACCO's perspective on this issue is that DCJ should look to fund ACCOs to provide this additional organisational effort (as currently this work is unfunded). The ACCO shared its belief that this work is extremely valuable and leads directly to outcome attainment, and as such should be made sustainable via DCJ funding.

In the case studies, non-ACCOs emphasised their understanding of the specific cultural needs of their Aboriginal clients. For instance, one provider explained that it is intentional in delivering services in a culturally safe manner for its Aboriginal Children and Families:

> *"We've always been upfront to their families - what do you need support with within your culture. For us, it comes down to building trust and it's at the forefront of what we do when working with Aboriginal families. This is important given the history of distrust with statutory services and child removal….*
>
> *…For families, regardless of culture, they will want their kids to be involved with cultural activities. Encouraging Aboriginal kids to be proud of, and express their culture. Being open and encouraging about how to connect children with culture. Our staff are specifically conscious about this. We are all sensitive and respectful of cultural considerations."*

We interviewed two Aboriginal clients accessing TEI services at a non ACCO. One of these clients remarked:

> *"Before I started, I thought it [TEI Provider] was just more DCJ,[67] more of the same. I've come to realise that they've come to help. I thought they really cared. They've helped give me the confidence to not give up on life."*

When asked about the cultural appropriateness of the provider's services, both clients were highly supportive of the efforts the provider had made to provide culturally safe services and environments. For instance, one client commented that:

> *"The services they have provided are definitely culturally appropriate. I don't mind working with either Aboriginal or non-Aboriginal services - I got to choose what support I needed the most. What was most important, was they were passionate about supporting us."*

On the other hand, a number of Aboriginal clients who attended ACCO TEI services noted that ACCO service delivery was critical to their positive experience of TEI:

- *"I went to another non-Aboriginal service once, I had to cut her off - she became very pushy about how I was raising my kids. But you don't know me, you don't know my kids, we've lived in the bush for the last 10 years - you have no idea what we have been through, what we have gone through. This was the first service that made me feel safe and respected about my past".*
- *"It feels like I'm not being judged, not being looked at sideways. At the non-Aboriginal service, I've always been made to feel bad about the way I'm parenting."*
- *"They actually advocate like we are family - they advocate as Aboriginal people on behalf of Aboriginal people. Someone's always got your back, but with a non-indigenous service – all they have is their policies and procedures. I just wouldn't feel safe [at a non-ACCO]."*

We note that we cannot confirm that these clients are comparing the TEI services they received, to an equivalent TEI service provided by a non-Aboriginal controlled provider.

Several non-ACCO providers suggested that Aboriginal clients may benefit by having a choice between Aboriginal and non-Aboriginal controlled organisations. One provider explained that:

> *"Our Aboriginal workers, Aboriginal elders and community members and a local Aboriginal service provider operated by our local Land Council have consistently told us that it is important to give Aboriginal people a choice, as some Aboriginal families say they sometimes want to come to mainstream services as they don't want mob to 'know their business'".*

---

[67] This client had informed us that her children had previously been removed from her care under statutory child protection, but had since been reunited.

*However, in the provider survey and interviews (as well as guidance shared by the Aboriginal Reference Group), many ACCOs noted that some TEI providers are not providing a culturally safe service for Aboriginal clients and are not able to meet the needs of this cohort. One ACCO emphasised that this requires more than just tokenistic efforts from providers: "it's not just artwork on the wall, it's not having one Aboriginal worker - it's about connecting with the community. If you can't do that, then it's not culturally appropriate."*

At the time of this evaluation, there is no available data that would allow us to assess whether Aboriginal children and families attain greater outcomes through ACCO providers. As a result, we are unable to draw a firm conclusion as to the particular efficacy of ACCO TEI service delivery. However, we believe that the qualitative evidence suggests that, at minimum, Aboriginal children and families would benefit greatly if all providers employed dedicated efforts to improve the cultural appropriateness of their services (including suggestions set out under Section 6.4 of the Interim Report). To this extent, our conversations with some Aboriginal clients suggest that currently there exists some TEI service providers that fall short of the standards set by the non-ACCO providers we have interviewed.

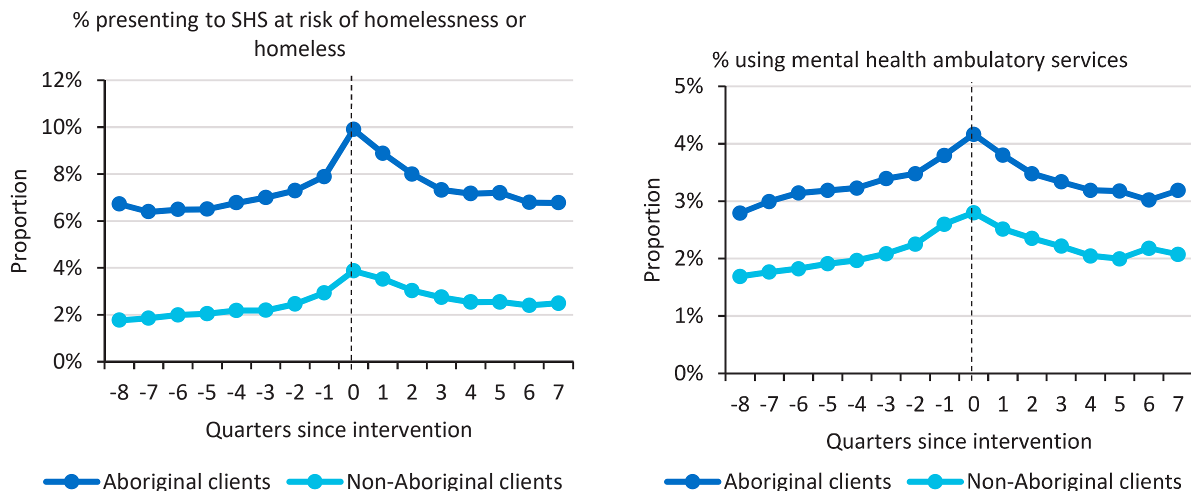
Whilst it is likely that Aboriginal clients benefit from having a choice in provider type, it is also likely that many Aboriginal children and families do not have a choice of ACCO provider available to them (given investment levels in Aboriginal-led programs)[68]. This reinforces the need for DCJ to meet these targets for Aboriginal-led investment going forward (see recommendation 10.1.1).

### 8.3.2 Other outcomes

***For housing and health outcomes, Aboriginal children and families attending TEI programs also saw similar outcome trends as non-Aboriginal participants***

Figure 8.10 shows the service usage of Aboriginal TEI participants before and after TEI intervention for specialist homelessness services and community mental health. Similar to observations for safety outcomes, the behaviour is similar to that of non-Aboriginal participants, except at a higher overall rate. Charts for other outcomes can be found in Appendix I.3

Figure 8.10 - Proportion of Aboriginal TEI participants presenting to Specialist Homelessness Services as homeless or at risk of homelessness (left) or using mental health services (right) (HSDS)




Due to the propensity match limitations relating to inability to establish a complete matched comparison cohort discussed in 6.5.1, we were unable to estimate TEI's contribution to observed

---

[68] See Section 6 of the Interim Report.

behaviour, in particular noting that by only analysing a subgroup of participants, the data becomes more volatile and more difficult to interpret.

***Comments from Aboriginal clients on TEI Social and Community outcomes***

Aboriginal clients interviewed suggested that they were able to achieve a range of outcomes from across the TEI Outcomes Framework (in line with findings from Section 6.5.2 about the broader TEI cohort). Most of the Aboriginal clients we spoke to were young mothers, many of whom were or had been in extremely vulnerable situations. One client encapsulated this by explaining:

"*There are some problems that only time can heal. The women here, they've been through domestic violence, mental health crisis, they've been through it all."*

Another client explained that:

*"I don't know what would have happened without [ACCO]. I wouldn't have overcome the trauma of my past - I wouldn't have all the goodness I've been blessed with now. Knowing that my children are loved by someone who's not their mum – it's somewhere they can come to. It's going to make them grow up to be more whole. It really does take a village to raise a family."*

A third client told us that:

*"If I didn't have support from (TEI Supported Playgroup), I think that life would be very different. The playgroups are a place where we can all support each other and connect to culture with our kids together."*

One young person [69] we spoke to also noted:

*"There are so many elders here, I can come here and hear their knowledge - they teach me so much about how to look after my two daughters… Without the art group, my kids wouldn't get connection with culture. I feel at home being here".*

***Empowerment Outcomes***

We also heard client testimony around empowerment outcomes, particularly amongst the young people interviewed. One young person told us that the TEI community connections program allowed them to better understand their Aboriginal culture, and the program's flexibility allowed them to feel a sense of ownership and agency over their learning.

*"It was one of the first times I felt empowered in my life…we knew what we were going to get, it was a safe space, and we knew that we were being looked after, that we were being listened to - it was the simple things, the feeds, reliability, [ACCO] always being there to pick us up and drop us off, never had anyone put so much effort into supporting me. I was used to living in chaos, if I had to do something I did it on my own."*

Another young person commented that:

*"They gave me the confidence to make a decision for myself, they helped me stand on my own two feet. It was the first time I made a big decision for myself.… we workshopped my options together, and we managed to come up with the solution"*

*"Without [ACCO]'s support, there's a serious chance I wouldn't even be here today. I was lost. I had no idea what my options were, and I was tired of being tossed around".*

***Aboriginal Design and Commissioning***

Stakeholder interviews and several survey responses highlighted the importance of self-determination as a principle underlying improving outcomes for Aboriginal families. These stakeholders and providers

[69] For this evaluation, we have termed a 'young person' as between the ages of 18 and 21.

advocated for a renewed focus on Aboriginal-led commissioning, co-designed approaches to identifying needs, setting priorities, procuring services, monitoring delivery and reviewing outcomes. In the survey, ACCO providers noted that without adequate Aboriginal-led commissioning or co-design, Aboriginal people and their perspectives will not be front and centre. These providers noted that Aboriginal-led design and commissioning has been difficult to implement, as this is not specifically funded or supported by DCJ. In our conversations with DCJ, we also identified that there are currently limited examples of genuine Aboriginal-led design or commissioning taking place.

In the case study, one ACCO explained how it delivers *TEI Community Connections* services via its women's art therapy program – an example of successful co-design. The program provides Aboriginal women, many of whom are mothers or carers, an opportunity to connect and practice cultural art within a safe and inclusive community space. The program emerged organically from a community-led initiative, which the ACCO then supported for three years. The design of the program and its activities are entirely community and Aboriginal-led – the ACCO provides an Aboriginal caseworker to support with facilitation. The ACCO staff believe that Aboriginal-led and designed programs offer a powerful way of engaging the cohort that TEI would otherwise struggle to support.

*"The art group helps gives the ladies a voice, gives them pride, builds self-esteem. It's so important for these ladies to feel connection."*

These outcomes were also reflected in client comments:

*"Getting to know your community, your mob, like this - it's incredible. We talk about everything; we all support each other. So many of us ladies come here so lost – we help form each other's support networks, and we all help each other stand proud."*

However, the ACCO pointed out that the women's group was an isolated example that was not easily replicated.

*"The art group was only possible because [a caseworker] was very connected to the community. She kept going and kept building it up, building on those cultural connections".*

The ACCO commented that overall, TEI is not supportive of Aboriginal-led design. They believe that the TEI framework imposes too many stipulations and requirements, without support to establish co-design.

*"Overall, we think that TEI doesn't support Aboriginal-led programming. We would love to do more, establish more cultural stuff like the art group, but the funding is simply too prescriptive. We are forced to deliver TEI in a certain way… we are just provided a description of what we need to achieve. If DCJ wants to support Aboriginal-led programming, they need to consult with the providers, and communities about what they want, and what they need. Right now, there's no initial conversation from the government end."*

The lack of genuine Aboriginal-led programming was also noticed by one of the ACCO's TEI playgroup clients, who commented that:

*"The playgroup is amazing, and it's so important that they can build in Aboriginal cultural elements. However, I can't help but feel that what they are providing right now is still the white man's model…I want there to be yarning circles, elders coming in, traditional language, possum cloaks for the babies to play with. It feels like there is potential to unlock so much more."*

***Aboriginal clients also spoke of cultural outcomes which aren't captured through TEI reporting***

Stakeholder interviews and a small number of survey responses noted the absence of cultural outcomes in TEI reporting. They emphasised that the current reporting framework would understate outcomes for Aboriginal clients and families as it did not allow for qualitative data or culturally specific stories, events and outcomes.

This perspective was also reflected in some case study interviews. Both ACCO providers we spoke to stressed the importance of cultural outcomes they believe clients have achieved through TEI.[70] For some clients, they see that cultural outcomes (such as connection or kinship with culture and country) are a key pre-requisite for other TEI outcomes.

***Aboriginal client testimony on cultural outcomes generated by TEI***

In interviews with Aboriginal clients, around one third spoke of the cultural outcomes they had attained through TEI without direct prompting.[71] Some of these clients identified that it was the very absence of cultural connection that had led them down difficult paths in life. By contrast, these clients felt that the TEI services they were receiving from an ACCO was allowing their children to grow up within culture – something that they felt would greatly benefit their future lives.

Clients explained that as children, they had often been kept away from their culture and traditions. Clients believed that TEI services provide an opportunity for their children to attain cultural connections, allowing them to avoid the troubles that stem from lack of culture and identity.

- *“My nan passed away in 2019 – it was only after she passed that we understood we were Aboriginal. ACCO helped us understand culture, and identity. Without culture and identity, I think my kids would have ended up lost – sort of like me.”*
- *“I’ve always wanted to learn my culture and embrace it - I’m never going to hide culture from my children like my grandmother did. Having a service like this – it’s something I never had and it will set up my kids so well for the future”*

Clients also directly related the cultural outcomes they had attained to outcomes such as health and social participation.

- *“Being part of this playgroup with my boys, it’s part of our healing process. It’s healing our intergenerational shame. Growing up, I was always missing something and I believe that’s what led me down some dark paths. Through [ACCO]’s playgroup, I can help ensure that my boys will grow up surrounded by mob, grow up understanding who they are. You have no idea how big of a difference that will make for their lives, for OUR lives.”*
- *“They get to understand who their mob are, feel connected with each other straight away from an early stage of their lives.”*

*“Growing up I didn’t know much about culture, and I’ve suffered as a result, and I really want it to be different for them. A lot of my troubles, my problems, I can see now that they stemmed from my disconnect about who I was.”*

Understanding the relationship between cultural outcomes and other TEI outcomes will be important in determining how to best support Aboriginal children and families (see recommendation 10.1.6, which sets out the need to capture outcomes which are relevant to the key focus areas for ACCOs and Aboriginal clients, including outcomes related to connection to culture and country). Evaluation partner, G.U.I.R, notes that Aboriginal evidence involves recognising Aboriginal ways of knowing and values over current Western approaches. The Aboriginal perspective and framework emphasises strengthening the interconnectivity of multiple dimensions of being, and supporting respectful relationships between participants, services and the environment. This often differs from Western epistemological frameworks which emphasise validating a distinct variable’s causal relationship with an outcome.

---

[70] As set out in Section 8.3, cultural outcomes achieved were often the result of dedicated cultural connections work from the ACCO providers. This means that these outcomes may be, at least in part, the result of additional organisational efforts rather than TEI generally.

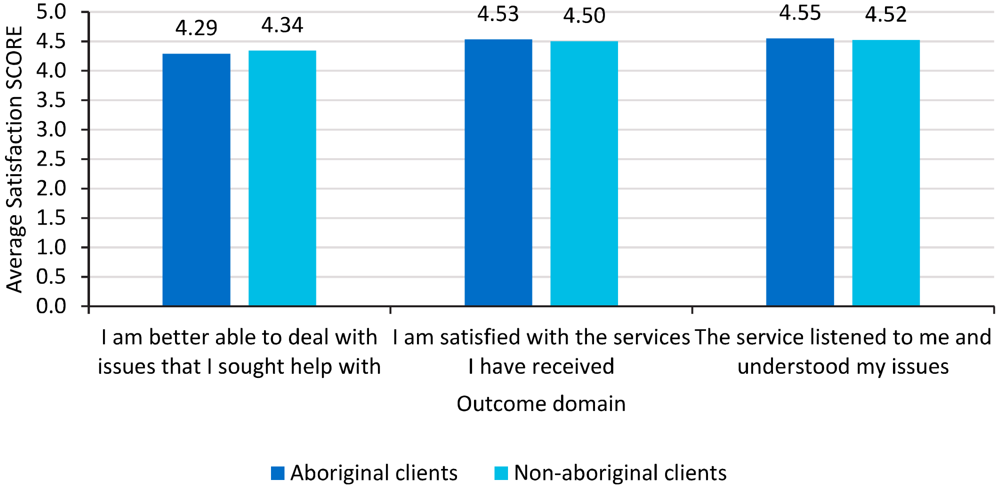
[71] In total 19 of the 47 total clients interviewed identified as Aboriginal.

### 8.3.3 Client satisfaction

***Aboriginal clients have reported a high level of satisfaction for TEI support that is consistent with non-Aboriginal clients***

Figure 8.11 below shows that Aboriginal clients have reported high levels of Satisfaction for TEI support across all three domains assessed[72], similar to non-Aboriginal clients, despite Aboriginal clients often having more complex circumstances as described in Section 8.1. This reaffirms the positive feedback received from Aboriginal clients and service providers.

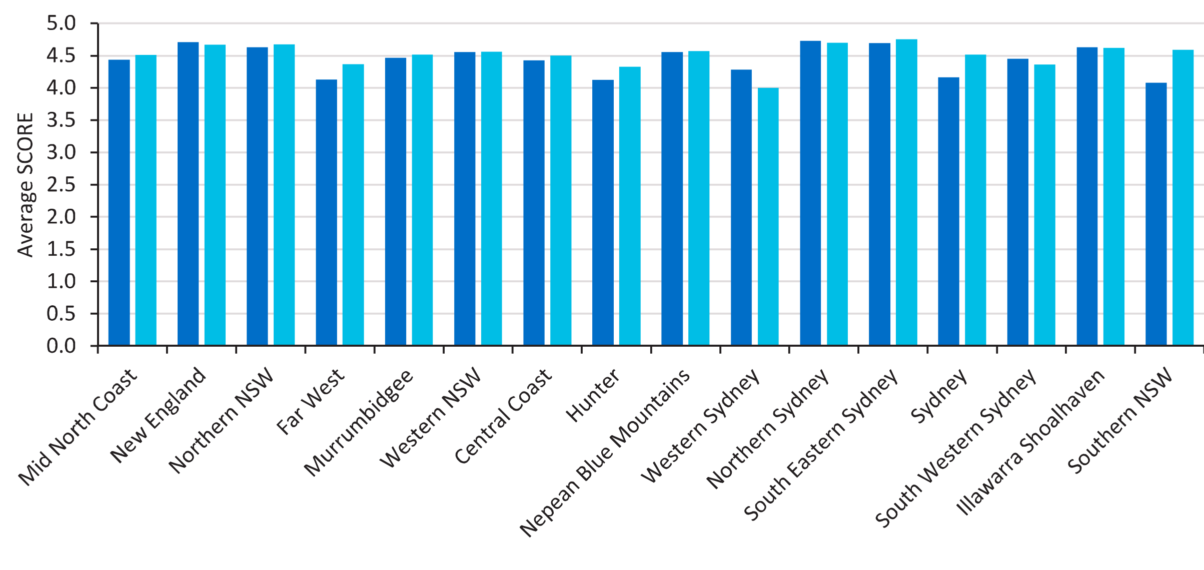
Figure 8.11 – Average Satisfaction SCORE for Aboriginal and non-Aboriginal clients by each outcome domain (DEX, all years)




Some small variations exist across districts for the average satisfaction reported by Aboriginal clients compared to non-Aboriginal clients as shown in Figure 8.13 below. Southern NSW district has the largest gap between Aboriginal and non-Aboriginal clients. The chart reports the average of all three Satisfaction SCORE domains. Separate breakdowns by the individual domains can be found in Appendix H.5.

[72] Rated on a scale of 1 (client disagrees with the statement) to 5 (client agrees with the statement)

Figure 8.12 – Average Satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district (DEX, all years)

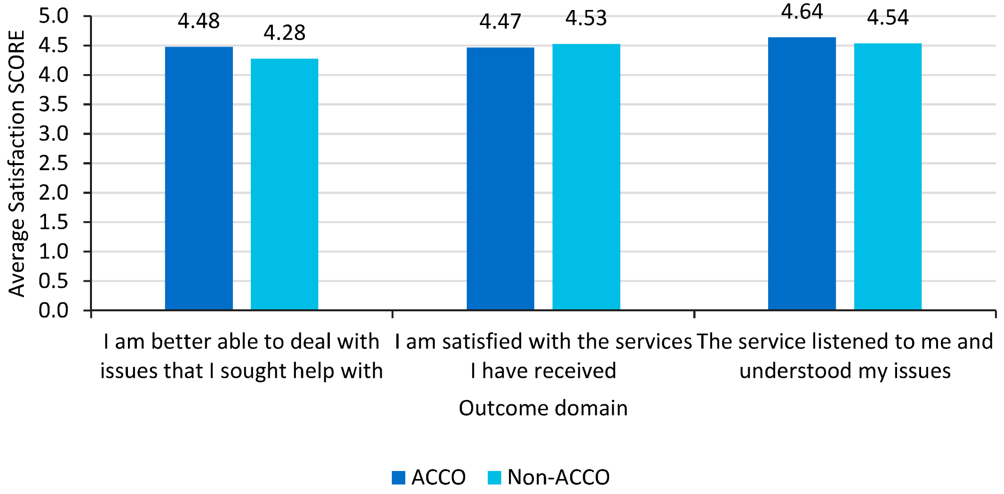



Note: To avoid distorting the broader trend, we have excluded SCORE results from the one outlet in Nepean Blue Mountains due to the potential data issue where the provider scored the same score for all clients for two years.

Figure 8.13 below compares the average Satisfaction SCORE rating for Aboriginal clients between ACCO and non-ACCO providers. We see that Aboriginal clients who received services from ACCO providers have reported slightly higher rating for the domains "I am better able to deal with issues that I sought help with" and "The service listened to me and understood my issues". Though the observed difference in the average is small, there is a statistically significant difference in the underlying distribution of ratings between 1 to 5, with ACCO providers having a greater proportion in the higher ratings[73]. This means the difference, while small, is likely genuine rather than being by chance. Note that these observations are again subject to the data sampling and recording issues discussed in Section 4.2.2 and again in Section 6.8.1, and care needs to be taken when generalising these results to the whole Aboriginal client population.

[73] P-value < 0.001 from a Chi-squared test for whether proportions from two different samples are the same

Figure 8.13 – Average Satisfaction SCORE for Aboriginal clients from ACCO and non-ACCO providers by each outcome domain (DEX, all years)




## 8.4 Costs and benefits of the program relating to Aboriginal children and families

***The target 30% investment in Aboriginal-led early intervention providers has not been met yet***

The proportion of funding to ACCOs has grown slightly over time, however still remains short of the target of 30% as discussed in Section 8.1.

Figure 8.14 - Proportion of funding to ACCOs over time

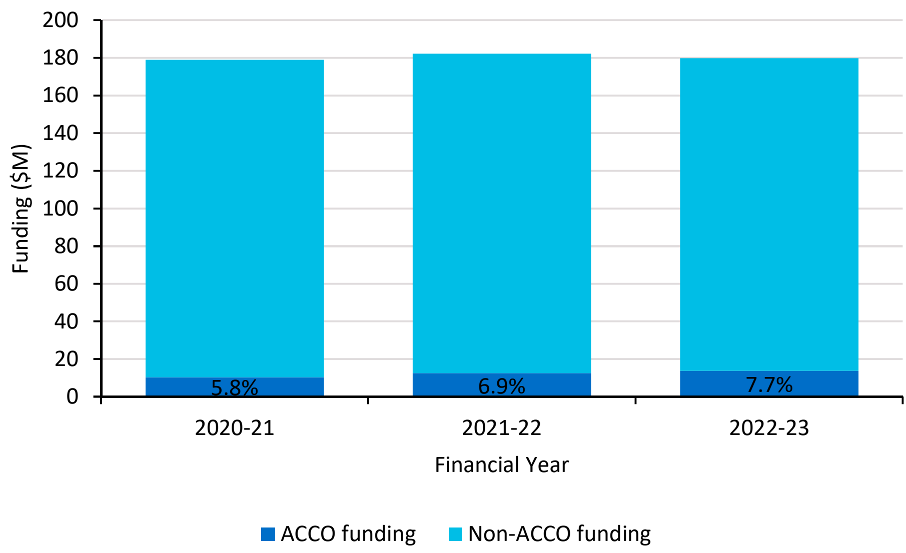
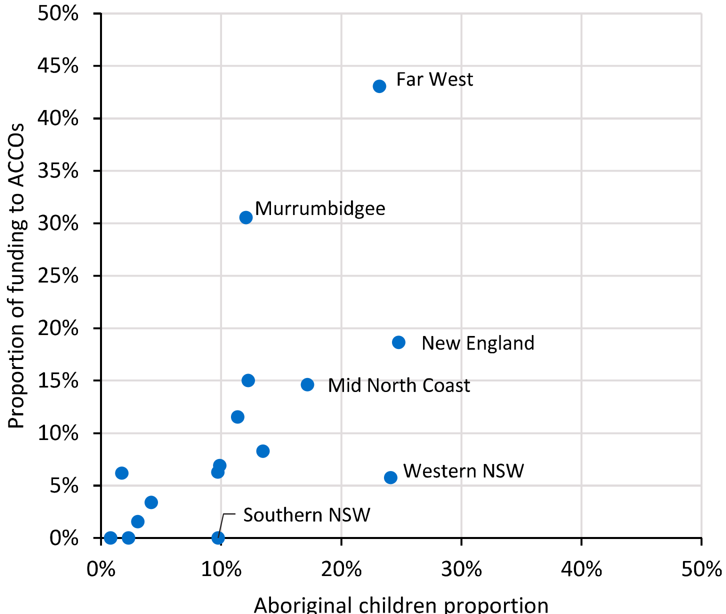



Figure 8.15 shows the relationship between the proportion of Aboriginal children and ACCO funding in 2022-23. In general, districts with higher proportions of Aboriginal children also had higher proportions of funding to ACCOs.

Figure 8.15 - Proportion of funding to ACCOs compared to proportion of children that are Aboriginal, by DCJ District, 2022-23




Note: See Appendix K.3 for the underlying statistics on the full list of DCJ districts. Only districts that have a noticeably different proportion of funding to ACCOs relative to their proportion of Aboriginal children have been labelled in the chart.

***The cost of each session is significantly larger for ACCOs, with each organisation providing fewer sessions on average each year compared to non-ACCOs. This may be a reflection of the more tailored services provided by ACCOs, for which there is qualitative evidence as being effective for improving the circumstances of Aboriginal clients.***

Figure 8.16 shows that although the average cost of ACCO sessions has decreased over time, it is still around 3 times larger than that of non-ACCOs. Some of this difference may be attributable to economies of scale; based on case studies, ACCOs tend to be smaller organisations providing more tailored services and consequentially fewer sessions. This is shown in Figure 8.17 where it can be seen that ACCOs provide far fewer sessions each year on average compared to non-ACCOs. Part of these differences may also be driven by difference in data recording quality as discussed in Section 5.1.

Figure 8.16 - Average cost per session, by ACCO classification (DEX and Funding data)

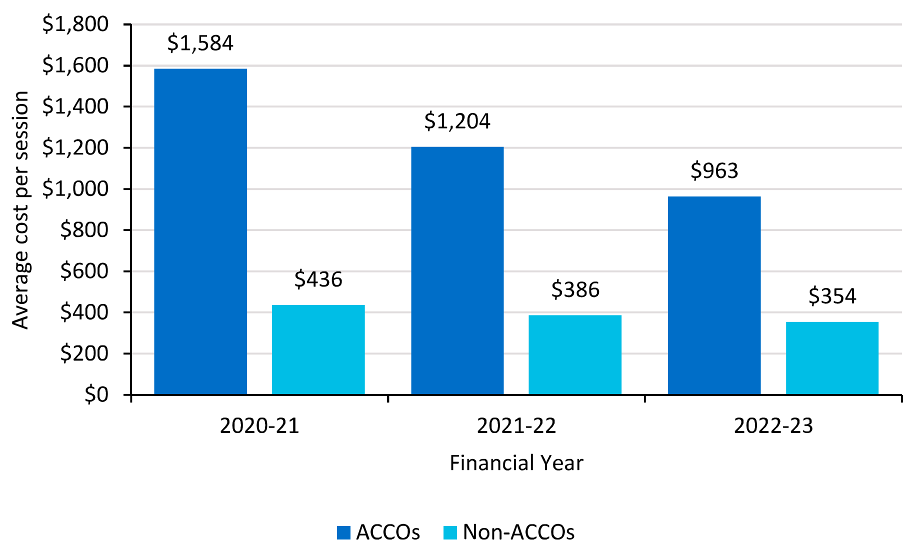
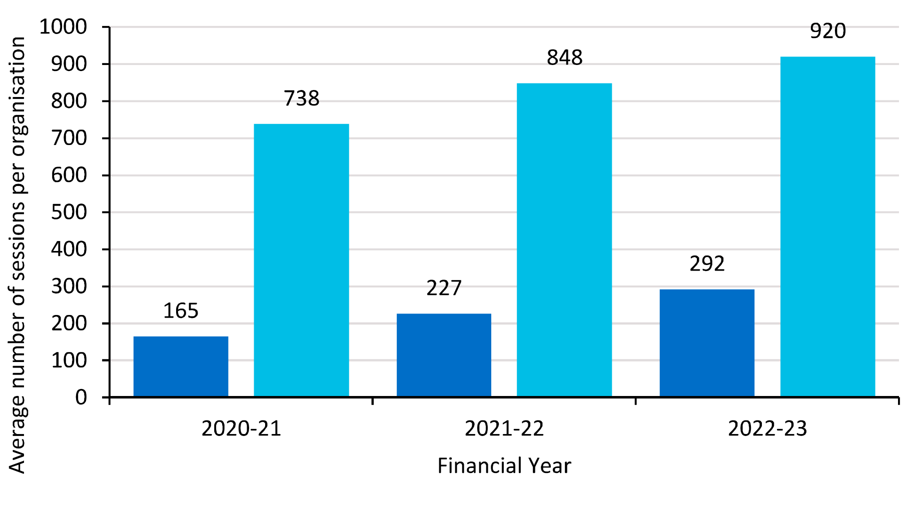


Figure 8.17 - Average number of sessions per organisation (DEX and Funding data)




***Economic benefits attributable to ACCO providers were not able to be isolated out due to data limitations.***

This is a limitation of the current analysis design meaning that it is not possible to link client outcomes to the type of provider service attended. It is an important consideration for future analysis to be able to link service usage outcomes to ACCO providers in order to measure the effectiveness of their program designs. This will allow for evaluation of the economic benefits attributable to ACCO providers specifically and comparison to the associated costs.

# 9 Economic Evaluation

This Section of the report considers the following evaluation questions:

- What are the quantifiable benefits of the overall TEI program and/or at a program stream level? And are there benefits that cannot be quantified?
- What are the costs of delivering the TEI program, and do the quantifiable benefits of the program outweigh its costs?
- For which program stream/program activities did benefits outweigh costs?

To answer these questions, the evaluation draws on multiple sources, including outcomes analysis (refer Section 6), funding and cost data.

## 9.1 Benefits of the TEI program

### 9.1.1 Approach to benefit recognition

In line with NSW Treasury Cost Benefit Analysis guidelines, we have required a high standard of evidence for benefit recognition – focusing on areas where there are statistically significant improvements in linked data outcomes. Since the use of data linkage for evaluating programs similar to TEI is still emerging, this differs from other approaches that are sometimes adopted. Some key features of the approach:

- We have not relied on improvements in provider-reported SCOREs. While we have shown these are useful indicators of client outcomes (see Section 7), the ability to track outcomes to linked data is more robust as we can measure via actual service usage data. Change in SCORE is used in some evaluations, for example the recent Family and Relationship Services Economic Evaluation[74].
- We have not relied on existing literature surrounding the benefits of youth and family support services (of the type TEI offers). Again, we have preferred to focus on benefits that can be directly estimated.
- We have only used outcomes with statistically robust improvements. This means that benefits related to justice, education, employment, health and housing have not been valued as there were no statistically significant improvements against these outcomes. Some stakeholders perceived benefits in these domains. Our benefits are restricted to the safety domain. This limitation is discussed in detail in Section 6.
- We have not assigned economic benefits to some of the observed benefits to TEI that have been found in survey and qualitative work as per standard treatments in cost-benefit analysis. In particular, navigation support and better access to services has a clear individual benefit, but in a way that is difficult to quantify (and in some cases may increase cost-to-government if people are assisted to access an entitled support).
- We do not assign a benefit to group clients – only to children who are individually identified, or whose parents are individually identified. We were not able to measure any benefits due to practical issues (estimating how many unique children are in groups) and theoretical ones (we are unable to test if outcome improvements for group clients are similar to those of individually-identified ones).

---

[74] https://frsa.org.au/wp-content/uploads/2023/09/CIE-Final-Report_FRSA_Family-and-Relationship-Services-Evaluation-11092023.pdf

Given the above, we regard our approach is therefore relatively conservative, and in line with cost-benefit analysis guidelines.

Full details of the benefit calculation are available in Appendix J. In short, we:

1. Extract the total quarters in which identified clients aged under 18 were impacted by TEI, split by quarters since entry in 2022-23 from the DEX data. Note that since our benefit model is quarterly, a single client will be counted (at most) four times. This potentially includes ongoing benefits arising in 2022-23 related to TEI service receipt in earlier years.
2. Scale up to allow for effect of children not recorded in the DEX but are impacted by TEI through their parents (i.e. indirect clients as defined in Section 5.3 and consistent with all other HSDS analysis). This factor was selected based on HSDS analysis and differs by activity type.
3. Multiply by proportion of TEI entrants in OOHC, or not in OOHC depending on whether the outcome is conditional on being in OOHC at intervention or not.
4. Apply regression estimates of TEI impact from the models in Section 6.4.1 to calculate the number of quarters with service episodes avoided (or clients exiting for OOHC). This is the estimate of TEI's impact after controlling for risk-factors. We use the regression estimates for each of the eight quarters after entry and these are included in Appendix J.2.
5. Multiply improvement outcomes with per-event dollar savings/benefits. These per-event values are based on the most recent version (April 2024) of DCJ's benefit and unit cost manuals:
   - $270 of government avoided cost per quarter with child protection report avoided (a unit cost associated with handling the report)
   - $10,583 of government avoided cost per quarter with ROSH Report avoided (the long-term value associated child protection costs related to an additional ROSH for a child)[75]
   - $5,275 of benefit to the individual per quarter with ROSH Report avoided (disability weight associated from reduced quality of life if PTSD develops)
   - $376,143 of government avoided cost per additional OOHC exit (the long-term value associated child protection costs related to remaining in OOHC).

### 9.1.2 Benefits estimate

***Improvements in safety outcomes translate to an estimated $92 million in annual benefits***

There is evidence that the TEI program has improved the safety outcomes for clients, as detailed in Section 6. Where possible, we have attached dollar savings to these benefits and estimated the economic benefit attributable to the TEI program over 2022-23. The total estimated benefit is $92 million, with $79 million of this being avoided costs to government and $13 million being broader economic benefits accruing to the individual client in receipt of TEI services. The benefits are summarised in Table 9.1 below.

[75] Note that while the decrease in ROSH reports is not statistically significant at a 5% significance level, we have allowed for its benefits in our estimation due to the similarity of its effect size to concern reports, which increases our confidence in the estimate, as discussed in Section 6.4.1.

Table 9.1 – Economic benefits from improvements in safety outcomes, 2022-23

| Outcome [(a)] | Number of children impacted [(b)] | Number of avoided events /additional OOHC exits[(c)] | Benefit per avoided event /additional OOHC exit | Total benefit[(e)] |
|---|---|---|---|---|
| Concern report | 263,667 | -4,037 | $270 | $1.1 million |
| ROSH report | 263,667 | -2,557 | $10,583 to government<br>$5,275 to the individual | $27.1 million to government<br>$13.5 million to the individual |
| OOHC – in OOHC at entry | 9,992 | -134[(d)] | $376,143 | $50.5 million |

Notes

(a) The change in use of OOHC by children not in OOHC at intervention (entry into OOHC) was not included as a cost or benefit due to less confidence in the modelled impact.

(b) The number of children-quarters identified, divided by the four quarters of 2022-23. This is a slight underestimation as clients who began during 2022-23 will have been impacted for less than four quarters. Note that these children may have started accessing TEI services prior to 2022-23 and need not necessarily have used TEI services in 2022-23.

(c) The incremental change due to TEI over 2022-23 (as estimated by regression models) is applied to each entry cohort and totalled. Example calculations are set out in Appendix J.

(d) OOHC exits are assumed to be cumulative (i.e. each child can only exit once).

(e) Number of avoided events/additional OOHC exits (c) multiplied by benefit per avoided event/additional OOHC exit (d).

Note that while the decrease in ROSH reports is not statistically significant at a 5% significance level, we have allowed for its benefits in our estimation due to the similarity of its effect size to concern reports, which increases our confidence in the estimate, as discussed in Section 6.4.1.

The benefit attributed to additional exits from OOHC is largest even though it applies to a smaller population, due to the large lifetime costs to government associated with OOHC.

***Quantifiable benefits were not split by program stream/activity level***

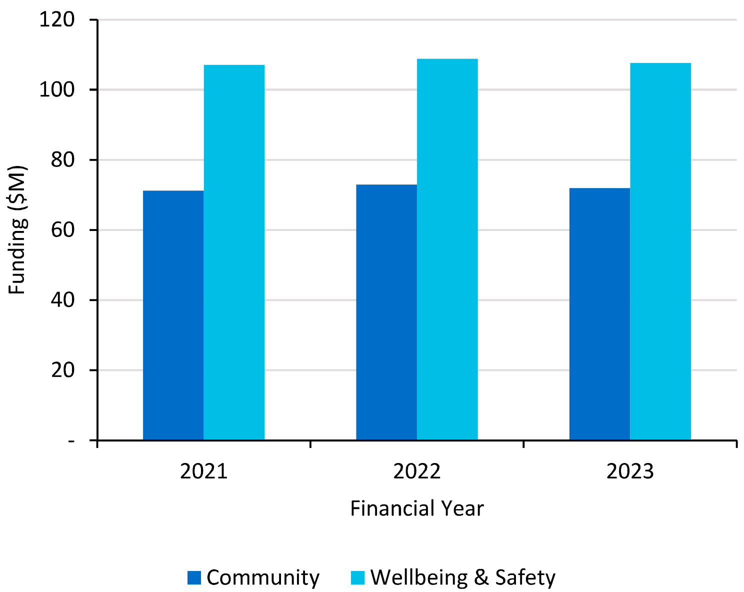
From the regression analysis introduced in Section 6.2, there was no strong evidence that quantifiable benefits differed by program stream/activity level (but there is some weak evidence of differences between streams). Additionally, on the cost side, funding breakdowns by activity type are only available as at the beginning of each year and do not necessarily represent actual funding spent on each activity type. This meant that at this evaluation we could not conclude if specific program stream/activities provided benefits that outweighed its costs.

## 9.2 Costs of the TEI program

***Total annual TEI costs for 2022-23 were $181 million, with 60% allocated to the Wellbeing and Safety stream.***

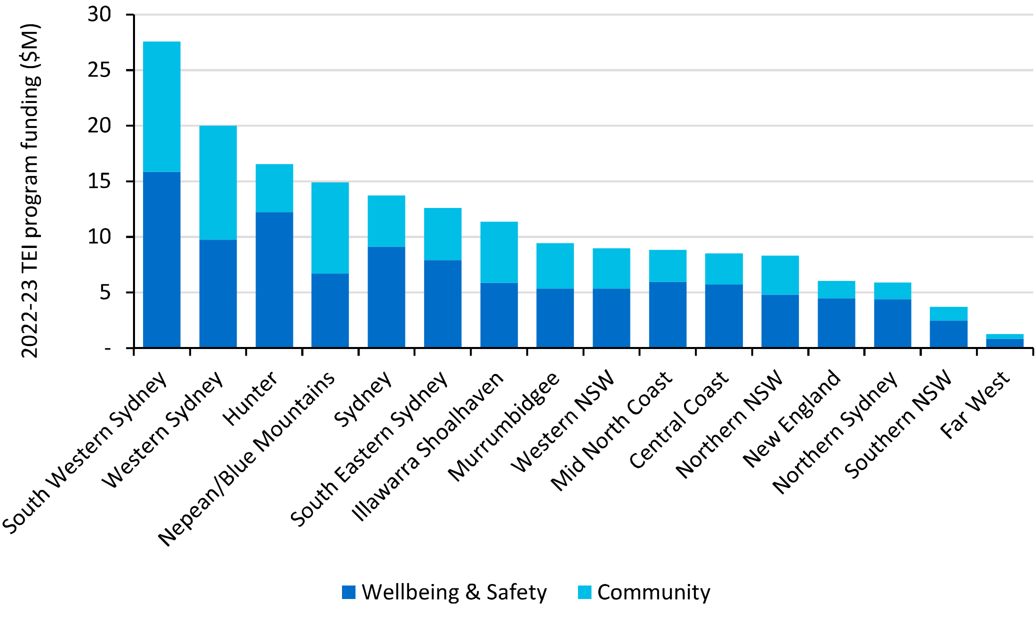
The majority of TEI's program costs are funding costs of service providers. Figure 9.1 shows that these costs have remained stable since TEI's inception and totalled $180 million in 2022-23.

Figure 9.1 – Service provider funding costs, in 2022-23 dollars




Funding is not split equally between DCJ Districts. As shown in Figure 9.2, service providers in the South Western Sydney, Western Sydney and Hunter districts receive the most funding, while service providers in the Northern Sydney, Southern NSW and Far West districts receive the least. The allocation is based on historical funding allocations and, as discussed in Section 5.2, is broadly a function of population size and demand.

Figure 9.2 - 2022-23 funding costs, by DCJ District and stream




It can also be seen that the proportion of funding allocated between the two service streams varies from district to district. The Hunter, New England and Northern Sydney districts have the largest proportion of funding allocated to the Wellbeing and Safety stream (around three-quarters), while the Nepean/Blue Mountains, Western Sydney and Illawarra Shoalhaven districts have the lowest proportion allocated (around half).

There are additional costs associated with the administration of the program. In 2022-23, these totalled:

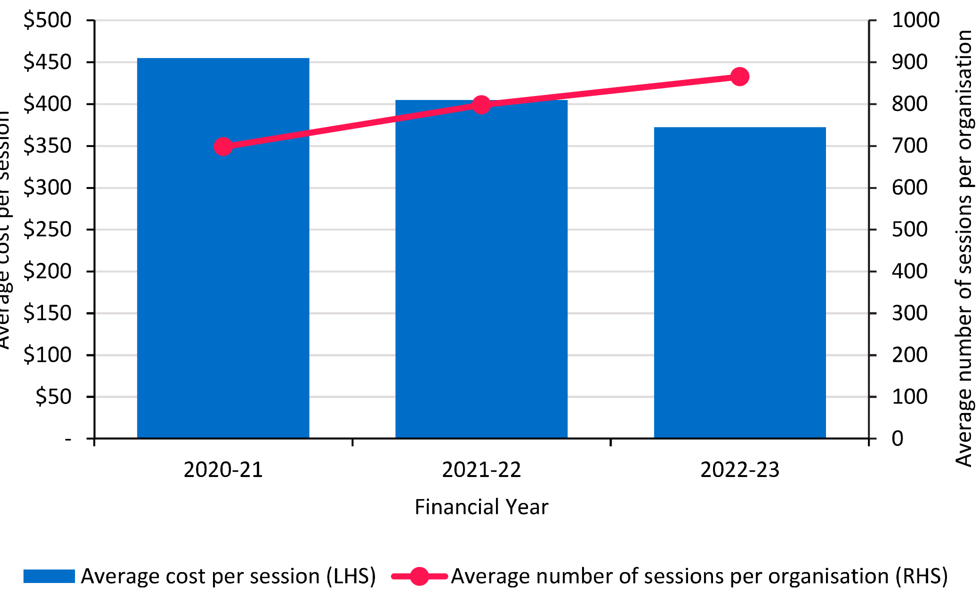
- DEX licensing fees of $520,000
- Employee related expenses (salaries and on costs) of $488,568

The total cost of the TEI program for 2022-23 was $181 million (in 2022-23 dollars).

***Average cost per session has decreased over time and there is noticeable variation in cost-to-serve between districts and by stream.***

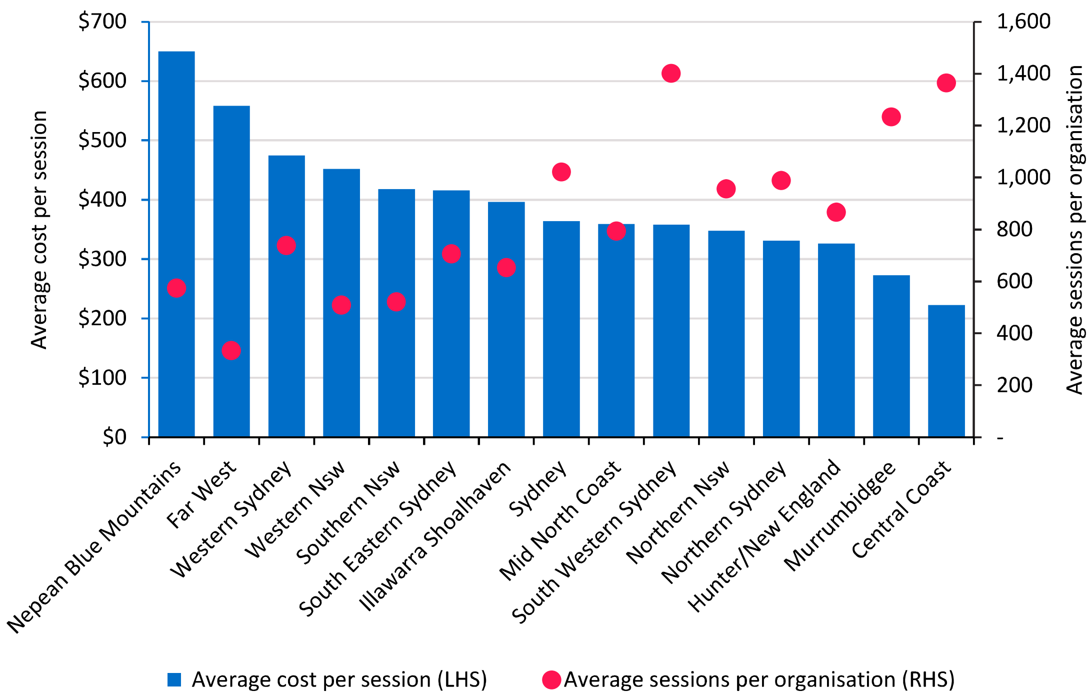
A natural question related to costs is how funding is being translated to services and whether this is being achieved efficiently. Looking across both streams, Figure 9.3 shows that the average cost per session has decreased over time while the average number of sessions per organisation has increased. This reflects that there are some economies of scale to be had; fixed and initial overheads such as rent, IT systems and staff onboarding are now being spread across more services.

Figure 9.3 - Average cost per session (LHS) and average number of sessions per organisation (RHS) over time (DEX and Funding data)




Looking across both streams, Figure 9.4 shows the average cost per session in each DCJ district and that there is a significant amount of variation, with sessions in the Nepean Blue Mountains district costing on average almost three times those in the Central Coast, even though both districts have the same proportion of Wellbeing and Safety sessions (around 50%). Organisations providing more sessions tend to also have a lower average cost per session, supporting that economies of scale play some part in the cost efficiency of service provision.

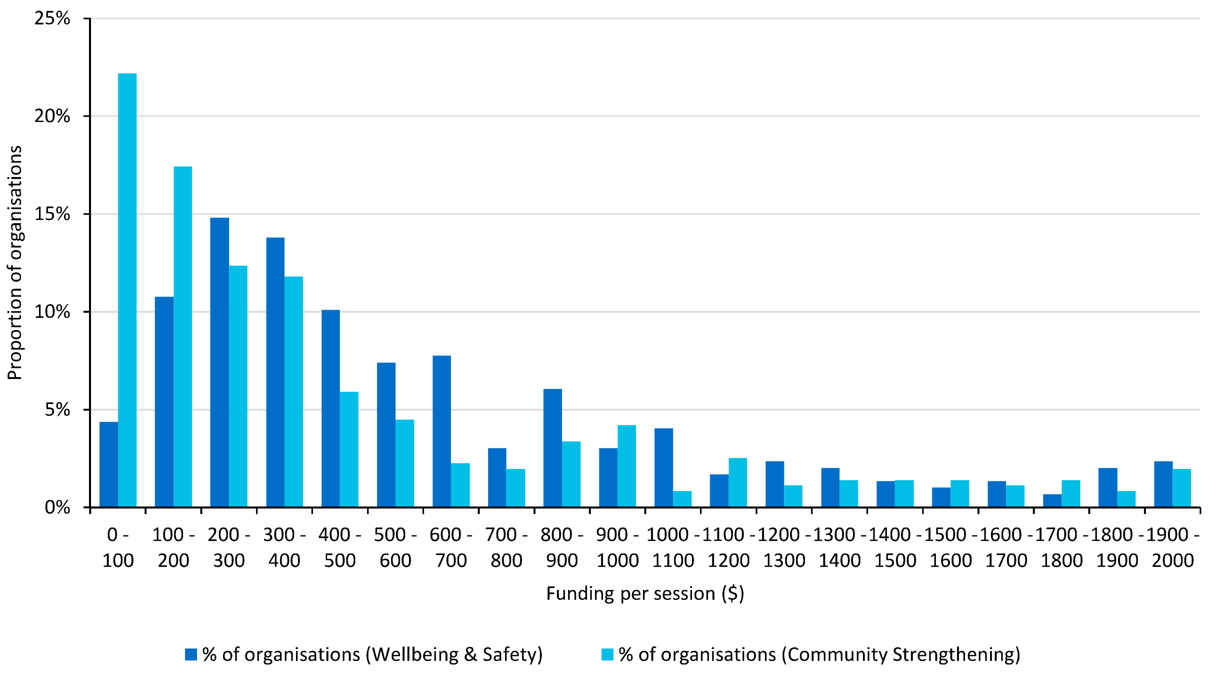
Figure 9.4 - Cost per session (LHS) and sessions per organisation (RHS) by DCJ District, 2022-23 (DEX and Funding data)




Note: Results for Hunter and New England are reported as one region due to the nature of the funding data available.

Wellbeing and Safety sessions also tended to be more expensive to provide. Figure 9.5 shows that when examining average session costs by organisation, Wellbeing and Safety sessions are most likely to cost $200-300, while Community Strengthening sessions are most likely to cost less than $100.

Figure 9.5 - Distribution of funding per session by activity stream, 2022-23 (DEX and Funding data)

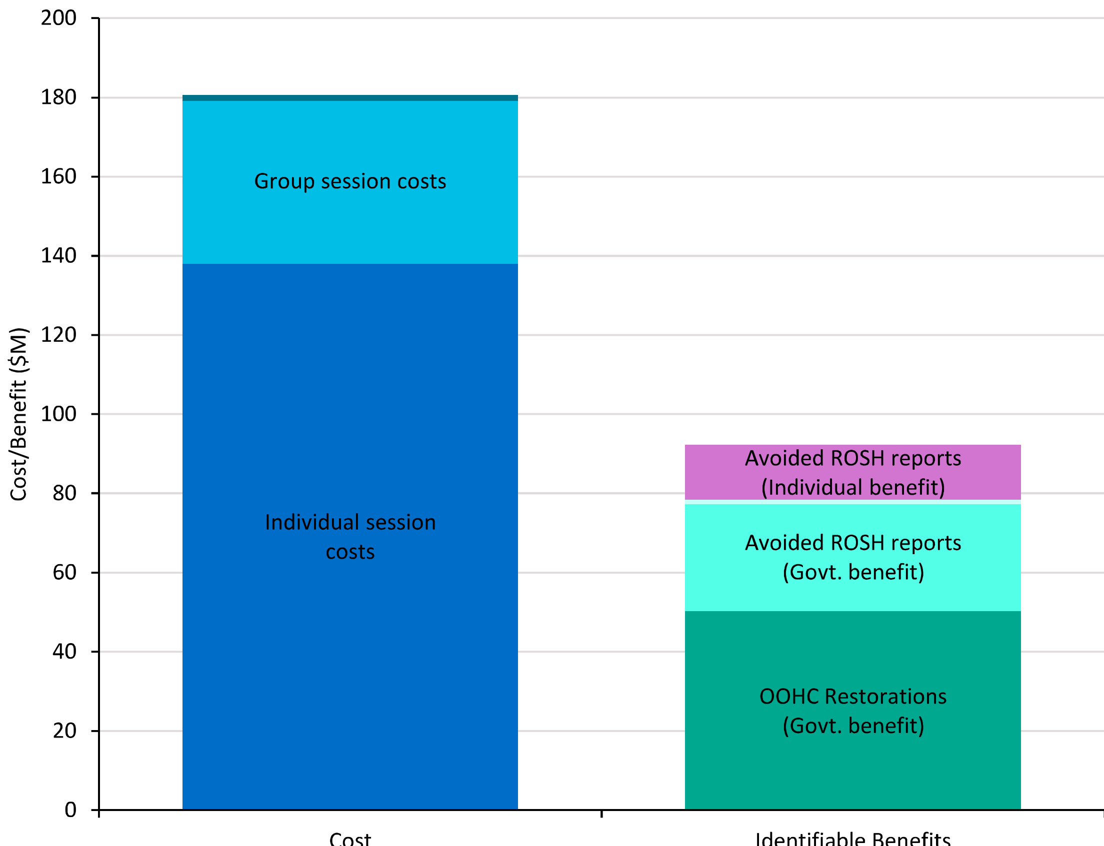


## 9.3 Economic impact of the TEI program

***We have found that there were 66 cents of benefit for each dollar cost of the TEI program in 2022-23 for individually-identified people or a benefit-cost ratio (BCR) of 0.66***

Figure 9.6 summarises the costs and identifiable benefits to individually-identified people of the TEI program, as calculated in Section 9.1 and 9.2.

Figure 9.6 – Cost-benefit summary




The costs of the program over 2022-23 were $181 million, of which $139 million is attributable to individual sessions. The identifiable safety benefits for individual sessions of $92 million represents a cost-benefit ratio of 1 to 0.66. We note that:

- There is some uncertainty associated with the benefit estimation, particularly in terms of the number clients impacted.
- It is likely that there are economic benefits achieved by the TEI program but which are not quantified and not included in this comparison, as discussed in Section 9.1.
- We can additionally calculate the benefits accruing to government only by omitting individual benefits (the purple bar in the chart). In this case benefits to government are $79 million and the cost-benefit ratio is 1 to 0.56[76].

[76] Numbers may not calculate exactly due to rounding

## 9.4 Interpreting costs and benefits

***Economic evaluation is supportive of the TEI program impacts***

Section 9.3 shows a cost-benefit ratio related to individual-level sessions of 1 to 0.56 for government (through avoided cost), with additional benefits to individuals. While a ratio greater than one would represent a stronger result, there are a few things to note when interpreting results:

- Being able to establish quantifiable outcome gains for early intervention programs is not to be taken for granted, and there are relatively few comparable public cost-benefit analyses. The estimate relies on actual linked outcomes quantified from the HSDS, and so provides a very credible measurement of benefit.
- The analysis also provides useful evidence (shown in Section 7) that SCOREs (and changes in SCOREs) are predictive of outcomes. This is useful for other evaluations (past and future) that rely on SCOREs.
- As discussed, NSW Treasury CBA guidelines mean there are several points of conservatism in the work, so we regard this as a robust estimate that may potentially understate the overall benefit of the program. This is echoed by some of the qualitative findings suggesting strong benefits beyond the child protection space.
- There is no intrinsic level of cost-benefit for government that represents a ‘good’ result, particularly when services provide individual and community benefits in addition to government avoided costs.

# 10 Opportunities and recommendations for the TEI program

This Section of the report considers the following evaluation questions:

- Are there opportunities to improve implementation of the program and commissioning of services?
- Are there opportunities to make the program more culturally safe, especially for Aboriginal people?

The below opportunities have been identified from the evaluation findings. The level of evidence to support each opportunity varies. In some cases, we have drawn heavily on the qualitative analysis to identify opportunities in situations where the quantitative analysis was unable to identify specific service provision and cohort factors which influence client outcomes. We note that the difference between quantitative and qualitative data in these situations denotes the possibility that TEI is not as effective in achieving outcomes as key stakeholders perceive, especially given the BCR ratio of less than 1. However, given the overwhelmingly positive qualitative feedback received from a wide range of TEI stakeholders, we believe it is prudent to interpret results alongside the limitations set out in section 3.4 prior to drawing any conclusions regarding the differences between quantitative and qualitative findings.

It is important to note that some of these opportunities are not new, rather they represent activities that are already planned or underway as part of the implementation of TEI reforms and/or the upcoming recommissioning process. Under each opportunity, we have provided suggestions for what would be required to effectively deliver on the opportunity.

## 10.1 Potential opportunities to improve the TEI program

### 10.1.1 Increase funding and capacity of ACCOs to deliver TEI services

***How does this relate to the evidence?***

It was not possible to apply the quantitative evaluation methodology to compare outcomes for Aboriginal clients receiving services from ACCOs as compared to non-ACCOs, due to data limitations. Similarly, the economic evaluation could not compare the cost of ACCO service delivery against outcomes from ACCO services, although the cost of each session is significantly higher for ACCOs (potentially due to more tailored services provided, limited economies of scale and other operational challenges such as recruitment and retention of Aboriginal staff).

However, through the qualitative components of the evaluation, Aboriginal stakeholders, TEI providers and clients spoke of the importance of culturally appropriate services for Aboriginal clients as a critical enabler for positive outcomes. There were examples of non-Aboriginal service providers delivering high quality and valued supports to Aboriginal people. However, there was also strong feedback about the importance of having Aboriginal led services, by ACCOs, available to Aboriginal people.

The evaluation has not, therefore, identified an investment target for ACCO service provision. Instead, we have deferred to DCJ's investment target of 30% of total funding to be delivered by ACCOs. Whilst increases are planned from current levels, that target level is not yet being met.

***What might this look like in practice?***

As mentioned, DCJ has already recommitted to increasing investment in early intervention services delivered by ACCOs in the next funding cycle 2025-2030. This is to be implemented alongside increased shared decision making and authority through service system co-design and Aboriginal-led

commissioning. We note that DCJ is currently developing Aboriginal-led commissioning principles in consultation with the sector.

To reach its investment targets and to support ACCOs ability to achieve outcomes through TEI, there will also need to be increased focus on supporting new, emerging and growing ACCOs to ensure they have the capacity to successfully deliver TEI.

### 10.1.2 Focus on increasing TEI access in high population-growth and remote areas

***How does this relate to the evidence?***

Section 5.2 compares how districts are meeting demand on a few measures, noting that there is no single perfect indicator of unmet demand. There is no concrete evidence of unmet demand in any district, however the high-level regional analysis suggests that the South Western Sydney and Western Sydney districts have fewer sessions and resourcing compared to levels expected based on SEIFA. A related consideration is the implications of forecast general population growth. Strong growth is expected in some LGAs in Western Sydney, South Western Sydney, Hunter and Illawarra Shoalhaven. This reflects recent trends and planning around new housing developments. All else equal, we would expect greater need for TEI services to grow in these areas over time.

In terms of specific service types, there is a lack of outlets delivering Counselling services and Specialist Support services in the more remote districts, which have resulted in very few clients from remote areas receiving these services. This is despite finding evidence as part of the quantitative analyis that these two services provide relatively large improvements in safety outcomes (reduction in concern report rates) for clients.

***What might this look like in practice?***

As part of the recommissioning process, DCJ should consider increasing funding and support to areas with strong general population growth as identified above. This may require additional supports to grow the capacity of new, emerging or expanding service providers especially in new suburban areas with limited existing community infrastructure.

For remote areas, if increasing the capacity of physical outlets is not feasible, virtual options should be considered. In particular, DCJ should also review the availability of Counselling and Specialist Support services in remote areas.

### 10.1.3 Greater opportunity for contract and funding reviews during a contract period

***How does this relate to the evidence?***

Through the qualitative components of the evaluation, TEI providers gave strong feedback about disconnect between funding allocations, community need and the actual resourcing required to deliver the services. They also spoke of the impact of funding limitations on their ability to achieve outcomes with clients.

While the TEI reforms intended to see funding distribution aligned to local needs, these reform aims have not been fully realised – instead funding decisions were largely based on historical contracts. The TEI reforms did result in longer contract durations, which providers valued for the increased stability and certainty that they provide. However, providers have described having limited opportunities to renegotiate funding based on changes in need or other environmental changes. An obvious example is that providers cannot expand services if they see a strong growth in demand.

***What might this look like in practice?***

While retaining the planned 5-year contract duration, DCJ could implement more frequent opportunities for contract and funding reviews for TEI providers. This would allow DCJ to make informed decisions

about appropriate levels of resourcing and funding to match changes in need or other environmental factors which affect TEI providers and their clients.

The contractual basis for these reviews would need to be determined by DCJ in line with the recommissioning approach. However, it will be important that DCJ adequately promotes and encourages this process with TEI providers, and that the process is sufficiently streamlined to ensure providers are aware of opportunities for interim reviews and can reasonably act on these opportunities when appropriate.

### 10.1.4 Increased flexibility in service provision

***How does this relate to the evidence?***

The evaluation found that flexibility was one of the most valued aspects of the TEI program among providers – which allows them to tailor services to match the needs of their clients and thus enables them to achieve outcomes with clients. This flexibility was also highly valued by TEI clients engaged for the evaluation, who appreciated the willingness of TEI providers to develop creative client-centred solutions to address their unique needs, circumstances and preferences – rather than following a more narrow or inflexible approach. This is supported by the quantitative analysis which showed that clients who attended more sessions had a larger measured improvement in their safety outcomes. However, providers often also describing a desire for *additional* flexibility, in the way that they design services or determine client eligibility.

***What might this look like in practice?***

The design of the TEI program could be simplified to allow providers to deliver a range of activities in their local district. One way this design simplification could occur is through the reduction in the number of distinct service types, instead allowing for greater flexibility within a smaller number of service types. This could allow for more organic development of community-led approaches – which represent specialised responses based upon the specific needs of communities.

Secondly, additional encouragement to explore flexibility could be given to district Commissioning and Planning Officers and TEI providers with regard to defining local priority groups (to the extent local priority groups differ from TEI priority groups). For example, in some communities, this might see a greater focus on supporting extended families and community elders.

There is also opportunity for DCJ to clarify with providers how much flexibility already exists under the existing design. Over the evaluation it was found that some providers were mistaken about the number of supports sessions that were allowed to be provided to clients.

### 10.1.5 Support for community engagement and partnership development

***How does this relate to the evidence?***

Analysis of DEX data showed that TEI providers were recording relatively few internal or external referrals for clients in their service. In the TEI Provider Survey, providers also had mixed feedback about whether they were currently able to make suitable referrals in the case that they were unable to support a child, young person or family. Feedback from providers suggested that local coordination meetings and interagency meetings could be helpful to build local partnerships and relationships to enable effective referrals, but that effective forums were not in place in all regions. Further providers noted that local community engagement and partnership development, while very important, is resource intensive and cannot always be accommodated within limited TEI funding.

***What might this look like in practice?***

DCJ could look at reinvigorating interagency meetings and local provider forums in regions where these have lapsed or are not operating as effectively as they could – drawing on the lessons from those forums which are considered to be most effective.

As part of the recommissioning process, DCJ should look to provide sufficient funding for providers to participate in local forums and to undertake outreach to build partnerships in their local communities. Where they do not currently exist, DCJ should consider funding the establishment of interagency meetings for providers. Furthermore, the resources involved in undertaking these activities should be taken into account when estimating service costs and determining funding allocations.

#### 10.1.6 Updated outcomes measurement approaches

***How does this relate to the evidence?***

Providers gave a range of feedback about current outcomes measures approaches, particularly in terms of the use of SCORE assessments and use of DEX. This feedback is detailed in the Interim Report. In addition, the analysis of the DEX data showed that while there have been signs of improvements in data collection, potential data quality issues still exist, which indicates that current data collection measures require improvement. This is coupled with the evidence that SCOREs results are useful indicators of improved client outcome, especially from SCORE domains that are relevant to the client's situation, so there will be value in continued improvements.

***What might this look like in practice?***

DCJ should update both the TEI Outcomes Framework, as well as the supporting data collection processes. Guidance on outcome selection, consistent measurement and repeated measures needs will need to continue.

In terms of the outcomes framework, there is a need to reflect outcomes which are relevant to the key focus areas for ACCOs and Aboriginal clients, including outcomes related to connection to culture and country. DCJ could also explore opportunities to incorporate qualitative evidence as part of its outcomes measurement approach, particularly where this may enable more culturally appropriate methods of reporting on outcomes achieved.

In terms of data collection processes, the evaluation notes that DCJ already has a data quality improvement strategy in place and that many of the data quality issues observed through the evaluation are already in the process of being addressed (consistent with our more detailed findings in our Interim Report). DCJ should continue to progress this strategy with a focus on increasing Circumstances and Goals SCORE collection for clients at different points of their client journey while ensuring the consistency of SCORE assessments. Consistency in SCORE assessments is important as it means that a change in SCORE is more likely to reflect a genuine change in the client's circumstances rather than a change in standards of assessment. In addition, DCJ should consider ways to incorporate principles of Indigenous data sovereignty in its data collection processes.

DCJ should also look for ways to strengthen outcomes measurement for Community Strengthening services. This includes continuing the use of community SCOREs in the DEX, that can capture empowerment and cohesion outcomes.

Continued efforts made to improve the number of individual client records will also facilitate better outcomes measurement. Even if SCOREs aren't completed for individual clients, the ability to link to datasets like the HSDS will allow tracking of client outcomes and measurement of program effectiveness. Better recording of individual clients also allows for a better understanding of program reach as it reduces the double counting of clients.

### 10.1.7 Define the focus of future evaluations

***How does this relate to the evidence?***

This evaluation provided an important foundational assessment of the overall impact of the TEI program, with measurable improvements in safety outcomes, particularly within the Wellbeing and Safety stream. However, it was not able to reliably quantify the benefit of the TEI program for outcomes other than the child protection outcomes. It was also limited in its ability to definitively identify TEI demographic and service provision factors which have an influence on client outcomes. For some of these factors it is due to the limited volume of clients which the longer term impact of TEI can be reliably measured from. While there were differences in impact measured by client segment and service type, we were generally not able to conclude that these differences didn't just occur by chance (not statistically significant) given the small sample sizes we had to analyse. Other factors are not observable in the data at all – for example, the analysis was unable to identify types of providers to test differences in outcomes as provider information was not available in the HSDS. Specifically, we couldn't test for any variation in the effectiveness of TEI between ACCO and non-ACCO providers.

***What might this look like in practice?***

Any significant changes to the program arising from the recommissioning creates opportunities for evaluation. Shifts in funding will likely see changes in access patterns to services that will enable more precise impact measurement. Measurement of outcomes for ACCO clients is a natural example that should be prioritised for future evaluation if funding significantly increases.

In future evaluations, DCJ should also include a particular focus on understanding which factors lead to greater positive outcomes for clients. This should also include further efforts to better understand the specific impact of different TEI program activities and service types. TEI is a diverse service system, and this could allow DCJ to understand how TEI can improve its outcomes or ascertain a broader range of outcomes. While this has proven challenging in the current evaluation due to the lack of data volume especially for services in the Community Strengthening stream, data volumes available for analysis will increase with continued collection over time and efforts made to improve the number of individual client records will also facilitate better outcomes measurement. This will enable a more detailed exploration of what supports work best for who.

Furthermore, longer-term outcomes can be tracked for people supported in the current round of TEI, further validating impact on safety outcomes and potentially enabling better measurement of changes in other domains. This will enable a more holistic and reliable benefit cost ratio to be determined for the program that captures benefits from a greater range of outcomes and captures a greater time horizon.

# Appendix A Case studies

## Case Study methodology

The case study methodology was developed alongside close consultation with the DCJ internal evaluation working group, the independent Aboriginal Reference Group consisting of nine external members from ACCOs, including AbSec (see Section 3.3.4) as well as DCJ's internal Aboriginal Advisory Group comprised of Aboriginal DCJ staff. The methodology was also informed by the results relating to outcomes available to us at the time of writing the Interim Report (June 2023). The methodology also factored in feedback and perspectives received from providers (via the survey) and stakeholder interviews.[77] From these sources, it was agreed that the case studies should cover:

- two ACCOs out of the five proposed case studies. This would give appropriate representation to the number of TEI clients that identify as Aboriginal, as well as reflect TEI's intended ACCO investment target.
- districts with a large proportion of Aboriginal clients.
- an ACCO provider with an example of Aboriginal led co-design or co-commissioning.
- a regional district.
- both large and smaller providers.
- South Western Sydney and Hunter Central Coast districts, given interim findings that these districts had proportionally stronger performance on outcomes. South Western Sydney was also prioritised as a district with a large number of CALD clients.

We then worked with the DCJ internal evaluation working group to identify a short list of potential providers using the above criteria. This list was then further refined based on the following factors:

- Availability and willingness to participate in process.
- Ability and capacity to host up to 10 clients for in person interviews.
- Availability of staff for interviews.

This methodology resulted in the following five selections for case studies.

- **Muloobinba** – a medium sized ACCO TEI provider based in the Hunter region. Muloobinba was identified as a provider who had supported community led co-design of a TEI service.
- **Gudjagang Ngara li-dhi** (GNL) – a small ACCO TEI provider based in the Central Coast. The Hunter Central Coast district was prioritised given its status as the region with fastest growing Aboriginal population.
- **Intereach –** a large provider primarily based out of the Murrumbidgee district, with services extending to regional offices such as Deniliquin, Albury and Corowa.
- **Creating Links –** a small provider based out of Bankstown in the South Western Sydney district. Creating Links has strong links with the local Bankstown community and services a large proportion of CALD TEI clients.

[77] Stakeholder interviews included conversations with Sector Peak bodies, DCJ Executives, and TEI commissioning and planning teams.

- **Uniting** (South Western Sydney) – a large provider of TEI services. Conversation was focused on Uniting's provision of TEI services in South Western Sydney, which includes a mix of urban, rural and regional LGA's such as Campbelltown, Cabramatta, Camden, Wollondilly and Wingecarribee.

For each case study site, we worked with the providers to identify suitable staff and clients to interview. Staff were chosen at the providers discretion based upon their knowledge and experience of TEI service delivery. Clients were chosen by providers largely based upon availability and willingness, with considerable effort required of providers in explaining to clients the reason and merits of the case study interviews. Clients were provided a $50 voucher for their participation.[78]

#### Limitations of Case Study methodology

There are several limitations to the case study methodology that should be considered when evaluating case study findings.

- Sample size - The overall TEI cohort is large. While we spoke to a large sample of clients, there is a risk that the clients we have spoken to are not fully representative of the broader cohort, particularly given that we did not cover all TEI districts across the case studies. Similarly, staff at the providers we interviewed may not form a representative sample of providers across TEI given the specific criteria used to select providers.
- Sampling bias – to address sample size concerns, the methodology we adopted prioritised high client numbers over prescriptive criteria. This meant providers had discretion over client selection, largely based upon willingness. This means there is a risk that clients we interviewed were relatively more positive about the TEI services they received, or alternatively that providers may have selected for clients with more positive views of TEI.
- Attribution to TEI – Providers of TEI services often provide other services that are not funded through TEI. For clients, the distinction between TEI and non TEI services is likely not clear, and in many cases would not be actively communicated by providers. As a result, client feedback about impact and outcomes may not be fully attributable to TEI.

## A.1 Gudjagang Ngara li-dhi (GNL) TEI Case Study

### A.1.1 Organisation Overview

Gudjagang Ngara li-dhi (GNL) is an ACCO that supports vulnerable children, young people and families in Darkinjung Country on the Central Coast of NSW. For its services, GNL aims to replicate a system of care that the *Aboriginal World Views* encourage: one that is collaborative, consultative and engages all stakeholders to provide the best care for the community[79] and a model that embraces self-determination and the Aboriginal definition of Health.

Gudjagang Ngara li-dhi means *"Listen to the children"* in Darkinyung, a notion that underpins GNL's belief that Aboriginal families, children, and young people need to participate and contribute to their story through connection to community and culture.

In working with DCJ in delivering TEI services, its partnership approach is derived from two Darkinyung concepts:

---

[78] Clients were informed beforehand that the vouchers were sourced from DCJ funding.

[79] See 'About Us', at gnl.org.au/about

- **NGURA:** The wholeness of belonging and a richly embedded meaning for connection to place and country.
- **NGARA:** Listening to one another through continual cultural learning.

**TEI Services provided by GNL**

GNL provides TEI services across both TEI streams.

| TEI Stream | TEI Activity | TEI Service Type |
|---|---|---|
| Community Strengthening Stream | Community Connections | ▪ Community Engagement<br>▪ Information/Advice/Referral<br>▪ Social participation |
| | Community Centres | ▪ Community Engagement<br>▪ Education and Skills Training<br>▪ Indigenous community engagement<br>▪ Indigenous social participation<br>▪ Information/Advice/Referral<br>▪ Social participation |
| | Community Support | ▪ Advocacy/Support<br>▪ Education and Skills Training<br>▪ Indigenous Advocacy/Support<br>▪ Information/Advice/Referral<br>▪ Social participation |
| Wellbeing and Safety Stream | Targeted Support | ▪ Education and Skills Training<br>▪ Family Capacity Building<br>▪ Indigenous social participation<br>▪ Indigenous supported playgroups<br>▪ Information/Advice/Referral<br>▪ Intake/assessment<br>▪ Material aid (multiple items, parcels or vouchers)<br>▪ Mentoring/Peer Support<br>▪ Parenting programs<br>▪ Supported playgroups |

**TEI Outcomes Observed**

Interviews with GNL clients provided examples of outcomes in the following areas:

In interviews, clients were not specifically asked about each of the outcomes from the TEI outcomes framework. Rather, these outcomes were highlighted through the natural course of the interviews.

Furthermore, while most clients interviewed across all case studies received only TEI services (noting that the evaluation worked with providers to identify clients who primarily received TEI services only), some clients may have received non-TEI services from their provider. In these situations, a limitation of the case study interview process is that clients are unlikely to be able to distinguish between TEI and broader provider services.

### A.1.2 Key themes emerging from the conversations with GNL

**GNL's perspectives on creating outcomes with clients**

GNL aims to find *community* responses for children and families in need and to provide a service that clients feel a strong sense of belonging – and that parents and children can feel proud to say that are part of.

*"We provide a service where clients can come and go. The intervention or program itself could be short, but we ensure that clients are always welcome to come back, pick up the phone, even just to talk about life. This is essential for achieving outcomes, as it sets the foundation for ongoing trust and communication. Many of our clients are extremely vulnerable, and have a high distrust, or poor experiences, with family services. It means we can be there for clients when they need it – that's the biggest thing."*

GNL believes that client outcomes are driven by two elements:

*Firstly, the genuine care they are able to provide to clients and families.*

- This sentiment was reflected in feedback shared by GNL clients.
- For instance, one client explained that: *"GNL have had a massive role in saving my life, and for my kids to have a mum really. I didn't have much hope or light left. I was just there. GNL…it's just all about having a place that you feel welcomed, and safe and loved."*

*Secondly, the culturally specific understanding and support that they can provide to families.*

- GNL described practices which aim to create cultural safety in action – a theme reflected across GNL's services as well as reflections from interviews with both clients and staff.
- We also heard from multiple clients about the importance of GNL's cultural understanding.
- One client stated that: *"The trust, relationships that GNL can build are essential. - I went to another non-Aboriginal service once, I had to cut her off - she became very pushy about how I was raising my kids. But you don't know me, you don't know my kids, we've lived in the bush for the last 10 years - you have no idea what we have been through, what we have gone through. This was the first service that made me feel safe and respected about my past".*

From GNL's perspective, both elements contribute to high levels of trust and engagement among clients, and manifest as a service that is willing to go the *extra mile* to ensure positive family and cultural outcomes. This is especially important as GNL believe that a major reason why some outcomes are lagging in Aboriginal communities is the lack of cultural connection, supports and community.

GNL provided examples of its efforts using local connections and cultural understanding to help ensure that families avoided the need for an Alternative Care Arrangement (ACA). In one example, GNL was supporting a grandmother and child as part of a TEI supported playgroup. Following an accident to the grandmother, as well as increasingly challenging behaviours from the child, the grandmother was no longer able to provide care. Rather than let the child move into an ACA, GNL canvassed its community network and identified a local Aboriginal community member that was a suitable interim caregiver. Working with the grandmother and child, GNL helped forge a relationship that all parties were

comfortable with, and helped ensure that the child could remain with a local caregiver that was acutely aware of their cultural background and needs.

Our conversations with GNL clients help evidence similar examples of the ‘extra effort’ provided by GNL, with their testimony attributing these examples directly toward positive client and community outcomes. Importantly, GNL wished to highlight that developing and employing ‘community led approaches’ represents extra work that the organisation is not funded to provide under TEI. GNL expressed frustration about this, as such efforts are seen to save the Department significant money (i.e. through avoided ACA placements) and help keep Aboriginal children within Aboriginal families.

*“There’s a lot of work that an ACCO does and it’s all unfunded. Really, it’s all about community-led responses, and you can’t have that response, if you don’t know your community. We continue to do the best we can for our mob”.*

**GNL’s perspectives on Aboriginal-led service delivery and programming within the TEI program**

GNL does not believe TEI supports Aboriginal-led programming. As stated by GNL:

*“TEI forces ACCOs to deliver in a linear rigid way, that doesn’t work for the community.”*

GNL described how ACCOs operate to deliver services in a way that is fit for purpose for community. They explained that ACCOs rely upon in-depth and expert understanding of culture and local links to deliver programs that evolve organically. GNL feels that the way TEI is funded can force ACCO’s to deliver in a way that is either not suitable, or not sustainable.

For instance, an example was given of TEI’s evidence-based parenting programs, which for GNL, often run counter to cultural norms of collective parenting.

*“While what a facilitator is saying to these mothers might be informed by evidence, the mothers in our community will have no way of enacting it. It’s culturally inappropriate.”*

GNL’s Aboriginal program design and delivery is informed by their own understanding of community need. GNL gave examples of how their community connections programs evolved organically. For example, GNL has developed cultural dance, music and roller-skating programs – each of these were developed directly in response to community interest.

GNL also commented that they believe it is difficult to envisage that non-ACCOs are doing the level and type of cultural connection work necessary to ensure strong outcomes for Aboriginal clients.

*“We’re doing a lot of the work that other [non-ACCO] agencies don’t do – it’s not just artwork on the wall, it’s not having one Aboriginal worker – it’s about connecting with the community. If you can’t do that, then it’s not culturally appropriate.”*

The importance of culturally appropriate delivery provided by ACCO’s was underscored by GNL’s clients. Many GNL clients described that the services provided by GNL were different to mainstream services, with mainstream services often lacking cultural safety. One client commented that:

*“At GNL, it feels like I’m not being judged, not being looked at sideways. At the non-Aboriginal service, I’ve always been made to feel bad at the way I’m parenting.”*

Similarly, another client explained that:

*“If it was a non-Aboriginal service - they would be judgemental against us, they wouldn’t be inclusive - wouldn’t give us as much. When I’ve gone to other services, they weren’t Aboriginally safe - but GNL actually advocates like we are family - they advocate as Aboriginal people on behalf of Aboriginal people. Someone’s always got your back, but with a non-indigenous service – all they have is their policies and procedures. I just wouldn’t feel safe [at a non ACCO].”*

**GNL's concerns with the TEI funding model**

As outlined above, GNL believes that its role as a holistic provider of services for community requires significantly more resources than what is currently funded under TEI. Additionally, GNL believes that ACCOs are limited by TEI as:

- They need to meet criteria/indicators that do not always directly correlate with client outcomes. This comment was made by reference to the GNL's perspective that outcomes specific to Aboriginal clients and communities are not necessarily recognised.
- They are funded based on the ability to meet these criteria/indicators, and not for other work that is more strongly correlated with client outcomes.

The organisation believes that the way TEI is funded undersells the labour-intensive work around the program, particularly in the provision of wrap-around, holistic support, that is needed to support the best client outcomes.

GNL notes that this problem is exacerbated by client needs becoming more resource intensive. While TEI is funded as early intervention, actual TEI service delivery requires additional work and support relative to funding., Overall, GNL feel that the work closely resembles "intensive programs" like family preservation, despite receiving only a proportion of the funding.

*"Early intervention is getting the short end of stick – there's no brokerage, there's no wriggle room. We want more caseworkers to meet the demand, but instead, we have to scrap around on really small contracts…."*

GNL also noted that their service delivery was helping support cultural connection for families, something that GNL believes is critical for unlocking client outcomes. Take for example, the following client comment:

*"GNL is my first go to. They're not judgemental. I can say anything to them. They are very loving - they love to help people. They go above and above. They're also able to teach us different things about our culture. When I was growing up - my mum was ashamed she was Aboriginal. So, I never grew up with culture. GNL have helped my kids, and they are very conscious of their culture now. My oldest now wants a job doing the bush tucker stuff."*

Again, GNL commented that this work is not funded appropriately under TEI.

*"Were not getting paid to facilitate cultural connection – it's way more work. So many of the families have problems because they don't have connection, no social supports, no community."*

### A.1.3 Additional themes and insights from conversations with GNL's clients

**Client perspectives on the importance of holistic support**

We heard from clients' examples how GNL's 'holistic' approach and wrap around support was able to generate outcomes relating to empowerment and safety.

One such client was a young person [80] who first encountered GNL through a community connections program. The client commented that the program allowed them to better understand their Aboriginal culture, and the program's flexibility allowed them to feel a sense of ownership and agency over their learning.

*"It was one of the first times I felt empowered in my life".*

[80] Defined as a TEI client under the age of 21.

The client commented the program established a sense of reliance and safety. A key part of this was GNL's willingness to drive out and pick them up when their carers were unable to take them to the program.

*"The program (TEI Community Connections) was like a family - we knew what we were going to get, it was a safe space, and we knew that we were being looked after, that we were being listened to - it was the simple things, the feeds, reliability, GNL always being there to pick us up and drop us off, never had anyone put so much effort into supporting me. I was used to living in chaos, if I had to do something I did it on my own."*

Another young person who accessed TEI services through GNL's community connections program similarly commented that the holistic support provided by GNL garnered enough trust and respect for him to open up to GNL about his troubles at home. When the client's home life became more difficult, they felt comfortable to lean heavily on GNL for advice, as well as their understanding of the system.

*"(GNL) gave me the confidence to make a decision for myself, they helped me stand on my own two feet. It was the first time I made a big decision for myself…. we workshopped my options together, and we managed to come up with the solution. We ended up asking if my friend's family could take me in. His family was also Aboriginal, which was important to me."*

GNL and the client identified that a fellow community member's family could provide support, and this would provide a significantly better option than going into out of home care with an unknown carer. GNL helped organise the change, which included contacting and liaising with their caseworker. For the client, the impact of this decision was profound:

*"Without GNL's support, there's a serious chance I wouldn't even be here today. I was lost. I had no idea what my options were, and I was tired of being tossed around".*

While this support may not fall within the confines of TEI, it is illustrative of how an ACCO such as GNL is able to augment the impact of a TEI program through organisational effort/initiative.

Another example was support provided for a local father, who was also the primary caregiver for his mother. The client came to GNL in a state of distress, and greatly appreciated the advocacy support that GNL provided to him alongside the care and attention he and his children received through the playgroup program:

*"All the other agencies, Centrelink, DOCS, Medicare, none of them would listen. Every time I would call, I would waste time. I was completely stressed out and going nowhere. It was such a bad time. GNL understood the problem, they actually listened to me. They helped me work through the problems, and helped me work through each of the other services. I've got the confidence back to do it on my own now."*

**Client perspectives on the importance of GNL's advocacy support**

We also heard from clients who felt that GNL's advocacy support had played an essential role in keeping their families together. GNL outlined that this support took place during the course of TEI services, but that the extent of support that GNL provided may fall outside the scope of TEI. While this meant that some of GNL's efforts were consequently unfunded, GNL identifies that the support provided was critical to support improved client outcomes.

One client simply stated that:

*"If GNL weren't around - I really think I would have had to give the kids up. I just wouldn't be able to handle it by myself. They provide the community to help me raise the kids together."*

With another client, GNL helped the client achieve economic and housing outcomes, in the process keeping a young family together:

*"We almost lost our house. GNL gave us critical support. We couldn't pay the rent. I couldn't get through this super tough time. I wasn't getting anywhere. GNL helped relieve the stress better - we tried to go through housing - but they wouldn't help until we got the eviction notice. I couldn't risk getting to the point we would be homeless due to having a young daughter."*

Another client commented that:

*"In the end, without GNL, I wouldn't have gotten the help I needed to keep my family together. My children would've been removed. I always remember with my first child; Kevin Rudd came out with his apology - and then they stole him two months later. Without GNL, there would be more Aboriginal children in care, because that's what GNL cares the most about - keeping families together."*

A final client added that:

*"If GNL wasn't here, our families would have suffered. If my kids had been taken, I would have considered self-harm. But I had GNLs support - and kept my kid in my care."*

**Client perspectives on the importance of GNL's extra community building and client connection work**

GNL's believes that by going the 'extra mile' (i.e. by going beyond what the organisation is funded to deliver under TEI), as well as offering genuine care and affection, it can help maximise the impact of TEI for its clients. GNL believes that its model, while financially difficult to maintain under current TEI funding, leads to vastly superior outcomes for Aboriginal children and families who acutely require community led approaches. This assertion was generally supported by comments from GNL clients, who indicated the attainment of social and community participation outcomes. One client commented that:

*"It's the fact they help me out for whatever, whenever. They really do never say no. One example I can give; my car broke down when it was 40 degrees. They picked up my kids, took them to their centre to play, and helped me call the tow truck. I would have been so stuck without them. I know they weren't getting paid for it, but they were able to help me when I needed it."*

Almost all interviews involved clients with highly traumatic past experiences. For these clients, GNL additional support and community connection was especially important. One client noted that:

*"They always know the names of every child. The love they have for everyone's kids, I think it creates respect amongst the kids. All the workers here are amazing… During covid - we could call them at any time. When things got bad, we would just zoom call them. It really helped our family stay connected to a broader community. - all this is super important because of the trauma and violence that they had in the past. I feel that I can always come to GNL – they're always there for me. I feel like it's family here".*

Another client who had previously escaped domestic violence commented on the health outcomes that GNL helped her achieve:

*"I don't know what would have happened without GNL. I wouldn't have overcome the trauma of my past - I wouldn't have all the goodness I've been blessed with now. Knowing that my children are loved by someone who's not their mum – it's somewhere they can come to. It's going to make them grow up to be more whole. It really does take a village to raise a family."*

Finally, an elder currently caring for multiple children commented that:

*"I wouldn't have been able to cope without the GNL support. I can't express my gratitude enough. I would not know which corner to turn without them. They are literally helping every day. I had covid last week, so they helped with transport to childcare. It really is ongoing the type of support that they are able to provide."*

**Client perspectives on the importance of building cultural connections.**

Finally, we heard from clients that GNL has helped establish cultural connections for their families. We note that cultural connections are not recognised as part of the current TEI outcomes framework. Client

testimony suggests that for some Aboriginal children and families receiving TEI support, obtaining cultural connection is key pre-requisite before other outcomes can be attained.

- *"My nan passed away in 2019 – it was only after she passed that we understood we were Aboriginal. GNL have really helped us understand culture, and identity. We didn't grow up in culture, so it's so important that we keep it alive for my kids. Without culture and identity, I think my kids would have ended up lost – sort of like me...Only once I started to reconnect with culture did I start to make my way in this world"*
- *"I've always wanted to learn my culture and embrace it - I'm never going to hide culture from my children like my grandmother did. having a service like this – it's something I never had and it will set up my kids so well for the future"*
- *"It's critical that GNL is an Aboriginal service. Growing up I didn't know much about culture, and I've suffered as a result, and I really want it to be different for them. A lot of my troubles, my problems, I can see now that they stemmed from my disconnect about who I was."*

### A.1.4 Key Learnings from GNL

Our key learnings from this case study include:

- GNL staff and clients described the importance of community led approaches for achieving outcomes for Aboriginal children and families. Importantly, these approaches can oftentimes be characterised as specific to GNL, rather than to TEI more broadly. Nonetheless, GNL's client testimony illustrate how a TEI provider with deep connection to place and community may potentially be able to greatly augment the impact of TEI service delivery.
- Currently GNL's delivery model includes activities and efforts that are unfunded under TEI – leading to questions over its long term financial and staffing sustainability. GNL's perspective is that this is due to the lack of flexibility under TEI when it comes to addressing the needs of Aboriginal communities – and that it cannot deliver services in the way prescribed by TEI as it is simply unsuitable for its community. GNL believes that TEI needs to fund the cultural connection work necessary to support strong outcomes for Aboriginal clients.
- While all clients interviewed were positive about TEI, we noticed the particular warmth and affection that clients displayed when asked about GNL and GNL's TEI services. This is reflected in comments by GNL, who firmly believe that 'collective parenting' is the key for achieving outcomes in Aboriginal communities. For GNL, this begins with offering true love and affection, and by providing a space that all families can call home.

## A.2 Muloobinba Case Study

### A.2.1 Organisation Overview

Muloobinba Aboriginal Corporation, established in 1991, was formed to provide support services to Aboriginal families and individuals in Newcastle and surrounding Local Government Areas. Muloobinba is a not for profit, community-based organisation that is specific to the needs of Aboriginal individuals and families.

Since its formation, Muloobinba has extended its programs, to include Youth Support, Family Preservation, Out of Home Care Agency (Cultural Journeyz) and Early Childhood Education services at its Nikinpa Aboriginal Child and Family Centre. Muloobinba has also increased the reach of its service for the Family Preservation program into Port Stephens, Maitland, Cessnock, Singleton and Muswellbrook.

The word “Muloobinba” comes from the Awabakal language and means “Newcastle” and “Place of Sea Fern”.

**TEI Services provided by Muloobinba**

Muloobinba provides TEI services across the TEI streams.

| TEI Stream | TEI Activity | TEI Service Type |
|---|---|---|
| Community Strengthening Stream | Community Connections | ▪ Indigenous social participation |
| | Community Centres | ▪ Community Engagement<br>▪ Information/Advice/Referral<br>▪ Social participation |
| | Community Support | ▪ Education and Skills Training |
| Wellbeing and Safety Stream | Targeted Support | ▪ Education and Skills Training<br>▪ Family Capacity Building<br>▪ Indigenous supported playgroups<br>▪ Information/Advice/Referral<br>▪ Intake/assessment<br>▪ Parenting programs |

**TEI Outcomes**

Interviews with Muloobinba clients provided examples of outcomes in the following domains of the TEI outcomes framework:

In the interviews, clients were not specifically asked about each of the outcomes from the TEI outcomes framework. Rather, these outcomes were highlighted through the natural course of the interviews.

Furthermore, while most clients interviewed across all case studies received only TEI services (noting that the evaluation worked with providers to identify clients who primarily received TEI services only), some clients may have received non-TEI services from their provider. In these situations, a limitation of the case study interview process is that clients are unlikely to be able to distinguish between TEI and broader provider services.

### A.2.2 Key themes emerging from conversations with Muloobinba staff

**Importance of Aboriginal-led programming**

A major theme that emerged from interviews with Muloobinba staff was the importance of culturally informed programs, and Aboriginal-led design. The perspective shared by Muloobinba staff is that Aboriginal-led and designed programs offer a powerful way of engaging the cohort that TEI would otherwise struggle to support.

Muloobinba provides *TEI community connections* services via its women's art therapy program. This is hosted from Muloobinba's Nikinpa Aboriginal community centre and supports the TEI program aim of empowerment of Aboriginal communities and families. The art therapy program provides Aboriginal women, many of whom are mothers or carers, an opportunity to connect and practice cultural art within a safe and inclusive community space.

The art therapy program emerged organically from a community led initiative, which Muloobinba subsequently supported for the last three years. Artistic works produced by the group have received external recognition, with wreaths produced by participants displayed at both local and international cultural conventions. The design of the program and its activities are entirely community and Aboriginal led – with Muloobinba providing an Aboriginal caseworker to support facilitation. As described by Muloobinba staff:

*"The key to success is letting the group own the group. Let them take agency over what they want to achieve. It's a great example of flexibility and co-design."*

Accordingly, Muloobinba's perspective is that having an Aboriginal-led program provides its participants with a level of engagement that is difficult to achieve through its standard TEI programs. This engagement forms the foundation from which Muloobinba is able to support its clients in achieving outcomes. For instance, Muloobinba staff described how the art therapy group has been able to achieve significant outcomes for clients, relating to social participation and empowerment.

*"The art group helps gives the ladies a voice, gives them pride, builds self-esteem. It's so important for these ladies to feel connection."*

These outcomes were also reflected in by comments by clients, one of whom noted:

*"Getting to know your community, your mob, like this - it's incredible. We talk about everything; we all support each other. So many of us ladies come here so lost – we help form each other's support networks, and we all help each other stand proud."*

Muloobinba also notes that the art therapy group helps engage women who would otherwise not engage with services.

*"It's a safe space, where culture is practiced and celebrated. A culturally safe space - That's a big drawcard for people in the community."*

Muloobinba also highlighted that the art program acted as a key information source for its participants – particularly for women who were feeling lost or confused by the broader social services system.

For example, one art group participant described the art group as a 'hub', and described how the art group helped lead to empowerment outcomes:

*"The art groups help connect people, connect people to services. It really helps that they [Muloobinba] have people from Centrelink, funeral services, legal centres come in and talk to us in the one place."*

Another client commented that:

*"We help each other out - Centrelink, NDIS, whatever – the elders help the younger girls understand what services are out there. If we are feeling down and out, we come here and share. Knowledge is power, and this is a place to share. It's a place to grow."*

Numerous clients also spoke about the art group being a source of support to grow their parenting skills and capabilities. One young person [81] who attended art group as well as TEI supported playgroup services through Muloobinba noted:

*"There are so many elders here, I can come here and hear their knowledge - they teach me so much about how to look after my two daughters… Without the art group, my kids wouldn't get connection with culture. I feel at home being here".*

An elder echoed this sentiment by stating:

*"We get lots of single mums. Usually when they come, they are lost. We get them connected to people, we become an extended family for them. In our culture, this is how we parent, how we raise children. We share our experience. We share our knowledge and experiences with the younger mums – this is our culture, and it takes place through the art group".*

**Challenges establishing Aboriginal-led programming through TEI**

Muloobinba staff shared that while TEI services can be effective for Aboriginal families and communities, it is often in spite of the overall design of the TEI program, rather than because of it. They believe that as currently designed, TEI does not support Aboriginal-led programming. Comments raised by Muloobinba staff include:

*"TEI is working, but in our opinion, it needs to be adjusted to benefit Aboriginal families - we make it our own, we make it work for our families and make it work for the community."*

And also,

*"The art group was only possible because [a caseworker] was very connected to the community. She kept going and kept building it up, building on those cultural connections…*

*Overall, we think that TEI doesn't support Aboriginal-led programming. We would love to do more, establish more cultural stuff like the art group, but the funding is simply too prescriptive. We are forced to deliver TEI in a certain way."*

Another staff member added that:

*"What it takes is genuine co-design. Instead, we are just provided a description of what we need to achieve. If DCJ wants to support Aboriginal-led programming, they need to consult with the providers, and communities about what they want, and what they need. Right now, there's no initial conversation from the government end."*

The limitations on Aboriginal-led programming were also noticed by one playgroup client, who commented that:

*"The playgroup is amazing, and it's so important that they can build in Aboriginal cultural elements. However, I can't help but feel that what they are providing right now is still the white man's model…I want there to be yarning circles, elders coming in, traditional language, possum cloaks for the babies to play with. It feels like there is potential to unlock so much more."*

***Importance of ACCO service delivery***

Muloobinba staff interviewed identified that their status as an ACCO is a key factor in driving empowerment and community participation outcomes.

*"We build stronger connections with clients. We can give them a safe space where they feel culturally safe and build interaction and engagement from there. Allowing a client to feel free and comfortable - that's what keeps them come back.…*

---

[81] Defined as a TEI client under the age of 21.

*Clients often tell us they feel like they are being watched or observed at other places. An ACCO can be a safe space that they be comfortable in and look forward to coming to."*

Muloobinba staff also commented that its ability to act as a community hub, especially through its Nikinpa community centre, was critical in reaching families that otherwise would not engage with services.

*"An ACCO can engage clients through connection with culture. By hosting family days, big feeds – we can encourage families to meet other families, and get to know us as well."*

Several clients commented that they felt the community activities hosted by Muloobinba were highly beneficial given the cultural context:

*"The boys get to understand who their mob are, feel connected with each other straight away from an early stage of their lives."*

We also heard from clients about the importance of Muloobinba's cultural connection work and the implication for safety and social participation outcomes. One client explained:

*"Being part of this playgroup with my boys, it's part of our healing process. It's healing our intergenerational shame. My grandmother hid our culture from us, so I was always lost. Growing up, I was always missing something and I believe that's what led me down some dark paths. Through Muloobinba's playgroup, I can help ensure that my boys will grow up surrounded by mob, grow up understanding who they are. You have no idea how big of a difference that will make for their lives, for OUR lives."*

Another client commented that:

*"The difference between Muloobinba and other [non- ACCO] playgroups is that Muloobinba can incorporate indigenous things into the day-to-day activities. This might be something as simple as explaining to my kids what dot paintings mean. It's helping set the foundations for them – so that they can grow up with culture. It's something that I never had."*

**Importance of flexibility**

Muloobinba staff interviewed also commented that flexibility in service delivery was an important factor in supporting client outcomes. Muloobinba believes that TEI's flexibility in delivery timeframes has been a major improvement over previous government-funded early intervention programs.

*"One of the good changes of the latest TEI – we've got flexibility to continue support after 12 weeks. We are helping most of our clients for longer – it takes a long time to make a difference.*

*… We also ensure that they know we are always open for them - you can always come back [via self-referral] if you need help in the future".*

**Increasing complexity of client needs**

Muloobinba staff interviewed noted the impact of the changing nature of demand for supports. Staff commented that overall, they are seeing an increase in the proportion of clients who are presenting with significant and complex support needs, which cannot always be addressed through early intervention focussed supports. As explained by a Muloobinba staff member:

*"We try not to take families who have an open case with DCJ as it's simply too intense – we are meant to be providing an early intervention service. But it's hard to say no because we want to be able to support the families."*

Muloobinba also commented that COVID-19 appeared to be a driver of changing demand:

*"Ever since COVID, we've noticed a big shift in our clients. It seems like much more support is needed for parenting."*

### A.2.3 Additional themes from client interviews

**Muloobinba's women's art therapy group was a key driver of Social and Community outcomes**

Throughout interviews with clients who attended the Women's art therapy group, we heard numerous examples of social participation outcomes through involvement with the art therapy group. These clients emphasised the importance of cultural connection in supporting the attainment of these social participation outcomes. For example, one client explained that:

*"I just love it. When there are so many problems at home, there are so many things wrong - the art group can connect me with culture and elders. It's so important."*

Clients also commented on how the art therapy group played a role in supporting health outcomes. One client explained:

*"There are some problems that only time can heal. The women here, they've been through domestic violence, mental health crisis, they've been through it all. That's why the art group is so important. It's a place for us to heal. Only healed, mentally healthy and strong women can be the best versions of themselves as parents".*

One Aboriginal elder described the impact that the art therapy group had upon her daughter.

*"My daughter, the art group has helped her immensely - she's gone from feeling completely lost and wanting to commit suicide, to wanting to come here every week. She has completely changed now. She's got purpose, community, and kinship."*

**Safety and education outcomes through TEI supported playgroup**

Through Muloobinba's supported playgroup, parents reported they have been able to develop their parenting skills. One parent interviewed suggested that this has contributed to safety outcomes:

*If I didn't have support from the playgroup, I think that life would be very different. The way I was raised - It's not the way I want to raise my children. But I didn't know how to do it myself, I didn't have the knowledge or the tools. Muloobinba has helped bridge the gap, and I owe it to them for the parent I've grown into today."*

Another client noted that the supported playgroup appeared to have education outcomes for their child:

*"Muloobinba has guided my parenting journey. I think it's been quite holistic, they've made me a stronger mum, a stronger person. Before the playgroup, I was barely surviving. You can't be a good parent like that…*

*For the kids, they've helped heaps with helping them be socialised and have better control over their emotions. For my oldest, this is important as we don't have much family around. Through the playgroup, I think she's a lot more ready for school. She's a lot more in control."*

**Information referrals, and knowledge sharing through TEI supported playgroup**

Clients also noted the importance of supported playgroup in accessing information. Muloobinba staff interviewed note that playgroup functions as an 'information hub' where information about a range of services (e.g. health, legal) are shared to clients. This information sharing appears to have supported some clients in achieving empowerment outcomes by increasing awareness of potential services, and by providing support networks and encouragement on how to access these services. For instance, one client commented that:

*"Muloobinba also help heaps with providing information for mums. They help us understand what services are out there. One example, I got my son free hearing tests through an ENT specialist, which has made a big difference in both our lives. I wouldn't have known about it otherwise. Muloobinba also got me a referral to the [Aboriginal Legal Service] after I told [my caseworker] about my problems at playgroup."*

Another client commented that:

*"I really value the opportunity to support other moms, with my experience and my perspective - it's really important for mums that are isolated. The playgroups are a place where we can all support each other and connect to culture with our kids together."*

### A.2.4 Key Learnings from the Muloobinba

Our key learnings from this case study include:

- Muloobinba's experience that Aboriginal-led programming can lead to extremely strong engagement from Aboriginal clients, however that TEI is generally not flexible enough to accommodate Aboriginal-led programming.
- Muloobinba's perspective that ACCO service provision is essential in driving outcomes for Aboriginal children and families. Muloobinba highlighted that ACCOs are able to foster community connection, sense of belonging and safety, and heightened participation through culturally relevant activities. Many clients also identified that without an ACCO, they would have not engaged with the TEI services provided in a meaningful way.
- Muloobinba's clients described how TEI supported playgroup was able to help them achieve a range of outcomes within the context of culturally appropriate and sensitive service delivery.

## A.3 Intereach Case Study

### A.3.1 Organisation Overview

Intereach is a non-profit community organisation that has worked to support communities throughout the Riverina-Murray region of NSW for over 50 years. Intereach currently employs 573 staff along with 90 volunteers. In addition to TEI, Intereach offers a wide suite of social and community services, ranging from Aged Care, Disability services, through to Intensive Family Preservation and Community No Interest Loan Schemes.

Intereach's purpose and values draw on three key elements:

- Strengthen and improve social and personal well-being for individuals, families, and communities.
- Promote and facilitate access, resilience, and equality, and
- Deliver services that are of quality and have value.

**TEI Services provided by Intereach.**

Intereach provides a broad range of services across the TEI spectrum.

| TEI Stream | TEI Activity | TEI Service Types |
|---|---|---|

| | | |
|---|---|---|
| Community Strengthening Stream | Community Connections | ▪ Community Engagement<br>▪ Community sector coordination<br>▪ Indigenous community engagement<br>▪ Social participation |
| | Community Centres | ▪ Community Engagement<br>▪ Information/Advice/Referral<br>▪ Social participation |
| | Community Support | ▪ Advocacy/Support<br>▪ Indigenous Advocacy/Support<br>▪ Social participation |
| Wellbeing and Safety Stream | Targeted Support | ▪ Family Capacity Building<br>▪ Indigenous supported playgroups<br>▪ Information/Advice/Referral<br>▪ Intake/assessment<br>▪ Mentoring/Peer Support<br>▪ Parenting programs<br>▪ Supported playgroups |

To develop this case study, we spoke to TEI managers, caseworkers and clients who represented Intereach's offices in Deniliquin, Albury and Corowa about the TEI services Intereach delivers.

**TEI Outcomes**

Interviews with Intereach clients provided examples of outcomes in the following areas:

In Interviews, clients were not specifically asked about each of the outcomes from the TEI outcomes framework. Rather, these outcomes were highlighted through the natural course of the interviews.

Furthermore, while most clients interviewed across all case studies received only TEI services (noting that the evaluation worked with providers to identify clients who primarily received TEI services only), some clients may have received non-TEI services from their provider. In these situations, a limitation of the case study interview process is that clients are unlikely to be able to distinguish between TEI and broader provider services.

### A.3.2 Key themes emerging from the conversations with Intereach.

**Importance of providing a soft entry point for TEI services**

For Intereach, the ability for TEI to generate positive client outcomes begins with a soft entry point for its clients. This helps to reduce the barriers that families can experience in accessing supports.

*"We know there is stigma associated with going to a service for help. Some families, even if they've been told about our services - they won't reach out. But if we provide a program that is a bit more fun - if it's not just about teaching, it really helps get them in. They are learning things while they are there - they feel more comfortable to reach out if things become more serious later."*

Without first establishing a stable and strong relationship, Intereach's staff believe that many of their clients would not engage with their TEI services in a meaningful fashion.

One caseworker commented:

*"What's critical is building strong relationship with clients and helping them get that sense of safety in coming to Intereach. We feel that it is important that TEI can provide a soft entry point that creates a sustainable relationship."*

Another caseworker added that:

*"It's essential from early intervention perspective that clients have a strong foundation with us. For many clients, we will try to walk alongside them across many life and development milestones. Soft entry means building relationships and support before they ever need a service."*

Intereach believes that they are well positioned to provide a soft-entry point for clients given their broader service offering, and their ability to wrap additional services alongside TEI.

*"We have a 'no wrong door' policy - we find a way to assist clients. There are lots of tools in our toolkit, for example, we have a lot of children who, at the same time have developmental concerns, or require NDIS support that we are able to assist them with our other (non-TEI) programs. It allows us to wrap services around TEI support and adds to the case management that we can do for them."*

*"Being in the one organisation, families don't need to tell their whole story again. It helps with the relationship we can build, and how willing they are to actually access the TEI services we can provide."*

One client noted:

*"It's important that (Intereach's services) are all under the one roof. Because I've been getting support from Intereach for NDIS already…not having repeat my story, all my information is already there, and the trust factor is already there as well."*

Intereach also commented that its wider service offering and brand, allowed it to spread the reach of its TEI program amongst the broader community:

*"Because we are bit bigger - other services and community sector will know a bit more about us. We can then use this recognition to inform them about our TEI offerings. Being the one stop shop for clients, we find it breaks down a lot of barriers, something that is especially important given the remote and regional context of many of our clients."*

**TEI and parenting skills**

For Intereach's caseworkers, another important way that TEI services help clients achieve positive outcomes is through parenting skills – particularly alongside the provision of emotion regulation strategies. Through its TEI services (Intereach is funded through TEI to provide parenting services), the Intereach participants believe it is an important contributor of an overall level of parenting skills present within their communities.

*"I think if you took away what we are doing for parents and their parenting skills, there would be a big toll on families. This directly flows through to Child Protection (outcomes)".*

One caseworker suggested that the ability to provide education on parenting skills was particularly important in certain regional communities, where many parents do not have access to support networks that could otherwise support them.

*"Often families don't have their own family and community around them. We find that there are a lot of parents struggling alone, or without the knowledge of what to do in certain situations We can really help provide them that support network and familiarity and help them see parenting strategies in a different light."*

Specifically for emotion regulation, Intereach believes it has seen significant progress and improvement among its clients.

*"We've done a good job at helping parents understand that there's often a reason behind emotional outbursts behind toddlers – i.e. that there's an unmet need. We teach parents to go through a checklist. A lot of the time it's easily resolvable. By employing these techniques parents can really help take the pressure and anxiety off themselves"*

One client noted:

*"Helped us become to better parents - and also better partners for each other. It has helped us understand and regulate our emotions. We think we have a much closer bond with our children as a result."*

Another client who accessed support under Intereach's TEI parenting programs highlighted the importance of parenting strategies for her family:

*"(Without Intereach's TEI service) I probably would have put my daughter up for my adoption. I would try to battle it alone, but once I lost the support of my maternal nurse, I really felt isolated. I don't think I would have been able to handle the ups and downs of my child. My family is judgemental, Intereach listens and helps, they provide me strategies and ways of dealing with my daughter. My family doesn't do that, they just judge me for being a bad parent. I would have been lost."*

**Importance of delivery in regional context**

Intereach emphasised that its TEI services are especially important given the regional and rural context of their clients and communities:

*"Because of the regional context, we think that our TEI service its especially critical. The communities that we cover just don't have much other services offered there."*

Intereach also believes that availability of services in regional areas is particularly limited for clients requiring more intensive support. As a result, Intereach is forced to cover this gap:

*"There are no services out here that cover those more complex cases. There is a big gap between TEI and statutory removal. For example, brighter futures struggles to get out here. Intereach can handle it through TEI because we have caseworkers that have backgrounds in child protection. We cover a lot of ground."*

Another caseworker commented that Intereach's wide range of TEI services play an important role in reducing isolation, something that is particularly impactful for clients living in remote locations:

*"We think that our services do a lot for ensuring our community is more connected - we know that early parenthood is a stressful time. A lot of the parents we see just won't have the outlet or ability to meet others due to sheer distance."*

**TEI's flexibility is critical in remote contexts**

In order improve access, Intereach invests substantial time and resources visiting clients in their homes in order to deliver TEI services.

*"We will go out to those families. It's important to understand for many families, they would have to travel hours to get to a bigger city for a service. I think without this, these clients would just be much less likely to access services."*

One client noted that:

*“They visit me at my home. It’s super important that they do this. We live two hours from (Deniliquin), it’s hard enough to visit them as is with a kid and all. But think of the fuel. I wouldn’t be able to afford this support.”*

Another client commented that:

*“It’s also important that in a regional town - my little girl she’s a stickler for routine. She’ll act up if routine changes. Whereas at home she won’t make a difference. It’s a lot easier on my anxiety riddled brain, that they come and visit me”.*

Caseworkers at Intereach gave examples of clients who were struggling with mental health. For these clients, the visits from the Intereach caseworker were the only support network for clients.

*“It’s like you’re the only person there responding to this need - there’s nothing else for them. Not even close. We’re picking up all the pieces.”*

Overall, Intereach believes that flexibility in supporting clients is a core element of their overall service offering:

*“I love the flexibility that we can provide. We don’t have to do a group - we can offer a parenting program one on one, we can go to their home, we can give them choices, help them see what the support looks like. Really listen to the community needs - and provide them what they need.”*

Clients also reflected the importance of flexibility. For example, one client commented that:

*”…it’s flexible. This last one was done on teams - it allowed me to be at home with my newborn. And for the ones I missed, I just called up and they caught me up on the content. It’s been very flexible.”*

**Stigma remains a major challenge for TEI**

Intereach commented that a major challenge is the stigma that exists within community towards family and parenting services. This stigma means that some community members are unwilling to engage with TEI, and often only reach out once a crisis support is required.

As explained by one caseworker:

*“Quite often, there are people who are referred to TEI - and they simply don’t engage with our services. Often, it’s that 'oh no I don’t need it' mentality. The stigma holds people back from engaging with services.*

*…*

*It’s an engrained mentality - I won’t ask for help unless I really need it, or there’s a fear of being judged for wanting help.”*

One client felt that community stigma was holding back the potential that Intereach’s TEI services had to offer:

*“I’ve seen a lot of really, really good programs come out of Intereach. I’ve seen what they’ve been advertising this year. Intereach offers lots of different things that are covering everyone. I really think every new parent could benefit from them. They have to reduce the stigma – they have to find a way to explain to people that it’s a community program and NOT that you are desperate for help. Maybe this is a job for the department and not just Intereach – get the nurses and health system talking about the services early.”*

Intereach has adapted to this feedback by seeking out neutral and community venues to host its supported playgroups.

*“In Corowa - we were trying to understand why we weren’t getting people coming to mother goose group. People had said they would come to playgroup - but they wouldn’t go to Intereach. They felt coming to our offices was saying that they needed help. We listened to that, and we have taken things*

*outside of the Intereach office, and instead had them at community centres, clubs and we've had an explosion in numbers."*

### A.3.3 Additional insights from client interviews

**Importance of Advocacy and Casework support**

Numerous clients discussed support in navigating the broader service system as an important element of the TEI service they received. Clients noted that Intereach's ability to provide information about the wider service system was particularly important given the regional communities they were situated in. For example, one client commented:

*"Corowa is a small town, and Intereach is the hub for most things including Centrelink. I've been in the area for 9 years – as a single parent they are the point of contact for resources. There is not much available in terms of information. It is the first port of call for parents who are unsure or need help with something."*

Numerous clients also spoke highly of the advocacy support they received for other social services. This appeared to be a major driver of empowerment outcomes. For example, one client stated that:

*"(Intereach's advocacy) is a big deal in a small country town. Without them, a lot of people would be incredibly lost and displaced. Linking in with other services - the only way is to go through Intereach. It's vitally important that they are here. They might be a small operation in this town, but their impact is very large, and they really take care of the individual. Without them, people would be suffering…lost, displaced, homeless."*

**Counselling and Casework support**

Numerous clients highlighted the importance of trust and connection as a foundation for achieving outcomes. They felt that Intereach was able to foster this trust through advocacy and caseworker support.

*"They were people I could really trust. I could really feel the love that they have for me, and my son.*

*…*

*I was going through family court. My support worker really helped me throughout the court process. She was amazing. It made a huge difference in my life. She saved me."*

Another client commented that:

"*I've tried other services - they're not even close. The communication, the positive way that the program is delivered, that's the difference for me. Otherwise, I won't engage… My caseworker - she's been fantastic. She genuinely cares about the family and the child. Same for my daughter, it was the level of trust that made the difference."*

For this client, the support Intereach's caseworker was able to provide made a dramatic difference to the quality of the client's and her child's life and helped her child to achieve outcomes related to education and social participation.

"*Without them (Intereach), my daughter and I would still be struggling to communicate. She still wouldn't be going to school. Intereach have helped her attend school more often, through the programs, by giving her the confidence to return to school. She's a totally different person this year. she's been going to school every day. It's been awesome."*

**Parenting Skills**

Clients also emphasised the role of Intereach's TEI parenting programs and supported playgroups in improving parenting skills, as well as increased bonds between their children.

*"It's really opened my eyes, that there are other ways of dealing with challenging behaviours. Having that guidance from someone who's completely unbiased, it helps reassure that I am doing a great job as a parent, that my daughter is doing well under my care."*

Clients also commented that the parenting programs helped clients regulate their emotions around their children by providing them with strategies and perspectives around challenging behaviour. Comments from these clients suggest that parenting programs had a direct bearing on safety outcomes.

*"The courses have helped me as a parent. 110%. I'm a better mum, I'm not so angry anymore. It helped me understand that I'm not a bad parent. I really used to be lost without (Intereach's) support".*

A second client commented that:

*"I'm able to deal with things in a different way that's not yelling and screaming, I feel like I'm finally more responsible as a parent - I am trying to give them a good life, and it's really helping to know how to deal with challenging behaviour."*

In addition to parenting strategies, parenting information supplied through Intereach's parenting programs is also valued:

*"I think the way I parent would be different. I think I would be relying on google and things like that. There's no real way of knowing the answers I'm getting are the best strategies, and they wouldn't necessarily be tailored for me. Intereach is tailored for me. Without Intereach, the relationship we have with our kids would be different."*

**Vulnerable clients**

Intereach was able to assist clients with heightened vulnerability. These clients felt that Intereach's support was critical in keeping their family together – with some clients indicating that safety outcomes had been achieved directly because of the support provided. For example, one client explained that:

*"I wouldn't be the mum I was today. I think my son would have been removed from me. The support they have given me, to push me to become a better person. You must understand, we were going through a lot of domestic violence. We had to uproot our lives to move to another state to stay safe."*

*…*

*When I first started at Intereach - I really didn't want to open up. But it's gotten easier and easier, and now they've helped me thrive."*

Another client explained how the holistic support Intereach has been able to provide TEI has been transformational for the client's family.

*"My son has cerebral palsy. Kids have been through domestic violence from their mother, drugs were involved. To be a single parent, it's hard. Without Intereach, I think I would have lost my kids. I was going backwards. I didn't know what to do. They helped me find my feet at a bad time.*

*…*

*With the parenting programs, they've helped me control myself. It's my second lot of kids, it's not the same. They've put me in different spots - it's all new. They've also provided support - financial support when I really needed it.*

*…*

*I'm not a great talker, and they help me express things. For example, they also helped me with NDIS - we weren't getting what we were supposed to be getting. Intereach helped me in these conversations."*

**Client's perspective on regional context**

Many of Intereach's clients noted the importance of Intereach's TEI service given the regional and remote context. One client explained that:

*"What Intereach does is even more important given the regional area I live in - without it, you just couldn't live here. Our healthcare out here is terrible, if there was no Intereach, I think it would be dire. Especially being a single mum in a small town. They help you get through difficult times, which is critical without family support."*

A second client noted that:

*"We are one hour drive from Albury. To drive into town every time you want to go to a Centrelink appointment for example, it makes it way more stressful. There is nothing anywhere nearby. It's so important that Intereach can help bridge this gap.*

### A.3.4 Key Learnings from the Intereach

Our key learnings from this case study include:

- The perspective shared by Intereach around the importance of providing wrap around support. For Intereach, the ability to provide TEI services alongside other relevant services for clients provides a soft-entry point for TEI services. This in turn helps reduce barriers and foster greater engagement with the TEI services offered.
- The importance of organisational flexibility (i.e. willingness to travel) in order to provide TEI services to regional and remote clients. Without this organisational effort, we heard how many clients would likely not access TEI services at all.
- Intereach's perspective that stigma against accessing TEI services can be quite strong within communities. Intereach has described how it has had to 'think outside the box' to foster engagement and circumvent stigma, however support from DCJ may be needed to reduce stigma at a broad-based level.
- We heard how TEI supported playgroup was able to assist clients in attain a range of TEI outcomes.

## A.4 Creating Links TEI Case Study

### A.4.1 Organisation overview

Creating Links is a non-profit multicultural community service provider serving communities across South West Sydney. It started in 1972 as the Bankstown Community Services Cooperative and has served thousands of children and families in the over 50 years since then. It transitioned into Creating Links in the early 2000s and now includes disability services, foster care, child and family services and financial wellbeing supports. Creating Links believes in a holistic person-centred approach and recognises the importance of culture and community.

Creating Links provides TEI services for parents, children and young people in the Bankstown local government area, helping them to build strong relationships and promoting healthy, resilient, and caring families. Its programs are designed to increase parenting capacity, access to services, and education in positive child rearing practices.

The team at Creating Links includes multicultural Client Services Officers who provide flexible support to members of the community from all religious and cultural backgrounds.

**TEI services provided by Creating Links**

Creating Links provides services within both the Community Strengthening and Wellbeing and Safety Streams of TEI, offering a broad range of service types.

| TEI Stream | TEI Activity | TEI Service Type |
|---|---|---|
| Community Strengthening Stream | Community Centres | ▪ Community Engagement<br>▪ Social participation |
| | Community Support | ▪ Advocacy/Support<br>▪ Education and Skills Training<br>▪ Social participation |
| Wellbeing and Safety Stream | Targeted Support | ▪ Counselling<br>▪ Family Capacity Building<br>▪ Intake/assessment<br>▪ Material aid (multiple items, parcels or vouchers)<br>▪ Parenting programs |

To develop this case study, we spoke to managers and case workers in Creating Links Child and Family Services division, who are responsible for overseeing and delivering TEI services.

**TEI Outcomes**

Interviews with Creating Links clients provided examples of outcomes in the following domains of the TEI outcomes framework.

In the interviews, clients were not specifically asked about each of the outcomes from the TEI outcomes framework. Rather, these outcomes were highlighted through the natural course of the interviews.

Furthermore, while most clients interviewed across all case studies received only TEI services (noting that the evaluation worked with providers to identify clients who primarily received TEI services only), some clients may have received non-TEI services from their provider. In these situations, a limitation of the case study interview process is that clients are unlikely to be able to distinguish between TEI and broader provider services.

### A.4.2 Key themes emerging from interviews with Creating Links staff

**Importance of TEI as a soft entry point**

Creating Links staff described how TEI programs provide an opportunity for clients to get to know the organisation and develop trusting relationships with staff. From there, Creating Links staff can help clients to identify additional supports that might help them to achieve the outcomes that they seek for themselves or their families. Creating Links staff noted:

*"TEI is a good soft entry point. It can help bring them in and out of the service, before engaging long term support".*

Once people are connected to Creating Links, there are multiple ways they can stay engaged with the service, beyond their initial interaction. For example, one client talked about bringing her children to regular school holiday activities. Such activities keep families' relationships with the service active, and if additional support needs arise, it is easy for them to re-engage.

Another client described how they'd become engaged with Creating Links after seeing a parenting program flyer. Once they were there, they talked to the facilitator about how they were feeling and were able to access counselling and improve their mental health:

*"The pain after the baby was too much and I couldn't do anything. I was lost… Now that I am here with Creating Links, I know how to look for support. I know who to call and where the support is. But before I had nothing."*

**Holistic and complementary supports**

Creating Links staff described the benefits of having multiple, complementary service offerings within the one organisation. If a client has additional support needs, it is easy to make an internal referral. There is no need for the client to build relationships and trust with a separate organisation:

*"Creating links incorporates counselling, financial counselling, NDIS - if a family is saying they need help with their child, but don't have money for a psychologist, the benefit is that we have all the other supports available to help them."*

Another described:

*"It makes it easier for clients to get the support they need all at the one place. It's hard to get clients in the door, especially highly disadvantaged or vulnerable clients. By having multiple services in the one place, it means we can book them in for back-to-back appointments for example. Without this flexibility, we know it would be so hard to get the client in for the second service. The client simply wouldn't get the full range of support they need."*

Creating Links clients also spoke to the benefits of being able to access multiple services through the one organisation. For example, some comments from clients included:

*"It's really good to come to one place and have a lot of services offered. With other organisations, when the time is up, you get referred to someone else and you have to start all over - because you have to explain everything again and when that 3 months is up you start all over again. Even now, I know I can call up [my caseworker] to say, 'can you answer this question? can you help with this form?' because he knows us. Even though our time is up..."*

*"All the help is one place. It really helped me to sort out my other problems, it lets me concentrate my effort and energy on parenting. They've really cared for me when I was really lost."*

**Navigating the services system**

Creating Links described TEI as playing an important role in helping clients to navigate the broader services system, for example, accessing NDIS, accommodation support, legal services or Centrelink payments. This helps clients get the services they need, while also helping to alleviate stress from clients who might feel overwhelmed by the various applications, assessments and processes involved. Some relevant comments from staff included:

*"We help clients to navigate forms, language, administrative barriers … helping clients to understand what other services might be there, and how to actually engage with those services."*

*"… you're linking them for support and as a result, they're feeling more relaxed, now they feel less stress. It leads to short term wellbeing impacts."*

*"Connecting them with legal aid - and helping them to understand their rights - it's a big deal. This holistic support is essential for outcomes to occur. Especially for services you can't access on your own [for example, if a referral is required] - case management advocacy and support is important for clients to gain access."*

By providing this navigation support, they see TEI as also relieving pressure on other parts of the services system.

*"Without TEI, would be placing pressure on every other service… it's helping to prevent clients from being escalated to higher risk and support needs. TEI is very much needed as a touch point that can be accessed by any parent, to help them navigate other services and eventually advocate for themselves. By doing this, TEI is helping to ensure that those families with extreme need don't need to wait as much. I can't even imagine how bad things would be [without TEI]."*

The above points are supported by comments from Creating Links clients, who described how stressful and daunting the process of navigating the social service system can be, and how this can exacerbate existing inequities and vulnerabilities. For instance, multiple Creating Links clients described how challenging it is to fill in forms with limited English language ability. Where clients were also navigating experiences of trauma, the process of engaging with services could be mentally draining at a time they were already feeling overwhelmed – in which case the navigation and advocacy support provided by

Creating Links was an important lifeline. For example, one client who had escaped domestic violence commented.

*“It's REALLY hard to get government paperwork done. And having someone to help ... it might sound small but it's a very, very big help.”*

For Creating Links, an important client outcome is contributing to a client’s ability to eventually advocate for themselves. One client noted that:

*“After Creating Link had helped me a few times, I started to feel confident calling up Centrelink myself, and getting things done for myself and my family. The dread started to fade.”*

**Strengths and challenges of current TEI processes**

For Creating Links, TEI’s open and flexible service delivery is an important enabler in allowing the organisation to be adaptable to benefit its clients.

“*There is no formulated structure in terms of how we achieve engagement with clients. This has created a strong synergy with our ethos of flexibility. It’s important as it allows us to prioritise adaptability in meeting the specific needs and goals of the clients*.”

Creating Links is able to tailor its approach to varying needs of clients. In practice, this might include meeting clients outside of normal working hours, meeting clients at home, adjusting the intensity or duration of supports provided (as much as possible), and matching clients with the most appropriate case worker based on their cultural or language background.

Clients described the benefits of this flexibility:

*“Dealing with Creating Links is easy. They come to my house which is very convenient, especially for a single mum. They are dealing with me on a personal level. I trust them. It was an easy process.”*

However, Creating Links sees opportunities to improve TEI, by providing greater universal access for all families. For example, one staff member commented:

*“Looking at the broader context of TEI, there’s still a lot of work DCJ needs to do in promoting the benefits of accessing targeted intervention. Work to be done in breaking down stigma of accessing these services - parents will wait until they are at crisis.”*

In addition, Creating Links staff described increasing pressure on the service to support clients with intense support needs, and the need for DCJ to review the types of clients referred into TEI.

*“We haven’t had non-ROSH referrals for months. Perhaps there is barrier there within DCJ's own processes”.*

The shifting focus within TEI onto clients with higher needs can have the effect of limiting the amount of time staff are available to support clients who would benefit from true ‘earlier’ intervention.

*“Overall, there’s a higher level of parents who need more intensive support - who really should be at Brighter Futures - but they’re now with us for up to 6 months. It’s taking resources away from families who might need short intervention, and in the meantime, their issues are now bubbling away.”*

### A.4.3 Key themes emerging from conversations with Creating Links clients

**Support after experiences of trauma and difficulty**

We spoke with multiple clients who had received support from Creating Links TEI services after an experience of significant trauma or period of difficulty in their lives. They described the services as being critical to their ability to move forward. Clients described how Creating Links helped them to achieve outcomes related to housing, safety, health and economic wellbeing. Some comments from Creating Links clients included:

*"I am a single mum with no money. Creating links helped me a lot, a lot. I suffered from abuse from my ex-husband… Before Creating Links, I was so down. I was crying and crying and crying."*

*"I also have my own issues. I am a cancer survivor. I am only on Centrelink payments, with no job. I have too much going on. Creating Links helped me whenever I need support from any other service, food vouchers, services - everything really.*

*"If no Creating Links, it would be like before. I would have been stuck and I would have felt sick."*

**The importance of culturally sensitive support**

For many clients, the culturally sensitive support provided by Creating Links was very important. This support helped them to feel confident engaging in the community, with the education system and with services that can provide benefit for themselves and their families.

*"When I came to Australia, everything was new, and I didn't know where to go. Nobody suggested anything, and people judge you if you ask for help, they call you mentally unstable, because of that stereotype people don't ask for help. I now recommend [Creating Links] to people."*

*"I have been getting really stressed as a single mum. I have no one to help me. While I can talk a little in English, it's not so easy to understand. I need someone with me to help me feel to be more confident. They have been helping with my daughter at school. They help talk with the school counsellor. Any problems at school, the Creating Links people help me."*

*"Lots of families need Creating Links. We are actually all relying on them to get through. Families like mine who are new to Australia, we just don't know where to go for support."*

*"The first time I contacted them I was scared. I was worried about my language, but they said no worries. They feel like family. I don't have family here - I miss them and I don't have family support to help my mental health, but they sit with me. They help. When I see people here, even when I am not here, out in the community, I feel more confident."*

*"Australia is very different than my country. My family might give me ideas, but they are different to here. They can't always give me advice. For example, my mum tells me to listen to my husband, but here Creating Links helps me understand that I have rights [if my husband mistreats me], and where and how I should go for help."*

**Support to achieve outcomes across multiple domains**

Clients described how they can rely on Creating Links to help link them to the support that they need, whatever it may be. Clients see the TEI services as an important source of support to improve outcomes for themselves and their families.

Some clients described support to improve their economic wellbeing, for example:

*"Creating Links helps me by get in touch with other services I needed. I was really in trouble. She helped me get food vouchers. [My caseworker] also asks me how I am going, she never leaves until everything is sorted. It's a massive help for me. I'm just by myself - I can't imagine how I would have gone through without their support."*

*"For me, the best part about TEI, was that they help me apply for and get a job. This is super important for me. It made me feel positive about the future again."*

Other clients described feeling empowered, relieved and encouraged by the supports provided:

*"Creating Links has helped me lift that weight from me and my family. They hear you out, write out a plan, check I'm happy."*

*"When I talk with them, they are patient with me when I'm speaking even with the language gap. They make me believe in myself. It makes me feel like a good mum. A lot of the time I feel like maybe I'm not good enough, but they make me feel more hopeful. It gives me energy to believe in myself."*

Several clients described how the services had helped them to improve their mental health and build their capacity and skills for parenting. For example:

*"They help me be a better parent - because they help me to feel better. They give me more energy to parent - they take away a lot of my other problems.  It lets me concentrate on my kids."*

*"Creating Links has helped me be a better parent. Because before it was just me. I was so stressed. I just feel like I couldn't do anything."*

*"The counselling has given me tips and tools for parenting. How to support the kids, especially as they become teens. It's a big help. I couldn't find any other service that would provide counselling as well. My previous support worker never told me about this."*

In addition, clients talked about how TEI programs helped them to participate in the community and reduce social isolation.

*"These programs are really important to our mental health, especially for mums with young kids. Having this in our schedule can give us something to look forward to, break out of the normal schedule, help to meet people and relax and create bonds and create good experiences. Get out of the house and makes a big difference."*

*"[The kids are] engaging with other people and I'm engaging with other people, other adults. We're relaxed in that environment."*

## A.5 Uniting South West Sydney

### A.5.1 Organisation Overview

Uniting NSW/ACT (**Uniting**) is the social care and advocacy arm of the Synod of the Uniting Church in New South Wales and the Australian Capital Territory. Uniting is one of the largest not-for-profit organisations in Australia, offering over 550 services in the areas of aged care, retirement and independent living, early learning, disability, chaplaincy and community services.

The focus of this case study is on the TEI services that Uniting's Child and Families Support (CAFS) services in South West Sydney provides. These include short term, early intervention for children aged 0 - 12 and families living in the Campbelltown, Cabramatta, Camden, Wollondilly and Wingecarribee Local Government Areas. These generally focus on the Wellbeing and Safety Stream of Targeted Early Intervention, as shown in below.

| TEI Stream | TEI Activity | TEI Service Type |
|---|---|---|
| Wellbeing and Safety Stream | Targeted Support | ▪ Education and Skills Training<br>▪ Family Capacity Building<br>▪ Information/Advice/Referral<br>▪ Intake/assessment<br>▪ Mentoring/Peer Support<br>▪ Parenting programs<br>▪ Supported playgroups |

**TEI Outcomes**

Uniting client interviews provided examples of outcomes in the following areas:

In the interviews, clients were not specifically asked about each of the outcomes from the TEI outcomes framework. Rather, these outcomes were highlighted through the natural course of the interviews.

Furthermore, while most clients interviewed across all case studies received only TEI services (noting that the evaluation worked with providers to identify clients who primarily received TEI services only), some clients may have received non-TEI services from their provider. In these situations, a limitation of the case study interview process is that clients are unlikely to be able to distinguish between TEI and broader provider services.

### A.5.2 Key themes from conversations with Uniting's staff

We spoke to Uniting TEI managers, caseworkers and clients receiving services in Cabramatta and Campbelltown in South West Sydney. These locations were chosen on the basis of staff and client availability.

**How Uniting contributes to client outcomes**

Uniting staff described three ways that believes that TEI helps to create outcomes with clients:

- Uniting noted that TEI advocacy support was critically important for its CALD community members.

  *"For CALD clients, there's an especially important role for TEI to play. We find that CALD parents are often extremely isolated. Our TEI service helps get them out of the shell. Only once they trust us, are we able to get them to properly engage with other services."*

- Reducing social isolation - Uniting staff believe that a core element of TEI is its role in ensuring that clients can access community and support networks in circumstances where they would otherwise feel isolated. For Uniting, these networks play a key role in ensuring that clients achieve outcomes around social participation and improved mental health.

  For example, we heard multiple examples from Uniting's clients of how isolation in the months after childbirth was a significant driver of anxiety and depression. For these clients, the ability to interact with Uniting's TEI services was a key factor in their ability to maintain their mental wellbeing. For example, one client commented that:

  *"It was important that Uniting helped me get into a (supported) playgroup. I was going nowhere, and staying home with the kids was making me incredibly stressed. It's been a place I can relax and the kids love it too."*

- Assisting clients to navigate and access other services – Uniting staff highlighted that TEI's role as a soft entry point into the broader social services system was a critical factor in ensuring that clients' wider needs were met and addressed. They see TEI as playing an important role in addressing unmet need in the community, which could otherwise escalate and require more intensive and complex supports from other services and providers.

  From interviews with Uniting's clients, we heard examples of how Uniting's advocacy support played a critical role in achieving positive outcomes for clients. In one example, a client commented that Uniting's advocacy across multiple social services (including health, NDIS and Centrelink) was instrumental in helping her "get back on her feet". Without this support, the client believed that:

  *"I probably would have had DCJ involvement again - speaking from personal experience. Due to our past…my kids and I really rely on having a support service safety net. I know that without support, my family might not be able to stay together."*

- Improving parenting capacity and capabilities – Uniting staff described a strong focus on improving parenting skills and education outcomes. Uniting believes that their TEI services have helped support parents to become more confident and capable in parenting their children. For example, Uniting staff report that among their supported playgroups, one of the most common starting points for parents is a feeling of confusion, concern or isolation when it comes to parenting. Uniting believes that its TEI services provide both support and guidance for parents, resulting in parents being able to *"build a deeper understanding of themselves, their children and their potential together"*.

  For Uniting staff, one of the keys to improving parenting skills is to share evidence-based methods and research-proven approaches to parenting. Uniting has been intentional in ensuring that its staff members and caseworkers are trained in the 'science and evidence' of early intervention, and understand the nuances associated with childhood development.

As described by a Uniting staff member, this is important as:

*"A parent will feel more confident getting support, and especially engaging us in long term support, if they can understand the importance and benefit of the intervention. It's all strength based…building on what they need, and working with them to build the capacity for the challenges they face."*

*"We literally have parents telling us - I finally understand my child now".*

**Perspectives on supporting CALD families**

Uniting noted that TEI's parenting programs and capacity building is especially important for CALD families and children. About half of Uniting SWS clients identified as coming from a CALD background. These clients spoke of receiving Uniting TEI support while suffering from 'culture shock', with extremely limited understanding of Australian social service systems.

For example, one client explained:

> *"I don't have any family here. I didn't know anyone. Sometimes I am the only person who understands my son's language. I believe some parents might stress if they think their child has a (developmental) delay. Uniting help me to understand how the schools would help if my child has a delay."*

Through TEI, Uniting believes that it can support CALD parents to build confidence and understanding. Uniting works to support clients to achieve education outcomes guidance about the formal education system, and by helping to ensure that children are well prepared for the transition to formal education. Uniting staff commented that this form of support is especially important as it comes at a critical point in the developmental timeline of children.

**Perspectives on TEI Timeframes**

Uniting staff believe that the primary limitation of TEI in achieving client outcomes is the short timeframe that providers have to work with clients. Although the Department does not prescribe fixed time-limits for each client or service, funding constraints mean that Uniting will only be able to spend a maximum of 6 months with each client.

Uniting staff are concerned that TEI often struggles to create lasting, sustainable and deeper outcomes as this timeframe is simply too short relative to the developmental timeline for children:

> *"We're not sure if we're having the greatest impact, because we must move those kids through in a 6-month timeframe and there is usually a long way to go for where they need to be. We can miss some key transition points in a family's lives - like being ready for school, starting school, accessing key services like NDIS".*

**Perspectives on TEI funding for 'extra work'**

Uniting staff highlighted limitations with current TEI funding. The work needed to develop relationships and partnerships with community is unfunded – meaning that Uniting can only invest limited time and resources into this work:

> *"If we were paid properly for the partnership work, we could do more work to open up and understand the pathways for clients and actually intervene early at critical periods. For example, when we do go out and work with schools, the school will flag early that a kid has had no ECE, playgroup access, etc - the school can get us in early and we can make a big impact for a child. But this work is not funded by the department, so we can selectively pick only a couple of schools."*

Another Uniting staff member commented that:

*"The essential groundwork is not funded. While we have a commitment to do that type of work, there's incredible pressure on us to meet targets. This flows through to high utilisation and pressure on staff, high turnover. It's a cycle, staff will burn out a lot quicker, and that turns into further challenges for the organisation".*

Uniting staff also commented that increasing complexity in demand is also contributing to the increasing difficulty in undertaking partnership/relationship work:

*"Right now, there is a big incentive not to undertake community development work. However, 10 years ago, when need was less complex, our workers might have had the time to build relationships. But now, we are getting referrals when families are very much near or at crisis point."*

Uniting also shared that this issue was particularly challenging when working with CALD communities, due to the additional barriers and costs associated with language and culture translation:

*"There is no funding for translation services. Even for services supporting CALD communities. There are 75 cultures we work with, particularly up north [in Cabramatta]. You can't employ translators full time and as a result it makes it hard to connect with people and help them understand what we can help them with. For us, it's about equal access for all people, and Uniting is being asked to bear the additional cost of the language and translation work".*[82]

**Perspectives on Uniting's role in supporting Aboriginal families**

Uniting also shared its perspective on working with Aboriginal families as a non-Aboriginal controlled organisation. It shared that throughout its engagement with Aboriginal clients and families, it has a very strong focus on helping to avoid family separation. Uniting recognises that it is common for Aboriginal families to distrust family services based on historical injustices, and understands the importance of building trusted and safe relationships as a foundation for effective service delivery.

Uniting it is intentional in delivering services in a culturally safe manner:

*"We've always been upfront to their families - what do you need support with within your culture. For us, it comes down to building trust and it's at the forefront of what we do when working with Aboriginal families. This is important given the history of distrust with statutory services and child removal."*

*"For families, regardless of culture - a lot of parents, they will want their kids to be involved with cultural activities. Encouraging Aboriginal kids to be proud of, and express their culture. Being open and encouraging about how to connect children with culture. Our staff are specifically conscious about this. We are all sensitive and respectful of cultural considerations."*

We interviewed two clients accessing TEI services at Uniting. One of these clients remarked:

*"Before I started, I thought it [Uniting] was just more DCJ, more of the same. I've come to realise that they've come to help. I thought they really cared. They've helped give me the confidence to not give up on life."*

When asked about the cultural appropriateness of Uniting's services, a second Aboriginal client commented that:

*"The services they have provided are definitely culturally appropriate. I don't mind working with either Aboriginal or non-Aboriginal services - I got to choose what support I needed the most. What was most important, was they were passionate about supporting us."*

---

[82] The Department notes that TEI providers are able to negotiate for the inclusion of translator funding within TEI contracts.

**Perspectives on increasing complexity of client needs**

Uniting staff emphasised a clear change in the complexity of support needs among clients presenting to its TEI services. These staff members believed that clients are increasingly presenting to TEI services with greater need, and are requiring more intensive support.

For Uniting, this change has significant ramifications for the way that TEI is delivered.

> *"We've noticed that clients are presenting with far more difficult cases. It's particularly clear when you think about the level of difficulty we had before. It's difficult because funding only allows for a particular length of time. Mostly, we cannot get them what they need."*

One Uniting caseworker with long term experience commented that:

> *"When I first started as a caseworker 6 years ago, the same level of complexity just wasn't there. We see a lot more financial violence, domestic violence, school refusal, financial need, addiction. A lot more homelessness. Post COVID - things had changed a lot - especially with school refusal…. there is much higher risk rate. We just don't want them in the child protection system."*

Uniting see that COVID-19 has been a significant driver of changing complexity among clients. On the one hand it increased the challenges faced by clients, and on the other, it had the effect of eroding familiarity and trust with services that may have helped provide support in a client's family life.

> *"Since COVID, we feel that isolation has increased significantly among the community. Especially in Cabramatta, it took a long time to encourage families to come back out and engage with us. This is understandable given the particular harshness of the lockouts in our communities. We believe that it made clients lose trust with the service system. It's going to take us a long time to rebuild that client trust with the services. It also had the effect of pushing developmental milestones of children way further behind as well."*

Another caseworker suggested that:

> *"Since COVID we've seen families become more isolated, they've become anxious about their children. I think that this has had a clear impact on socialisation, seeking of support, family capacity."*

Uniting believes that changing complexity places considerable pressure on its TEI service delivery.

> *"First of all, it places huge pressure on our workforce. With more complex clients, more is asked of our people. We find that this means our workers are at a higher risk of burning out. This is why TEI's longer contracts are so important – it allows us to provide our workers with some permanency, which improves our ability to attract and retain staff despite these trends."*

The other impact articulated by Uniting is that higher complexity of client needs creates competing demands toward both training and resourcing.

> *"With increasing client difficulty and complexity, we want to be able to give them more and better training and supervision so they are well equipped and can make the biggest impact. But we also need to help reduce the caseloads of caseworkers if they are facing more and more complex cases. If we invest in reduced caseloads, there is less money and time for training. The funding isn't there to do both."*

### A.5.3 Additional themes emerging from client interviews

**Support for clients experiencing vulnerability**

While Uniting supports a range of clients with very different needs through its TEI services, roughly half of the clients who spoke with us described commencing TEI programs after significant trauma or difficulty in their lives. Their comments underscore the importance and, often, the intensity of work that

is associated with Uniting's TEI service delivery. For many, Uniting's TEI services were critical to their ability to achieve outcomes related to safety. For instance, one client commented that:

> *"I am a survivor of domestic violence. When I came to Uniting, I was in a dark place and extremely depressed. I have [a large family who depend on me] – I can't imagine what the impact on them would be if Uniting wasn't around to support me."*
>
> *Another client had recently stepped down from Intensive Family Preservation. They noted that Uniting's TEI service was currently providing a critical support for her family.*
>
> *"Since I had children, I always had DCJ in the background at all times. My son was removed out of my care, and I got him back 13 months later. This time the first time DCJ hasn't opened a case. I feel really supported. It's made me who I am today…*
>
> *With Uniting's support – I've reached a lot of goals and got my kids into the services they need. They've even helped me abstain from using drugs. I feel like I can finally move forward with my life."*

Another client described the importance of Uniting's TEI services (family capacity building and counselling) at a highly stressful time:

> *"My life was in chaos. It meant a lot to me to receive Uniting's support - to go from where we were. We hit rock bottom. I was suicidal…*
>
> *I couldn't say where I would be without them. I probably wouldn't have my kids. I would have had to give them up."*

**Support for clients from CALD backgrounds**

In South Western Sydney, Uniting serves diverse client communities, including many clients from CALD backgrounds. Several clients from CALD backgrounds described how TEI helped them to overcome language and culture barriers to access supports for their families or participating in the community. One client described her situation as:

> *"I am a mother of [a large family]. It was very hard for me to learn the language. I started understanding but it was hard for me to speak and make conversation and if someone asked me a question, I'd be very nervous and scared."*

Another client commented that TEI played an important role in providing information and reassurance, when they otherwise had little information about the formal education system:

> *"I am really worried about my son. But when you have an organisation that can tell you, your son is doing okay, you feel happy. You always worry, but hearing from Uniting that he will be okay at school, you feel much better."*

**Importance of TEI advocacy and casework in service system navigation**

Several Uniting's clients also provided examples of TEI support with broader service system navigation that led to empowerment and health outcomes.

One client commented:

> *"Uniting helped me with the entire NDIS process. We had actually been refused before, but this time they helped with all the paperwork that I just couldn't get together myself. They helped get a copy of an original birth certificate and organised a speech therapist and OT at the community centre. Beyond that, they also helped advocate for me when problems started up at the daycare centre with my other child. They have also helped me out with Centrelink as well*
>
> *…*

*All this help, it's been really beneficial to my mental health. Without it, everything would have deteriorated".*

Another client explained that:

*"They helped me with the kids schooling, doctors' appointments, anything I really needed, they helped me with. The counselling support they provided me has helped me get to a much better place for myself and my kids. In the past, I wasn't doing a good job with my kids. They weren't going to school, and I wasn't really taking them to their medical appointments…*

*The counselling has helped provide me the confidence to not give up on life, that I didn't have to give up on the kids. They make me feel like I could actually do this."*

**Developing parenting skills**

Several clients emphasised the role of Uniting's parenting programs and case work support in developing parenting skills and ability to support their children to regulate emotions. The comments from these clients indicated that this support was playing a role in achieving safety outcomes. For example, one client commented that:

*"[My caseworker] really helped give me insight into what's going on with my two-year-old. She helped me understand that everything is normal. I just thought my kid was wild - his behaviour was causing me anxiety. [my caseworker] helped me understand the importance of positive parenting, and came up with some tailored strategies for me…*

*My son and I now have a beautiful attachment, but I think without [my caseworker] it would have taken a much longer time to get there. I think there would have been a lot more hurt along the way."*

Another client commented that:

*"Being able to see [my counsellor] helped me not bottle everything up. It helped me with when the kids are playing up – it's taught me to be patient. I was taking it out on them. The kids are listening to me now. I'm a better parent now."*

A third client commented that:

*"What helped the most was Uniting providing me with strategies for handling big emotions. My kid can sometimes be explosive, and I feel like I know how to manage that better now. And it's helped my daughter too. We've grown closer as a result."*

**Importance of supported playgroups in combatting isolation and anxiety**

We heard multiple examples of how Uniting's TEI playgroup helped support community participation outcomes for both parents and children. One client from a CALD background noted that playgroup had an important unifying impact:

*"The playgroup has lots of our Cambodian community here. It's easy to talk and make friends. We have a different way of raising children because of our different culture and nationality…*

*Because we have the same religion and culture it's easier make friends and feel at home. It's easy between mums and we're closer. It's the feeling - we know how hard it is to make these friends otherwise."*

Similarly, another client from a CALD background commented that:

*"I had a lot of postpartum depression. Went from working 5 days a week to just looking after the kids. Thanks to the playgroup, I feel like I had a chance to have a village for my kids like we would back home. For me, Uniting is like my chief, I feel like I've got a village now*

*…*

*Without the playgroup I wouldn't be as involved and in tune with my kids as now. It came so easily to me when I was surrounded by other mums and children. I don't have much family or friends here. All I had access to was my mother in law's opinion."*

Finally, another client noted that:

*"Coming to playgroup makes me feel relaxed because there is everything ready for them to play. There is a routine. We have time to play together with other children, to get the benefit and learning from educators to add more detail to what we do at home, to help our children learn."*

### A.5.4 Key Learnings from the Uniting Case Study

Our key learnings from this case study include:

- The perspective shared from Uniting and its clients over the importance of TEI advocacy support, particularly within the context of CALD communities.
- Uniting's clients provided testimony and evidence that TEI has played a key role in reducing social isolation and improving parenting capacity.
- Uniting's perspective that longer timeframes (in working with clients under TEI) may be needed to achieve greater depth of outcomes. Similarly, partnership/relationship work undertaken by providers (that is currently unfunded) may be a key to unlocking outcomes.
- External factors such as COVID-19 appear to be significant contributors to changing complexity of demand.

# Appendix B TEI Service Types

Table B.1 – Service types and descriptions under Community Connections program activity, Community Strengthening stream

| Service type | Description |
|---|---|
| Community Engagement | Organise community events or festivals that are in line with TEI outcomes. This can only be counted if the service is responsible for organising and running the event. For example, contributing resources, time and staff to organise it, not just participating or attending. If an event runs for 3 days, record one session for each day the event occurs, therefore 3 sessions would be recorded for this event. |
| Community sector coordination | Activities undertaken to support coordination and collaboration; strengthen organisational capacity of local TEI organisations. Examples include coordinating inter-agency activities (chairing, secretariat, venue, etc); backbone support to collective impact work; interdisciplinary place-based projects; local consultation processes; coaching/mentoring; good governance; and being a conduit between NGOs, government, business and wider community. Sector staff attending these activities may be recorded as an unidentified group or as individual clients. |
| Community sector planning | Activities undertaken to assist organisations and community networks to plan and support their communities to achieve TEI outcomes. Examples include representation/advocacy, brokering partnerships, networking, information clearinghouse, research and evaluation, policy advice and professional development. Sector staff attending these activities may be recorded as an unidentified group or as individual clients. |
| Education and Skills Training | Activities that increase the knowledge and skills of community organisations to strengthen social capital, local networks, social inclusion, and sense of belonging to different communities. Sector staff attending these activities may be recorded as either unidentified or individual clients. |
| Indigenous Community Engagement | Organise Aboriginal community events or festivals that support Aboriginal communities or community events promoting Aboriginal issues. This can only be counted if the service is responsible for organising and running the event. For example, contributing resources, time and staff to organise it, not just participating or attending. If an event runs for 3 days, record one session for each day the event occurs, therefore 3 sessions would be recorded for this event. |
| Indigenous Social Participation | Initiate or facilitate activities for Aboriginal communities that are in line with TEI outcomes. This could include social, cultural, recreational, youth, art or language activities; workshops; or linking up members of a community around a shared issue, memorial days, reconciliation activities, erecting plaques or monuments. |
| Information/Advice /Referral | Provision of standard advice/guidance or information for individuals or families in relation to a specific topic. Referrals include to another service provider or within the organisation. This referral is effective and timely, facilitates client engagement, builds and maintains referral pathways and partnerships, and proactively helps individuals and families to easily access services and determine the way their support is provided. |
| Social Participation | Initiate or facilitate community activities that are in line with TEI outcomes. This could include social, cultural, recreational, youth activities, art or language |

| Service type | Description |
|---|---|
| | activities; workshops; or linking up members of a community around a shared issue. |

Table B.2 – Service types and descriptions under Community Centres program activity, Community Strengthening stream

| Service type | Description |
|---|---|
| Community Engagement | Planning activities undertaken with community members to develop plans that would achieve the TEI outcomes. Examples could include: a child protection, housing, education, health or employment plan or a plan that addresses a number of these.<br>Note: Service has to facilitate the sessions and write the plan to count this as an activity, not just participate in consultations run by other services. Plans should include the change that the community is trying to achieve and how this will be measured, including both short and medium/long term measurement. Each meeting held to discuss a plan would be counted as a session. |
| Education and Skills Training | Community centre activities that build the knowledge and skills of community members to better meet, interact and/or volunteer. These may include individualised, group based, or other client-centred approaches. Online activities can be recorded where specific workshops or modules are delivered to a group of individual clients. |
| Information/Advice /Referral | Provision of standard advice/guidance or information for individuals or families in relation to a specific topic. Referrals include to another service provider or within the organisation. This referral is effective and timely, facilitates client engagement, builds and maintains referral pathways and partnerships, and proactively helps individuals and families to easily access services and determine the way their support is provided. |
| Social Participation | Provide clients an opportunity to connect with others, such as a community centre, informal location, or online to achieve the TEI outcomes. Examples could include providing a meeting space or hiring out rooms to functions or forums, parenting groups, youth groups, early childhood education, care or support, maternal and child health services, Aboriginal Elders, Men's and Women's Groups, Aboriginal enterprises; and/or providing access to internet and Wi-Fi; and/or equipment, such as toys, books and car seats. Count each occasion of service as a session. Providers should aim to collect individual client details for each participant/attendee where possible. |

Table B.3 – Service types and descriptions under Community Support program activity, Wellbeing and Safety stream

| Service type | Description |
|---|---|
| Advocacy and Support | Includes advocating for, problem solving and being an intermediary for child/ren, young people, families and communities, to help and inspire people to find the support that is right for them. |
| Business Planning | Initiate or support the development of Aboriginal led enterprises that are in line with the TEI outcomes. Examples could include: a social enterprise run by Aboriginal people which produces and sells Aboriginal art or bush tucker for profit. Count each planning meeting as a session. |

| Service type | Description |
|---|---|
| Education and Skills Training | Community support that increases community member's knowledge, skills, experience, confidence; wellbeing; social inclusion, participation, or individual capacity. Examples could include literacy, numeracy, life skills, financial management/budgeting, whether delivered to individuals or in a group. Online activities can be recorded where specific workshops or modules are delivered to a group of individual clients. |
| Facilitate Employment Pathways | Programs that build the skills of community members, including young people, to provide facilitate pathways to employment. Examples could include résumé writing workshops, employment skills development and volunteering, whether delivered to individuals or in a group. |
| Indigenous Advocacy/Support | Includes advocating for, problem solving and being an intermediary for Aboriginal child/ren, young people, families and communities, to help and inspire people to find the support that's right for them. |
| Indigenous Healing Workshops | Any activity which facilitates healing for Aboriginal communities, families or individuals. Examples could include grief and loss workshops. |
| Information/ Advice/Referral | Provision of standard advice/guidance or information for individuals or families in relation to a specific topic. Referrals include to another service provider or within the organisation. This referral is effective and timely, facilitates client engagement, builds and maintains referral pathways and partnerships, and proactively helps individuals and families to easily access services and determine the way their support is provided. |
| Social Participation | Activities that encourage connectedness for community members, which would increase social inclusion and participation. For example mentoring, leadership programs, relationship, social skills, whether delivered one on one or in a group. |

Table B.4 – Service types and descriptions under Targeted Support program activity, Wellbeing and Safety stream

| Service type | Description |
|---|---|
| Counselling | Counselling provided by a qualified practitioner such as a Psychologist or Psychotherapist to one or more clients or family members. Techniques, orientations and practices used should be broadly accepted, validated and based on client need. |
| Education and Skills Training | Targeted support that builds the knowledge and skills of people with known vulnerabilities, e.g. domestic and family violence, mental health needs, drug and/or alcohol needs, and social/economic disadvantage. These may include individualised, group based, or other client-centred approaches. Online activities can be recorded where specific workshops or modules are delivered to a group of individual clients. |
| Family Capacity Building | Family support activities provided during case management, which involve undertaking activities to implement the case plans of individual clients (child/ren, young person or family). This could include home visiting, support (legal, language or to access TIS), advocacy, counselling; mediation; referrals and skills development to help clients achieve outcomes. It could also include providing education (such as life skills or budgeting) in line with the case plan. It also includes a review with the client of what has been achieved and an exit plan. Services should be able to demonstrate that they use a system for doing case |

| Service type | Description |
|---|---|
| | management (including file notes, templates, policies and case management meetings), monitoring and evaluating the effectiveness of the services being delivered to the child/ren and family. |
| Indigenous Supported Playgroups | Supported playgroups are an opportunity for Aboriginal parents or parents of Aboriginal children to share experiences of parenting and learn new parenting skills while being supported by workers who coordinate the activities. They also provide children with an opportunity to socialise play and learn in a structured and positive environment as well as participating in age-appropriate learning experiences and activities to help them become school ready. Supported playgroups are facilitated by a professional worker with qualifications or experience in early childhood or in working with families with children. |
| Indigenous Social Participation | This only includes camps for Aboriginal children, young people and families to experience Aboriginal culture, language or traditions. |
| Information/ Advice/Referral | Provision of standard advice/guidance or information for individuals or families in relation to a specific topic. Referrals include to another service provider or within the organisation. This referral is effective and timely, facilitates client engagement, builds and maintains referral pathways and partnerships, and proactively helps individuals and families to easily access services and determine the way their support is provided. |
| Intake/ Assessment | Intake and assessment in a case management setting, which includes providing assessment and case planning to assess the strengths and needs of the child, young person and family, including any risks; plan and coordinate a mix of services to meet the child/ren, young people and family's needs and address risks; |
| Material Aid | Material aid in a case management setting, where funds are used to purchase goods and/or services (including child care) which are in line with the case plan developed for the child/ren, young person and family. |
| Mentoring/Peer Support | This includes facilitating self-help/peer support groups for parents experiencing particular issues. An example could include post-natal depression groups. |
| Parenting Programs | Programs that provide support specifically targeted at parent/child relationships and/or practical skill building for parents. Parenting programs are usually structured and delivered in a group or one to one setting. Program selection should be driven by local need, client compatibility and cultural safety. |
| Supported Playgroups | Supported playgroups are an opportunity for parents to share experiences of parenting and learn new parenting skills while being supported by workers who coordinate the activities. They also provide children with an opportunity to socialise play and learn in a structured and positive environment as well as participating in age-appropriate learning experiences and activities to help them become school ready. Supported playgroups are facilitated by a professional worker with qualifications or experience in early childhood or in working with families with children. |

Table B.5 – Service types and descriptions under Intensive Support program activity, Wellbeing and Safety stream

| Service type | Description |
|---|---|
| Counselling | Counselling provided by a qualified practitioner such as a Psychologist or Psychotherapist to one or more clients or family members. Techniques, orientations and practices used should be broadly accepted, validated and based on client need. |
| Education and Skills Training | Intensive or specialist support that builds the knowledge and skills of people who have high and/or complex needs. These may include individualised, group based, or other client-centred approaches. Online activities can be recorded where specific workshops or modules are delivered to a group of individual clients. |
| Family Capacity Building | Intensive or specialist services delivered directly to individual families aimed at enhancing parent/child relationships, increasing family connectedness and reducing child distress. Family capacity building services should include additional level of intensity or specialisation than the parenting program/family capacity building service options delivered under Targeted Support. For example, services may include a therapeutic component, or a specialist framework intended to meet a specific intensive need. |
| Information/Advice /Referral | Provision of standard advice/guidance or information for individuals or families in relation to a specific topic. Referrals include to another service provider or within the organisation. This referral is effective and timely, facilitates client engagement, builds and maintains referral pathways and partnerships, and proactively helps individuals and families to easily access services and determine the way their support is provided. |
| Specialist Support | Specialist Support is delivered by a suitably qualified worker – in some cases this will involve engaging/employing specialist services for a fee to work with the family more intensively, where these services can't be engaged any other way, or in a timely manner. Services may include drug and/or alcohol services, intellectual and or physical disability services, family mediation, domestic violence and sexual assault support services and problem gambling services. |

Figure B.1 – Number of sessions delivered by service type in 2022-23 for service types in the Community Strengthening stream (DEX)

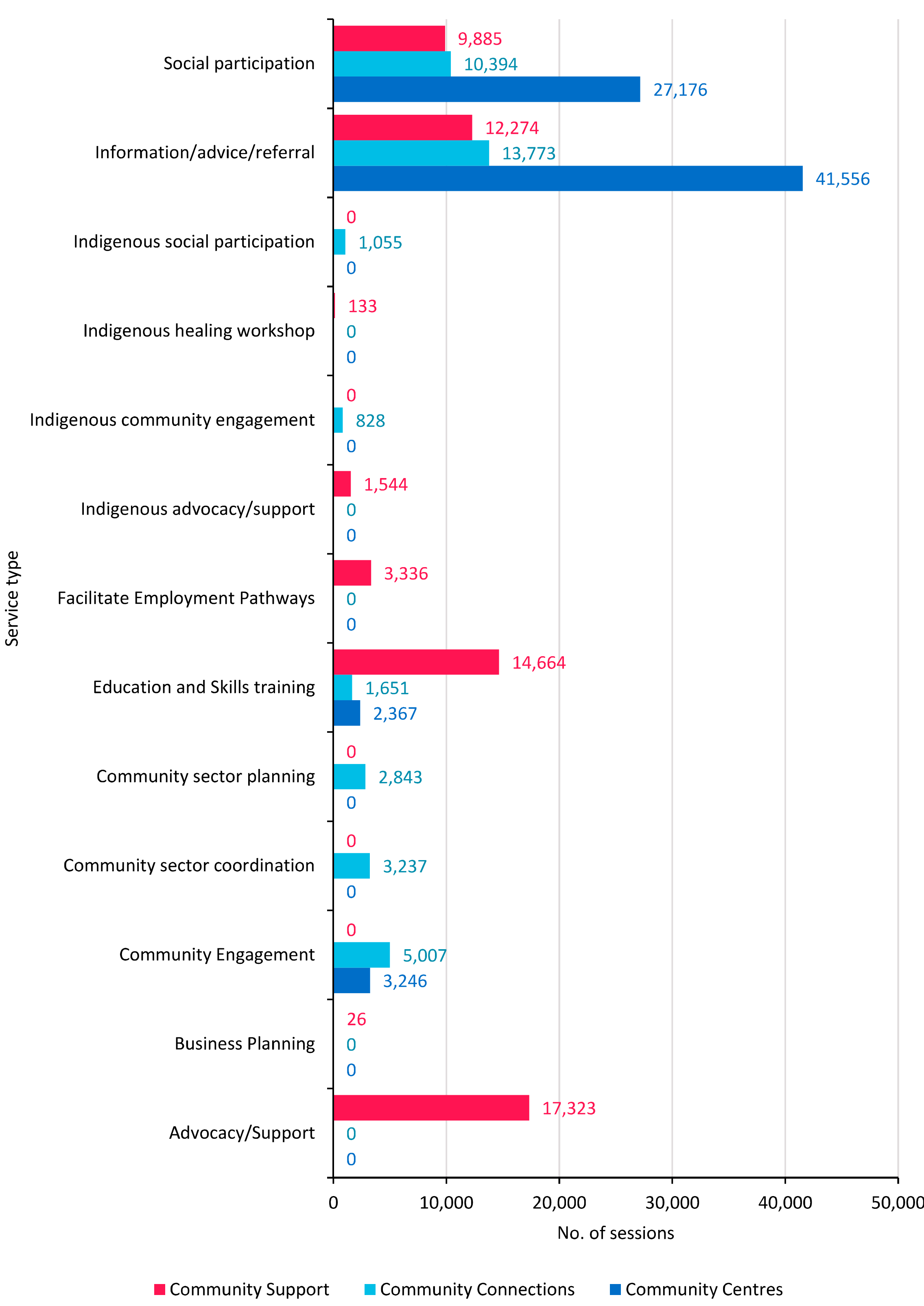
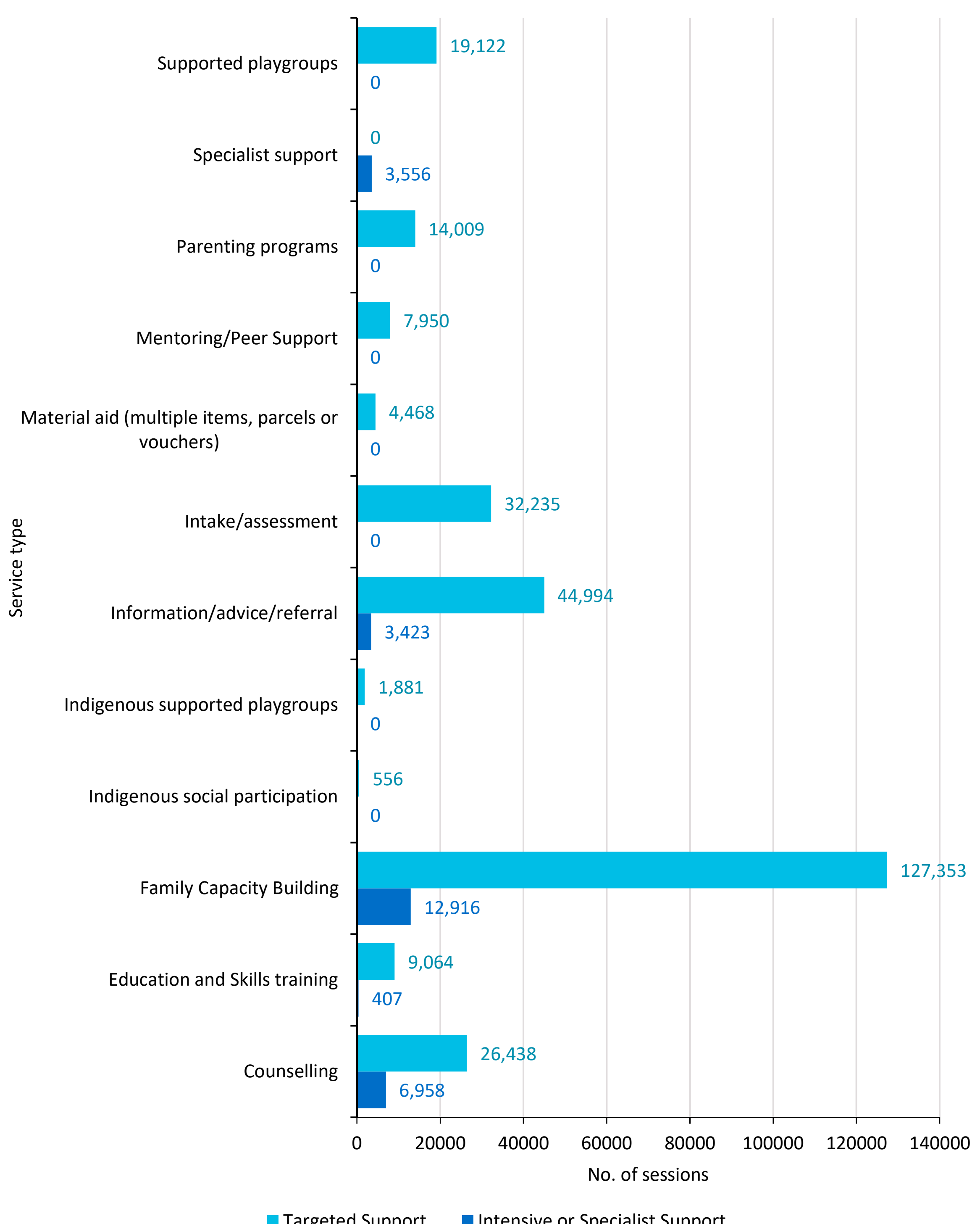


Figure B.2 – Number of sessions delivered by service type in 2022-23 for service types in the Wellbeing and Safety stream (DEX)



# Appendix C Types of referrals to other services recorded in DEX

| Purpose | Explanation |
|---|---|
| Physical health | the client is referred to assist with the impact of their physical health on their independence, participation and wellbeing. |
| Mental health wellbeing and self-care | the client is referred to help the impact of client's mental health and self-care issues on their independence, participation and wellbeing. |
| Personal and family safety | the client is referred to help with the impact of personal and family safety issues on their independence, participation and wellbeing. |
| Age-appropriate development | the client is referred to help improve age-appropriate development. |
| Community participation and networks | the client is referred to help with the impact of poor community participation and networks on their independence, participation and wellbeing. |
| Family functioning | the client is referred to improve family functioning and change its impact to improve the client's independence, participation and wellbeing. |
| Financial Resilience | the client is referred to help improve financial resilience and change its impact to improve the client's independence, participation and wellbeing. |
| Employment | the client is referred to help with the impact of a client's lack of employment on their independence, participation and wellbeing. |
| Education and Skills Training | the client is referred to help with the impact of a client's inability to engage with education and skills training on their independence, participation and wellbeing. |
| Material wellbeing and basic necessities | the client is referred to help with the impact of the client's immediate lack of money and basic items needed for day-to-day living to improve their independence, participation and wellbeing. |
| Housing | the client is referred to improve their housing stability or address the impact of poor housing on their independence, participation and wellbeing. |
| Support to caring role | the clients is referred to help with their caring responsibilities. |
| Other | the referral purpose is not captured in the list provided. |

# Appendix D Full data analysis relating to SCORE collection

## D.1 How SCOREs are collected

The SCORE is a flexible outcomes measurement tool that gives organisations the freedom to:

- Use the SCORE assessment tools directly, which include standardised client surveys, or use the organisation's existing outcomes measurement tools including their custom tools or other wider known validated tools (e.g. Personal Wellbeing Index). Department-provided translation matrices exist to convert measurements from validated tools into a SCORE measurement on the 5-point rating scale[83], and self-assessment translation templates help providers to translate their own measurement scales into one consistent with the SCORE. This reduces the admin burden for organisations from having to adopt new assessment tools.
- Choose whether the assessment is done by client themselves, their provider (practitioner), a support person of the client, or joint between the client and their practitioner. This allows providers to collect data in a way that makes the most sense for their service and client.

As discussed in Section 4.2.2, this flexibility comes at a cost of potentially compromising on the comparability of SCORE results. Figure D.1 and Figure D.2 below summarise by SCORE type the proportion of clients who have results taken from SCORE directly and from other validated tools, as well as the average rating from each. We can see from the charts that:

- Most organisations use SCORE directly across all three types of SCORE, especially for Satisfaction SCORE. This is expected as assessment of satisfaction is much more direct and there are fewer alternative tools for assessing satisfaction that is materially different to the standardised survey.
- When other validated tools[84] do get used for assessing client satisfaction, the average SCOREs tend to be a bit higher. However most of these cases are based in the Sydney district and therefore it is more likely driven by district variation.

[83] Australian Government (2019), *Data Exchange SCORE Translation Matrix*, https://dex.dss.gov.au/sites/default/files/documents/2022-07/1133-doc-score-translation.pdf

[84] Examples of validated tools can be found in the Data Exchange SCORE Translation Matrix above, however exactly which tool is used is not available in the data

Figure D.1 – Proportion of clients[85] with assessments collected directly from SCORE and from other validated tools (DEX, all years, n = 116,728)

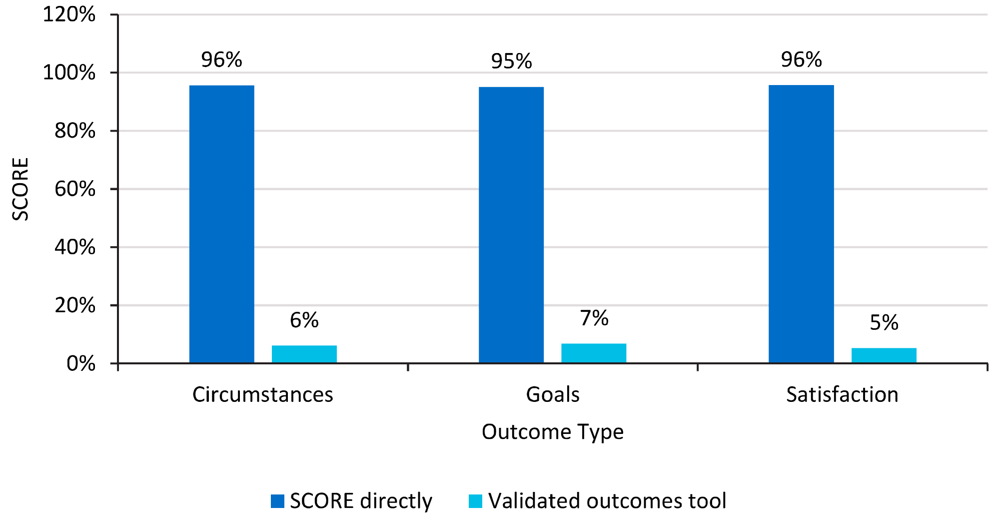



Figure D.2 – Average SCORE rating from SCORE directly and from other validated tools (DEX, all years)

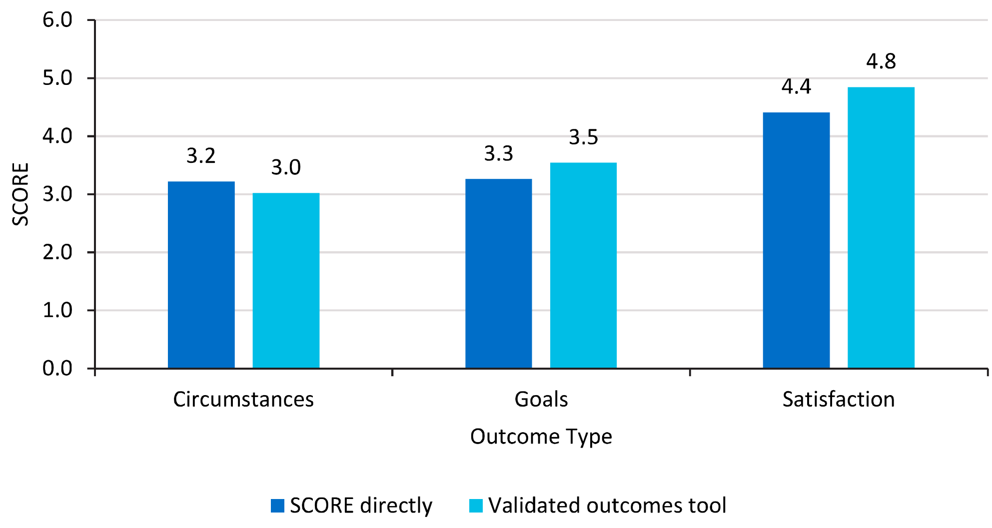



Figure D.3 and Figure D.4 below summarise by SCORE type the proportion of clients who have assessments completed by each given party, as well as the average rating from each. We can see from the charts that:

- Goals and Circumstances SCOREs are most often completed by the practitioner, while the Satisfaction SCORE is most often completed by the client themselves.
- Across all three types of SCOREs, the average SCORE rating is noticeably lower when it is completed by the practitioner. For each outcome type, the difference between practitioner-completed SCOREs and SCOREs completed by each of clients, support persons and joint is statistically significant.

[85] Clients can have SCOREs directly and SCOREs translated from validated outcomes tools within the same outcome domain, hence the percentages add up to more than 100%.

Figure D.3 – Proportion of clients[86] with SCORE assessments completed by each party for each outcome type (DEX, all years)

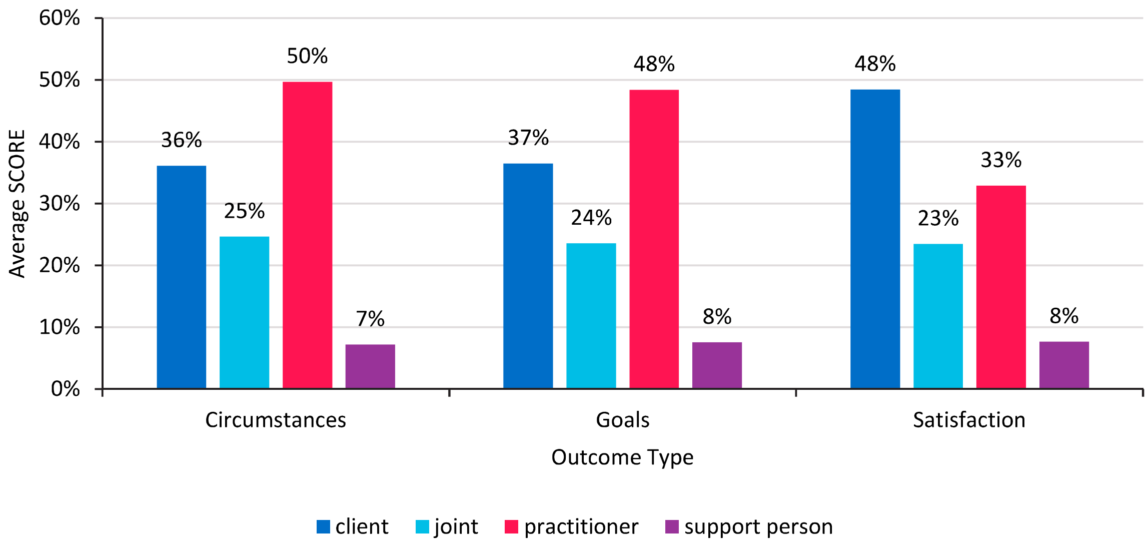
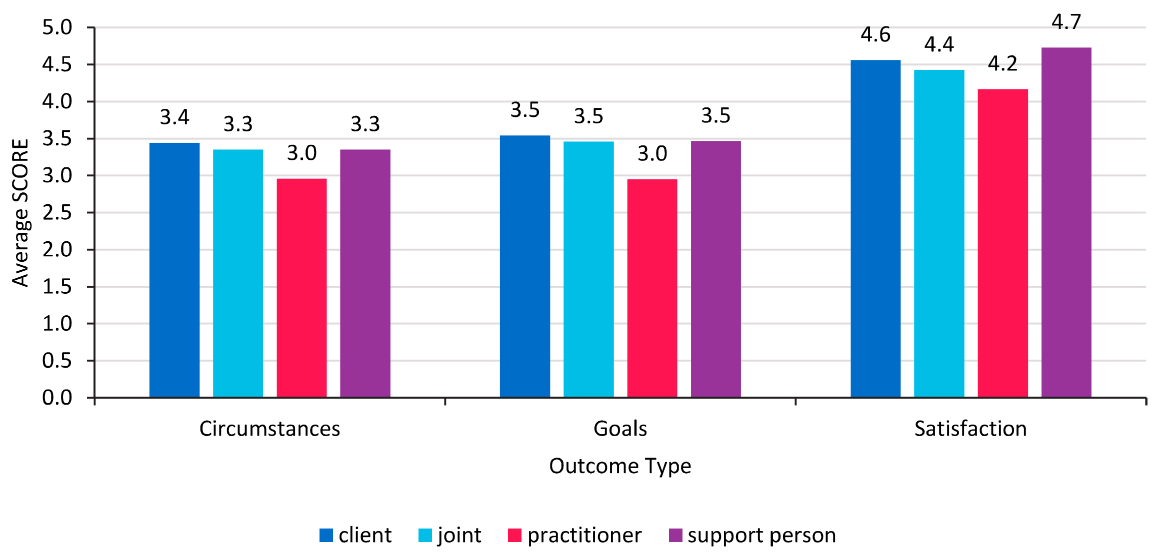



Figure D.4 – Average SCORE rating by who completed the SCORE assessment for each outcome type (DEX, all years)




## D.2 Rate for SCORE collection

From the TEI data collection and reporting guide[87], it is expected that at least 10% of individual clients have a satisfaction score per reporting period and an initial SCORE and at least one subsequent Circumstances/Goals SCORE for at least 50% of individual clients. This target has been achieved for Satisfaction SCOREs but not for Circumstances/Goals SCOREs despite the proportion of clients with any SCORE assessment completed increasing year on year for each SCORE type as shown in Figure D.5. The

[86] Clients can have SCOREs assessed by multiple people within the same outcome domain, hence the percentages add up to more than 100%.

[87] https://www.facs.nsw.gov.au/download?file=727030

increase in proportion of clients with SCOREs is observed in most provider districts except Nepean Blue Mountains, Murrumbidgee and Northern Sydney.

Figure D.5 – Proportion of individual clients with any SCORE assessment completed in the year by SCORE type (DEX, all years)

| % clients with SCORE | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|
| Circumstances | 26% | 32% | 36% |
| Goals | 25% | 31% | 34% |
| Satisfaction | 20% | 24% | 29% |

In Section 7 we see that client's changes in Circumstances and Goals SCOREs collected from different time points are useful in monitoring client outcomes post intervention. This requires collecting at least two SCOREs from the same domain for the same client. As at 30 June 2023, out of clients who have attended at least two sessions, only 27% of them have two or more Circumstances SCORE and 25% of them have two or more Goals SCORE completed from the same domain.

As illustrated in the Interim Report, some client groups are more likely to have SCOREs completed (using a model to understand the likelihood after controlling for client characteristics and risk factors from HSDS). We have refreshed this analysis using the additional year of HSDS data available and further explored differences by DCJ district, Aboriginal status and CALD status for each of the SCORE outcome types. The results are generally consistent across the three SCORE outcome types and reaffirms the results from the previous analysis, where we see (all else equal):

- Clients in more metro districts are generally around 10pp. (or 25%) more likely to have a SCORE recorded compared to clients in remote districts (Figure D.6)
- Non-Aboriginal clients are around 5pp. (or 15%) more likely to have a SCORE recorded across all three SCORE types (Figure D.7)
- Clients from CALD background are also around 5pp. (or 15%) more likely to have a SCORE recorded across all three SCORE types (Figure D.8)

For the charts below, the orange dotted line shows the overall state average rate of SCORE collection. Note that the overall SCORE collection rate from linked individual TEI clients in HSDS (which this analysis is based on) is slightly higher than the collection rate from DEX.

Figure D.6 – SCORE collection rate by District after controlling for differences in client characteristics and risk factors (HSDS)

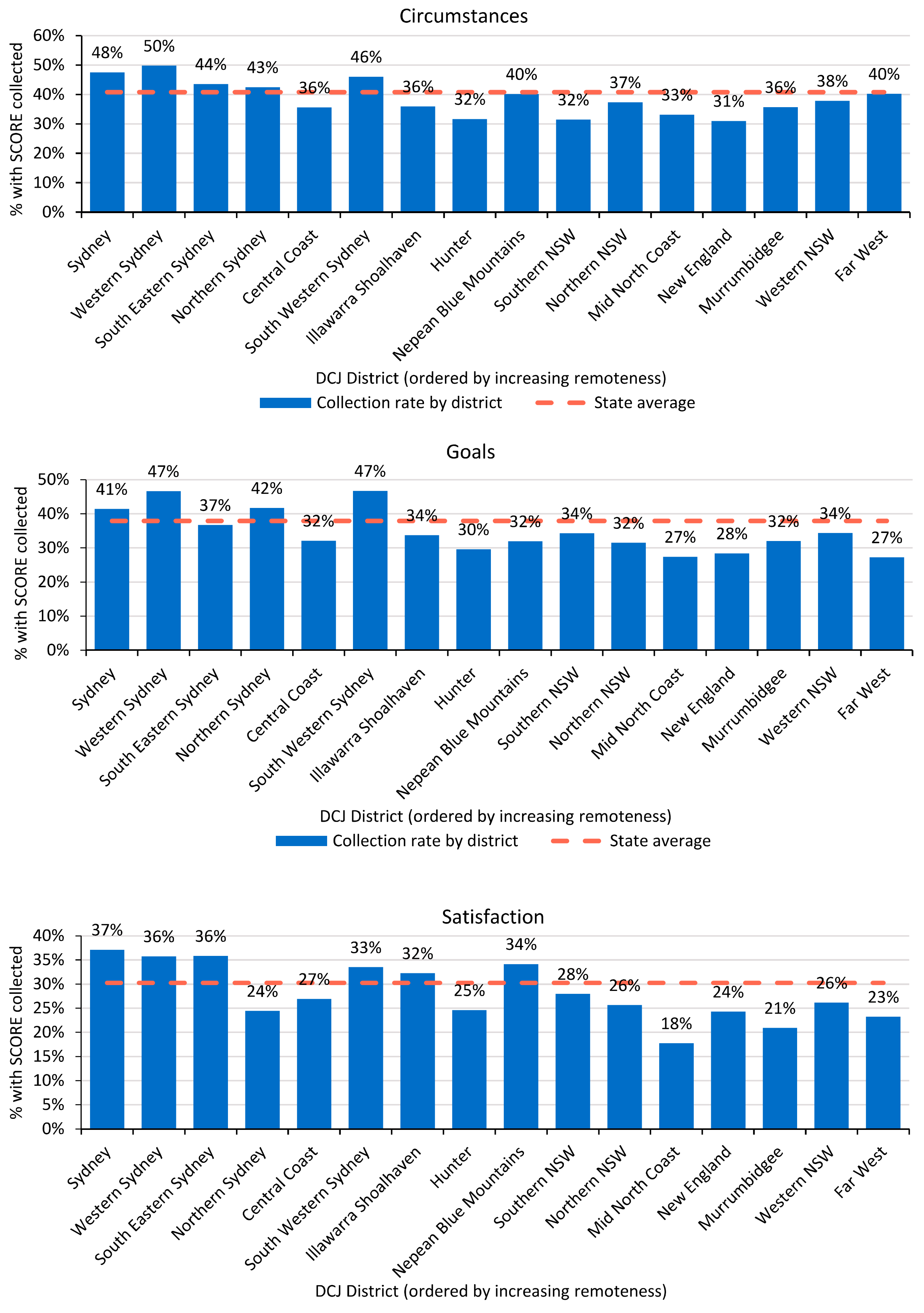


Figure D.7 – SCORE collection rate by Indigenous status after controlling for differences in client characteristics and risk factors (HSDS)

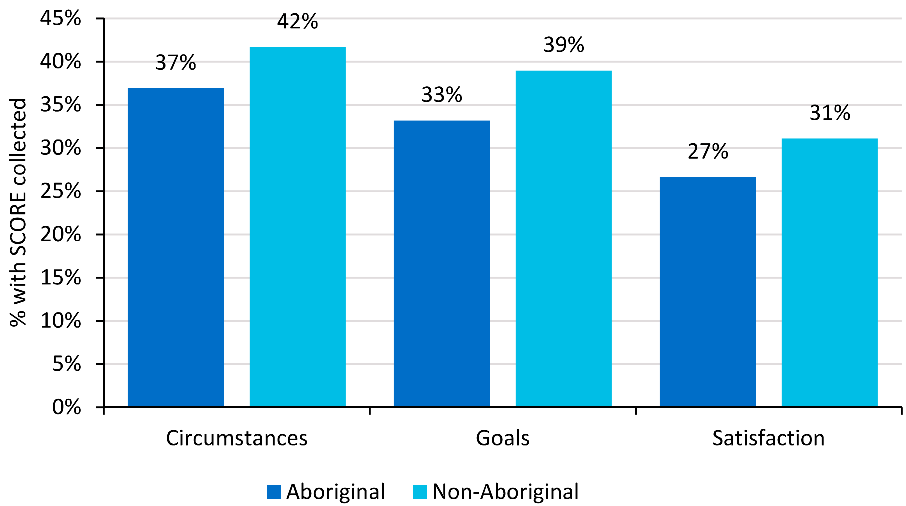
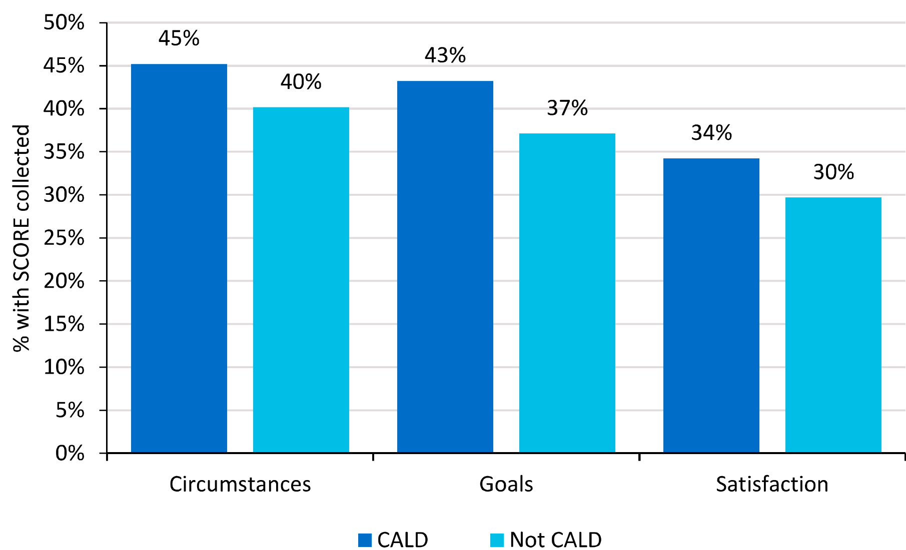



Figure D.8 – SCORE collection rate by CALD status after controlling for differences in client characteristics and risk factors (HSDS)




## D.3 Distribution of SCORE questions across services

One possibility for improved consistency would be to recommend particular SCORE questions for different types of services delivered. A review of the distribution of SCORES used within each service type (shown in the Table D.1 below) shows that this would be challenging. For example, while services labelled 'Facilitate Employment Pathways' have a higher level of SCORES corresponding to education and training, employment, and changed skills, these still represent a minority of overall Circumstance and Goal SCORES; many providers are completing SCORES across the full range of other domains.

The more practical approach for the future may be to continue permitting flexibility in which SCORE domains are completed (subject to providers being appropriately instructed to tailor to the individual), but consider more targeted outcome testing to further validate SCOREs across domains. That is, in this evaluation we examined the usefulness of SCOREs as an indicator of safety outcomes but there is opportunity to determine what SCOREs are the best indicators for a broader range of outcomes.

## Table D.1 – Distribution of SCOREs collected as percentage of the total number of SCOREs recorded for any attendee, for each service type (DEX, all years)

Note: Larger services with at least 10 responses in each SCORE category selected. Total number of SCOREs recorded for any attendee for each service type is shown in the last row of the table

| Category | SCORE | Advocacy/ Support | Community Engagement | Counselling | Education and Skills Training | Facilitate Employment Pathways | Family Capacity Building | Indigenous advocacy/ support | Information/ advice/ referral | Intake/ assessment | Material aid (multiple items, parcels or vouchers) | Mentoring/ Peer Support | Parenting programs | Social participation | Specialist Support | Supported playgroups |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Circumstances | Age-appropriate development | 0.9 | 1.4 | 2.8 | 4.4 | 1.5 | 4.7 | 1.1 | 2.6 | 4.7 | 3.4 | 2.5 | 4.1 | 3.7 | 2.1 | 11.6 |
| | Community participation and networks | 5.0 | 13.7 | 4.8 | 6.3 | 3.6 | 5.2 | 3.9 | 5.6 | 6.9 | 3.8 | 8.9 | 7.0 | 11.7 | 3.7 | 11.0 |
| | Education and Skills Training | 1.3 | 1.5 | 2.7 | 7.4 | 5.2 | 3.1 | 2.0 | 2.2 | 3.1 | 3.3 | 2.7 | 1.8 | 2.8 | 2.0 | 2.1 |
| | Employment | 1.9 | 1.0 | 1.6 | 1.9 | 6.8 | 2.6 | 2.0 | 1.9 | 2.4 | 3.1 | 1.0 | 0.7 | 0.9 | 1.4 | 0.7 |
| | Family functioning | 2.7 | 1.5 | 6.3 | 3.2 | 1.1 | 7.6 | 3.4 | 3.8 | 8.2 | 4.7 | 7.5 | 9.5 | 1.9 | 8.3 | 5.2 |
| | Financial resilience | 6.9 | 1.0 | 1.5 | 2.0 | 2.1 | 3.3 | 8.3 | 3.7 | 3.2 | 5.0 | 1.2 | 0.9 | 0.9 | 1.7 | 0.6 |
| | Housing | 4.0 | 1.2 | 2.1 | 1.2 | 1.2 | 3.6 | 5.7 | 3.0 | 3.5 | 3.5 | 1.7 | 1.0 | 0.9 | 3.1 | 0.8 |
| | Material wellbeing and basic necessities | 9.3 | 2.9 | 2.8 | 2.1 | 2.1 | 3.4 | 7.9 | 5.1 | 3.6 | 5.7 | 1.4 | 0.9 | 3.1 | 2.2 | 1.1 |
| | Mental health, wellbeing and self-care | 4.4 | 3.2 | 10.6 | 4.4 | 2.3 | 6.6 | 5.0 | 4.8 | 7.3 | 4.0 | 8.7 | 6.4 | 5.9 | 11.6 | 2.8 |
| | Personal and family safety | 3.6 | 1.4 | 5.1 | 2.7 | 1.1 | 6.1 | 2.8 | 3.4 | 6.5 | 3.5 | 7.1 | 5.9 | 2.1 | 5.8 | 2.1 |
| | Physical health | 3.6 | 1.5 | 3.4 | 1.6 | 0.9 | 3.3 | 3.7 | 2.9 | 3.9 | 3.3 | 2.0 | 1.0 | 2.4 | 2.6 | 1.2 |
| Goals | Changed behaviours | 1.9 | 3.3 | 5.9 | 5.2 | 7.3 | 5.3 | 2.6 | 3.5 | 5.9 | 4.2 | 8.6 | 9.4 | 5.4 | 5.4 | 6.2 |
| | Changed impact of immediate crisis | 4.8 | 4.1 | 6.3 | 3.5 | 6.0 | 4.3 | 2.9 | 4.0 | 4.0 | 5.8 | 3.2 | 3.0 | 2.9 | 4.4 | 2.0 |
| | Changed knowledge and access to information | 7.5 | 6.6 | 4.9 | 8.6 | 10.7 | 6.2 | 3.5 | 10.2 | 6.2 | 5.2 | 9.7 | 9.8 | 7.3 | 8.9 | 9.3 |
| | Changed skills | 1.7 | 4.8 | 7.9 | 8.8 | 12.7 | 5.2 | 2.4 | 3.6 | 5.7 | 4.9 | 9.7 | 11.1 | 6.5 | 4.9 | 8.7 |
| | Empowerment, choice and control to make own decisions | 3.8 | 3.9 | 6.7 | 7.1 | 8.5 | 6.7 | 3.2 | 4.5 | 6.2 | 5.3 | 6.3 | 6.2 | 5.9 | 9.7 | 5.7 |
| | Engagement with relevant support services | 5.9 | 12.3 | 6.7 | 6.1 | 8.4 | 6.6 | 4.3 | 9.2 | 6.3 | 5.4 | 4.9 | 4.8 | 5.9 | 5.8 | 7.3 |
| Satisfaction | I am better able to deal with issues that I sought help with | 9.7 | 10.7 | 4.9 | 7.0 | 5.7 | 5.3 | 11.1 | 8.0 | 4.4 | 8.2 | 3.9 | 5.1 | 8.4 | 5.2 | 6.3 |
| | I am satisfied with the services I have received | 11.0 | 13.1 | 7.9 | 9.5 | 6.9 | 5.5 | 12.8 | 9.4 | 4.0 | 9.2 | 4.5 | 6.0 | 12.9 | 5.5 | 9.1 |
| | The service listened to me and understood my issues | 10.3 | 10.7 | 5.2 | 7.0 | 5.8 | 5.4 | 11.4 | 8.5 | 4.0 | 8.2 | 4.3 | 5.3 | 8.7 | 5.6 | 6.2 |
| | **Total SCOREs collected** | 46k | 9k | 54k | 49k | 3k | 207k | 3k | 140k | 113k | 21k | 15k | 45k | 45k | 4k | 55k |

## D.4 Community SCORE collection

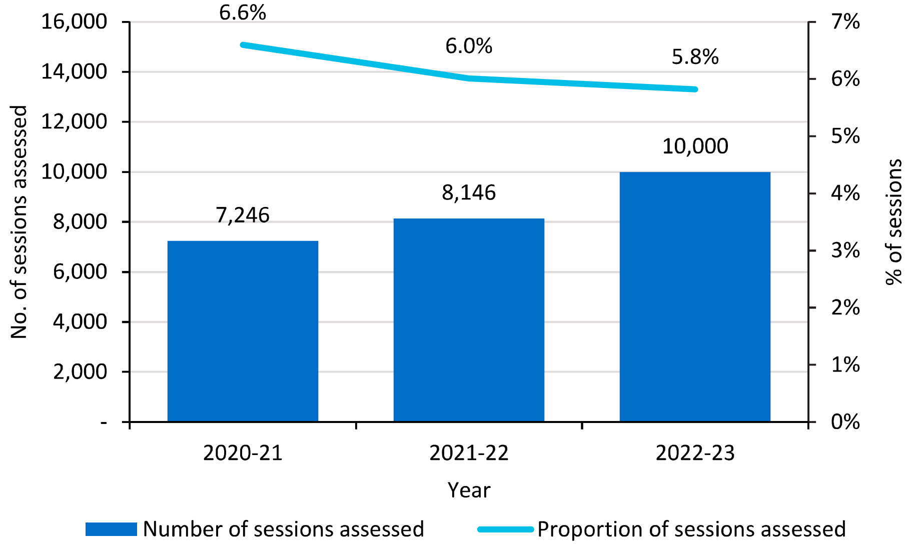
The Community SCORE tool can be used to assess outcomes for groups or communities. It assesses the impact of a session in one or more of the following four domains:

- Group/community knowledge, skills, attitudes and behaviours
- Social Cohesion (community connectedness)
- Organisational knowledge, skills and practices
- Community infrastructure and networks.

The first two domains focus on the change in outcome from a session for the group of clients attending the session, while the last two focuses on the connectedness of the organisation and its ability to address client's needs.

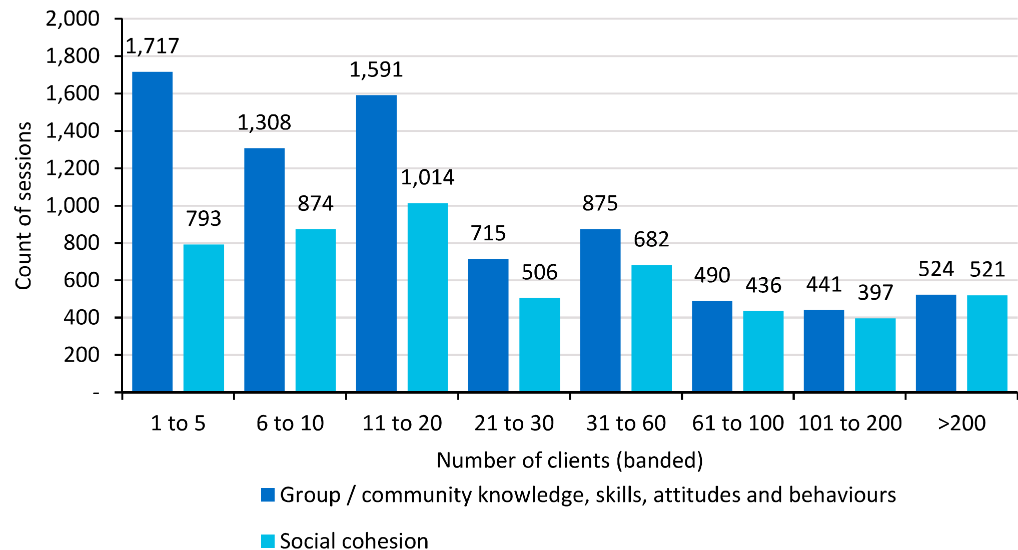
Overall, 10,000 or 85% of all Community SCOREs completed in 2022-23 are for Community Strengthening stream sessions, which corresponds to 5.8% of the total number of sessions conducted. Figure D.9 below shows that while the number of SCOREs completed for Community Strengthening sessions have steadily increased over the last two years, this was slower than the growth in the number of sessions conducted and hence the proportion of sessions assessed have reduced. However, the proportion of organisations delivering Community Strengthening stream services that have used any Community SCORE assessments have slightly increased from 58% in the prior year to 61% in 2022-23.

Figure D.9 – Number of sessions assessed (left) compared to proportion of sessions assessed (right) (DEX, Community Strengthening sessions only)




As mentioned above, a key purpose of the Community SCORE is to measure outcomes for groups of clients. In Figure D.10 below, we focus on the two SCORE domains that assesses outcomes for clients attending sessions and look at the number of clients (both individual and unidentified) attending sessions that have a Community SCORE assessment completed. We see that while Community SCOREs have been collected for a significant number of sessions with a large number of attendees (more than 500 sessions with over 200 attendees), there is also a considerable number of assessments that are conducted for sessions with a very small number of clients (over 15% of assessments are for sessions with 5 or less attendees). The ability to measure community connectedness and social cohesion for these smaller sessions may be more limited, and organisations should instead aim to collect individual SCOREs from clients in these sessions.

Figure D.10 – Count of the number of sessions with Community SCORE by the number of clients in each session



# Appendix E Full data analysis relating to service delivery

## E.1 Program clients

Figure E.1 depicts the total number of TEI clients by year as recorded in DEX. The number of TEI clients recorded has increased each year for both individual and unidentified group clients. Overall, the statewide recorded client numbers were:

- 161,602 individual clients in 2022-23 and 127,831 clients in 2021-22. This represents a 26% increase, which exceeds the 13% increase from 2020-21 to 2021-22, and is much higher than the estimated population increase of 2.2% in NSW. Around 110,000 clients from 2022-23 are new to TEI compared to around 90,000 new clients recorded in 2021-22. This shows that the reach of TEI to individual clients continues to expand at an increasing rate. Overall, TEI has provided services to around 310,000 unique individual clients over the last three years.[88]
- 1,133,760 unidentified group clients in 2022-23 and 977,815 in 2021-22. This represents a 16% increase which is less than the 37% increase in the previous year. Note, however, that the data for 2021-22 is subject to known data issues which may have inflated the number of unidentified group clients reported.

Figure E.1 – Total number of TEI clients (DEX)

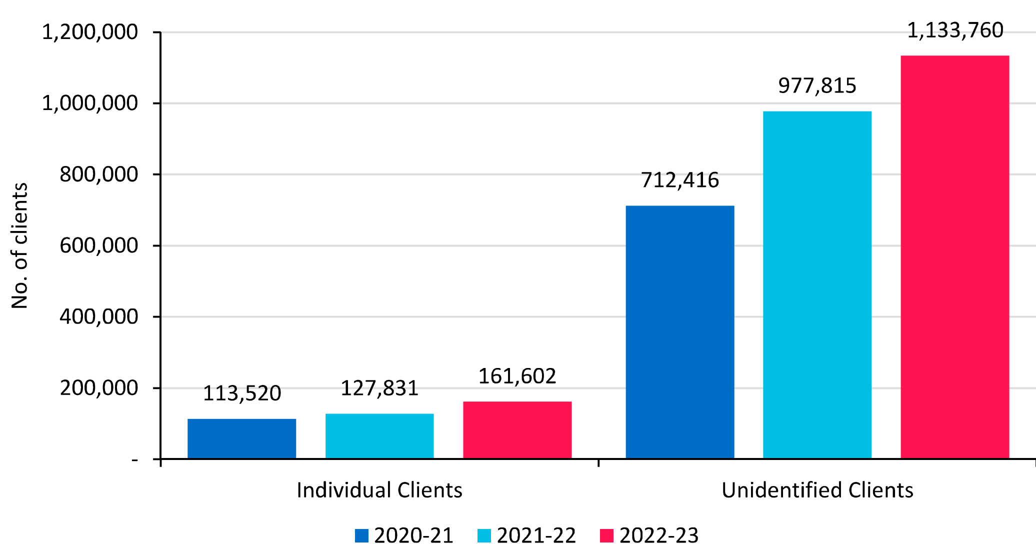



Figure E.2 and Figure E.3 below show the number of individual and unidentified group clients recorded across each program activity in each of the last three years. The figures show that the main drivers of the increase in clients are different in each of the last two years:

- For individual clients, the number of clients recorded by the two program activities in the Wellbeing and Safety stream each grew by around 20% from 2021-22 to 2022-23, compared to only a 3% increase for Targeted Support and a 6% decrease for Intensive or Specialist Support observed in the year prior. By contrast, the growth rate in clients recorded by program activities in the Community Strengthening stream is relatively consistent, at an average of around 30% per year.

[88] These client figures are slightly lower than those reported in the TEI annual report / TEI dashboard. The evaluation counted records with the same Statistical Linkage Key (SLK) as the same client, while the annual report treats each record with different client ID as different clients.

- For unidentified group clients, the increase in clients recorded in 2021-22 was mainly driven by the growth of Community Connections, which grew by 77%. In 2022-23, the growth rate in clients recorded is more even (excluding Intensive or Specialist Support which has very few group clients), with the highest growth rate observed for Community Support at 34%.

Figure E.2 – Number of individual clients by program activity (DEX)

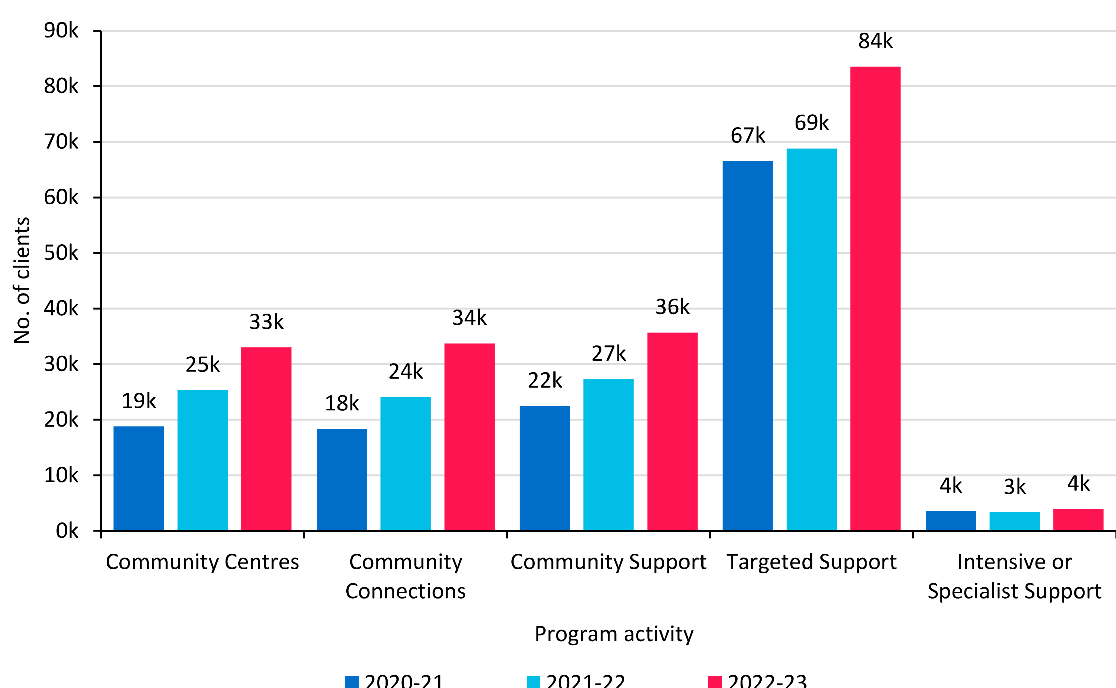


Figure E.3 – Number of unidentified group clients by program activity (DEX)

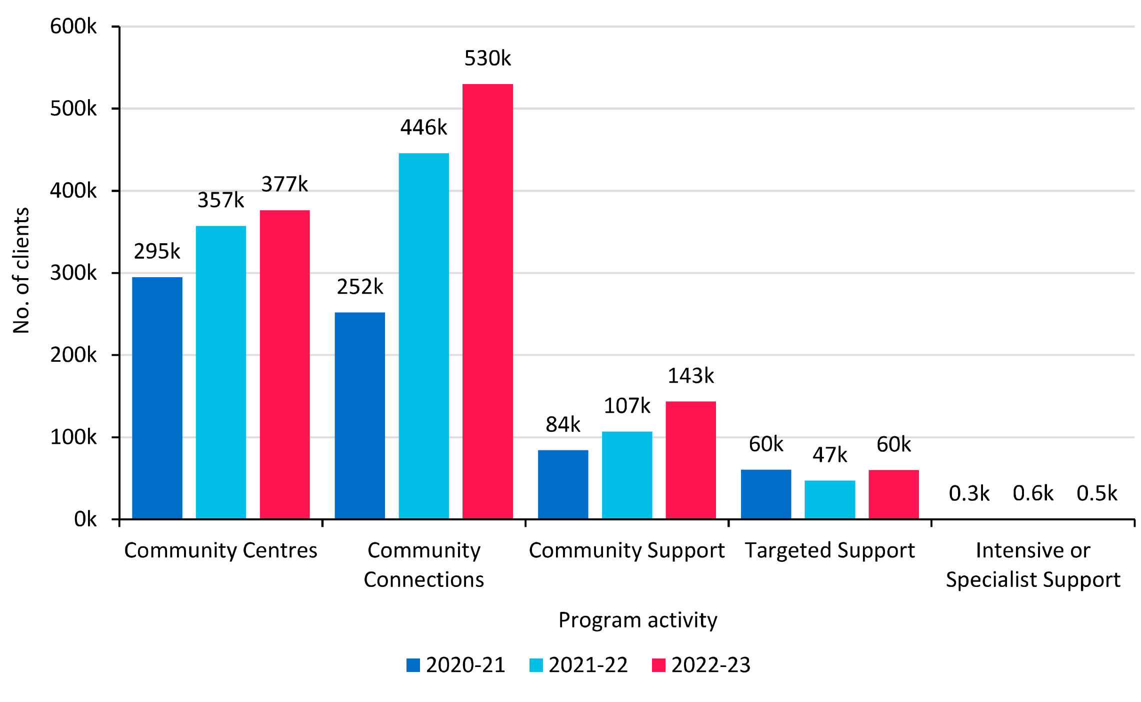



Figure E.4 and Figure E.5 look at the number of individual and unidentified group clients by DCJ District in the last two years. Note that the count of individual clients is based on clients' residential locations,

while the count of unidentified group clients is based on the location of the service outlet, as client location is unknown. The figures show that:

- The number of individual clients recorded has increased across all DCJ Districts. The rate of increase tended to be higher for the larger districts that already had more clients recorded in the previous year. Western Sydney, the district with the second most individual clients, had the highest growth rate at 36%. Western Sydney and South Western Sydney together account for 44% of the total increase in the number of clients across all districts.
- The change in the number of group clients is much more varied, with Nepean Blue Mountains, Illawarra Shoalhaven, Western Sydney and Central Coast recording the largest increases. However, part of the increase might have come from changes in data recording rather than a genuine increase in clients receiving TEI services, as the increases are concentrated amongst a small number of providers. For Western Sydney and Central Coast in particular, 3 outlets make up ~40% and ~50% of total increases in the districts respectively, and ~90% of the total increase in client numbers was driven by 10% of outlets. Some of the outlets that recorded a large increase in clients did not have a corresponding increase in the number of sessions. By comparison, around 70% of total increases were driven by 10% of outlets in Nepean Blue Mountains and Illawarra Shoalhaven, with the increase being more evenly spread across outlets.
- As discussed in the Interim Report, Sydney and South Eastern Sydney districts had a large increase in the number of unidentified group clients from 2020-21 to 2021-22 which was most likely caused by issues in data quality. This issue appears to be mostly resolved for the Sydney district, with providers that had a large increase in group clients in 2021-22 recording a decrease in 2022-23 to levels more consistent with what was observed two years ago. The data quality issue in the South Eastern Sydney district persists, with one provider recording around 120,000 group clients in each of the last two years. Excluding group clients from this provider, the total number of group clients in the district is around 70,000 in 2022-23.

Figure E.4 – Number of individual clients by DCJ district (DEX)

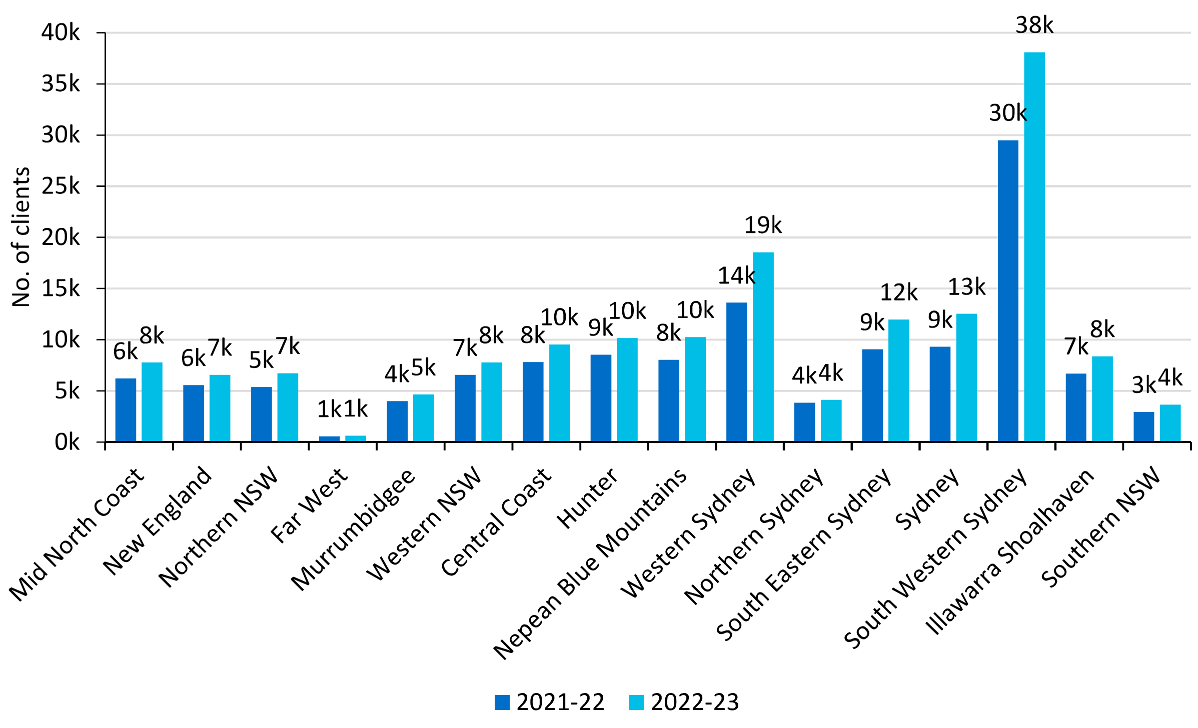
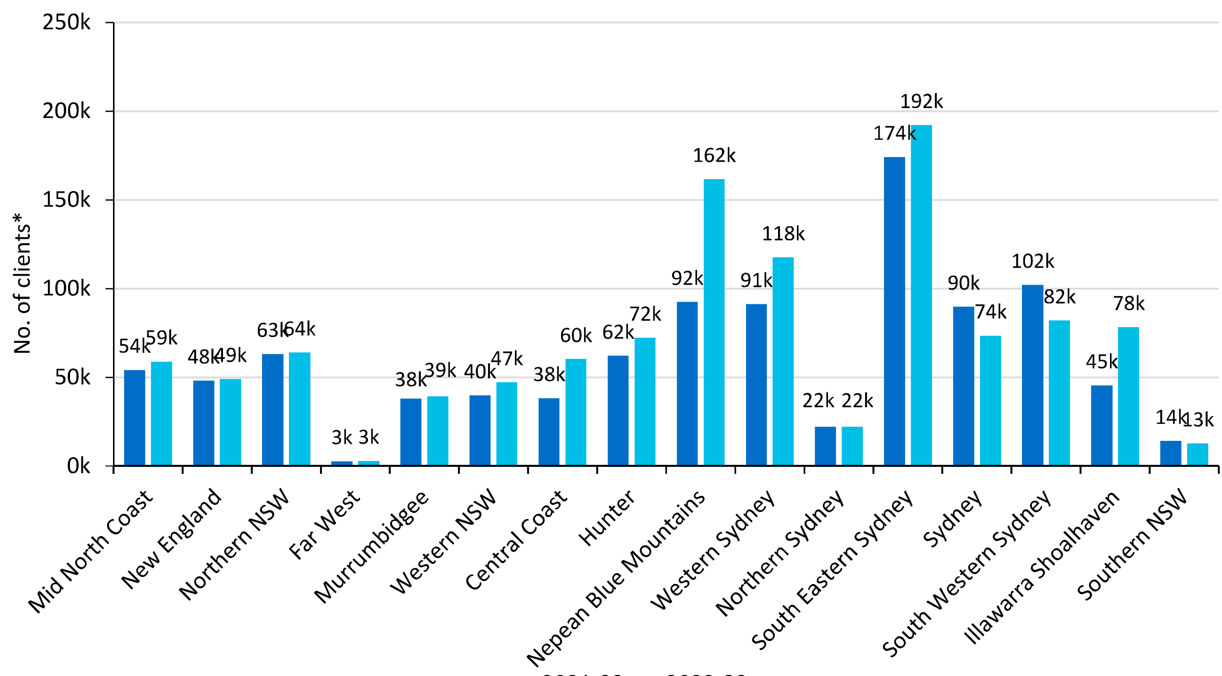


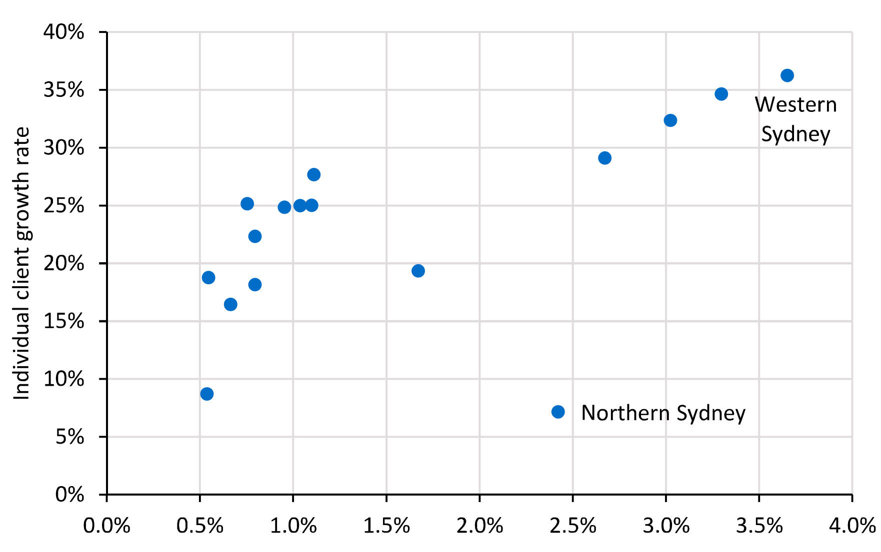
Figure E.5 – Number of unidentified group clients by DCJ district (DEX)




*Note: Number for South Eastern Sydney may have been inflated due to the data issue mentioned above

The growth rate in the number of individual clients is also correlated with the estimated population growth rate of the district ($\rho$=0.57), as shown in Figure E.6 below. This correlation was not observed for the growth from 2020-21 to 2021-22. It is also not observed in the growth in the number of group clients.

Figure E.6 – Individual client growth rate compared to population growth rate from 2021-22 to 2022-23 by district (DEX)

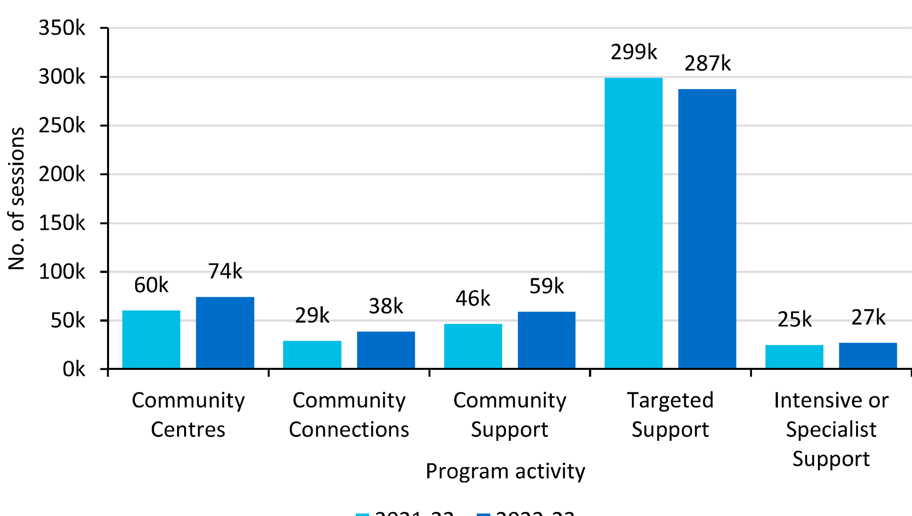



Note: See Appendix K.7 for the underlying statistics on the full list of DCJ districts. Only districts with relatively different experience have been labelled in the chart.

## E.2 Sessions delivered

Overall, the total number of individual and group TEI sessions conducted had increased by 6% from 461,434 in 2021-22 to 487,648 in 2022-23. All of this increase is driven by sessions from the Community Strengthening stream, which had increased by 27%, while the number of sessions from the Wellbeing and Safety stream had decreased by 3%. The breakdown of total sessions by program activity is shown in Figure E.7 below.

Figure E.7 – Number of sessions delivered by program activity (DEX)




The increase in Community Strengthening stream sessions is in line with the increase in the number of group clients observed in the previous section, hence there is likely to be a genuine increase in the number of group clients despite some potential inflation of numbers due to the data issues mentioned. For sessions from the Wellbeing and Safety stream, the number of individual clients recorded per session had increased from 2.5 in the last two years to around 3 in 2022-23, which has driven the overall increase in individual clients despite having less sessions conducted. This is likely a genuine increase in clients who received TEI services rather than improved identification of clients, as the average number of unidentified clients from these sessions had a similar increase.

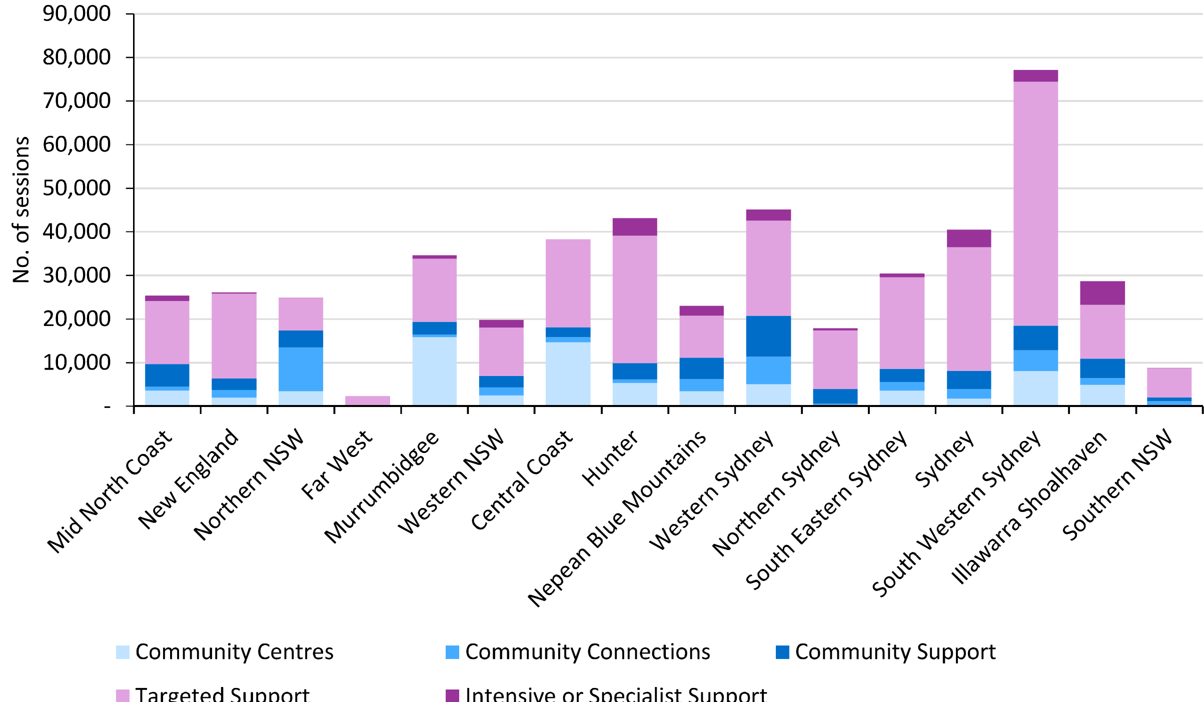
The share of sessions with individual clients recorded had remained at a similar level to the previous year, with 63% of Community Strengthening stream sessions having individual clients compared to 62% last year and 98.5% of Wellbeing and Safety stream sessions compared to 98.3% last year. Hence there should be minimal impact of change in data recording on the number of individual clients reported.

Figure E.8 below shows the number of sessions by program activity conducted in each district for 2022-23. The mix of sessions conducted across districts is mostly similar to the previous year, with the following key observations:

- The number of Community Strengthening stream sessions in the districts identified to have high growth in group client numbers (Western Sydney, Central Coast, Illawarra Shoalhaven and Nepean Blue Mountains) also had an increase of more than 40%. This again supports that there is likely a genuine increase in the number of clients who received TEI services from the Community Strengthening stream sessions despite some potential overstatement of the real increase due to change in data recording.
- The number of Intensive Support sessions conducted in the more remote districts is still very low.
- The number of Community Strengthening stream sessions in Far West had reduced significantly, from around 1,600 sessions conducted in 2021-22 to around 160 sessions in 2022-23.

- Other than Far West, in 2022-23 Sydney and Northern Sydney had the lowest proportion of Community Strengthening Stream sessions out of all sessions conducted, while Nepean Blue Mountains, Northern NSW and Murrumbidgee had the highest proportions.

Figure E.8 – Number of sessions delivered in each DCJ District in 2022-23 (DEX)



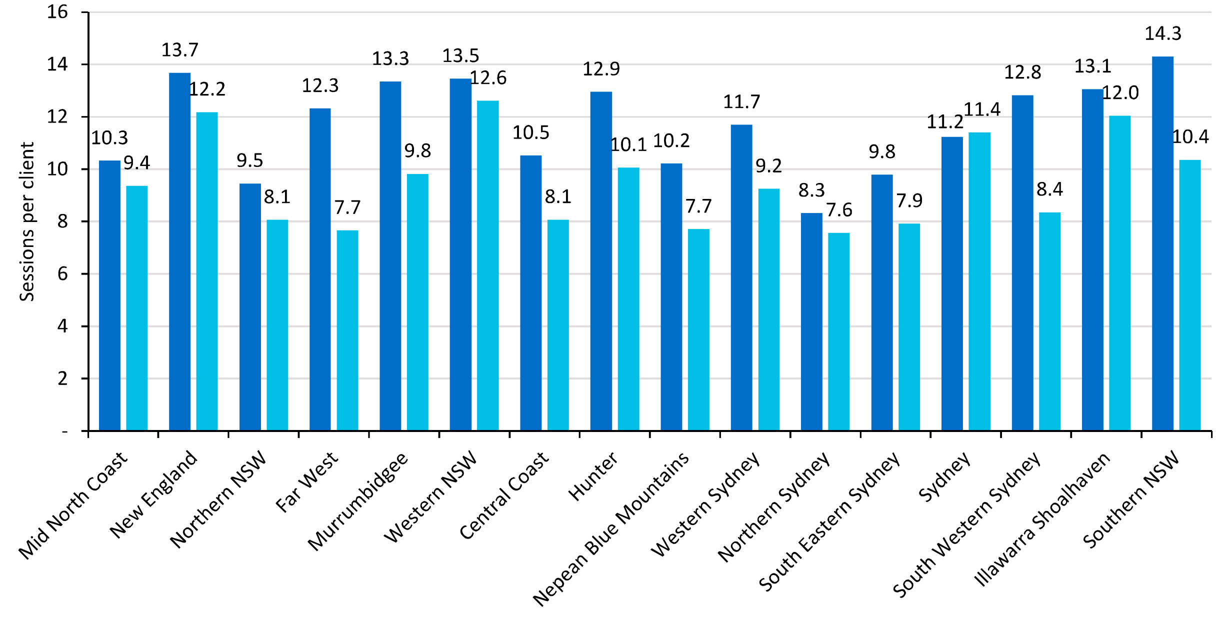

## E.3 Sessions per client

As at 30 June 2023, individual clients who entered in 2021-22 have received an average of 9 sessions per client[89]. In comparison, clients who entered in 2020-21 have received an average of 14 sessions, or 12 sessions if only sessions before 30 June 2022 is counted to ensure consistency in the length of the period being compared (i.e. in the year of entry and the following year). This drop in number of sessions per client is potentially another factor that contributes to providers being able to provide services to more clients while conducting a similar number of total sessions in the Wellbeing and Safety Stream.

This decrease in sessions per client is observed across all districts except the Sydney district, as shown in Figure E.9 below. The greatest proportionate decrease is observed in Far West and South Western Sydney, with South Western Sydney also being the district that had the highest increase in the number of clients recorded over the last two years.

[89] Note that this does not include attendances in group sessions. The actual average number of sessions attended is likely to be higher.

Figure E.9 – Average number of sessions per client by client's year of entry (DEX)

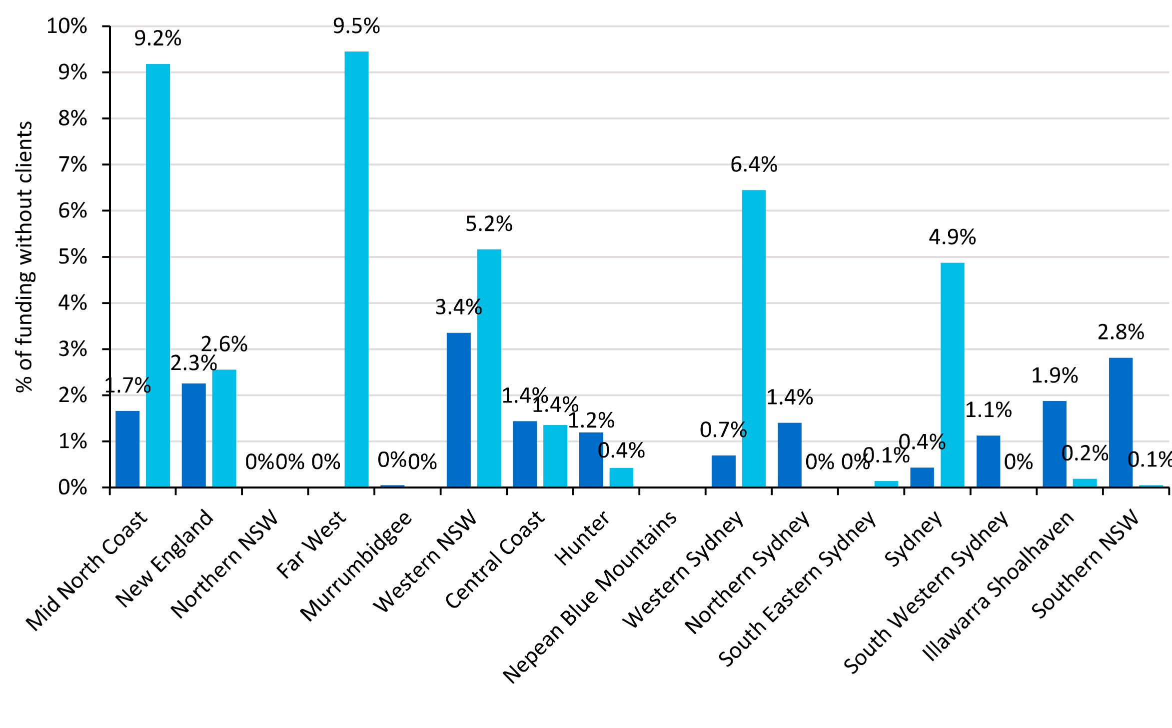



*Note: Includes sessions from the year of entry and the year after year of entry

## E.4 Service delivery and funding

To further investigate the quality of client records, we have identified organisations from the funding data that do not have any service delivery records in DEX and estimated the size of these organisations by the amount of funding that they were provided. Overall, organisations without any client or session recorded in 2022-23 accounted for 2.2% of total funding in the year. This is an increase compared to the 1.3% observed in 2021-22. Figure E.10 below shows that the greatest increase occurred in Mid North Coast, Far West and Western Sydney. These three districts along with Western NSW and Sydney districts all have at least 5% of total funding related to organisations without any client records, hence a greater chance that the client numbers are under-reported in these districts. In contrast all funded organisations in Murrumbidgee, Northern NSW, Northern Sydney and South Western Sydney had submitted client records for in 2022-23.

Figure E.10 – Proportion of funding for organisations without client data recorded in DEX (DEX and funding data)




For organisations that did submit client records in DEX, we have compared the number of clients and sessions with the amount of funding that they have been provided. The amount of funding appears to be more closely correlated to the number of sessions delivered ($\rho = 0.73$) than the number of clients recorded ($\rho = 0.40$). This is likely due to the discrepancy in recording of group clients, and the same number of individual clients can also receive different number of sessions which leads to varying cost. Therefore we have focused on comparing funding to the number of sessions in the additional analysis below.

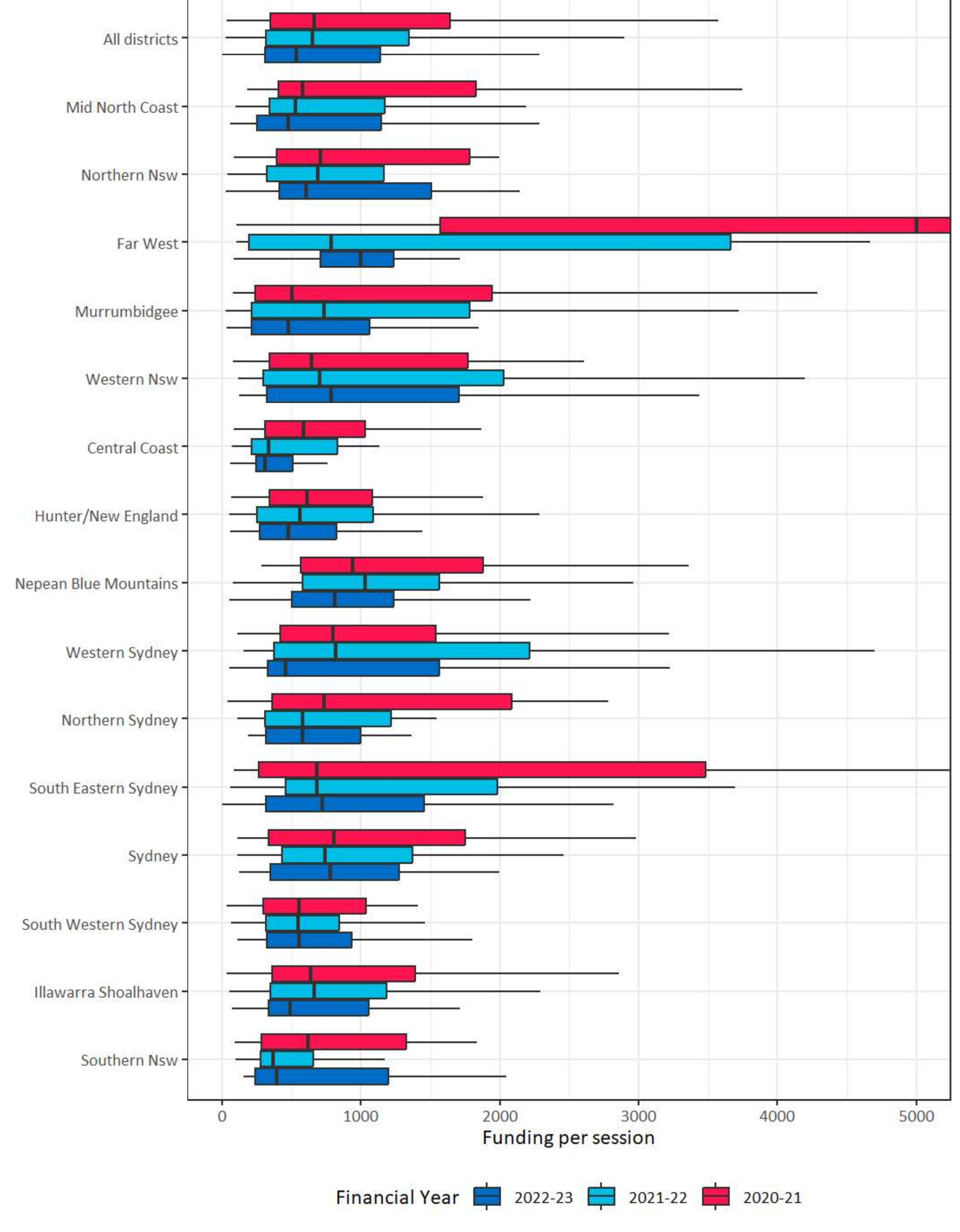
Figure E.11 illustrates the distribution of funding per session across different organisations, categorised by district and year of the session, using a box and whisker plot. It shows the following statistics relating to average funding per session by organisations for each district:

- The median (line inside the box)
- The 25th percentile (left ridge of the box) – 25% of organisations have average funding per session lower than this value
- The 75th percentile (right ridge of the box)
- Lower range of funding per session that is not considered an outlier[90] (left whisker)
- Upper range of funding per session that is not considered an outlier[91] (right whisker)

[90] Defined by Q1 – (Q3 – Q1) * 1.5, where Q1 is the 25th percentile value and Q3 is the 75th percentile value

[91] Defined by Q3 + (Q3 – Q1) * 1.5, where Q1 is the 25th percentile value and Q3 is the 75th percentile value

Figure E.11 – Distribution of the amount of funding per session for organisations by district (DEX and funding data)



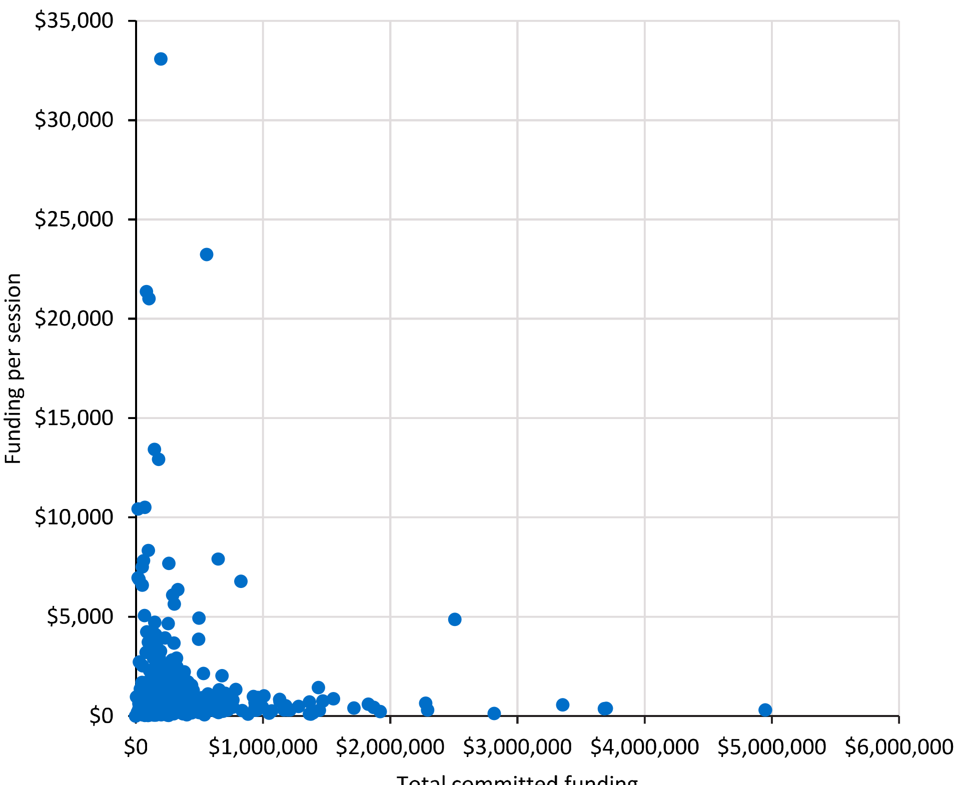

Note: The horizontal axis of the plot is cut-off at $5,000 to improve its comparability at the lower range where most data is. Results for Hunter and New England are reported as one region due to the nature of the funding data available.

Overall, the median funding per session for a given organisation reduced from around $650 in 2021-22 to around $530 in 2022-23. The funding per session tend to be the highest in Far West, Western Sydney and Nepean Blue Mountains, and the lowest in Murrumbidgee and Central Coast. Across most districts, the overall funding per session have reduced, especially for organisations at the high end of the distribution. This may be due to a combination of:

- Improved data recording by organisations leading to more session information being recorded, especially for organisations that experience a large decrease in cost per session from year to year. From 2020-21 to 2021-22, around 80 (~17%) organisations had a decrease in cost per session by more than 50%, compared to around 50 (~11%) organisations from 2021-22 to 2022-23. Majority of these organisations had less than 1,000 sessions recorded in the prior year. The higher number observed in 2020-21 to 2021-22 is likely due to data recording not being compulsory in the first half of 2021-22.
- A genuine reduction in funding per session. This is most likely the case for organisations that experience some reduction in cost per session while already having a large number of sessions recorded in the previous year. In 2022-23, around 75 (~15%) organisations had a decrease in cost per session of between 0-50% and have more than 500 sessions recorded in 2021-22.

Figure E.12 below plots each organisation by the total funding they received in 2022-23 and the corresponding funding per session. It shows that the larger organisations in terms of funding received tend to have lower funding per session, possibly due to economies of scale and more streamlined data recording. The few organisations which are outliers in terms of having very high funding per session are all smaller organisations in terms of funding amount. This gives assurance that there is no significant under-reporting of the number of sessions in DEX especially for the larger organisations.

Figure E.12 – Funding per session against total funding for each organisation (DEX and Funding data)



# Appendix F Full data analysis relating to potential unmet demand

## F.1 High-level regional level indicators of demand

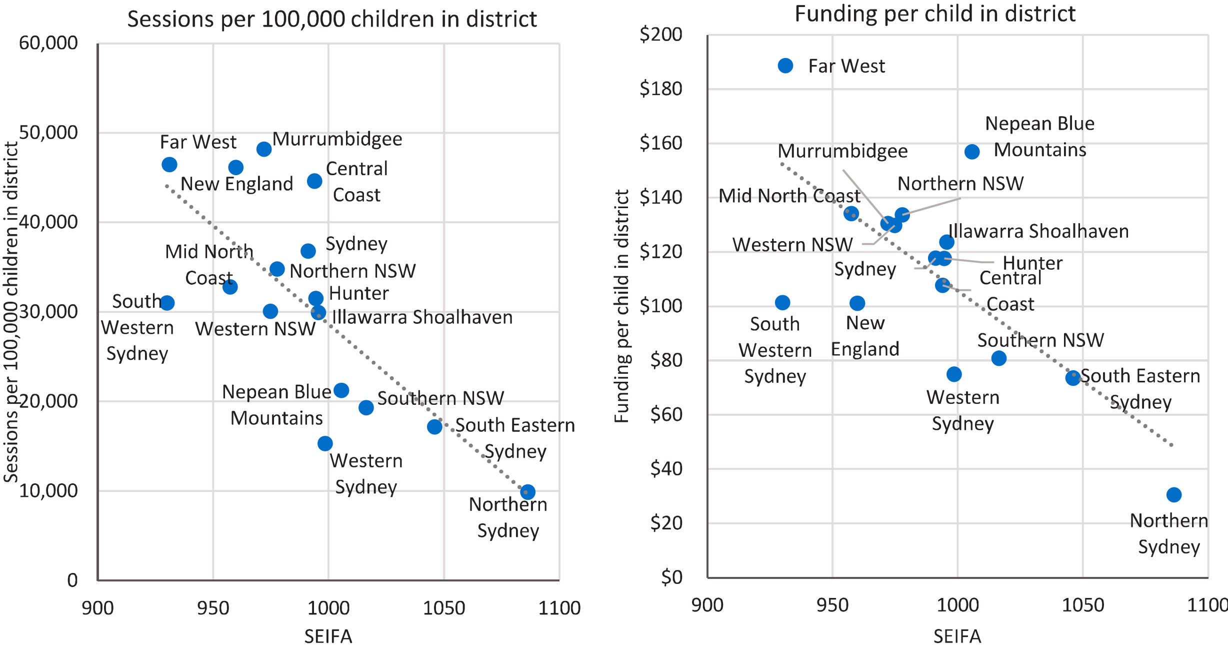
Section 5.2 explores potential unmet demand – further details are provided here. We have examined how TEI services are distributed relative to population and socio-economic status. In terms of potential need/demand for TEI services:

- Population (particularly of young people), and population growth are highly relevant to service allocation.
- Socioeconomic status will also affect resource allocation. While it is hard to pick an optimal rate of TEI service for a given socioeconomic status, we can look at the existing relationship and look for regions with relatively high or low levels of activity.

When plotting results against the socioeconomic level of the DCJ District, we have used the SEIFA Index of Relative Socio-economic Disadvantage[92] averaged for each DCJ District. Note that the SEIFA Index does not allow for other regional specific factors that tend to affect need and service delivery. For instance, larger proportions of Aboriginal people in some districts (such as New England, Far West and Western NSW), could represent additional need for early intervention, given over-representation of Aboriginal people in the child protection systems.

Scatterplots of the number of sessions (counting each group and individual sessions once) per 100,000 children, and average district funding per child are shown in Figure F.1.

Figure F.1 – Scatterplots of number of sessions per 100,000 children, and funding per child, against SEIFA. Line of best fits shown (DEX and funding data)



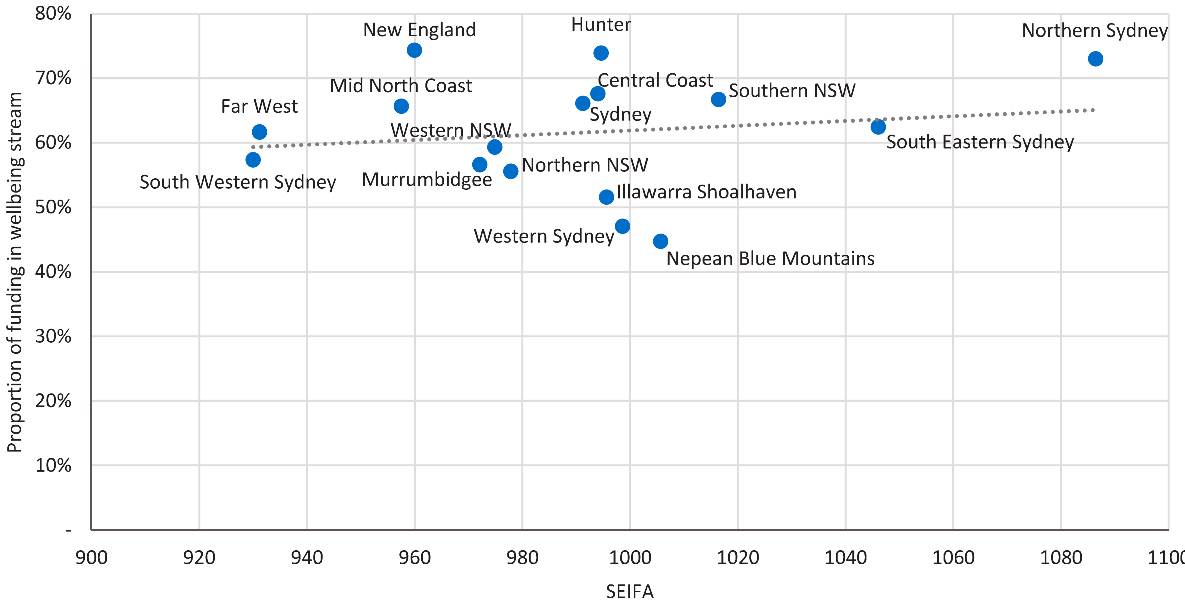

We observe:

92 https://www.abs.gov.au/statistics/people/people-and-communities/socio-economic-indexes-areas-seifa-australia/latest-release

- The SEIFA index is a good predictor of relative TEI session volume and funding with correlations of -0.73 and -0.71 respectively. The number of sessions per 100,000 children vary by a factor of five from highest districts (Far West) to lowest (Northern Sydney).
- The significant differences between the two scatters are driven by different average costs per session. These in turn relate to different operating models and utilisation rates.
- The outliers on one measure (sessions per 100,000 children) do not tend to be outliers on the second (funding per child). For example, Murrumbidgee has greater session volumes than its SEIFA would predict, but its funding is close to the average. This reflects a lower average cost per session in the region, presumably tied to the operating models of individual providers. Similarly, Far West looks high on funding per child, but in line on a sessions per child basis.
- South Western Sydney and Western Sydney both lie materially below the lines of best fit in both sessions and funding per child (suggestive of relatively less resourcing for these areas). These are also areas that have seen high population growth – see discussion later in this Section.

In interpreting these results, we also observe there are no clear patterns in the balance of the Wellbeing and Safety stream and Community Strengthening stream funding by SEIFA; this is shown in Figure F.2. For example, Hunter, Central Coast, Illawarra and Nepean Blue Mountains all have similar scores but very different allocations between streams.

Figure F.2 – Scatterplot of proportion of TEI funding going to Wellbeing Stream, against SEIFA



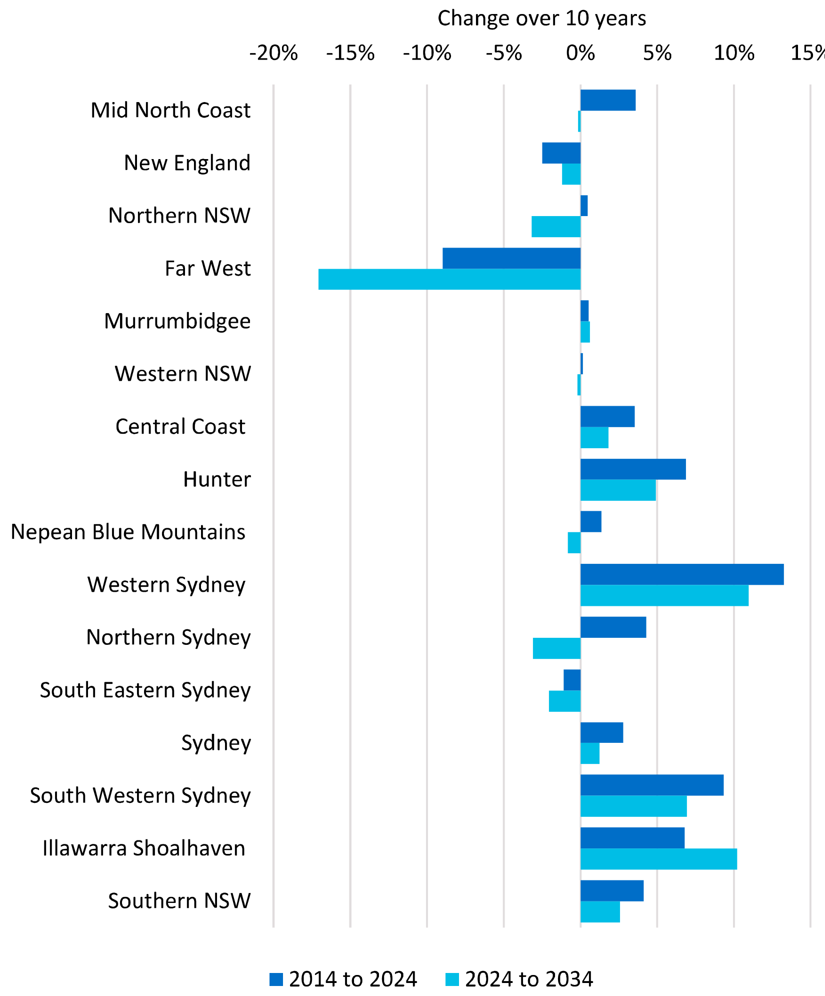

A related consideration is population growth. Growth in population of younger people for the past and projected 10 years is shown in Figure F.3, taken from NSW planning[93]. Past and projected generally align well. Strong growth is expected in Western Sydney, South Western Sydney, Hunter and Illawarra Shoalhaven. All else equal, we would expect greater need for TEI services to grow in these areas over time. At a LGA level:

- Within the Western Sydney District the fastest growing projected LGAs are Parramatta (15%) and the Hills (25%)
- South Western Sydney – Wingecarribee (A) (14%) Camden (20%) Wollondilly (21%)

[93] https://www.planning.nsw.gov.au/research-and-demography/population-projections/explore-the-data

- Illawarra Shoalhaven – Kiama (11%), Shellharbour (15%), Shoalhaven (11%)

Figure F.3 – Past and future population growth in people aged under 20



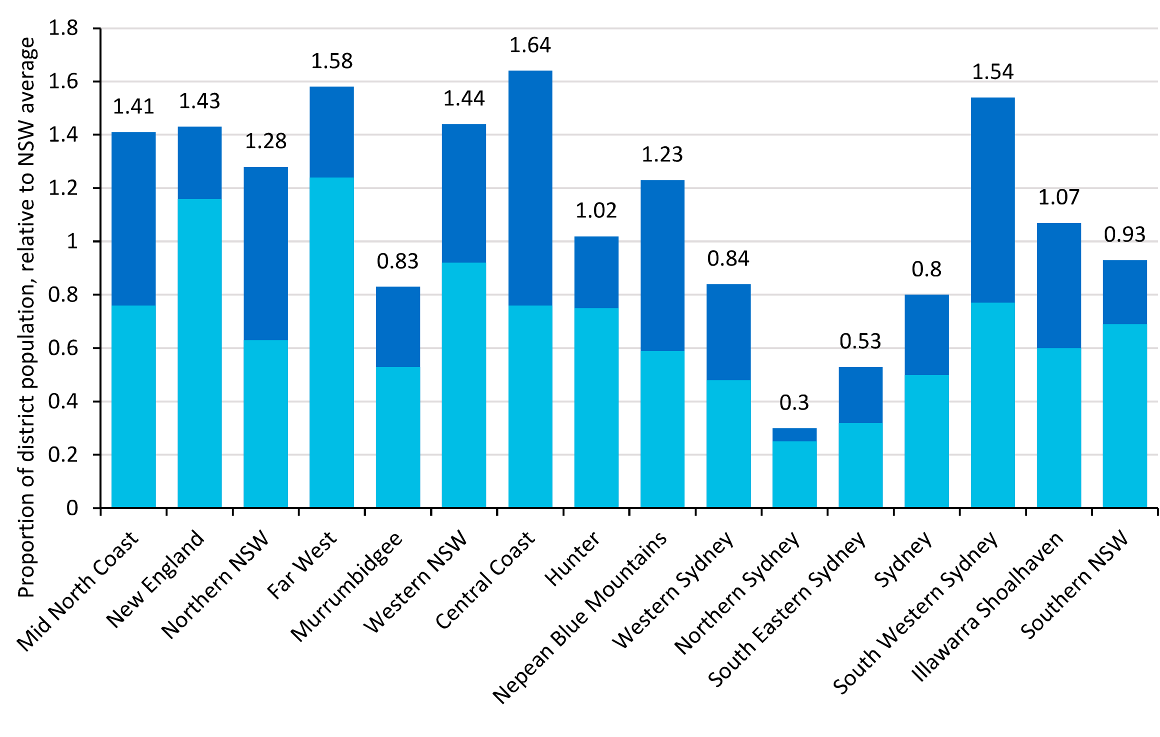

Source: NSW Planning

## F.2 Entry rates into TEI using HSDS

We have also analysed entry rates into TEI using HSDS data (where children of clients are considered to enter with their parents). This allows for a more detailed risk-standardisation compared to the high level analysis in Appendix F.1, with a trade-off that only individual TEI clients recorded in the DEX and their children are identifiable in the HSDS. This means a lower rate of TEI entry in a DCJ District could be partly explained by data quality issues. We also note that entry relates to the creation of an individual client record – so a person may have accessed TEI earlier as an unidentified (group) client.

The quarterly rates of entry into TEI over 2020-21 and 2021-22 show significant variation between DCJ Districts, with people living in the Central Coast entering at a rate more than five times higher than those in Northern Sydney, as seen in Figure F.4. Much of this variation is attributable to observed differences in resident risk profiles, for example, Northern Sydney has the lowest proportion of families in the key TEI groups.

Figure F.4 – Proportion of population entering TEI (individual clients), by DCJ District relative to the NSW average, 2020-21 and 2021-22 (HSDS)*



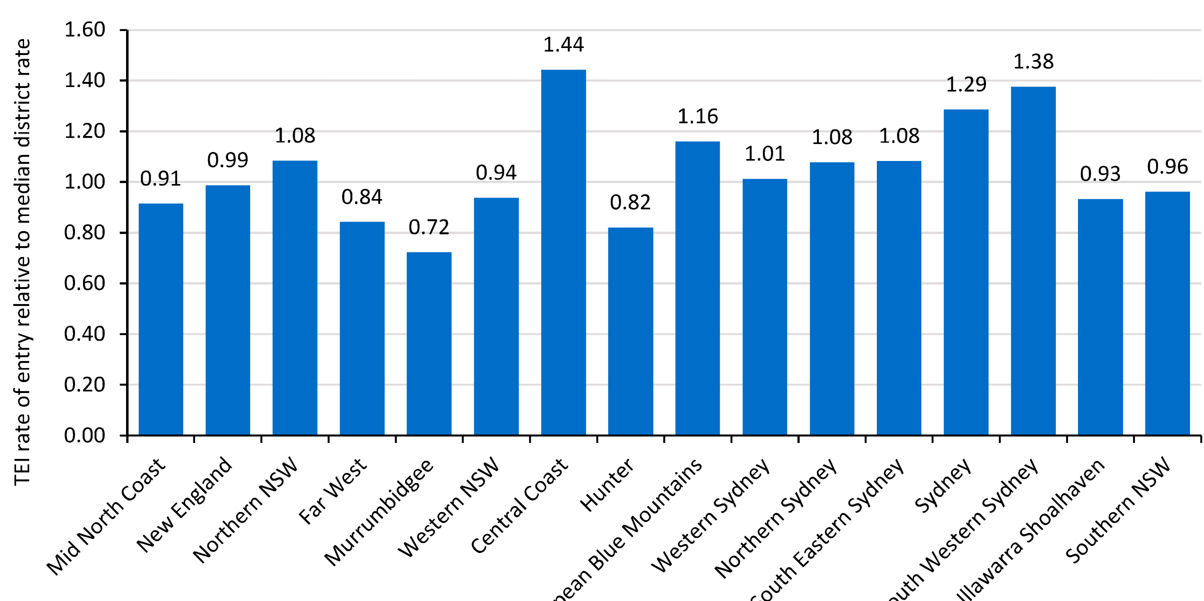

*Note: Only relative rates are shown as the absolute entry rates are understated due to issues discussed in the previous section

To better separate the impact of each DCJ District's risk profile from its entry rate, we have built a machine learning model (XGBoost[94]) to predict entry into TEI based on the same demographic and historical risk factors as the propensity models of Appendix H.2.2, with the exception that remoteness area was not included, since geospatial remoteness would not be a justification for the provision of more or less services. The model was calibrated using experience in 2020-21 and 2021-22 in the HSDS.

Through the model, we were able to estimate the variation in TEI entry rate attributable to each variable. The effect of DCJ District is presented in Figure F.5,, which shows the relative likelihood of TEI entry of the same person (i.e. exact same demographic and historical risk factors), if they resided in each of the different districts.

[94] Implemented in R using the XGBoost package. See https://xgboost.readthedocs.io/en/stable/R-package/xgboostPresentation.html# for details.

Figure F.5 – Risk-controlled rates of entry into TEI (individual client entries) by DCJ District, relative to median District (HSDS)*

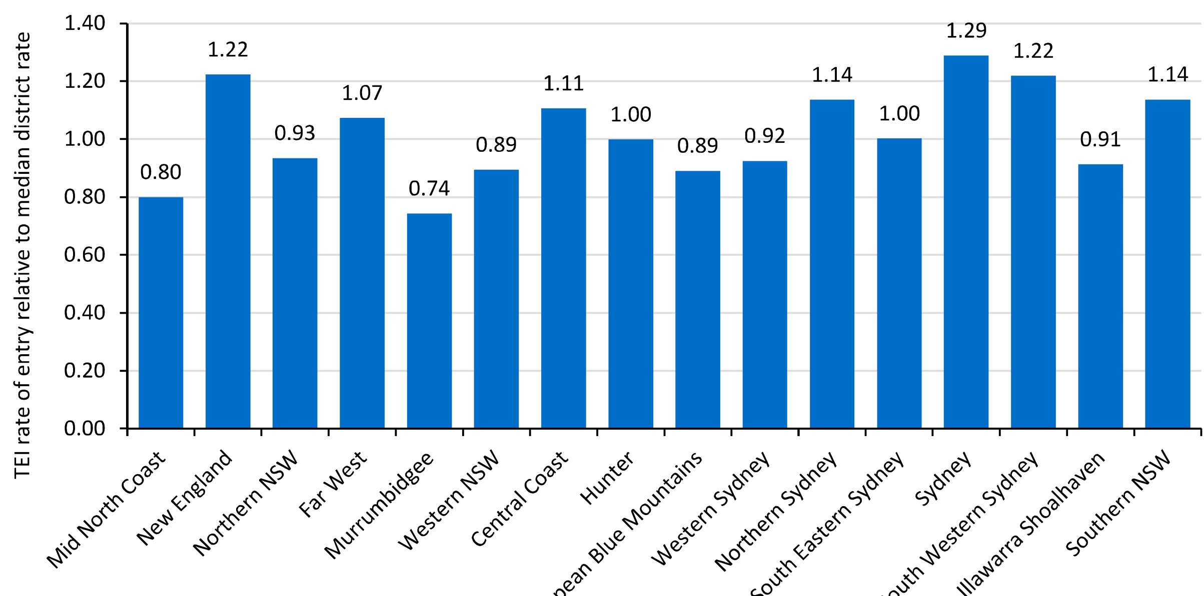



*Note: Only relative rates are shown as the absolute entry rate are understated due to issues discussed in the previous section

After controlling for the risk profiles of the districts, the Murrumbidgee, Hunter and Far West DCJ Districts showed the lowest rates of entry. This is a possible indication that the reach or capacity of providers in those districts are unable to meet the demand of the population. A person living in these three districts was modelled to be around three-quarters as likely to enter TEI compared to the median Districts, or around half as likely to enter compared to if they lived in the most likely DCJ District, Central Coast.

Figure F.6 shows the same analysis, but for entries into the Wellbeing and Safety stream only. Results are similar, with changes in relativity in line with how funding was split by program stream. Districts with higher proportions allocated to the Wellbeing and Safety stream (Hunter, New England, Southern NSW and Far West in particular) have correspondingly higher risk-controlled entry rates to the stream. The opposite is also true, for example for the Nepean Blue Mountains district. A breakdown of funding by stream is provided in Section 9.2.

Figure F.6 – Risk-controlled rates of entry into the Wellbeing and Safety stream (individual client entries) by DCJ District, relative to median District (HSDS)*




*Note: Only relative rates are shown as the absolute entry rate are understated due to issues discussed in the previous section

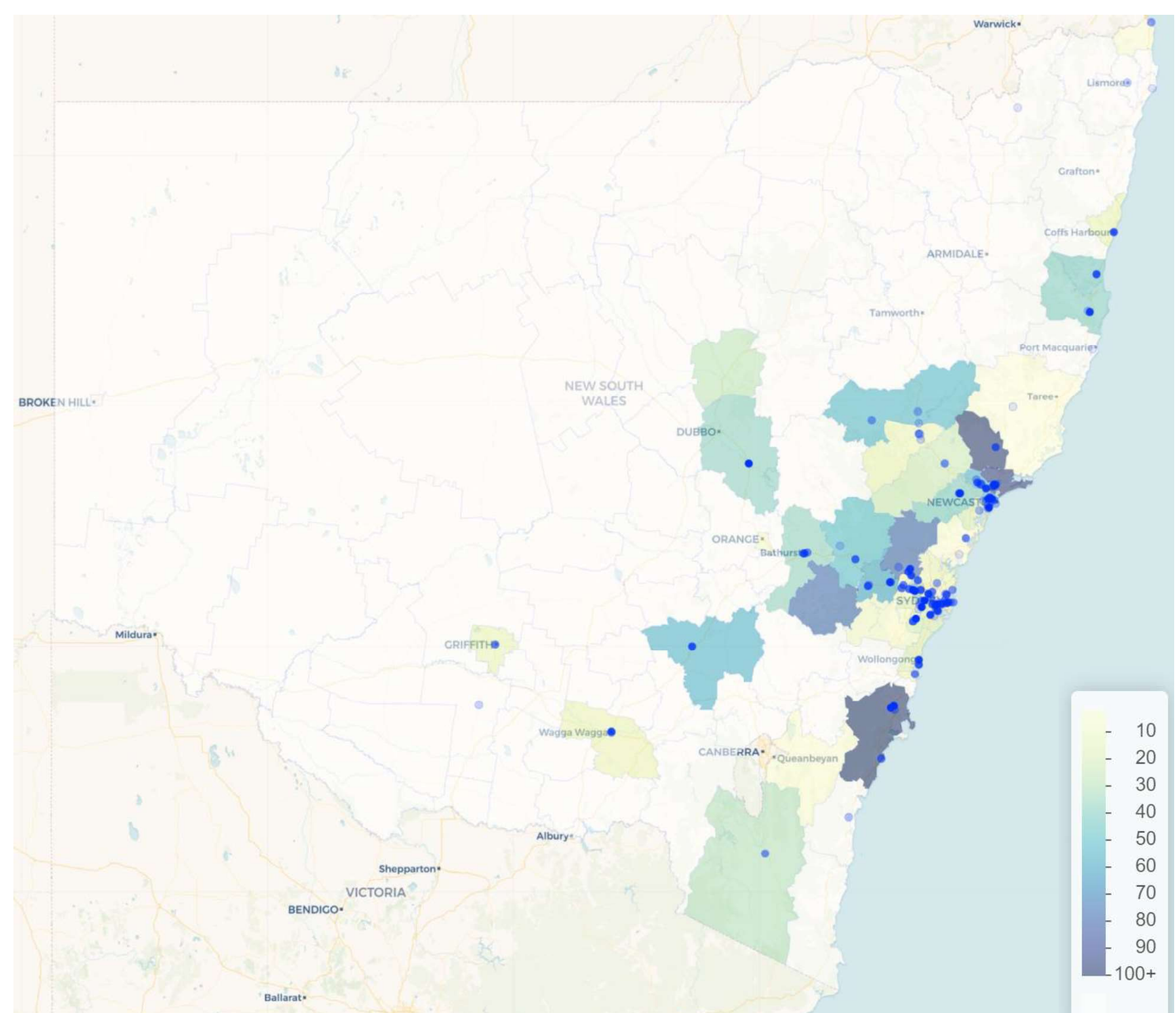
## F.3 Coverage of outlets delivering TEI services

In the Interim Report the number of TEI outlets delivering each type of program activity was compared against the relative support needs in each district. The number of children with concern reports was used as a proxy for demand as it is a common characteristic amongst TEI clients (however families without child protection history are also eligible for the program). A key finding from this analysis was that there is a lack of outlets delivering Intensive Support sessions in the more remote areas, which has resulted in very few clients receiving services from the program activity in these areas.

Figure F.7 below shows the number of clients receiving Intensive Support[95] per 1,000 children known to child protection in each LGA using the latest DEX data, overlaid by the location of outlets delivering Intensive Support in blue dots. It shows that most of the outlets delivering Intensive Support are concentrated around Sydney Metro and Hunter regions and very few outlets in more remote areas. This has led to numerous remote LGAs to not have any clients receiving Intensive Support (shown by regions in white). The lack of Intensive or Specialist Support sessions is due to the current TEI contracting arrangements which have meant that Intensive or Specialist Support are less likely to be contracted for delivery. There could also be a lack of specialists available in the more remote areas to provide the service.

[95] Average of the last two years (2021-22 and 2022-23) is used to increase the unique number of clients contributing to the statistic for each LGA and satisfy the data privacy requirements

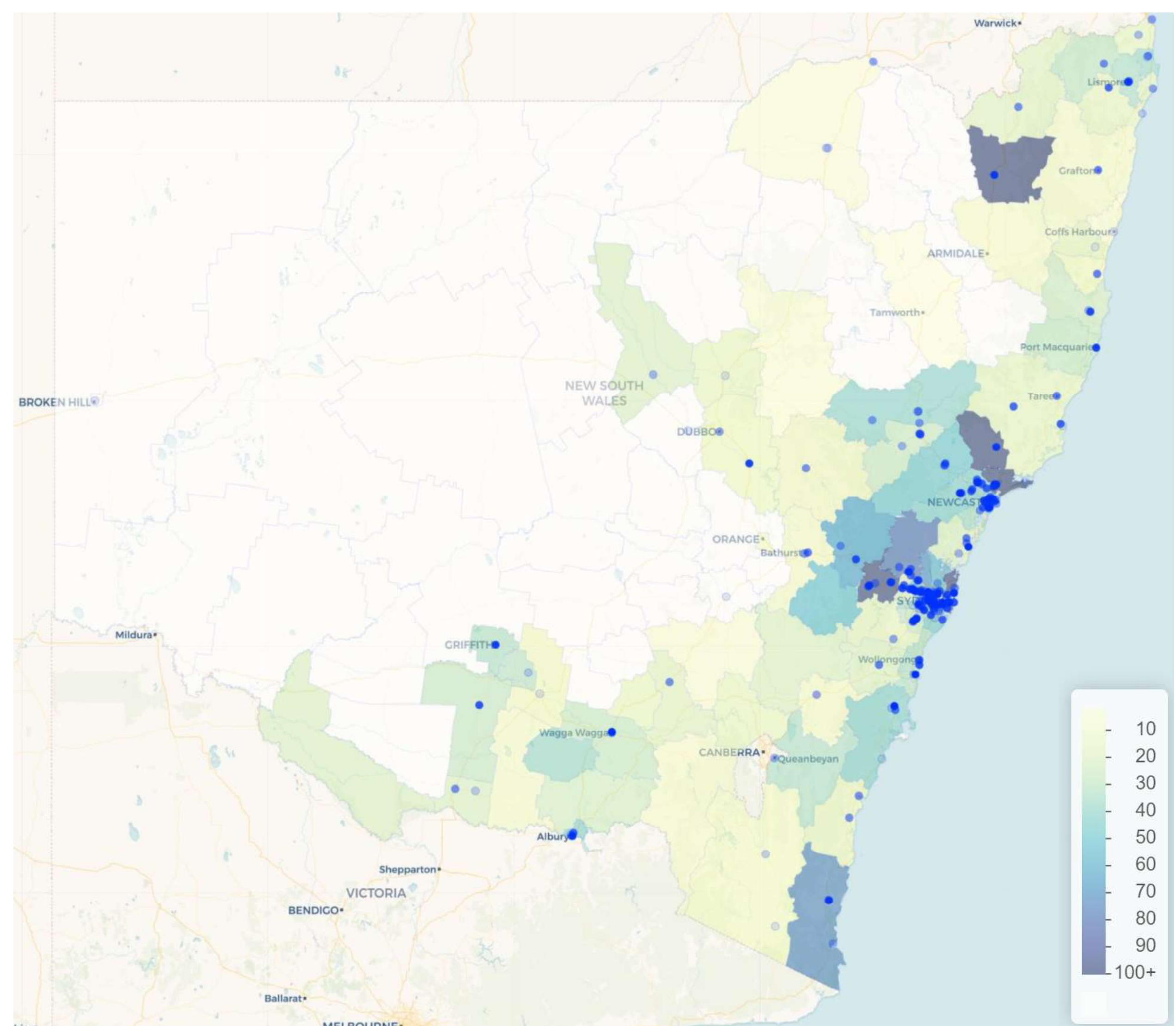
Figure F.7 – Individual clients receiving Intensive Support per 1,000 concern reports and outlets delivering Intensive Support (DEX, average of 2021-22 and 2022-23)*




*Note: Districts with less than 10 individual clients over 2021-22 and 2022-23 are all shown as white in the map for data privacy reasons

As discussed in Section 6.6.2, Counselling and Specialist Support service types have been provided to clients with higher risks, and there is some evidence that these services have contributed to a greater reduction in future child protection rates. Counselling support can be provided under both Targeted Support and Intensive or Specialist Support activity types, and there will no longer be distinction between the two activity types going forward. Therefore we have also examined the number of clients receiving these two service types specifically relative to need and the location of outlets delivering them. This is shown in Figure F.8 below – the number of clients receiving these two service types (regardless of program activity) relative to need is slightly higher and covers clients in slightly more LGAs, however much of the same conclusions can still be drawn.

Figure F.8 – Individual clients receiving Counselling and Specialist Support per 1,000 concern reports and outlets delivering these services (DEX, average of 2021-22 and 2022-23)*




*Note: Districts with less than 10 individual clients over 2021-22 and 2022-23 are all shown as white in the map for data privacy reasons

## F.4 Distance travelled by individual clients to receive services

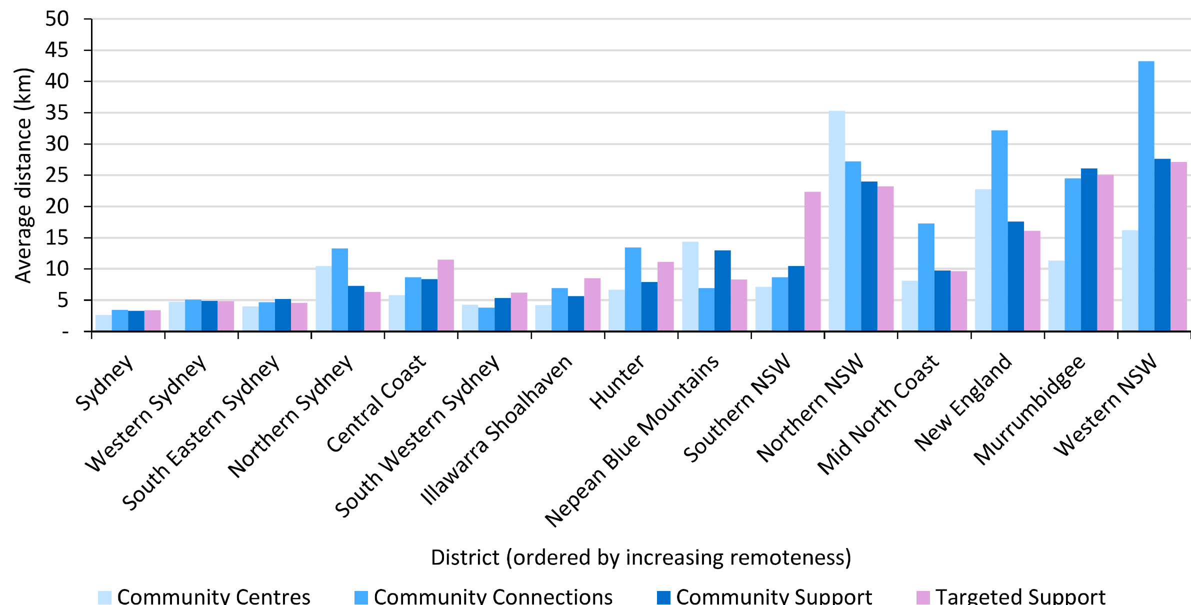
The average distance that individual clients had to travel to receive their TEI support as presented in the Interim Report had been updated using the DEX attendance data from 2021-22 and 2022-23[96]. Straight line distance was measured between the exact location of the service outlet and the centre of a client's Statistical Area 1 (SA1) region (exact location of the client was not available). Areas where the average distance travelled is high indicate either a lack of outlet coverage or the outlets in the area did not have the capacity to meet the nearby demand. Long distance travelled may be a deterrent to clients receiving the support that they need.

[96] Also includes a small proportion of sessions (<10%) where the service provider had travelled to the client's location to deliver the service. This does not change the conclusions from the analysis as long distance travelled by service provider would also be a sign of lack of local service coverage for the client.

Sessions where the mode of delivery is 'Video', 'Tele' or 'Digital' were excluded from this analysis. Each client was only counted once in the average regardless of the number of sessions they receive, to prevent clients with large number of sessions received skewing the average. Also note that the method of calculating distance travelled carries greater uncertainty for clients in more remote areas (especially in Far West) where the clients' SA1 region is larger.

The average distance that clients travel to attend their TEI sessions by program activity and the client's residential DCJ District is shown in Figure F.9. Intensive Support is excluded from the chart as there is already a clear gap in delivery identified. Clients in the Far West district travel significantly further for their sessions compared to other districts (average of >100km) and are also excluded from the chart as the numbers are more uncertain due to its remoteness and to preserve the chart's scale.

Figure F.9 – Average distance travelled by individual clients by DCJ District (DEX, 2021-22 and 2022-23)

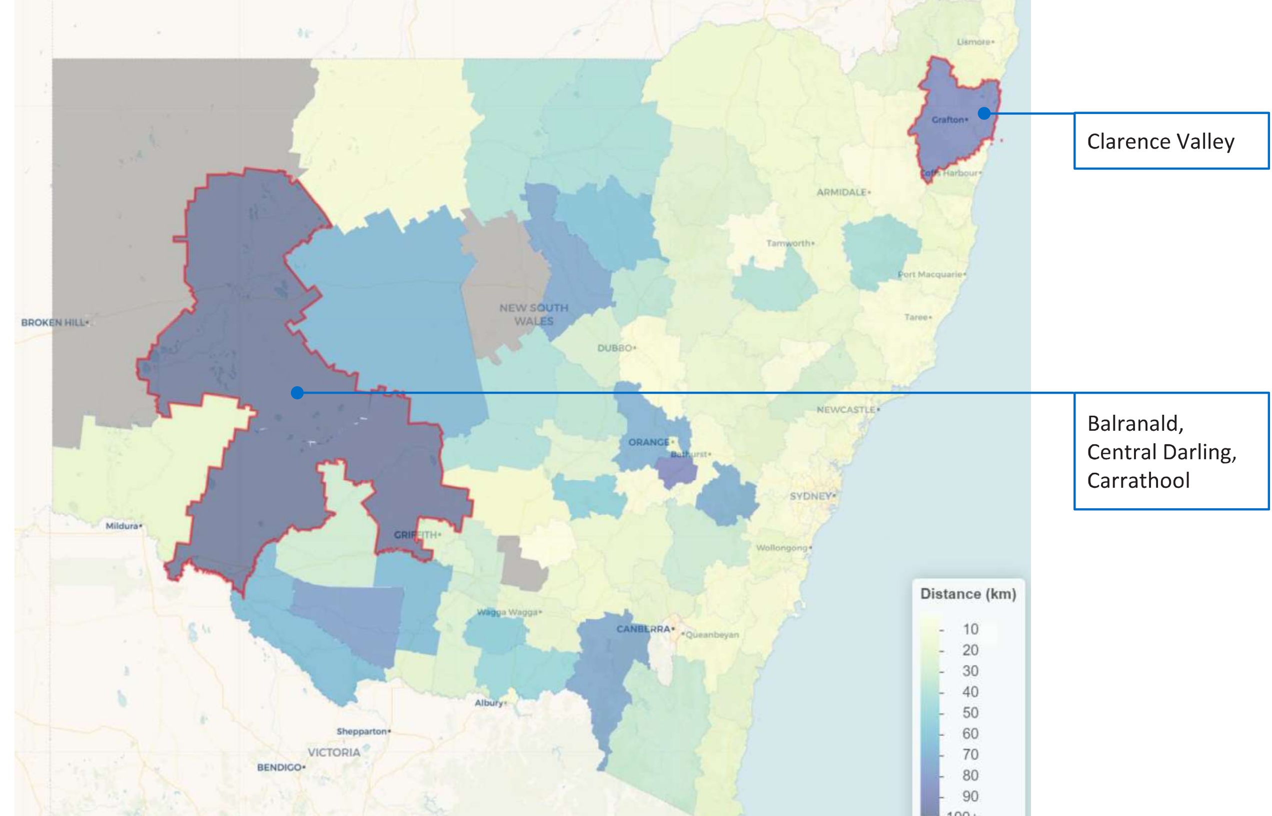



The observations are similar to the Interim Report – as expected clients in more remote areas tend to have to travel further due to lower population density. Clients in Sydney Metro areas travel 5km on average to attend their sessions while those in more remote areas travel around 20km on average (excluding Far West where clients travel much further).

As there is a large number of individual clients who have received Targeted Support, the average distance travelled can be broken down further by LGA to identify any gaps. Figure F.10 shows that clients from LGAs in metro and inner regional areas generally do not travel far for their Targeted Support sessions, suggesting a good coverage of outlets. The LGAs where clients have travelled the furthest are:

- Clients in the Clarence Valley LGA travelled around 85km on average for their sessions despite the region being mostly inner regional. It is mainly driven by numerous clients in the region who were recorded to have received support in Sydney. This indicates a potential lack of capacity for outlets in the area which may deter people from receiving TEI services.
- Clients in Balranald, Central Darling and Carrathool LGAs also need to travel over 100km on average for their sessions. This is mainly driven by a lack of coverage of TEI outlets in the area. However, as these LGAs are all in very remote parts of NSW, increasing the coverage of outlets would be more difficult.

Figure F.10 – Average distance travelled by individual clients by DCJ District (DEX, 2021-22 to 2022-23)*




*Note: Districts with less than 10 clients in 2021-22 and 2022-23 are shown as grey in the chart for data privacy reasons.

Conducting sessions via digital forms can be a way of reaching to clients in the more remote areas. Figure F.11 below compares the average distance travelled by individual clients to attend sessions in-person to the proportion of clients who have received sessions virtually. We see some of the LGAs have a high proportion of clients that have received support virtually and correspondingly the average distance travelled can be reduced, while clients in some LGAs travel a long distance to attend their sessions potentially due to a lack of virtual options as indicated by the low proportion of clients receiving virtual sessions. This shows that there is potential scope to increase the availability of support provided virtually to clients in more remote areas.

Figure F.11 – Average distance travelled by individual clients compared to proportion of clients receiving virtual sessions in each LGA (DEX, 2021-22 and 2022-23)*

*Note: LGAs with less than 10 clients receiving virtual sessions are excluded due to data privacy reasons

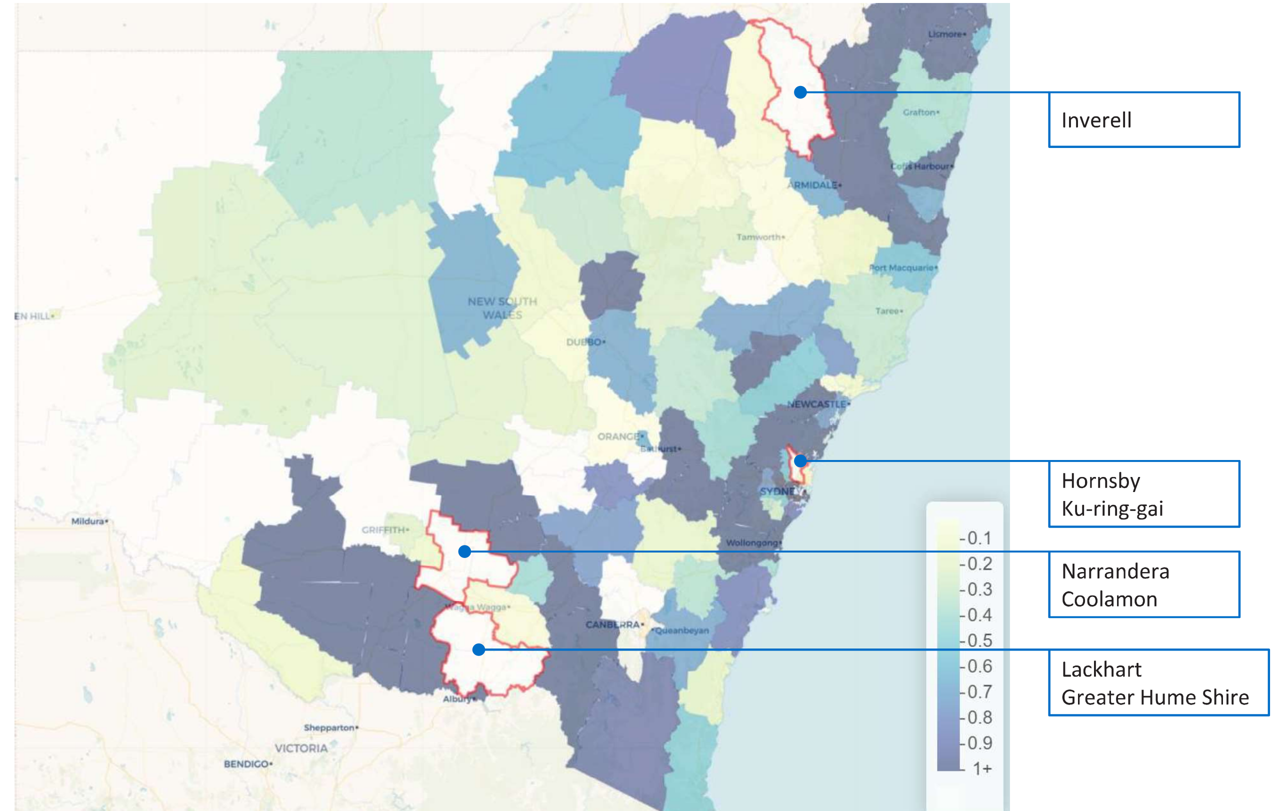
## F.5 Local coverage of Community Strengthening supports

The Interim Report had also examined the local coverage of Community Strengthening stream supports. This was done by comparing the number of Community Stream support sessions conducted at the LGA level against the number of children with concern reports during the same period as a proxy for the level of support need in the LGA. Providers have emphasised during interviews the importance of local presence and knowledge to understand the particular needs and dynamics of the community they are operating in when delivering Community Strengthening stream supports. Therefore, a lack of sessions delivered locally may result in unaddressed community needs.

We have updated this analysis with sessions conducted in 2022-23 from DEX (the latest year available) and number of concern reports in the same period from DCJ's Child Protection LGA Heap Maps[97], with results shown in Figure F.12Figure F.12 below.

[97] https://dcj.nsw.gov.au/service-providers/deliver-services-to-children-and-families/targeted-earlier-intervention-program/child-protection-and-out-of-home-care-data-local-government-area-heat-maps.html

Figure F.12 – Number of Community Strengthening stream sessions relative to concern reports (DEX, 2022-23)*




*Note: districts with less than 10 sessions conducted are all shown as white for data privacy reasons

This reveals four potential areas with a lack of local presence of outlets in providing Community Stream supports, each with 0.01 or fewer sessions per child known to child protection:

- Inverell – 703 children known to child protection, no sessions conducted
- Hornsby, Ku-ring-gai – 2,214 children known to child protection, 29 sessions conducted
- Narrandera, Coolamon – 377 children known to child protection, less than 10 sessions conducted
- Lockhart, Greater Hume Shire – 324 children known to child protection, no sessions conducted.

# Appendix G Assessment of program reach to priority groups

## G.1 Risk factors of individual clients in the program

Analysis of linked government service datasets in the HSDS showed that the risk profile of individual clients (including indirect clients)[98] entering TEI in its first two years (2020-21 and 2021-22) was more severe than the general population. TEI clients were at least twice as likely to have each risk factor examined. The more severe risk profile of TEI clients is the result of targeting vulnerable people for the program. This is consistent with TEI program specifications which guide providers to design services in response to the local context, and describe an expectation that clients will have known risk factors or known vulnerabilities. It is also consistent with stakeholder feedback and provider commentary about using TEI as a step-down response following successful statutory casework with families (these families would be expected to have a significant risk profile). Table G.1 presents the proportion of TEI clients having selected risk factors prior to the quarter of entry into TEI, either ever, or in the year prior. For each TEI client, five people in the general NSW population with the same age, sex and parental status (being a parent or not) was sampled to form the general population group for comparison purposes[99].

[98] Note that for all HSDS analysis in this Report, we have defined the TEI population as any clients in the TEI data (direct clients), plus their children (indirect clients if they are not a direct client already). This roughly doubles the amount of entrants included in the analysis.

[99] Additionally, to remove differences between TEI clients and the comparison group owing to visibility of individual service use in the data, time trends in the data and data processing changes or issues, TEI client service use in a given quarter was compared to general population service use in the same quarter. Further, those born in NSW were matched to those born in NSW and those born outside NSW were matched to those born outside NSW.

Table G.1 – Risk profile of 2020-21 and 2021-22 TEI population compared to the general population sample, n=176,214 (TEI), n=878,743 (General).

| Risk factor[(a)] | **TEI** (in quarter of entry) | **General** (in quarter of entry) | **TEI** (within 1 year prior to entry) | **General** (within 1 year prior to entry) | **TEI** (ever prior to entry) | **General** (ever prior to entry) |
|---|---|---|---|---|---|---|
| **Concern report** (of clients aged under 18) | 14.4% | 2.0% | 25.9% | 5.1% | 45.2% | 15.5% |
| **ROSH report** (of clients aged under 18) | 11.2% | 1.5% | 21.8% | 3.9% | 41.5% | 12.9% |
| **Substantiated ROSH report** (of clients aged under 18) | 2.0% | 0.2% | 5.3% | 0.6% | 18.7% | 3.7% |
| **Out of home care** (of clients aged under 18) | 3.6% | 0.6% | 3.9% | 0.6% | 6.6% | 1.2% |
| **Domestic violence victim survivor** | 2.5% | 0.3% | 6.4% | 1.0% | 21.9% | 7.3% |
| **Proven domestic violence offence** (of clients aged 11 or over) | 0.5% | 0.1% | 1.4% | 0.2% | 5.7% | 1.1% |
| **Proven drug or alcohol related offence** (of clients aged 11 or over) | 0.3% | 0.1% | 0.9% | 0.2% | 7.2% | 3.1% |
| **Time in custody** (of clients aged 11 or over) | 1.1% | 0.2% | 2.3% | 0.3% | 7.2% | 1.4% |
| **Interaction with criminal justice system** (of clients aged 11 or over) | 2.2% | 0.3% | 5.6% | 1.0% | 19.8% | 7.4% |
| **Youth cautions** (of clients aged 11 or over and under 18) | 0.8% | 0.2% | 2.3% | 0.5% | 4.8% | 1.0% |
| **School suspension**[(b)] (of clients aged between 5 and 18 with at least one day of public school enrolment) | 15.2% | 11.9% | 25.4% | 19.3% | - | - |
| **Did not achieve NAPLAN minimum standard at last NAPLAN** (of those with a NAPLAN record) | 19.6% | 7.5% | - | - | - | - |
| **HSC completion** (of NSW born clients aged between 19 and 31) | 40.4% | 63.9% | - | - | - | - |
| **SHS homeless presentation** | 5.1% | 0.3% | 7.2% | 0.7% | 16.1% | 2.3% |
| **Mental health ambulatory services** | 3.1% | 0.5% | 5.4% | 1.2% | 15.7% | 5.3% |

| Risk factor[a] | **TEI** (in quarter of entry) | **General** (in quarter of entry) | **TEI** (within 1 year prior to entry) | **General** (within 1 year prior to entry) | **TEI** (ever prior to entry) | **General** (ever prior to entry) |
|---|---|---|---|---|---|---|
| **Opioid treatment support** (of clients aged 15 or over) | 1.2% | 0.2% | 1.3% | 0.0% | 2.1% | 0.4% |
| **Hospital admission for mental health** | 0.5% | 0.1% | 1.3% | 0.3% | 6.1% | 2.4% |
| **Hospital admission for alcohol or drug use** (of clients aged 15 or over) | 0.4% | 0.1% | 1.5% | 0.3% | 8.2% | 2.6% |
| **Parental history[c] with custody** (of clients with at least one parent in linked data) | - | - | 5.9% | 1.2% | 23.3% | 6.5% |
| **Parental history[c] with drug/alcohol related services** (of clients with at least one parent in linked data) | - | - | 4.2% | 1.0% | 36.3% | 17.9% |
| **Parental history[c] with domestic violence** (of clients with at least one parent in linked data) | - | - | 19.5% | 4.1% | 60.5% | 26.9% |
| **Parental history[c] with justice** (of clients with at least one parent in linked data) | - | - | 12.8% | 3.1% | 58.1% | 32.9% |
| **Parental history[c] with mental health** (of clients with at least one parent in linked data) | - | - | 11.1% | 2.5% | 41.8% | 15.9% |
| **Parental history[c] with public housing** (of clients with at least one parent in linked data) | - | - | 18.0% | 3.7% | 32.5% | 9.0% |

(a) Bracketed conditions after risk factor are included when we restrict the client group for a more relevant comparison. For example, we only report the rate of concern reports for the subset of TEI and matched general population that are under 18. This means different rows will reflect different sub-cohorts.

(b) Suspension data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible data processing changes. Moreover, school data is not available from June 2020 due to covid or prior to 2018 due to data quality issues, so the 'ever prior to entry' measure is less than the true measure, and excluded. At least one day of school enrolment is applied to exclude children who are never recorded as attending an NSW public school.

(c) For a list of services considered in establishing parental history with a particular domain, see the domain definitions used to define client complexity in Appendix G.2.

The risk profile of TEI clients varies by the program activity of a client's first session, as seen in Figure G.1 through to Figure G.7, with the cohort first accessing Intensive Support services having the greatest risk factors and the cohort first accessing Community Connections services having the least risk factors.

- The Wellbeing and Safety stream, comprising the Intensive or Specialist Support and Targeted Support program activities, has the greatest proportion of clients known to child protection prior to entering the program. 47% of children first accessing Wellbeing and Safety stream program activities had a history of interacting with child protection prior to program entry compared to 42% for

children first accessing Community Strengthening stream activities. The Wellbeing and Safety stream includes activities that strengthen protective factors and respond to known risk factors, so the greater proportions are expected.

- The Community Strengthening stream, comprising the Community Centres, Community Connections and Community Support program activities, had overall a slightly greater proportion of clients who had interacted with the criminal justice system prior to TEI at 21% compared to 19% for the Wellbeing and Safety stream. The Community Strengthening stream also had the same proportion of individual clients who had been a victim of domestic violence (22%). However, note that unidentified clients make up most records in the Community Strengthening stream, and including unidentified clients into the analysis (if their service history was observable) would potentially change the relative prevalence of service history.

Figure G.1 – Proportion of clients who have completed the HSC first program activity (HSDS)

Figure G.2 – Proportion of clients achieving the NAPLAN minimum standard by first program activity, for each NAPLAN exam year last sat[100] (HSDS)

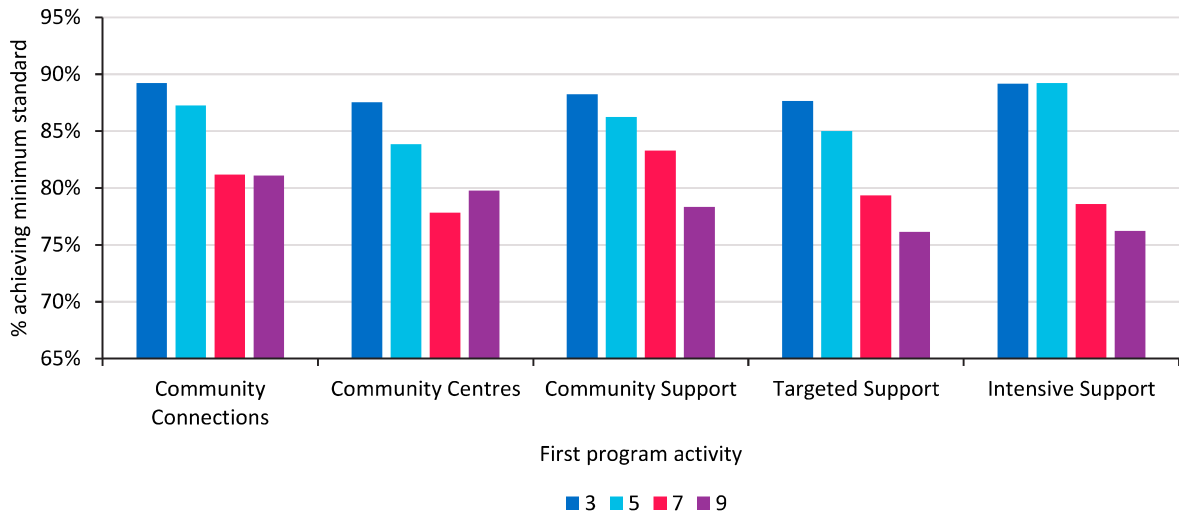
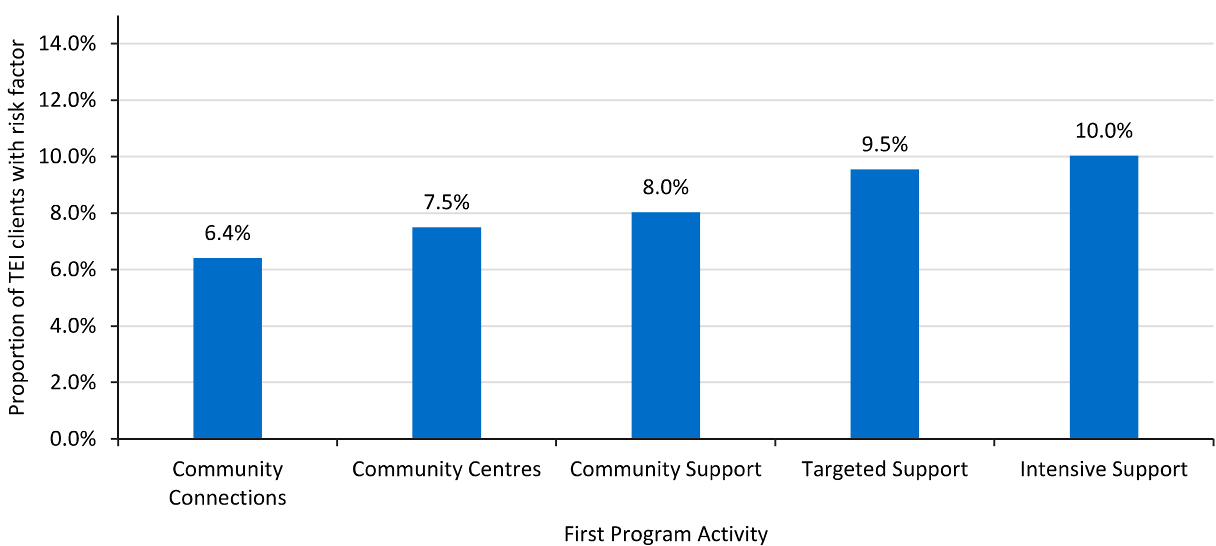



Figure G.3 – Average proportion of TEI clients' enrolled school days that were not attended by TEI clients, in the 1 year prior to entering TEI, by first program activity[101] (HSDS)




[100] The cohort of TEI clients who last sat NAPLAN for years 3, 5 and 7 typically span the 2 year age bands associated with the school years 3, 5 and 7 (8-10, 10-12 and 12-14 respectively). TEI clients who last sat the year 9 NAPLAN exam span ages older than the typical schooling ages, with 40% under 18 and 60% over 18, thus comprising some of the parent population.

[101] Attendance data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible changes in data processing. Students were encouraged to learn from home, where possible, for large periods of time during 2020 and 2021. There was also some evidence of varied attendance marking practices across schools in the period.

Figure G.4 – Risk profile of individual clients by first program activity – justice risk factors (HSDS)

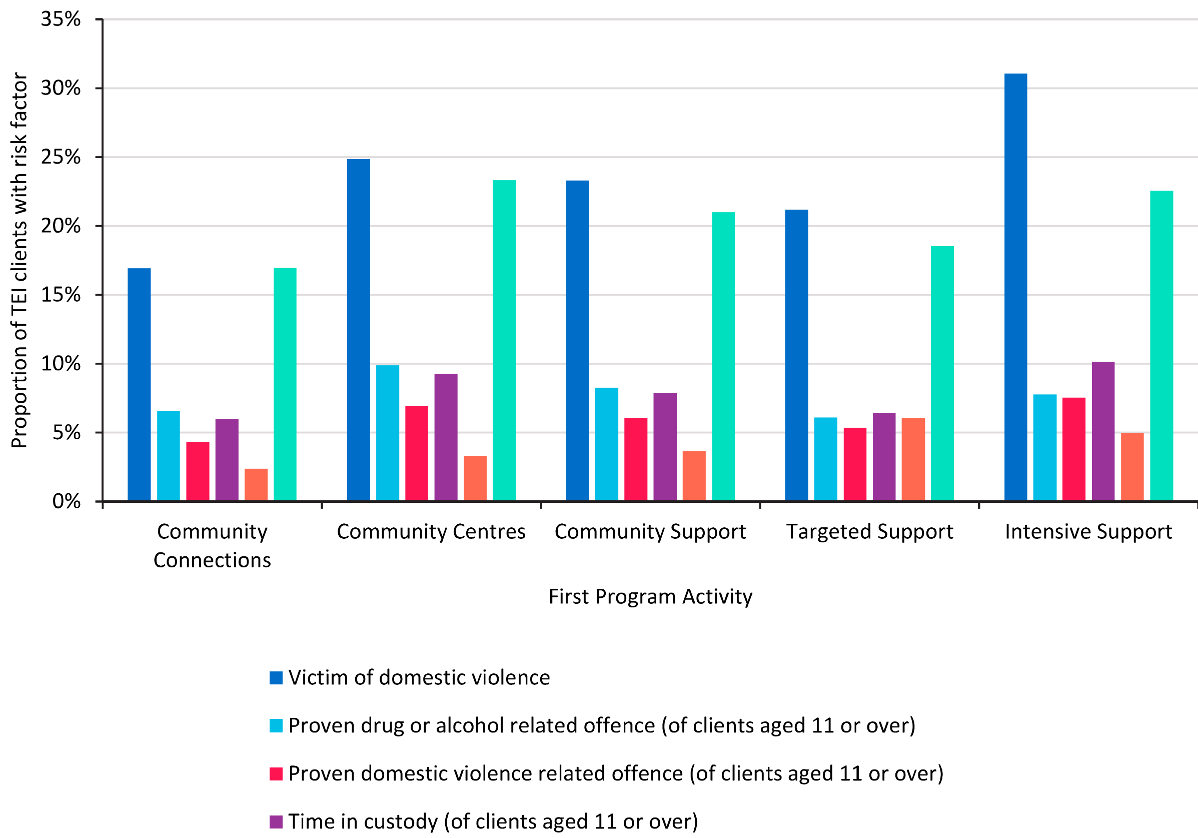


Figure G.5 – Risk profile of individual clients by first program activity – child protection risk factors (HSDS)

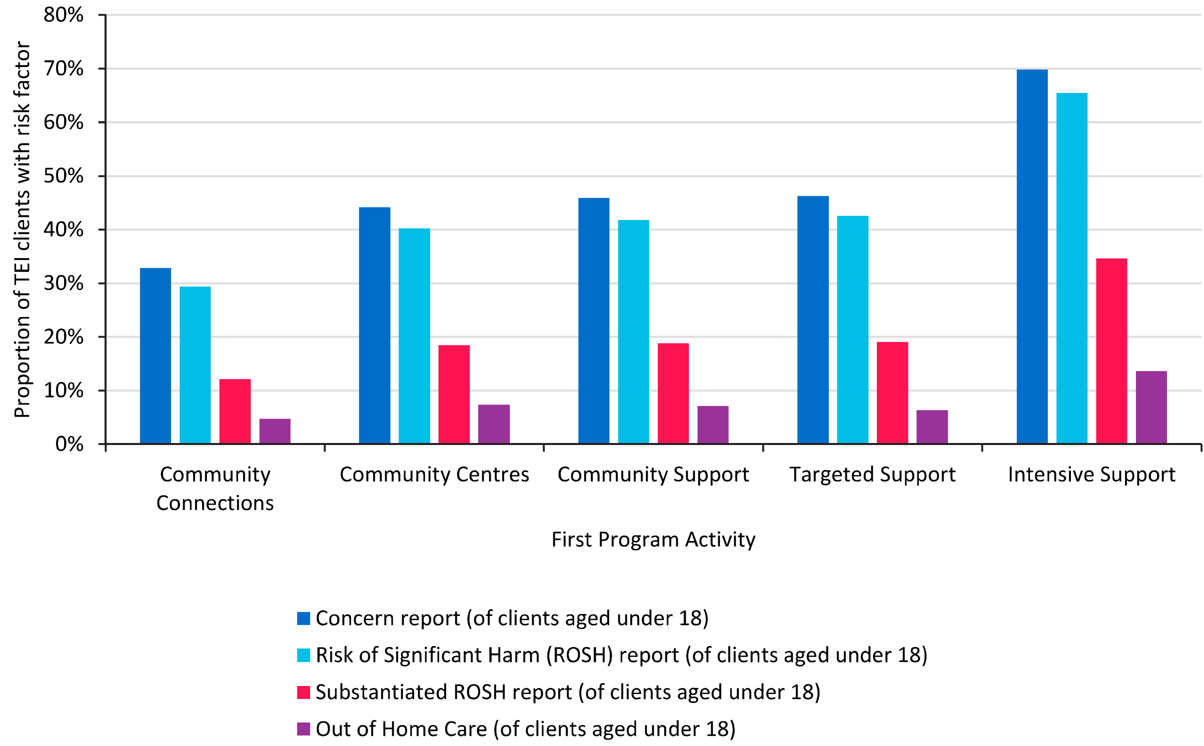



Figure G.6 – Risk profile of individual clients by first program activity – housing risk factors (HSDS)

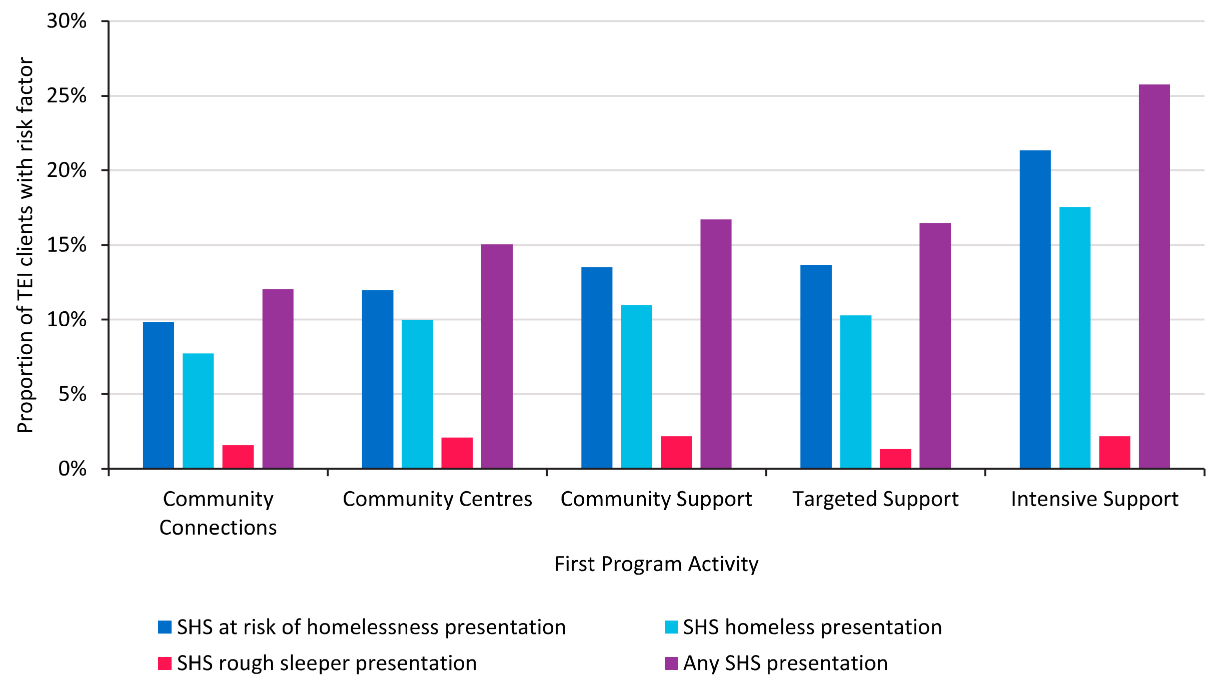
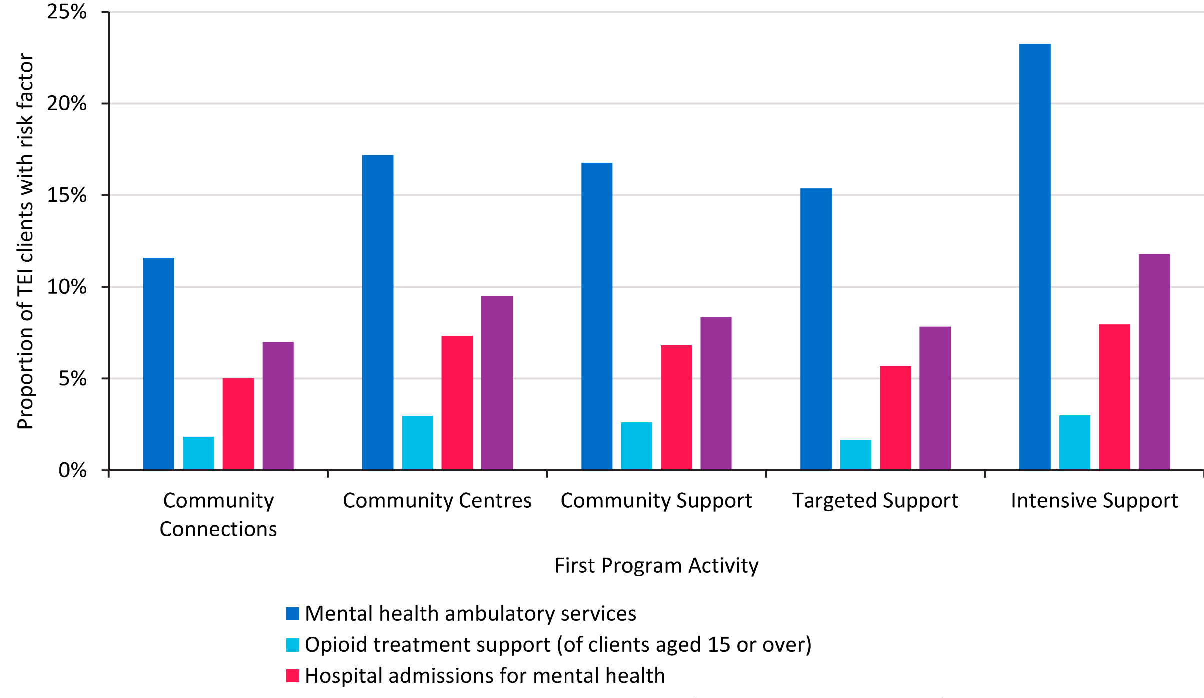


Figure G.7 – Risk profile of individual clients by first program activity – health risk factors (HSDS)




## G.2 Client complexity

As a measure of client complexity, in Section 5.3.1 we present analysis of the average number of domains out of 9 selected domains TEI clients used services in over different time periods. For each TEI client, five people in the general NSW population with the same age, sex and parental status (being a parent or not) was sampled to form the general population group for comparison purposes [102] and complexity for the general population calculated. The domains comprise service use related to:

- **Drug/alcohol use**: a hospital admission for drug/alcohol related reasons or a drug/alcohol related offence committed
- **Mental health**: use of mental health ambulatory services or a hospital admission for mental health related reasons
- **Justice**: an appearance at a Local, Children's, Drug, District or Supreme court, or a police caution issued, or youth conferencing attended
- **Domestic violence**: was a victim of a domestic violence incident, or committed a domestic violence offence
- **Custody:** was in custody
- **Public housing**: was in public housing
- **Homelessness services**: presented to Specialist Homelessness Services as either at risk of homelessness, homeless, or a rough sleeper

[102] Additionally, to remove differences between TEI clients and the comparison group owing to visibility of individual service use in the data, time trends in the data and data processing changes or issues, TEI client service use in a given quarter was compared to general population service use in the same quarter. Further, those born in NSW were matched to those born in NSW and those born outside NSW were matched to those born outside NSW.

- **Child protection**: had a concern report, a Risk of Significant Harm (ROSH) report, or a Substantiated ROSH report, or, spent time in out of home care
- **School suspensions**[103]: was suspended from a public school.

## G.3 Program reach to priority groups

The Department recognises four key TEI groups (priority groups) that are particularly important in the context of early intervention planning, and who are crucial considerations for its strategic planning. See Section 5.3.2 for analysis.

For the purposes of the evaluation, the priority groups are defined as follows:

- **0 to 5 year olds** – children aged between 0 and 5 years old (inclusive) in the quarter of entry into TEI.
- **Aboriginal children, young people, families and communities** – people identified as Aboriginal or Torres Strait Islander according to at least two government data sources in the HSDS.
- **Children and young people at risk of disengagement from school**[104] – while TEI also includes children and young people at risk of disengagement from family and community in this priority group, for this evaluation we have focused on disengagement from school due to data availability. The group is defined as children who were enrolled in school in the year prior to entering TEI, and, attended less than 90% of enrolled days of school.
- **Young parents with known vulnerabilities or hardships** – people who are parents and aged 21 or younger in the quarter of entry into TEI and has ever experienced any of
  - the risk factors in Table G.1 (with the exception of did not achieve the NAPLAN minimum standard, HSC non-completion, and parental service history),
  - a youth justice conference, or
  - Temporary Accommodation (data only available to 30 June 2017 due to unresolved data issues).

[103] Suspension data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible changes in data processing. Moreover, school data is not available from June 2020 due to covid or prior to 2018 due to data quality issues, so the 'suspended ever prior to entry' measure is less than the true measure.

[104] Attendance and suspension data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible changes in data processing. Students were encouraged to learn from home, where possible, for large periods of time during 2020 and 2021. There was also some evidence of varied attendance marking practices across schools in the period.

# Appendix H Outcomes results (full analysis)

## H.1 Individual-level safety outcome modelling

### H.1.1 Introduction

For evaluating the impact of TEI for individually identified clients on safety outcomes, we have relied on using regression models to perform targeted measurement and formal statistical significance testing (analysis including unidentified clients is given in Section H.3). We tested outcomes for both direct and indirect clients, i.e. children directly interacting with TEI and the children of parents interacting with TEI, provided they were able to be linked to the HSDS.

The regression models were individual-level models fit to the HSDS child population to examine the quarterly rate of three different safety outcomes (one with two sub-models). We have separate models for:

- Child protection concern reports
- Reports of Significant Harm (ROSH)
- Out of-home care (OOHC) – for those not in OOHC at the point of TEI entry
- Out-of-home care (OOHC) – for those in OOHC at point of TEI entry.

The regression setup allows for any difference in risk profile between TEI clients and the general population that can be observed in the data to be controlled for when comparing outcomes. This provides a fairer comparison between the groups and higher risk participants to be included in the analysis.

The hypothesis testing focuses on the rate of change in service use following entry, as discussed in Section 6.4.1. It is a form of difference-in-difference testing since we are looking at relative change over time compared to non-TEI children.

### H.1.2 Methodology

The approach used compares the outcomes of TEI children with those in the general population at different time points after TEI participation after controlling for the differences in their risk characteristics. To achieve this, the specific steps taken to prepare the data, perform modelling and hypothesis testing are detailed below.

A modelling dataset was prepared with the structure of having one row per child per quarter:

- The linked population dataset which contains individuals' demographic factors and service use history as at each quarter is filtered to only include children aged 0-17.
- Children born outside of NSW are excluded from the analysis. This is because their service use history may be incomplete if they had only recently moved into NSW, which results in potentially understating their level of risk. This step removed about 20% of the general population and 8% of TEI clients.
- The quarter of entry into TEI is flagged. This can either be the first quarter that the child themselves was recorded as an individual client of a session, or the first quarter that one of their parents was recorded as an individual client if the child did not directly participate in TEI.
- For the remaining children in the general population who do not have any TEI interaction recorded, they are randomly assigned to a quarter between Sep 2020 (first quarter since TEI inception) and Mar 2022 (2nd last quarter of available HSDS data). This assigned quarter is used to determine which

cohort of TEI children they will be compared against in the model and is also referred to as the 'entry quarter'.

- Due to computing resource limitations, the children population without TEI interaction is subsampled by randomly selecting one-fifth of the records in each assigned quarter to be kept in order to reduce the size of the dataset. The selected records are given a weight of five during modelling so the overall ratio of TEI to non-TEI cohorts remain the same.
- Only records of quarters after each child's entry quarter are kept in the modelling data so that we only examine outcomes post TEI.

Modelling was then undertaken:

- For each safety outcome (e.g. concern report), a Generalised Linear Model (GLM) is used to predict the probability of a child having the outcome for each subsequent quarter since program entry (or the quarter they were assigned for children without TEI interaction). The model standardises the treatment and comparison cohorts by considering the children's risk characteristics as at the entry quarter and determines whether the outcomes of the TEI group is significantly different.
- For the prediction of OOHC, separate GLMs are built for children who already have an OOHC episode in the initial quarter and for children who do not. This is done to separately examine the impact of TEI on the rate of entering and exiting OOHC. For the prediction of concern reports and ROSH, children who have an OOHC episode in the initial quarter are excluded from the model. This is to focus the analysis on the risk of escalating through the child protection system amongst those not already in OOHC. This results in a total of four models.
- Standardising variables from a wide range of domains were tested for the model to control for the difference in risk profile, including the child's demographic factors (e.g. age, indigenous status), service use history for the child and of the parent from domains including safety, justice, health, housing and education. The variables that are insignificant are then removed and the model is refit with the remaining variables. The full list of predictors tested and adopted by each of the four models is found in Table H.1 below. We determine the service use history using data up to the quarter of entry. It may be defined by the number of quarters since the last service use, the number of times the service was used in the five years and/or the proportion of quarters in the last five years with the service being used. The exact form of predictor used and the coefficients fit to each term are tabulated in Table H.4 to Table H.7 of the results section, H.1.4.
- We have assumed that the TEI cohort have additional risk factors that are not observed in the data due to the selection effect associated with TEI. The derivation and the size of the selection effect further illustrated in the model result section below.

Finally, hypothesis testing was performed using the model:

- The model estimates the impact of TEI as the difference in outcomes observed between the children who participated in TEI and those who did not, after standardising for differences in risk profiles between the two groups. The statistical significance, or the likelihood that the observed difference is due to chance, is also examined.
- The statistical significance of the TEI support is determined using the hypothesis test:
  $H_0$: Children with TEI support have outcomes that are no different than those without TEI support
  $H_1$: Children with TEI support have outcomes that are different than those without TEI support.

  In the regression framework this corresponds to a hypothesis test on the treatment parameter variable. In our case, this is an interaction term between TEI entry flag and time since TEI entry terms (duration) as we are examining differences at different quarters post program entry. We have

derived the p-value (the probability of evidence against the null hypothesis being stronger than observed) of the hypothesis test using a bootstrapping method[105].

- We apply the same hypothesis test to different cohorts of clients to analyse the impact of TEI support for clients of given characteristics or service history, as presented in Sections 6.4.1 and 6.6.2. In the regression framework, we add a three-way interaction term between TEI flag, duration, and indicator for whether the client belongs to the cohort of interest (e.g. have previous child protection interaction) to the model which allows separate estimates of the TEI impact for the two cohorts. The hypothesis test is then conducted on the combined effect of the interaction term between TEI flag and duration as well as the three-way interaction term. We derive the p-value using the same bootstrapping method, which corresponds to the probability of there being no rate reduction from TEI support for the given cohort.
- When considering whether the impact of TEI is different for children with prior child protection history and for children in each of the priority cohorts, we determine whether there is a statistically significant difference in the size of the estimated TEI impact using the hypothesis test:

  $H_0$: The size of the impact from TEI support for children in the cohort of interest is the same as the size of impact for children who are not in the cohort
  $H_1$: The impact of TEI support is different between the two cohorts.

  In the regression framework, this corresponds to a hypothesis test on just the three-way interaction term between TEI flag, duration, and indicator for whether the client belongs to the cohort of interest. The p-value is again determined using the bootstrapping approach.

Table H.1 – Demographic factors used by the regression model as control variables

| **Predictor** | **Concern report** | **ROSH** | **OOHC – not in OOHC at entry** | **OOHC – in OOHC at entry** |
|---|---|---|---|---|
| Age of child | ✓ | ✓ | ✓ | ✓ |
| Age of mother at birth | ✓ | ✓ | ✓ | |
| Sex | ✓ | ✓ | ✓ | ✓ |
| Indigenous status | ✓ | ✓ | ✓ | ✓ |
| SEIFA Economic Advantage decile | ✓ | ✓ | ✓ | ✓ |

Table H.2 – Service use history used by the regression model as predictors (refers to history for the child unless otherwise stated)

| **Predictor[(a)]** | **Concern report** | **ROSH** | **OOHC – not in OOHC at entry** | **OOHC – in OOHC at entry** |
|---|---|---|---|---|
| Concern report | ✓ | ✓ | ✓ | |

[105] Bootstrapping is a statistical method used to estimate the distribution of a modelled parameter. A distribution of the estimated TEI impact was obtained by repeatedly sampling individuals with replacement from the original data set and refitting the regression model on the resampled data. The null hypothesis states that the mean of this distribution is zero. The p-value corresponds to the proportion of times that the estimated TEI impact on resampled data was opposite in sign to, or more than twice the size of the observed (fitted) TEI impact. Bootstrapping was used rather than standard regression outputs to control for non-independence across rows of data (where the same child was in the dataset across multiple quarters).

| Predictor[a] | Concern report | ROSH | OOHC – not in OOHC at entry | OOHC – in OOHC at entry |
|---|---|---|---|---|
| ROSH report | ✓ | ✓ | ✓ | |
| SARA | ✓ | ✓ | ✓ | |
| OOHC | | | ✓ | ✓ |
| Latest OOHC placement type | | | | ✓ |
| Mental health service | ✓ | ✓ | ✓ | ✓ |
| Parental mental health service | ✓ | ✓ | | |
| Hospitalisation | ✓ | ✓ | ✓ | |
| Police cautions history | ✓ | ✓ | ✓ | |
| Parental interaction with any justice system | ✓ | ✓ | ✓ | |
| Victim of domestic violence incidence | ✓ | ✓ | ✓ | |
| Parent being victim of domestic violence incidence | ✓ | ✓ | ✓ | ✓ |
| Private rental assistance receipt | ✓ | ✓ | ✓ | |
| Public housing | ✓ | ✓ | ✓ | |
| Proportion of school days attended in the last year | ✓ | ✓ | | |

(a) We determine the service use history using data up to the quarter of entry. It may be defined by the number of quarters since the last service use, the number of times the service was used in the five years and/or the proportion of quarters in the last five years with the service being used. The specific form control variables used are documented in the regression coefficient tables of the model results section below.

Table H.3 – Other variables used by the regression model as predictors

| Predictor | Concern report | ROSH | OOHC – not in OOHC at entry | OOHC – in OOHC at entry |
|---|---|---|---|---|
| Mother was smoking at birth | ✓ | ✓ | ✓ | |
| Calendar quarter | ✓ | ✓ | | |
| Quarters since entry | ✓ | ✓ | ✓ | ✓ |
| TEI flag – indicator for either parent or child were TEI participants | ✓ | ✓ | ✓ | ✓ |
| Parent flag – indicator for only the parent was TEI participant and not the child | ✓ | ✓ | ✓ | ✓ |
| Most 'severe' activity type[(a)] received | ✓ | ✓ | ✓ | ✓ |
| Quarters since entry * TEI flag interaction | ✓ | ✓ | ✓ | ✓ |
| Quarters since entry * concern report history interaction | ✓ | ✓ | | |
| TEI flag * concern report history interaction | ✓ | ✓ | | |
| Quarters since entry * OOHC history interaction | | | ✓ | |
| TEI flag * OOHC history interaction | | | ✓ | |

(b) Activity types are ranked in the order of Community Centres, Community Connections, Community Support, Targeted Support and Intensive Support as a proxy for the intensity of the support needs. E.g. if a client have received Community Support and Targeted Support, then the most 'severe' activity type is Targeted Support

Some justification about specific aspects of our methodology:

- Unadjusted standard errors for such regressions can be optimistic; in our case, due to having multiple data rows relating to the same individual. We have applied a block bootstrap methodology to obtain more accurate standard errors and p-values (Angrist and Pischke, 2009)
- DiD is typically a pre-post setup, where comparability prior to enrolment is tested. Selection effects (specifically the increased risk observed around the time of entry) means that pre-program experience is less relevant. We tested the hypothesis that improvements for those accessing TEI are better with duration since entry, meaning that our 'pre' effect is effectively quarter 1 activity.
- We define comparisons with randomised quarter of entry ('quarter 1' for people in the comparison group will vary from September 20 to March 22 quarters). This is done to (roughly) match the timing of the TEI cohort, to reduce the risk of calendar time effects affecting the comparison between treatment and comparison.
- We control for child characteristics at entry. While control variables are not always used in DiD methodologies (if the parallel trends assumption hold then control variable effects are not needed), we judged it preferable for two (related) reasons:
  - The parallel trends assumption implicit in the DiD approach is less likely to hold without control variables. For example, the general reversion shape only holds for subgroups with recent history such as child protection events.

– The (unweighted) general population is too dissimilar from the TEI cohort, making it less likely that duration trends are a good comparison. The addition of covariates moves the comparison group (for the purpose of parameter estimation) closer to the treatment group.

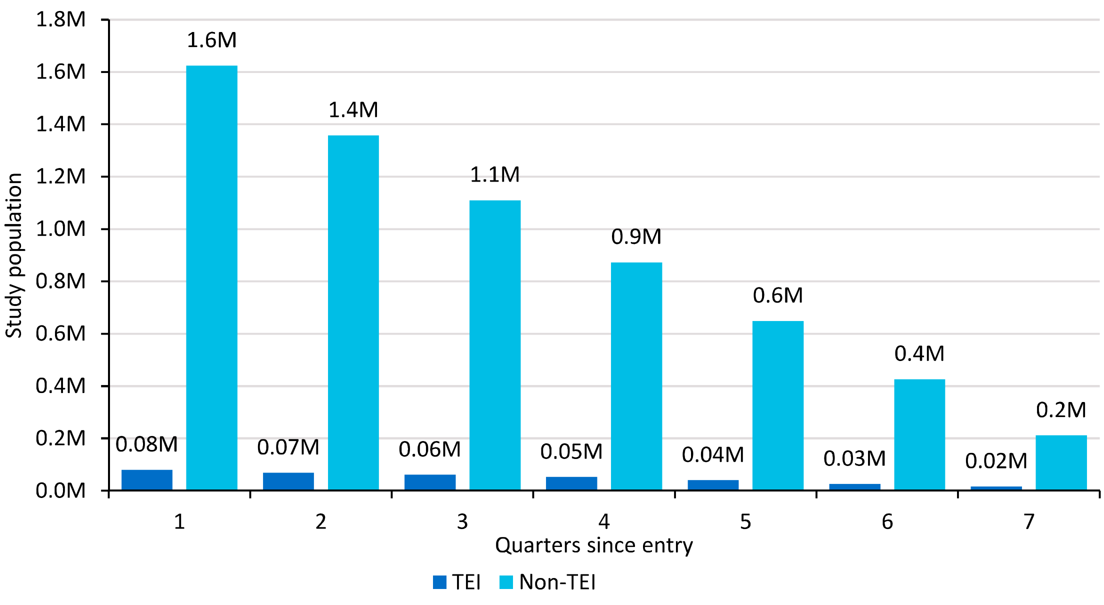
### H.1.3 Descriptive statistics of the study cohort

#### H.1.3.1 Children not in OOHC during the entry quarter

For the three models that predict concern report, ROSH and OOHC for children not in OOHC in the initial entry quarter, they use the same modelling data which includes around 80,000 children with TEI interaction and 1.6 million children in the general population without TEI interaction. Out of the 80,000 children with TEI interaction, about 34,000 of them were recorded as TEI clients themselves and the remaining 46,000 have their parents recorded as TEI clients but not themselves.

Figure H.1 shows the number of children included in these models for each quarter after entry for both the TEI and non-TEI[106] population. As the TEI program was introduced from 1 July 2020, the first quarter with entry into TEI is the Sep 2020 quarter, which gives a maximum of seven quarters of outcomes that can be observed after the initial entry quarter using the HSDS data available up to Jun 2022. Children who entered in the Jun 2022 quarter are excluded from the analysis as they do not have any observable outcomes data after the entry quarter. Furthermore, outcomes seven quarters after entry can only be observed from those who entered in the Sep 2020 quarter, while outcomes one quarter after entry can be observed from everyone who entered up until the Mar 2022 quarter. Therefore, the number of children with TEI interaction included in the model drops from the 80,000 one quarter after entry to around 16,000 seven quarters after entry, while the number of children without TEI interaction drops from 1.6 million to around 211,000.

Figure H.1 – Study population by quarters since entry for children not in OOHC in the initial quarter (HSDS)*




*Note: as discussed earlier, the non-TEI cohort is randomly sampled to reduce the size of the data, with the records in the sample being weighted so the total weight equals the total population count shown in the chart.

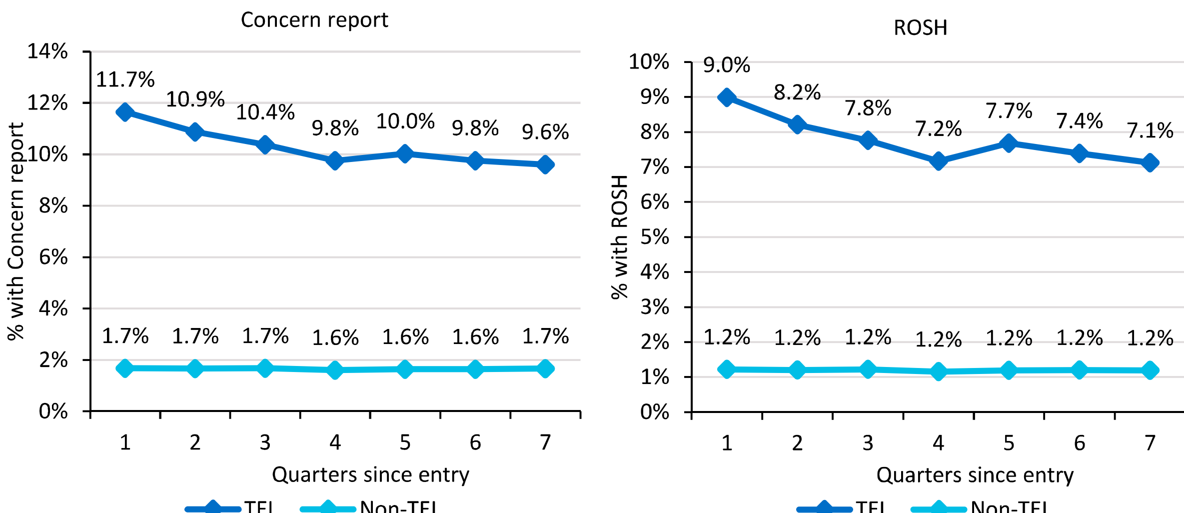
[106] Note that the non-TEI group is not a comparison group here.

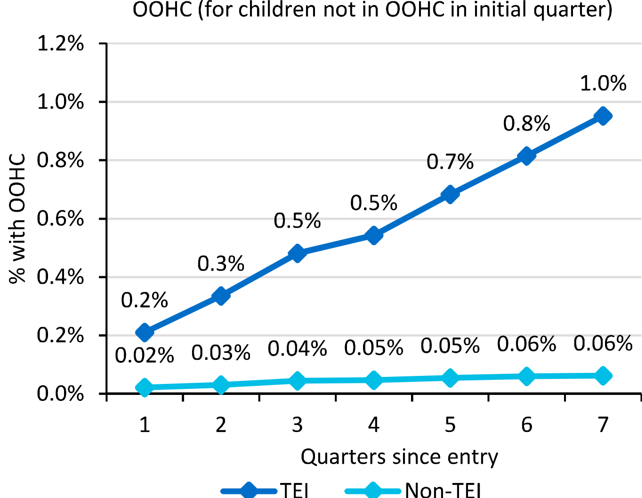
Children in the TEI cohort have significantly higher rate of child protection interaction across all three types of outcomes modelled. Figure H.2 shows the observed rate of concern report, ROSH and OOHC for each quarter after entry for both the TEI and non-TEI cohorts:

- For concern report, the rate for the TEI cohort is 10.6% at one quarter after entry and drops slightly to below 10% from four quarters after entry onwards. This is roughly six times of the rate for the non-TEI cohort, which is consistently at around 1.7%.
- The trend for ROSH is similar to concern report, with the rate for the TEI cohort at 8.8% at one quarter after entry and 7.5% at seven quarters after entry, compared to a consistent 1.2% for the non-TEI cohort.
- The rate of having an OOHC episode, the most severe form of child protection interaction, is much lower compared to the rate of concern report and ROSH. For the TEI cohort, the OOHC rate is 0.2% at one quarter after entry and increases to 1% at seven quarters after entry. This is about ten times of the rate for the non-TEI cohort, who has a rate of 0.02% at one quarter after entry and 0.06% at seven quarters after entry.

The higher rate of interaction with child protection services is a combination of the more identifiable risk factors (perhaps explaining roughly 90% of the gap), such as previous child protection interactions and usage of health services, plus additional (unexplained) elevated risk. This additional risk we treat as selection effects that are netted off in our difference-in-difference approach. See H.1.4 below for further details regarding the gap in risk profile and the selection effect.

Figure H.2 – Observed proportion of children with concern report, ROSH, and OOHC for children not in OOHC in the initial quarter (HSDS)

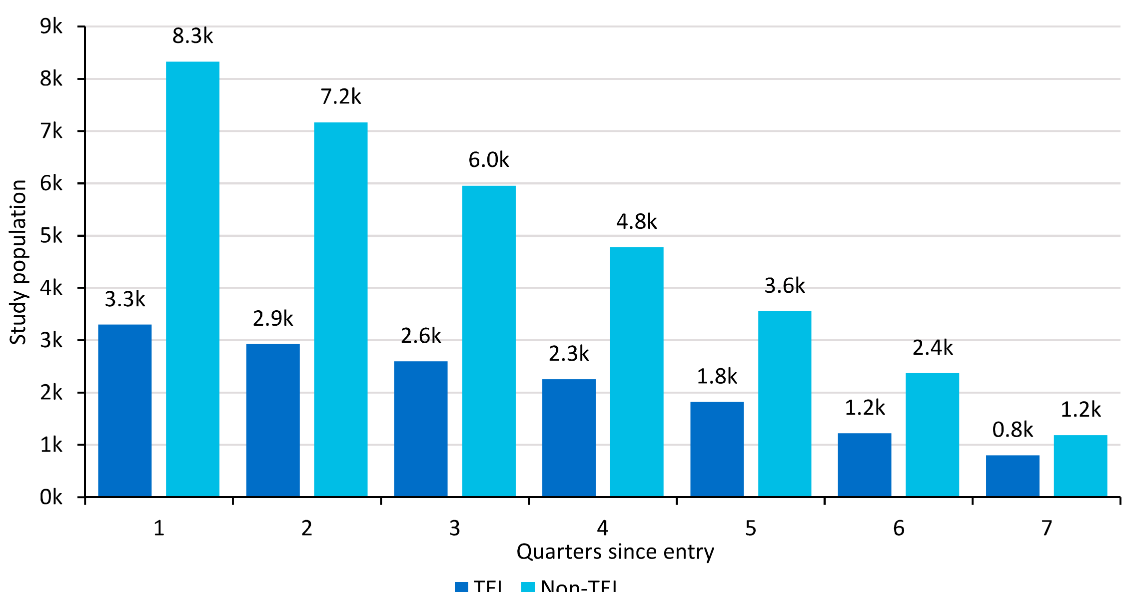





### H.1.3.2 Children in OOHC during the entry quarter

Figure H.3 shows the number of children included in the model for predicting OOHC entry for children who were already in OOHC in the initial quarter. As OOHC is the most severe type of child protection interaction with a lower frequency of occurrence, there are only around 8,000 children without TEI interaction and 3,000 children with TEI interaction included in this model. However, the proportion of the modelled cohort with TEI interaction is much greater at 28% compared to 4% for the previous model. This again shows that TEI is capturing a cohort with much higher risk than the rest of the population. The high level of interaction with TEI services for children in OOHC is notable in itself.

Figure H.3 – Study population by quarters since entry for children in OOHC in the initial quarter (HSDS)




Being in OOHC indicates that the child has already been in high-risk situations in the past for the OOHC placement to take place, and the current situation of their family is still not safe enough for them to be restored. Hence the difference in risk profile between the cohorts with and without TEI interaction is very low. As shown in Figure H.4, both the TEI and non-TEI cohorts still have around 96% chance of remaining in OOHC one quarter after entry. Then the rate drops to 81% for the non-TEI cohort and 75% for the TEI cohort. This decreasing trend is expected as the child's initial situation is already at the most severe having been placed in OOHC and the rate reduces as some of the children in OOHC are restored.

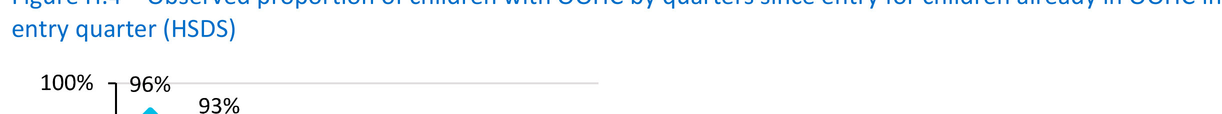
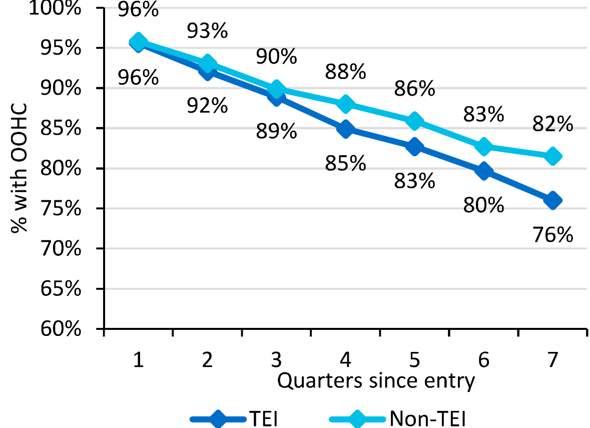


Figure H.4 – Observed proportion of children with OOHC by quarters since entry for children already in OOHC in the entry quarter (HSDS)




### H.1.4 Model results on the overall impact of TEI

Figure H.5 shows the results from the modelling of concern report rate for each quarter after entry. It consists of the following components which shows the model predicted concern report rate for:

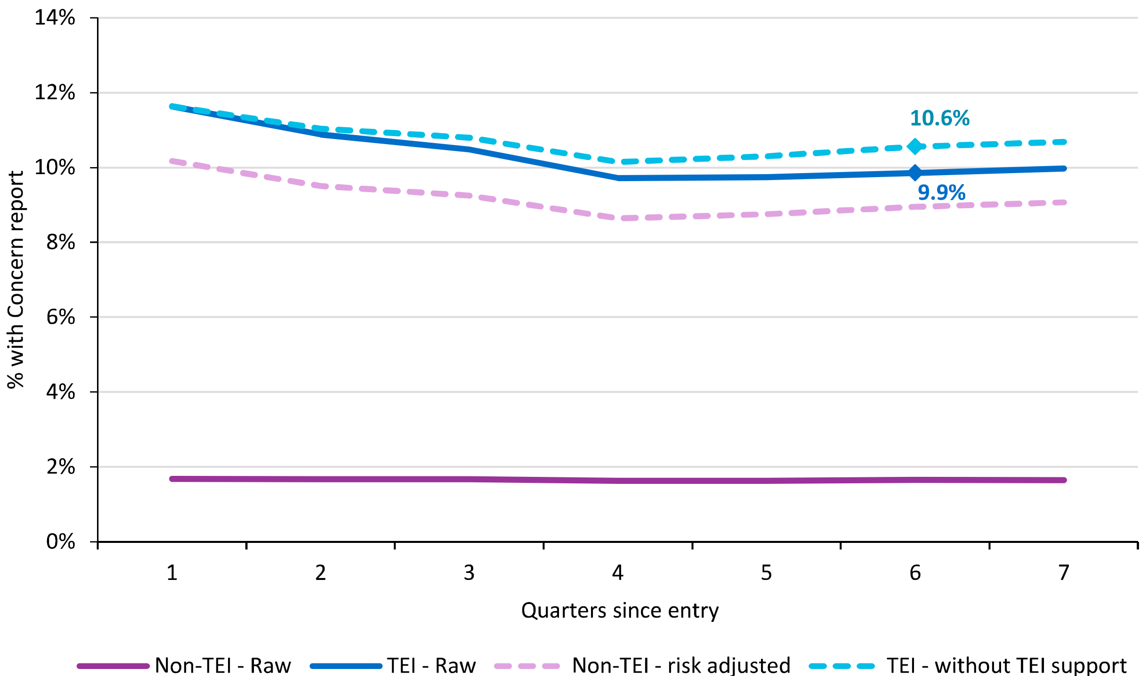
- Children without TEI interaction (series *non-TEI – raw*) – the model is calibrated so that this raw predicted rate is equivalent to the observed rate, except for some smoothing done by the regression model for the higher quarters since entry which has lower data volume to reduce the volatility in the observations.
- Children with TEI interaction (series *TEI – raw*) – this is again calibrated to the observed rates for each quarter as discussed above.
- Children without TEI interaction if they had the same risk characteristics as the TEI cohort (series *non-TEI – risk adjusted*) – this risk adjusted rate is much higher than the raw predicted rate of around 1.7% for children without TEI interaction, with a rate of 10.1% at one quarter after entry and remains above 8% subsequently. This again shows that the TEI cohort have significantly higher risk factors than the non-TEI cohort.

  However, the risk-adjusted rate is still lower than the rate for children with TEI interaction despite the standardisation in risk profile between the two cohorts. We attribute the difference at one quarter after entry to be the selection effect of the TEI program, where children in the TEI cohort have greater prevalence of additional risk factors that are not observed in the data. As we have identified in the client and provider interviews, the TEI program have assisted clients who have experienced issues such as postpartum depression or domestic violence that have not escalated to official police reports. These risk factors would not have been captured by HSDS and hence the standardisation of risk factors is imperfect. In this case, the selection effect increases the concern report rate from the expected 10.2% using observable risk factors to the actual rate of 11.6% at one quarter after entry.
- Children with TEI interaction if they did not receive the TEI support (series *TEI – without TEI support*) – this represents the expected trajectory of someone who have the same standardised risk characteristics as the TEI cohort (including the selection effect) but did not have any TEI interaction. It is derived from the model by adding the selection effect described above to the risk adjusted rate of the non-TEI cohort (*non-TEI – risk adjusted)* for each quarter. In the first quarter after entry, the predicted rate is always equivalent to the rate for children with TEI interaction (*TEI-raw)* as the selection effect is by definition the gap between the *non-TEI – risk adjusted* rate and the *TEI-raw* rate. After the first quarter, the predicted rate without TEI interaction sits above the actual rate for

children with TEI interaction, which means the TEI support have led to a reduction in concern report rate and the gap also widens over time.

The modelled rate for the TEI cohort with and without TEI support as at six quarters after entry are labelled on the chart for reference. These rates correspond to the results shown in Table 6.4 of Section 6.4.1.

Figure H.5 – Predicted concern report rate by quarter since entry (HSDS)




The modelled outcomes for each of the remaining models are derived using the same assumptions regarding the selection effect and the impact of TEI support. The results are shown in Figure H.6 to Figure H.8 below with the following key observations:

- There is a similar selection effect in the prediction of ROSH report rate for children with TEI interaction as the prediction of concern report rate. The rate for children with TEI interaction one quarter after entry is about 1pp. higher than what is expected based on their observed risk profile due to the assumed selection effect. Based on the adjusted risk profile including the selection effect, the observed ROSH report rate for the TEI cohort is also lower than the expected ROSH report rate if they did not receive the TEI support.
- In contrast, the observed selection effect is much lower for the prediction of OOHC rate for children not in OOHC in the initial quarter. Using the same definition as before, the rate for children with TEI interaction is only 0.02pp. higher than what is expected based on their risk profile. However, the observed OOHC rate for the TEI cohort increases faster than what is expected if they did not receive TEI support, indicating that the TEI support was not effective in preventing OOHC placements. This conclusion is different to the feedback from providers – the majority believe that TEI is either moderately or very effective at reducing the risk of entry into OOHC. The contrast could be due to the limitations present in both the quantitative (imperfect regression design, see H.1.7) and qualitative (based on perceptions of limited number of providers) analysis methods.
- For children already in OOHC in the initial quarter, these are children who are already in very high-risk situations and there is very minimal difference in the risk profile between the children with and without TEI interaction. The selection effect from additional unobserved risk factors is therefore also very small, with an observed OOHC rate of 95.4% for the TEI-cohort one quarter after entry

compared to expected rate of 94.9% based on their risk profile. The drop in OOHC rate subsequent to this is faster than the drop expected if they did not receive TEI support.

The modelled rate for the TEI cohort with and without TEI support as at six quarters after entry are again labelled on the charts for reference.

Figure H.6 – Predicted ROSH rate by quarter since entry (HSDS)

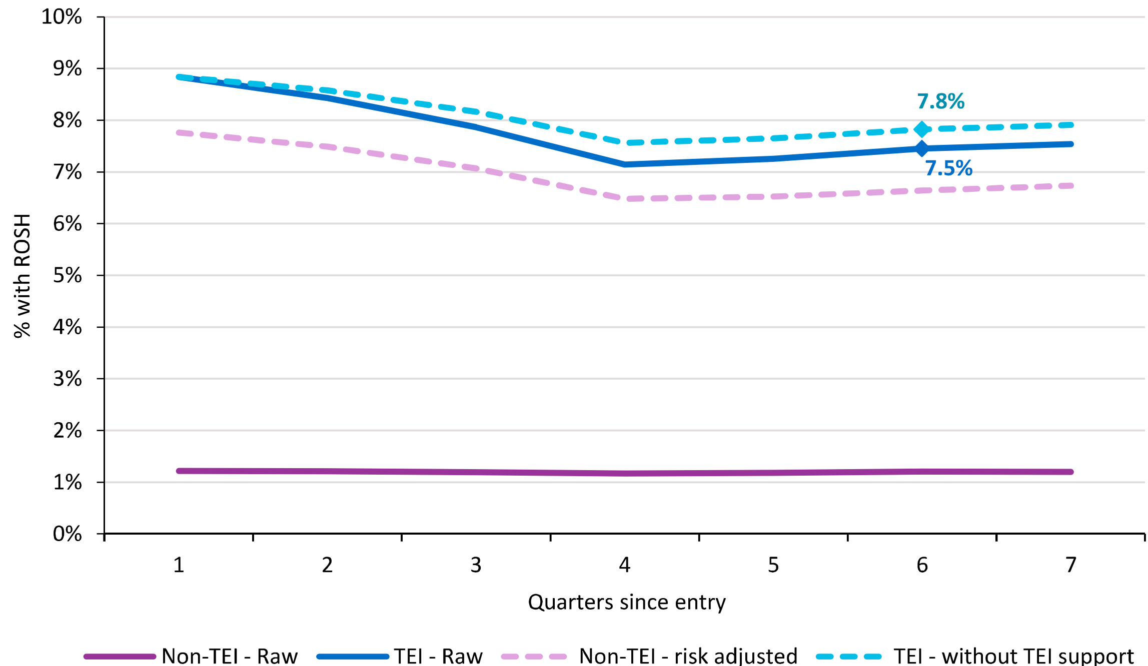



Figure H.7 – Predicted OOHC rate by quarter since entry for children not in OOHC upon TEI entry (HSDS)

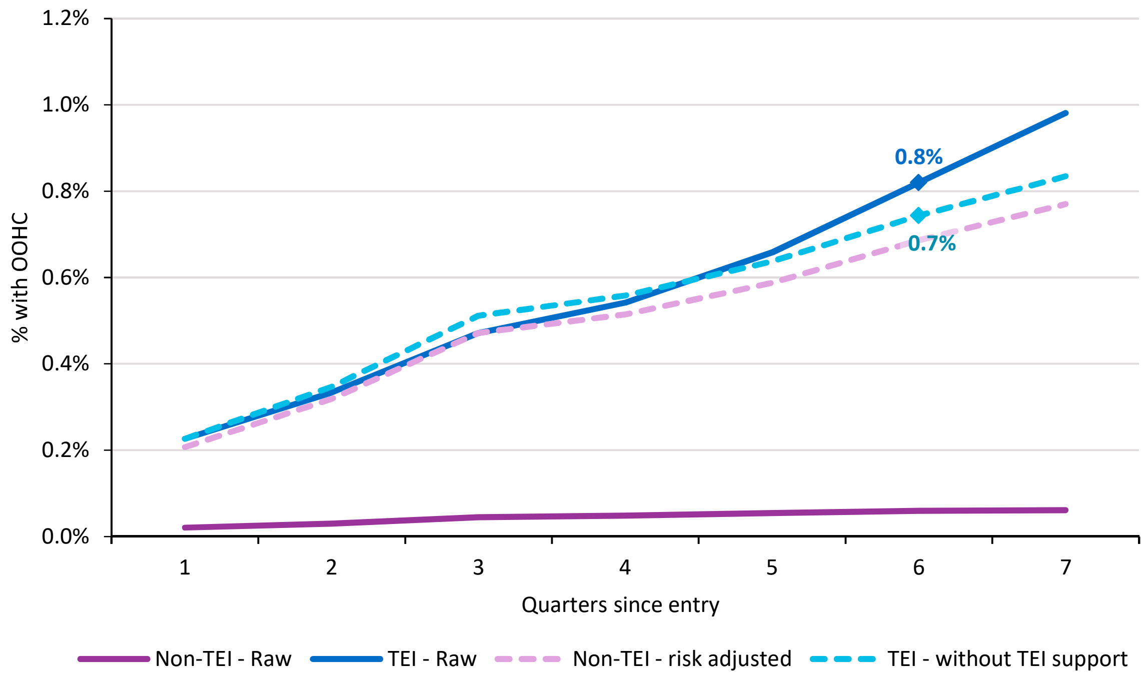


Figure H.8 – Predicted OOHC rate by quarter since entry for children in OOHC upon TEI entry (HSDS)

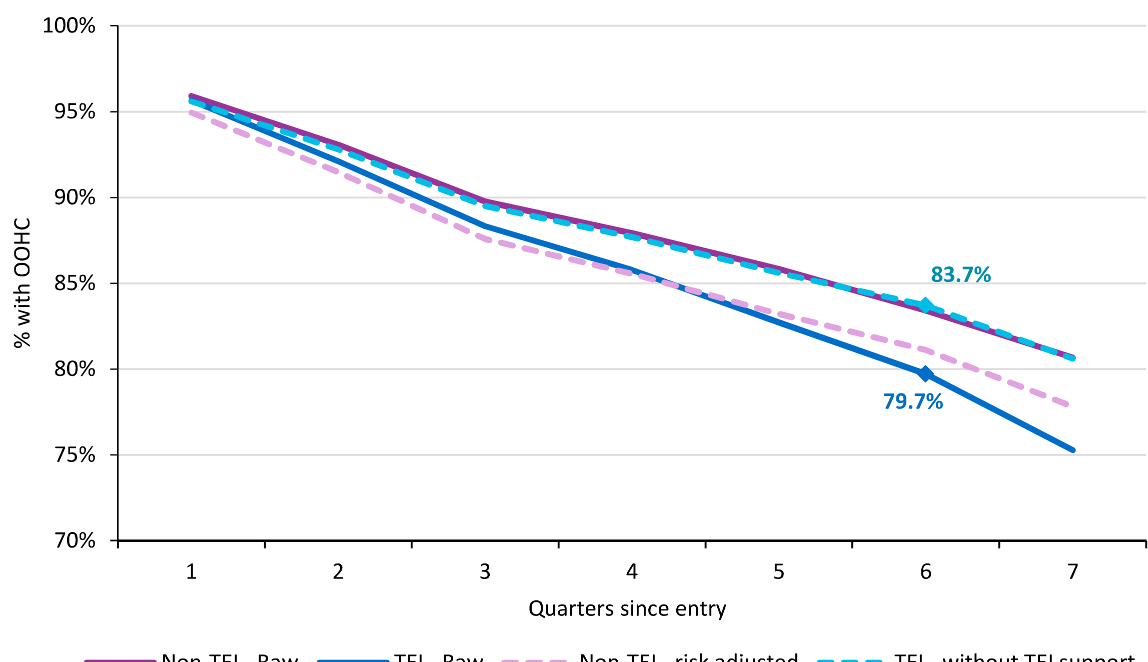



Table H.4 to Table H.7 contain the coefficients fit to each model term, for each safety outcome modelled. The tables also contain bootstrapped[107] standard deviations for each coefficient, and p-values of the test:

$H_0$: The coefficient of the given variable is zero, given all other terms are controlled for
$H_1$: The coefficient of the given variable is non-zero, given all other terms are controlled for.

Table H.4 – Concern Report model terms and coefficients

Note: Control variables related to child protection history and the duration effect are shown first in the table

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Proportion of quarters in the last 5 years with one or more concern reports (capped at 0.03) | 26.454 | 3.491 | 0.001 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.03 and capped at 0.08) | 6.416 | 1.229 | 0.001 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.08 and capped at 0.4) | 0.864 | 0.215 | 0.001 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.4 and capped at 0.8) | 0.818 | 0.170 | 0.001 |
| Proportion of quarters in the last 5 years with one or more ROSH reports (capped at 0.1) | 0.690 | 0.658 | 0.299 |
| Proportion of quarters in the last 5 years with one or more ROSH reports (cupped at 0.1 and capped at 0.4) | 0.359 | 0.238 | 0.127 |

[107] Bootstrapping is a statistical method used to estimate the distribution of a modelled parameter. The distribution of each coefficient was estimated by repeatedly sampling individuals with replacement from the original dataset and refitting the regression model on the resampled data. The null hypothesis states that the mean of this distribution is zero. The p-value corresponds to the proportion of times the bootstrapped coefficient estimate was more extreme (and unlikely) than the observed coefficient estimate, under the null hypothesis. Equivalently, the p-value is the proportion of times the bootstrapped coefficient was opposite in sign to, or more than twice the size of the observed (fitted) coefficient.

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Indicator for whether there was a concern report in the quarter of entry | 0.771 | 0.054 | 0.001 |
| Number of quarters since last concern report (excluding experience in the quarter of entry, capped at 8) | -0.094 | 0.006 | 0.001 |
| Number of quarters since last concern report (excluding experience in the quarter of entry, cupped at 8 and capped at 20) | -0.016 | 0.006 | 0.003 |
| Number of quarters since last concern report (excluding experience in the quarter of entry, cupped at 20 and capped at 60) | -0.005 | 0.002 | 0.019 |
| Indicator for whether there was any concern report more than 20 quarters prior to quarter of entry | 0.785 | 0.074 | 0.001 |
| Number of quarters since last ROSH report (excluding experience in the quarter of entry, capped at 20) | -0.009 | 0.003 | 0.003 |
| Indicator for whether there was any ROSH report more than 20 quarters prior to quarter of entry | 0.077 | 0.047 | 0.107 |
| Number of quarters since last Safety and Risk Assessment (SARA) (excluding experience in the quarter of entry, capped at 20) | -0.015 | 0.002 | 0.001 |
| Indicator for whether there was any SARA more than 20 quarters prior to quarter of entry | 0.160 | 0.036 | 0.001 |
| Indicator for having concern report in quarter of entry but never had concern report prior to quarter of entry | 0.966 | 0.161 | 0.001 |
| Indicator for having ROSH report in quarter of entry but never had ROSH prior to quarter of entry | 0.107 | 0.077 | 0.171 |
| Indicator for having SARA in quarter of entry but never had SARA prior to quarter of entry | 0.182 | 0.060 | 0.007 |
| Number of concern reports in quarter of entry (cupped at 1 and capped at 5) | 0.257 | 0.015 | 0.001 |
| Indicator for whether there was a ROSH report in the quarter of entry | 0.055 | 0.042 | 0.181 |
| Indicator for 2 quarters since entry | 0.136 | 0.038 | 0.001 |
| Indicator for 3 or more quarters since entry | 0.180 | 0.034 | 0.001 |
| Quarters since entry (cupped at 3 and capped at 6) | 0.040 | 0.016 | 0.011 |
| Interaction of quarters since last concern report (excluding experience at quarter of entry, capped at 8) and whether there was concern report in the quarter of entry | 0.057 | 0.011 | 0.001 |
| Interaction of quarters since last concern report (excluding experience at quarter of entry, cupped at 8, capped at 20) and whether there was concern report in the quarter of entry | 0.034 | 0.015 | 0.027 |
| Interaction of whether client had been victim of domestic violence in the quarter of entry and whether there was concern report in the quarter of entry | -0.784 | 0.211 | 0.001 |
| Interaction of whether client had been admitted to hospital in the quarter of entry and whether there was concern report in the quarter of entry | -0.281 | 0.087 | 0.003 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Interaction of whether parent had ever used mental health services and whether there was concern report in the quarter of entry | 0.323 | 0.038 | 0.001 |
| Interaction of TEI flag and whether there was ever concern report | -0.762 | 0.048 | 0.001 |
| Interaction of TEI flag and whether there was ever concern in the quarter of entry | -0.153 | 0.034 | 0.001 |
| Interaction of TEI flag and indicator for 2 quarters since entry | -0.049 | 0.053 | 0.357 |
| Interaction of TEI flag and quarters since entry (cupped at 3 and capped at 6) | -0.020 | 0.024 | 0.441 |
| Interaction of whether there was ever concern report and indicator for 2 quarters since entry | -0.113 | 0.046 | 0.017 |
| Interaction of whether there was ever concern report and indicator for 3 or more quarters since entry | -0.128 | 0.043 | 0.007 |
| Interaction of whether there was ever concern report and quarters since entry (cupped at 3 and capped at 6) | -0.036 | 0.020 | 0.073 |
| Interaction of whether there was concern report in the quarter of entry and indicator for 2 quarters since entry | -0.335 | 0.041 | 0.001 |
| Interaction of whether there was concern report in the quarter of entry and indicator for 3 or more quarters since entry | -0.457 | 0.043 | 0.001 |
| Interaction of whether there was concern report in the quarter of entry and quarters since entry (cupped at 3 and capped at 6) | -0.091 | 0.018 | 0.001 |
| Interaction of TEI flag and whether there was ever concern report and indicator for 2 quarters since entry | 0.032 | 0.061 | 0.609 |
| Interaction of TEI flag and whether there was ever concern report and indicator for 3 or more quarters since entry | -0.047 | 0.033 | 0.151 |
| Interaction of TEI flag and whether there was ever concern report and quarters since entry (cupped at 3 and capped at 6) | 0.002 | 0.028 | 0.959 |
| Intercept | -1.448 | 0.158 | 0.001 |
| Age at quarter of female child clients (capped at 1) | -0.403 | 0.104 | 0.001 |
| Age at quarter of female child clients (cupped at 1 and capped at 4) | 0.067 | 0.023 | 0.011 |
| Age at quarter of female child clients (cupped at 4 and capped at 10) | -0.021 | 0.009 | 0.013 |
| Age at quarter of female child clients (cupped at 10 and capped at 15) | 0.052 | 0.009 | 0.001 |
| Age at quarter of female child clients (cupped at 15 and capped at 17) | -0.332 | 0.043 | 0.001 |
| Age at quarter of male child clients (capped at 1) | -0.479 | 0.104 | 0.001 |
| Age at quarter of male child clients (cupped at 1 and capped at 4) | 0.079 | 0.023 | 0.001 |
| Age at quarter of male child clients (cupped at 4 and capped at 7) | -0.071 | 0.016 | 0.001 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Age at quarter of male child clients (cupped at 15 and capped at 17) | -0.197 | 0.040 | 0.001 |
| Age of the mother at birth (cupped at 20 and capped at 30) | -0.014 | 0.002 | 0.001 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, capped at 5) | -0.023 | 0.009 | 0.009 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, cupped at 5 and capped at 12) | -0.014 | 0.004 | 0.001 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, cupped at 30 and capped at 70) | -0.006 | 0.001 | 0.001 |
| Whether parent ever had domestic violence experience (excluding experience in the quarter of entry) | -0.824 | 0.035 | 0.001 |
| Whether parent had ever appeared at Children's, Drug, Local, District or Supreme Court (excluding appearances in the quarter of entry) | -0.157 | 0.020 | 0.001 |
| Number of quarters since parent last accessed mental health services (excluding access in the quarter of entry, capped at 8) | -0.020 | 0.004 | 0.001 |
| Whether parent had ever accessed mental health services (excluding access in the quarter of entry) | -0.366 | 0.032 | 0.001 |
| Number of quarters since last admitted to hospital (excluding admissions in the quarter of entry, capped at 55) | -0.002 | 0.001 | 0.001 |
| Whether there was any past hospital admission (excluding admissions in the quarter of entry) | -0.587 | 0.060 | 0.001 |
| Number of quarters since last accessing private rental assistance (excluding access in the quarter of entry, capped at 15) | -0.008 | 0.004 | 0.047 |
| Whether there was ever access of private rental assistance | -0.131 | 0.044 | 0.005 |
| Number of quarters since last accessing ambulatory mental health services (excluding experience in the quarter of entry, capped at 8) | -0.019 | 0.010 | 0.061 |
| Whether there was ever use of ambulatory mental health services (excluding experience in the quarter of entry) | -0.283 | 0.059 | 0.001 |
| Proportion of enrolled school days attended in the 1 year prior to entry (cupped at 0.85 and capped at 1) | -0.741 | 0.196 | 0.001 |
| Whether there was school attendance recorded | -0.348 | 0.028 | 0.001 |
| SEIFA Advantage decile (cupped at 5 and capped at 8) | -0.073 | 0.007 | 0.001 |
| Indicator for whether SEIFA Advantage decile is available | -0.322 | 0.100 | 0.001 |
| Indicator for whether mother was smoking at birth | 0.191 | 0.019 | 0.001 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Indicator for whether client accessed public housing in the quarter prior to entry | 0.147 | 0.024 | 0.001 |
| Indicator for whether the quarter is in 2021-22 | -0.181 | 0.017 | 0.001 |
| Indicator for whether client had been victim of domestic violence in the quarter of entry | 0.725 | 0.200 | 0.001 |
| Indicator for whether client had been admitted to hospital in the quarter of entry | 0.353 | 0.051 | 0.001 |
| Indicator for whether there was use of ambulatory mental health services in the quarter of entry | 0.167 | 0.059 | 0.007 |
| Indicator for whether the client had received youth cautions in the quarter of entry | 0.352 | 0.122 | 0.003 |
| Gender | 0.119 | 0.101 | 0.243 |
| Indigenous status | 0.208 | 0.021 | 0.001 |
| TEI flag | 0.987 | 0.046 | 0.001 |
| Indictor for when only the parent had been recorded as a TEI client | -0.122 | 0.022 | 0.001 |
| Indicator for when parent was recorded as TEI client before the child was also recorded as TEI client | 0.224 | 0.043 | 0.001 |
| Indicator for when parent was also recorded as TEI client on or after the child was recorded as TEI client | 0.220 | 0.028 | 0.001 |
| Indicator for most 'severe' activity type being Community Centres | -0.124 | 0.033 | 0.001 |
| Indicator for most 'severe' activity type being Community Connections | -0.237 | 0.045 | 0.001 |
| Indicator for most 'severe' activity type being Community Support | -0.094 | 0.026 | 0.001 |
| Indicator for most 'severe' activity type being Intensive Support | 0.065 | 0.036 | 0.075 |

Table H.5 – ROSH report model terms and coefficients

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Proportion of quarters in the last 5 years with one or more concern reports (capped at 0.03) | 29.951 | 2.918 | 0.001 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.03 and capped at 0.08) | 6.196 | 1.351 | 0.001 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.08 and capped at 0.4) | 0.757 | 0.231 | 0.005 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.4 and capped at 0.8) | 0.779 | 0.173 | 0.001 |
| Proportion of quarters in the last 5 years with one or more ROSH reports (capped at 0.1) | 0.918 | 0.713 | 0.207 |
| Proportion of quarters in the last 5 years with one or more ROSH reports (cupped at 0.1 and capped at 0.4) | 0.534 | 0.262 | 0.059 |
| Number of quarters since last concern report (excluding experience in the quarter of entry, capped at 8) | -0.098 | 0.007 | 0.001 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Number of quarters since last concern report (excluding experience in the quarter of entry, cupped at 8 and capped at 20) | -0.020 | 0.008 | 0.009 |
| Indicator for whether there was any concern report more than 20 quarters prior to quarter of entry | 0.788 | 0.071 | 0.001 |
| Number of quarters since last ROSH report (excluding experience in the quarter of entry, capped at 20) | -0.017 | 0.004 | 0.001 |
| Indicator for whether there was any ROSH report more than 20 quarters prior to quarter of entry | 0.152 | 0.057 | 0.007 |
| Number of quarters since last Safety and Risk Assessment (SARA) (excluding experience in the quarter of entry, capped at 20) | -0.014 | 0.002 | 0.001 |
| Indicator for whether there was any SARA more than 20 quarters prior to quarter of entry | 0.165 | 0.040 | 0.001 |
| Indicator for having concern report in quarter of entry but never had concern report prior to quarter of entry | 0.948 | 0.187 | 0.001 |
| Indicator for having ROSH report in quarter of entry but never had ROSH prior to quarter of entry | 0.178 | 0.085 | 0.041 |
| Indicator for having SARA in quarter of entry but never had SARA prior to quarter of entry | 0.217 | 0.059 | 0.001 |
| Indicator for whether there was a concern report in the quarter of entry | 0.678 | 0.055 | 0.001 |
| Number of concern reports in quarter of entry (cupped at 1 and capped at 5) | 0.231 | 0.014 | 0.001 |
| Indicator for whether there was a ROSH report in the quarter of entry | 0.165 | 0.045 | 0.001 |
| Quarters since entry (capped at 4) | 0.072 | 0.016 | 0.001 |
| Quarters since entry (cupped at 4 and capped at 6) | 0.041 | 0.029 | 0.151 |
| Interaction of quarters since last concern report (excluding experience at quarter of entry, capped at 8) and whether there was concern report in the quarter of entry | 0.064 | 0.011 | 0.001 |
| Interaction of quarters since last concern report (excluding experience at quarter of entry, cupped at 8, capped at 20) and whether there was concern report in the quarter of entry | 0.029 | 0.016 | 0.083 |
| Interaction of whether client had been victim of domestic violence in the quarter of entry and whether there was concern report in the quarter of entry | -0.671 | 0.224 | 0.003 |
| Interaction of whether client had been admitted to hospital in the quarter of entry and whether there was concern report in the quarter of entry | -0.335 | 0.090 | 0.001 |
| Interaction of TEI flag and whether there was ever concern report | -0.602 | 0.069 | 0.001 |
| Interaction of TEI flag and whether there was ever concern in the quarter of entry | -0.177 | 0.038 | 0.001 |
| Interaction of TEI flag and quarters since entry (capped at 4) | 0.000 | 0.026 | 0.991 |
| Interaction of TEI flag and quarters since entry (cupped at 4 and capped at 6) | -0.034 | 0.048 | 0.489 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Interaction of TEI flag and whether there was concern report in 1 to 8 quarters prior to entry | -0.219 | 0.039 | 0.001 |
| Interaction of whether there was ever concern report and quarters since entry (capped at 4) | -0.031 | 0.023 | 0.195 |
| Interaction of whether there was ever concern report and quarters since entry (cupped at 4 and capped at 6) | 0.066 | 0.042 | 0.131 |
| Interaction of whether there was concern report during quarter of entry and quarters since entry (capped at 4) | -0.162 | 0.016 | 0.001 |
| Interaction of whether there was concern report during quarter of entry and quarters since entry (cupped at 4 and capped at 6) | -0.067 | 0.029 | 0.027 |
| Interaction of whether there was concern report in 1 to 8 quarters prior to entry and quarters since entry (cupped at 4 and capped at 6) | -0.022 | 0.018 | 0.231 |
| Interaction of whether there was concern report in 1 to 8 quarters prior to entry and quarters since entry (cupped at 4 and capped at 6) | -0.136 | 0.033 | 0.003 |
| Interaction of TEI flag and whether there was ever concern report and quarters since entry (capped at 4) | -0.028 | 0.029 | 0.335 |
| Interaction of TEI flag and whether there was ever concern report and quarters since entry (cupped at 4 and capped at 6) | 0.046 | 0.054 | 0.413 |
| Intercept | -1.912 | 0.161 | 0.001 |
| Age at quarter of female child clients (capped at 1) | -0.447 | 0.114 | 0.001 |
| Age at quarter of female child clients (cupped at 1 and capped at 4) | 0.076 | 0.024 | 0.001 |
| Age at quarter of female child clients (cupped at 4 and capped at 10) | -0.025 | 0.010 | 0.009 |
| Age at quarter of female child clients (cupped at 10 and capped at 15) | 0.056 | 0.010 | 0.001 |
| Age at quarter of female child clients (cupped at 15 and capped at 17) | -0.325 | 0.047 | 0.001 |
| Age at quarter of male child clients (capped at 1) | -0.451 | 0.104 | 0.001 |
| Age at quarter of male child clients (cupped at 1 and capped at 4) | 0.066 | 0.024 | 0.009 |
| Age at quarter of male child clients (cupped at 4 and capped at 7) | -0.072 | 0.017 | 0.001 |
| Age at quarter of male child clients (cupped at 15 and capped at 17) | -0.205 | 0.045 | 0.001 |
| Age of the mother at birth (cupped at 20 and capped at 30) | -0.014 | 0.002 | 0.001 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, capped at 5) | -0.015 | 0.009 | 0.105 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, cupped at 5 and capped at 12) | -0.013 | 0.005 | 0.005 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, cupped at 30 and capped at 70) | -0.005 | 0.001 | 0.001 |
| Whether parent ever had domestic violence experience (excluding experience in the quarter of entry) | -0.760 | 0.038 | 0.001 |
| Whether parent had ever appeared at Children’s, Drug, Local, District or Supreme Court (excluding appearances in the quarter of entry) | -0.149 | 0.023 | 0.001 |
| Number of quarters since parent last accessed mental health services (excluding access in the quarter of entry, capped at 8) | -0.021 | 0.005 | 0.001 |
| Whether parent had ever accessed mental health services (excluding access in the quarter of entry) | -0.292 | 0.030 | 0.001 |
| Number of quarters since last admitted to hospital (excluding admissions in the quarter of entry, capped at 55) | -0.002 | 0.001 | 0.011 |
| Whether there was any past hospital admission (excluding admissions in the quarter of entry) | -0.494 | 0.062 | 0.001 |
| Number of quarters since last accessing private rental assistance (excluding access in the quarter of entry, capped at 15) | -0.008 | 0.004 | 0.045 |
| Whether there was ever access of private rental assistance | -0.091 | 0.047 | 0.053 |
| Number of quarters since last accessing ambulatory mental health services (excluding experience in the quarter of entry, capped at 8) | -0.017 | 0.011 | 0.115 |
| Whether there was ever use of ambulatory mental health services (excluding experience in the quarter of entry) | -0.257 | 0.064 | 0.001 |
| Proportion of enrolled school days attended in the 1 year prior to entry (cupped at 0.85 and capped at 1) | -0.647 | 0.219 | 0.001 |
| Whether there was school attendance recorded | -0.331 | 0.032 | 0.001 |
| SEIFA Advantage decile (cupped at 5 and capped at 8) | -0.077 | 0.007 | 0.001 |
| Indicator for whether SEIFA Advantage decile is available | -0.561 | 0.122 | 0.001 |
| Indicator for whether mother was smoking at birth | 0.199 | 0.020 | 0.001 |
| Indicator for whether client accessed public housing in the quarter prior to entry | 0.139 | 0.025 | 0.001 |
| Quarter number (quarter ending Sep 2020 is quarter 1, quarter ending Dec 2020 is quarter 2 etc., cupped at 2 and capped at 4) | -0.037 | 0.019 | 0.057 |
| Quarter number (quarter ending Sep 2020 is quarter 1, quarter ending Dec 2020 is quarter 2 etc., cupped at 4 and capped at 5) | -0.179 | 0.023 | 0.001 |
| Indicator for whether client had been victim of domestic violence in the quarter of entry | 0.606 | 0.208 | 0.003 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Indicator for whether client had been admitted to hospital in the quarter of entry | 0.389 | 0.054 | 0.001 |
| Indicator for whether there was use of ambulatory mental health services in the quarter of entry | 0.185 | 0.064 | 0.009 |
| Indicator for whether the client had received youth cautions in the quarter of entry | 0.334 | 0.133 | 0.003 |
| Gender | 0.098 | 0.110 | 0.363 |
| Indigenous status | 0.196 | 0.022 | 0.001 |
| TEI flag | 1.009 | 0.058 | 0.001 |
| Indictor for when only the parent had been recorded as a TEI client | -0.166 | 0.025 | 0.001 |
| Indicator for when parent was recorded as TEI client before the child was also recorded as TEI client | 0.292 | 0.046 | 0.001 |
| Indicator for when parent was also recorded as TEI client on or after the child was recorded as TEI client | 0.267 | 0.032 | 0.001 |
| Indicator for most 'severe' activity type being Community Centres | -0.115 | 0.034 | 0.003 |
| Indicator for most 'severe' activity type being Community Connections | -0.334 | 0.049 | 0.001 |
| Indicator for most 'severe' activity type being Community Support | -0.144 | 0.029 | 0.001 |
| Indicator for most 'severe' activity type being Intensive Support | 0.022 | 0.039 | 0.577 |

Table H.6 – OOHC (for clients not in OOHC at quarter of TEI entry) model terms and coefficients

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Number of quarters since last OOHC episode (capped at 10) | -0.234 | 0.043 | 0.001 |
| Indicator for whether the client had ever been in OOHC | -0.254 | 4.532 | 0.649 |
| Proportion of quarters in the last 5 years with one or more concern reports (capped at 0.05) | 16.844 | 8.559 | 0.059 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.05 and capped at 0.1) | 6.141 | 8.660 | 0.457 |
| Proportion of quarters in the last 5 years with one or more concern reports (cupped at 0.1 and capped at 0.4) | 0.689 | 1.346 | 0.603 |
| Proportion of quarters in the last 5 years with one or more ROSH reports (capped at 0.1) | 4.997 | 4.730 | 0.277 |
| Proportion of quarters in the last 5 years with one or more ROSH reports (cupped at 0.1 and capped at 0.4) | 2.145 | 1.409 | 0.139 |
| Number of quarters since last concern report (excluding experience in the quarter of entry, capped at 8) | -0.024 | 0.041 | 0.551 |
| Indicator for whether there was any concern report more than 20 quarters prior to quarter of entry | 0.459 | 0.871 | 0.377 |
| Number of quarters since last Safety and Risk Assessment (SARA) (excluding experience in the quarter of entry, capped at 20) | -0.108 | 0.014 | 0.001 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Indicator for whether there was any SARA more than 20 quarters prior to quarter of entry | 1.836 | 0.313 | 0.001 |
| Indicator for having ROSH report in quarter of entry but never had ROSH prior to quarter of entry | 1.393 | 0.459 | 0.005 |
| Indicator for having SARA in quarter of entry but never had SARA prior to quarter of entry | 1.318 | 0.392 | 0.001 |
| Indicator for whether there was a concern report in the quarter of entry | 0.778 | 0.186 | 0.001 |
| Number of concern reports in quarter of entry (cupped at 1 and capped at 5) | 0.280 | 0.060 | 0.001 |
| Indicator for whether there was SARA in the quarter of entry | 0.679 | 0.183 | 0.001 |
| Indicator for 2 quarters since entry | 0.430 | 0.073 | 0.001 |
| Indicator for 3 or more quarters since entry | 0.844 | 0.084 | 0.001 |
| Quarters since entry (cupped at 3 and capped at 7) | 0.090 | 0.042 | 0.039 |
| Interaction of whether client had been victim of domestic violence in the quarter of entry and whether there was concern report in the quarter of entry | -1.413 | 1.628 | 0.127 |
| Interaction of whether client had received youth caution in the quarter of entry and whether there was concern report in the quarter of entry | -1.349 | 5.153 | 0.275 |
| Interaction of indicator for whether the client had ever been in OOHC and whether client was a victim of domestic violence in the quarter of entry | -0.693 | 0.579 | 0.233 |
| Interaction of indicator for whether the client had ever been in OOHC and gender | -1.910 | 4.552 | 0.215 |
| Interaction of whether the client had ever been in OOHC and age at quarter for female clients (cupped at 1 and capped at 4) | -0.991 | 1.519 | 0.019 |
| Interaction of whether the client had ever been in OOHC and age at quarter for male clients (cupped at 1 and capped at 4) | -0.137 | 0.137 | 0.317 |
| Interaction of TEI flag and quarters since entry (cupped at 3 and capped at 7) | 0.103 | 0.053 | 0.049 |
| Interaction of TEI flag and indicator for 2 quarters since entry and whether the client had been in OOHC 1 to 8 quarters prior to TEI entry | -0.326 | 0.309 | 0.311 |
| Interaction of TEI flag and indicator for 3 or more quarters since entry and whether the client had been in OOHC 1 to 8 quarters prior to TEI entry | -0.870 | 0.317 | 0.007 |
| Interaction of TEI flag and quarters since entry (cupped at 3 and capped at 7) and whether the client had been in OOHC 1 to 8 quarters prior to TEI entry | -0.248 | 0.137 | 0.077 |
| Interaction of TEI flag and quarters since entry (cupped at 3 and capped at 7) and whether the client had ever been in OOHC | 0.211 | 0.110 | 0.059 |
| Interaction of TEI flag and quarters since entry (cupped at 3 and capped at 7) and age at quarter (cupped at 10 and capped at 15) | -0.085 | 0.023 | 0.003 |
| Intercept | -6.954 | 4.551 | 0.001 |
| Age at quarter of female child clients (capped at 1) | -0.774 | 0.491 | 0.097 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Age at quarter of female child clients (cupped at 1 and capped at 4) | 0.743 | 1.528 | 0.135 |
| Age at quarter of female child clients (cupped at 4 and capped at 10) | -0.054 | 0.062 | 0.381 |
| Age at quarter of female child clients (cupped at 10 and capped at 15) | -0.192 | 0.075 | 0.011 |
| Age at quarter of female child clients (cupped at 15 and capped at 17) | 0.379 | 0.403 | 0.285 |
| Age at quarter of male child clients (capped at 1) | -0.597 | 0.538 | 0.283 |
| Age at quarter of male child clients (cupped at 4 and capped at 7) | -0.166 | 0.096 | 0.097 |
| Age of the mother at birth (cupped at 20 and capped at 30) | -0.032 | 0.017 | 0.045 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, capped at 5) | -0.064 | 0.053 | 0.233 |
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, cupped at 5 and capped at 12) | -0.035 | 0.031 | 0.273 |
| Whether parent ever had domestic violence experience (excluding experience in the quarter of entry) | -0.911 | 0.351 | 0.007 |
| Whether parent had ever appeared at Children's, Drug, Local, District or Supreme Court (excluding appearances in the quarter of entry) | -0.317 | 0.213 | 0.105 |
| Number of quarters since last accessing private rental assistance (excluding access in the quarter of entry, capped at 15) | 0.045 | 0.027 | 0.105 |
| Whether there was ever access of private rental assistance | 0.610 | 0.311 | 0.039 |
| Whether the client had ever received youth cautions (excluding experience in the quarter of entry) | 0.508 | 0.347 | 0.145 |
| Indicator for whether mother was smoking at birth | 0.691 | 0.138 | 0.001 |
| Indicator for whether client accessed public housing in the quarter prior to entry | 0.106 | 0.146 | 0.461 |
| Indicator for whether client had been victim of domestic violence in the quarter of entry | 1.705 | 1.649 | 0.099 |
| Indicator for whether client had been admitted to hospital in the quarter of entry | -0.209 | 0.236 | 0.357 |
| Indicator for whether there was use of ambulatory mental health services in the quarter of entry | 0.632 | 0.359 | 0.099 |
| Indicator for whether the client had received youth cautions in the quarter of entry | 0.812 | 4.350 | 0.283 |
| Gender | 1.749 | 4.577 | 0.301 |
| Indigenous status | -0.146 | 0.139 | 0.281 |
| TEI flag | 0.087 | 0.226 | 0.699 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Indictor for when only the parent had been recorded as a TEI client | 0.022 | 0.138 | 0.877 |
| Indicator for when parent was recorded as TEI client before the child was also recorded as TEI client | -1.042 | 0.416 | 0.007 |
| Indicator for when parent was also recorded as TEI client on or after the child was recorded as TEI client | 0.049 | 0.218 | 0.859 |
| Indicator for most 'severe' activity type being Community Centres | -0.109 | 0.227 | 0.641 |
| Indicator for most 'severe' activity type being Community Connections | -0.672 | 0.484 | 0.131 |
| Indicator for most 'severe' activity type being Community Support | -0.185 | 0.170 | 0.279 |
| Indicator for most 'severe' activity type being Intensive Support | 0.288 | 0.213 | 0.195 |

Table H.7 – OOHC (for clients in OOHC at quarter of TEI entry) model terms and coefficients

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Indicator for 2 quarters since entry | -0.585 | 0.040 | 0.001 |
| Indicator for 3 or more quarters since entry | -1.032 | 0.045 | 0.001 |
| Quarters since entry (cupped at 3 and capped at 7) | -0.192 | 0.017 | 0.001 |
| Interaction of TEI flag and quarters since entry (cupped at 3 and capped at 7) | -0.061 | 0.027 | 0.021 |
| Proportion of quarters in the last 5 years with OOHC episodes (capped at 0.9) | 0.807 | 0.142 | 0.001 |
| Proportion of quarters in the last 5 years with OOHC episodes (cupped at 0.9 and capped at 1) | 2.756 | 0.932 | 0.005 |
| Indicator for OOHC placement type Residential Care in the quarter of entry | 1.532 | 0.185 | 0.001 |
| Indicator for OOHC placement type Foster Care in the quarter of entry | 1.587 | 0.147 | 0.001 |
| Indicator for OOHC placement type Independent Living in the quarter of entry | 2.356 | 1.695 | 0.001 |
| Indicator for OOHC placement type Kinship Care or non-related person in the quarter of entry | 1.385 | 0.142 | 0.001 |
| Indicator for OOHC placement type 'Parents', 'Supported Accommodation', 'Home-based' or 'Other' in the quarter of entry | -0.491 | 0.163 | 0.003 |
| Intercept | 1.066 | 0.186 | 0.001 |
| Age at quarter of female child clients (cupped at 11, capped at 15) | -0.103 | 0.030 | 0.005 |
| Age at quarter of male child clients (cupped at 3 and capped at 7) | 0.053 | 0.037 | 0.139 |
| Age at quarter of male child clients (cupped at 7 and capped at 15) | -0.027 | 0.019 | 0.157 |

| Variable description | Coefficient | Standard deviation | p-value |
|---|---|---|---|
| Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry, capped at 8) | -0.013 | 0.011 | 0.205 |
| Whether parent ever had domestic violence experience (excluding experience in the quarter of entry) | -0.209 | 0.163 | 0.197 |
| SEIFA Advantage decile (cupped at 2 and capped at 8) | 0.060 | 0.017 | 0.001 |
| SEIFA Advantage decile (cupped at 8 and capped at 10) | -0.179 | 0.077 | 0.031 |
| Gender | -0.109 | 0.111 | 0.321 |
| Indigenous Status | 0.113 | 0.063 | 0.059 |
| TEI flag | 0.095 | 0.151 | 0.543 |
| Indictor for when only the parent had been recorded as a TEI client | 0.172 | 0.221 | 0.443 |
| Indicator for when the parent entered TEI before the child | -0.323 | 0.342 | 0.339 |
| Indicator for when the parent entered TEI after the child | -0.178 | 0.255 | 0.473 |
| Indicator for most 'severe' activity type being Community Centres | -0.191 | 0.197 | 0.347 |
| Indicator for most 'severe' activity type being Community Centres | -0.173 | 0.260 | 0.477 |
| Indicator for most 'severe' activity type being Community Centres | -0.173 | 0.144 | 0.245 |
| Indicator for most 'severe' activity type being Community Centres | -0.176 | 0.178 | 0.317 |

### H.1.5 Impact of TEI by client characteristics

Using the four regression models and the methodology described at the end of Section H.1.2, we test the size of the impact of TEI support for different cohorts of clients as defined by their demographics / risk factors, including:

- Whether the child had previous interactions with the child protection system before entering TEI (as indicated by whether they had any concern report prior to entry)
- Whether the child belongs in one of the priority cohorts[108] (separate models are built to compare clients in each priority cohort to the rest of the TEI clients), i.e.:
  - Aboriginal Children
  - Children aged 0-5
  - Children who have young parents with risk factors
  - Young people at risk of school disengagement
- The client's age band (0-5, 6-11, 12-17)

[108] Detailed definitions for each priority cohort can be found in Appendix G.3. Note that as this Section focuses on the child protection outcomes, hence we examine the outcomes of the children who have young parents with risk factors, rather than the outcome of the young parents themselves.

- The client's residential DCJ district.

The results for each analysis are summarised in the Sections below. For each of the factors modelled, we first compare the raw concern report and ROSH rate in the first quarter after entry to understand the relative risks between the client characteristics. We choose the first quarter as this would be before the TEI impact has taken place and a more accurate reflection of the clients' underlying level of risk. We then show the modelled results for the size of TEI impact using the change in the modelled outcome rate six-quarters after TEI entry compared to what is expected based on the client's risk profile. The vertical line with the tails at both ends represents the two-sided 95% confidence interval around the model estimate derived using the bootstrapping method. The p-value corresponding to the hypothesis test with a null hypothesis that there is no reduction in the child protection outcome rate from the TEI support is also labelled on top of each data point. A low p-value supports the alternate hypothesis that there *is* a significant reduction in outcomes from the TEI support.

Figure H.9 and Figure H.10 below compares results by whether the child was already known to the child protection system prior to TEI entry. As discussed in Section 6.4.1, children already known to the child protection system also have a much higher rate of having additional child protection interactions after TEI entry, and TEI support contributed to a greater reduction in concern report and ROSH rates for these clients from the higher starting base. Note the result of 0% impact on OOHC rate for children not in OOHC upon entry in Figure H.9 is because it is extremely unlikely for someone without any child protection interaction history to enter TEI within seven quarters, both for the TEI and non-TEI cohorts. Therefore, any impact would be too small to be measured by the model. The results from the model for OOHC rate for children already in OOHC upon entry is not shown as by definition all these children have already been in contact with the child protection system and the results would be identical to the overall results presented in the previous section.

Figure H.9 – Observed outcomes rate one quarter after entry for children with and without child protection interaction prior to TEI entry (HSDS)

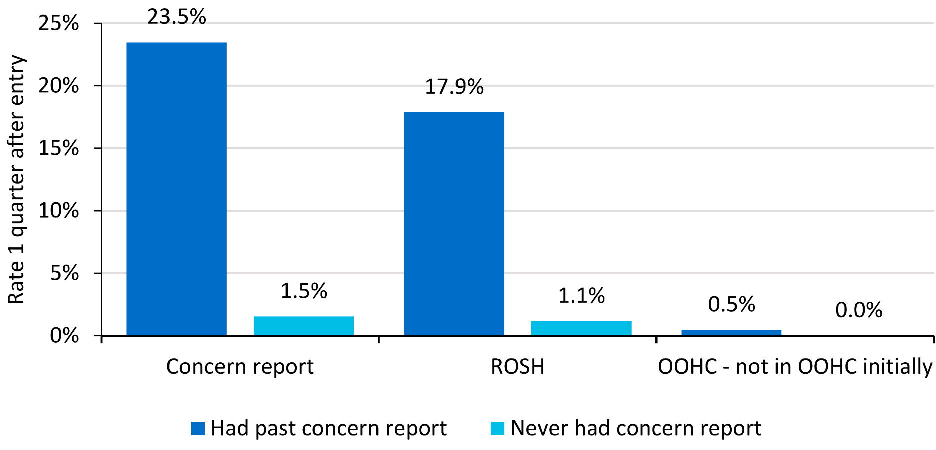



Figure H.10 – Modelled TEI impact six quarters after entry for children with and without child protection interaction prior to TEI entry (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.

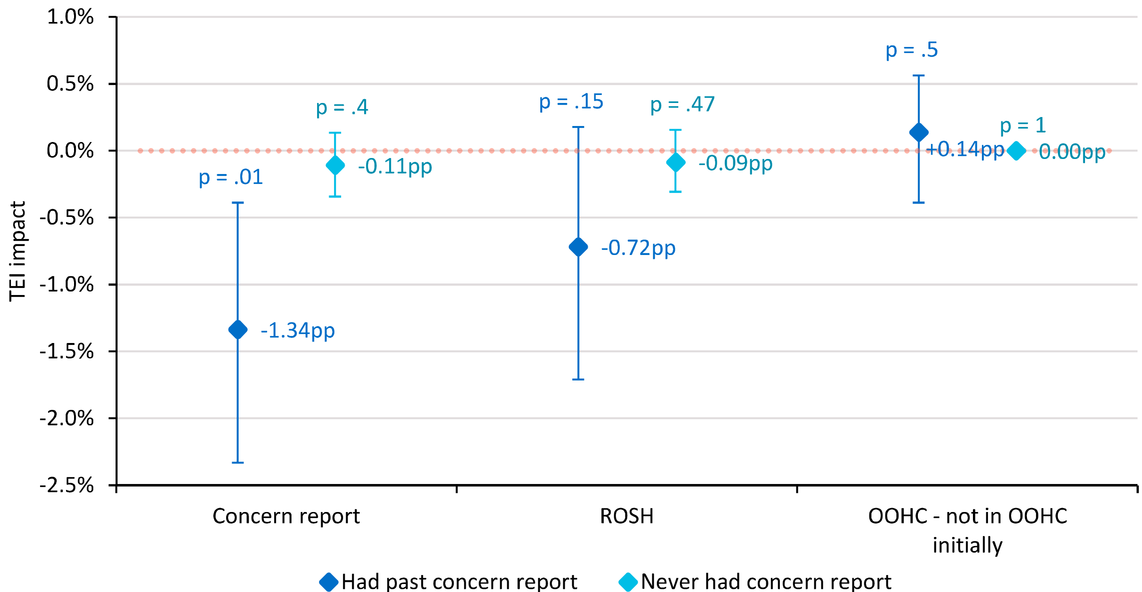



Figure H.11 and Figure H.12 below compare the results for children in each of the priority cohorts which were discussed in Section 6.6.2. Except for the cohort of children aged 0-5, the priority cohorts have much higher risk. Aboriginal clients and children at risk of school disengagement both have similar concern report and ROSH rate to children with previous interactions with the child protection system as we saw earlier. TEI support have also contributed to a greater reduction in concern report and ROSH rate for Aboriginal children from the higher starting risk level, again similar to the results for children with previous child protection interactions. The impact of TEI for the other TEI cohorts are less favourable, especially for children who have young parents with risk factors. However, we note that the confidence interval around the estimates for these priority cohorts are much wider due to lower data volume.

Figure H.11 – Observed outcomes rate one quarter after entry for children in the priority cohorts (HSDS)

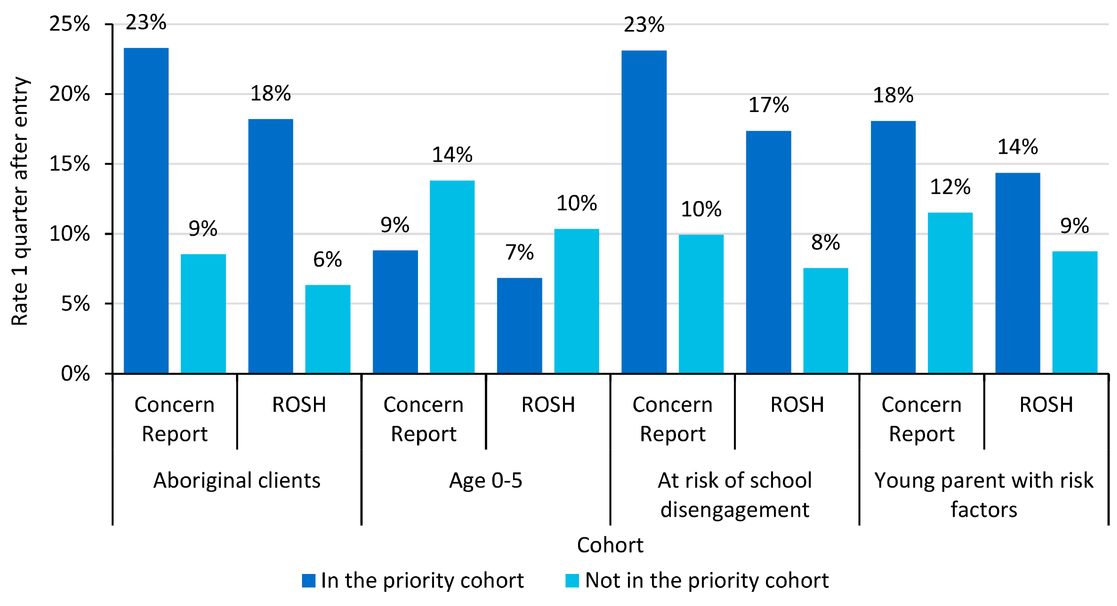
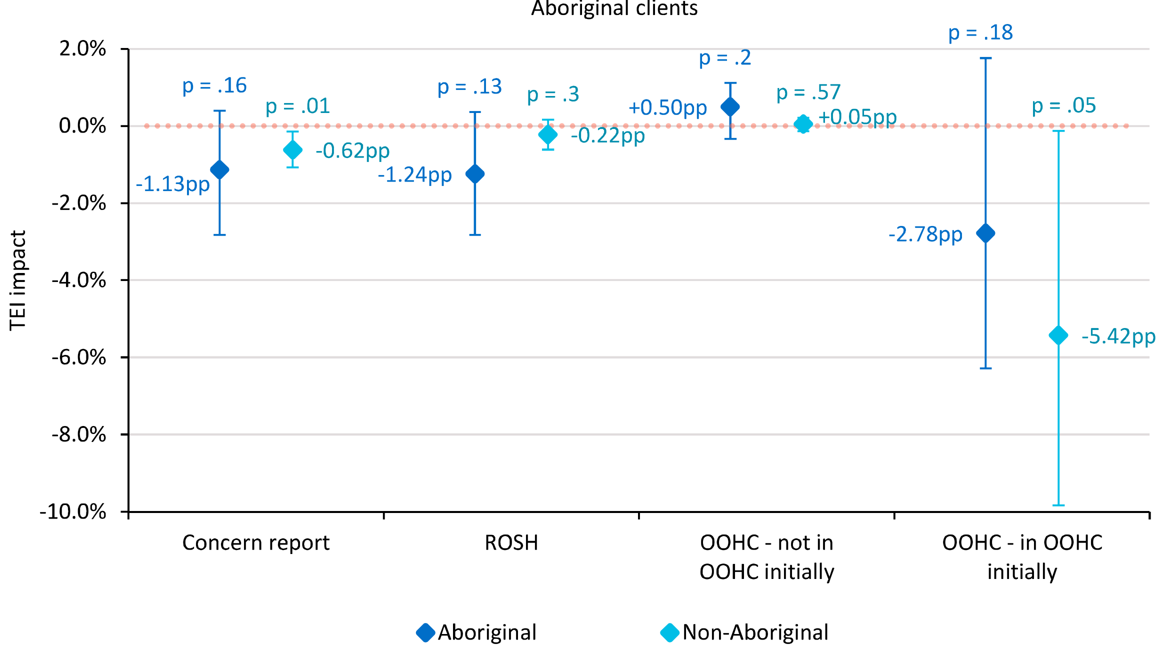
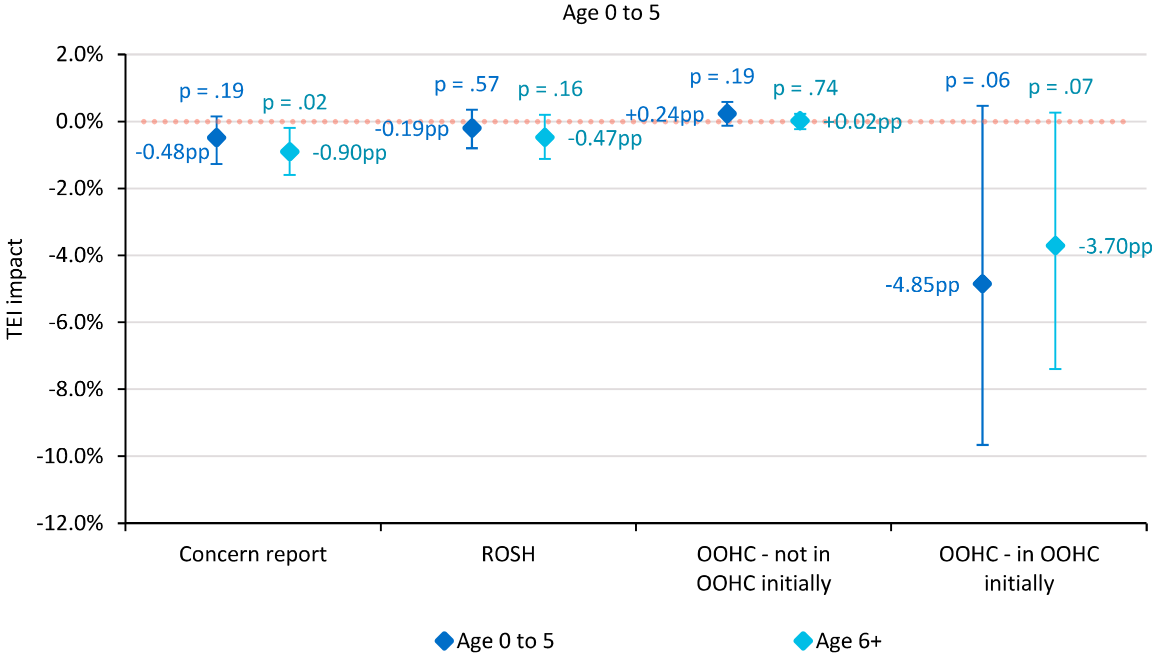
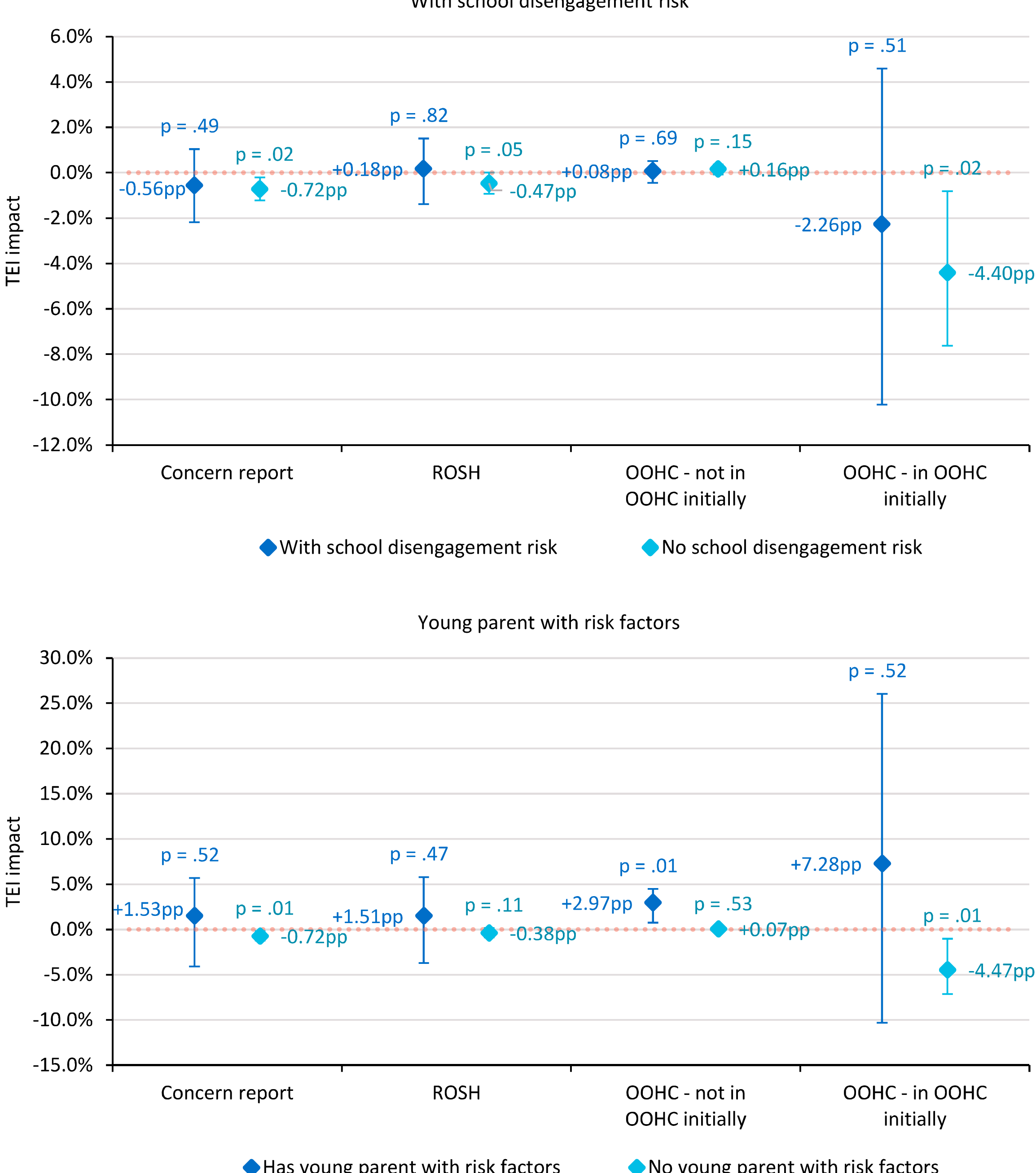



Figure H.12 – Modelled TEI impact six quarters after entry for children in the priority cohorts (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.


Aboriginal clients
2.0%
0.0%
-2.0%
-4.0%
-6.0%
-8.0%
-10.0%
TEI impact
p = .16
p = .01
p = .13
p = .3
p = .2
p = .57
p = .18
p = .05
-1.13pp
-0.62pp
-1.24pp
-0.22pp
+0.50pp
+0.05pp
-2.78pp
-5.42pp
Concern report
ROSH
OOHC - not in OOHC initially
OOHC - in OOHC initially
Aboriginal
Non-Aboriginal


Age 0 to 5
2.0%
0.0%
-2.0%
-4.0%
-6.0%
-8.0%
-10.0%
-12.0%
TEI impact
p = .19
p = .02
p = .57
p = .16
p = .19
p = .74
p = .06
p = .07
-0.48pp
-0.90pp
-0.19pp
-0.47pp
+0.24pp
+0.02pp
-4.85pp
-3.70pp
Concern report
ROSH
OOHC - not in OOHC initially
OOHC - in OOHC initially
Age 0 to 5
Age 6+




In addition to the investigation of clients aged 0 to 5 as part of the priority cohorts, we group clients into age bands 0 to 5, 6 to 11 and 12 to 17 based on the rough life stages and compare the results by age band in Figure H.13 and Figure H.14 below[109]. We see the risk of concern report and ROSH increases with age. For concern report and ROSH, we see a statistically significant reduction (at 5% threshold level) for clients aged 6 to 11. For OOHC rate of children already in OOHC upon entry, we see a statistically significant reduction for clients aged 0 to 5.

[109] Note that the results for age 0 to 5 is very slightly different to the results from the priority cohorts above as they are from separate models and there is a slight randomness to the bootstrapping approach.

Figure H.13 – Observed outcomes rate one quarter after entry by client age band at entry (HSDS)

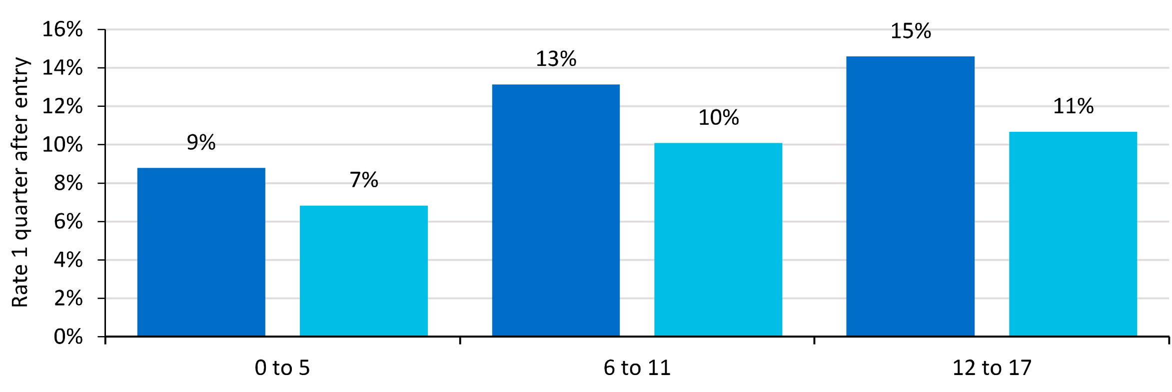
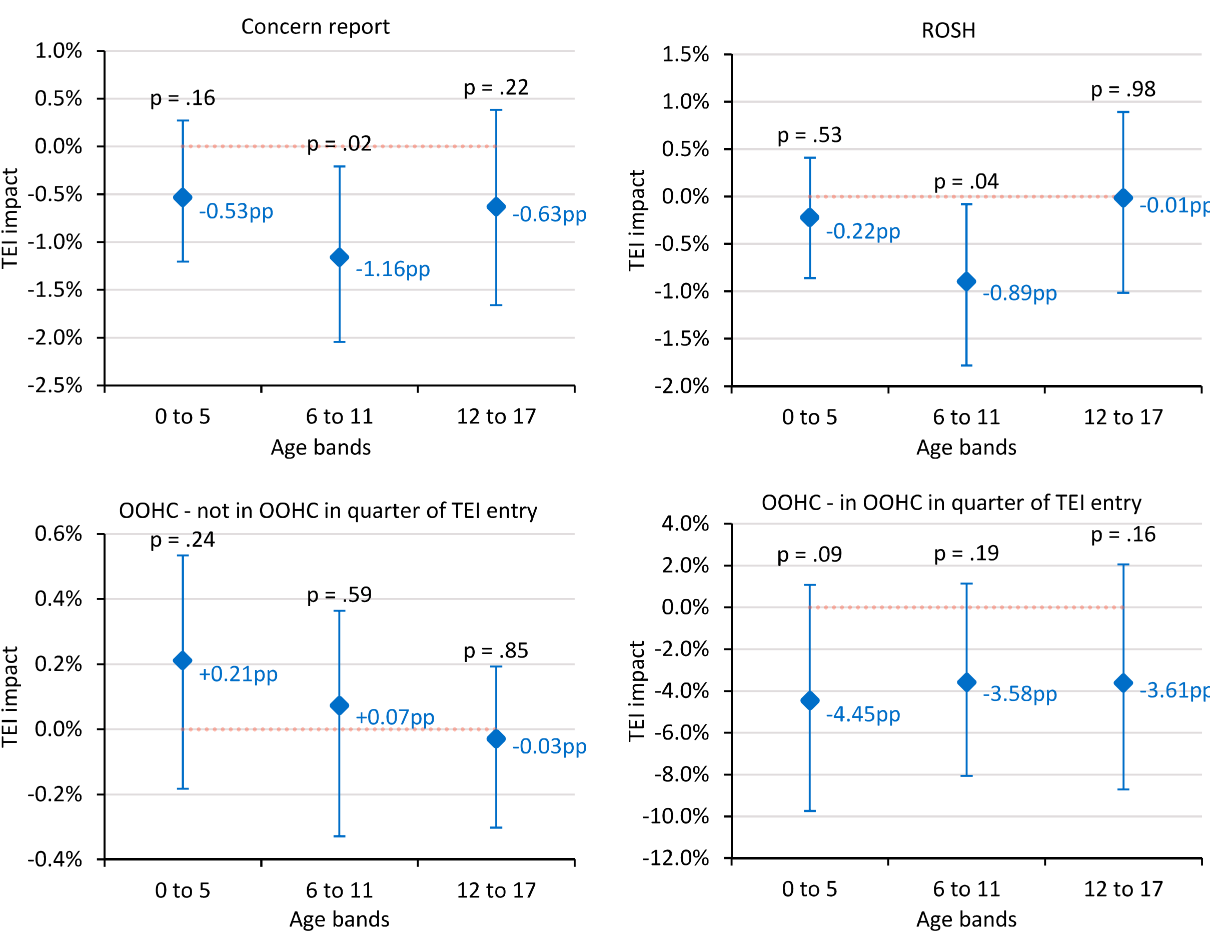



Figure H.14 – Modelled TEI impact six quarters after entry by client age band at entry (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.




Lastly, we compared results by client's residential DCJ district as at TEI entry with results shown in Figure H.15 and Figure H.16 below. Clients in the metropolitan Sydney districts generally have lower starting risk of Concern report and ROSH compared to the more remote districts. From the charts we see there are variations across districts for each of the outcomes modelled, with Northern Sydney standing out as the district that had a statistically significant reduction in all three outcomes. Note that the model for OOHC rate for children not in OOHC upon entry is not done by DCJ district as the volume of the target is very low in some of the districts and does not satisfy the data privacy requirements. For the same reason, results for Far West have been excluded from all the charts.

Figure H.15 – Observed outcomes rate one quarter after entry by client residential DCJ district at entry (HSDS)

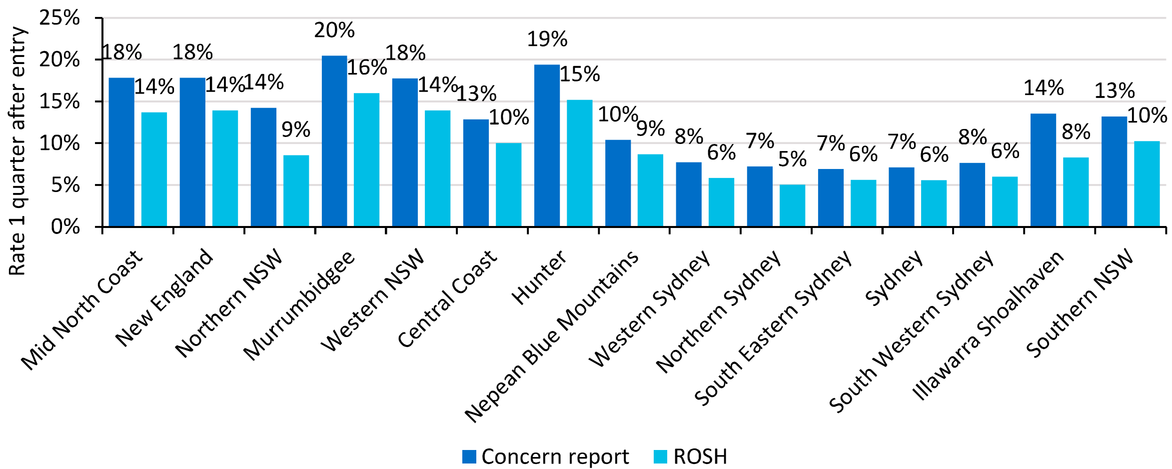
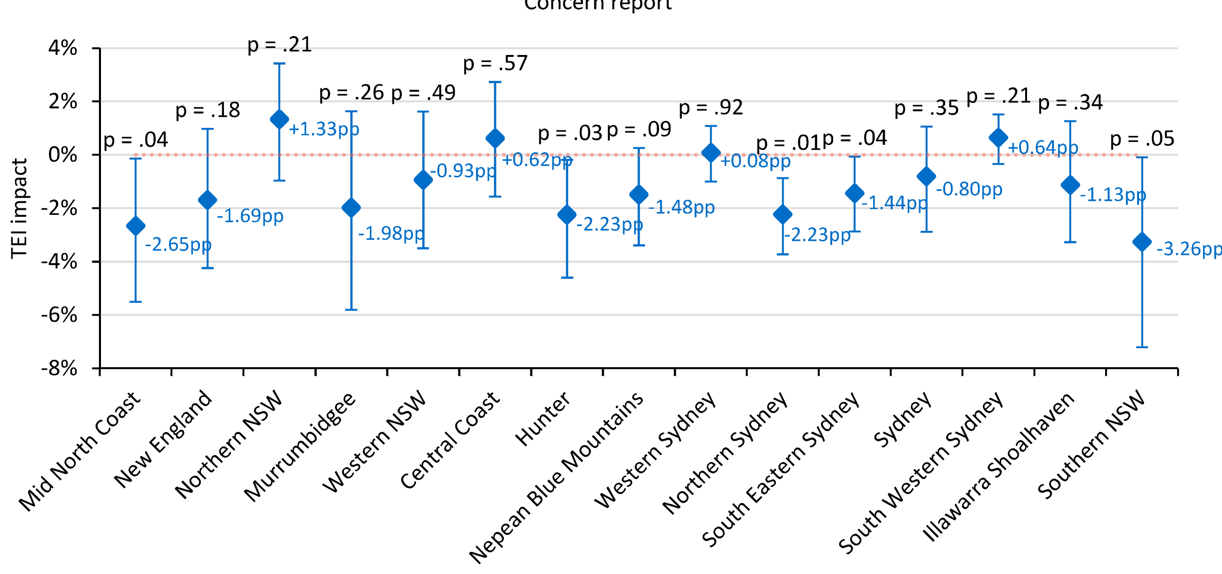
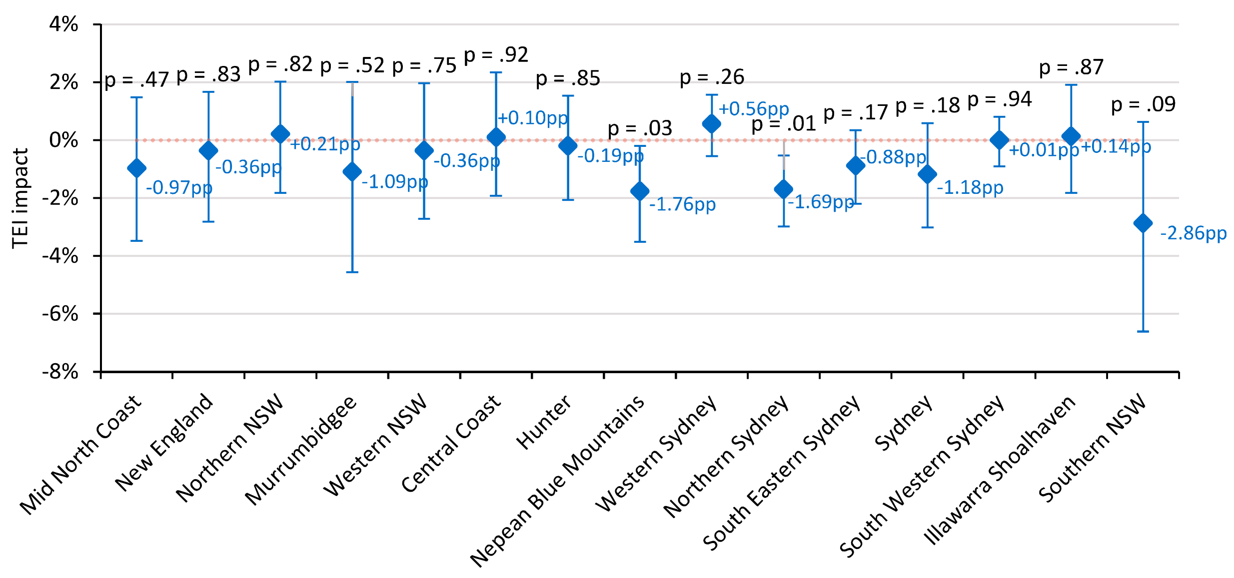
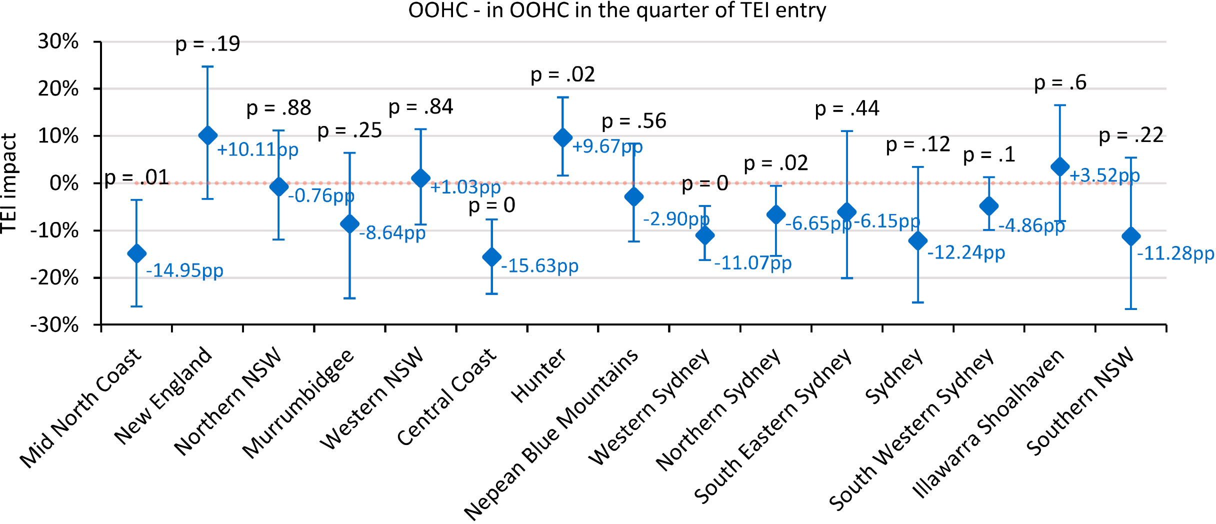



Figure H.16 – Modelled TEI impact six quarters after entry by client residential DCJ district at entry (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.






### H.1.6 Impact of TEI by services received

Using the same method as above, we also tested the size of the impact of TEI support for different cohorts of clients as defined by quantity of type of services that they have received, including:

- Activity types received
- Service types received
- For Aboriginal children specifically, whether they had received any services that are designed specifically for Aboriginal clients (includes service types Indigenous Community Engagement, Indigenous Social Participation, Indigenous Advocacy/Support, Indigenous Healing Workshops, Indigenous Supported Playgroups) – this is done separately to the one above which tests all service types for all children
- Total number of sessions attended

Note that the type and amount of support received is derived from the child's record if they are recorded as clients themselves, or from their parent's record if they were not recorded as clients but their parent was. We summarise the test results below using charts of the same formats as the previous section.

Figure H.17 and Figure H.18 below compares the results by the types of program activities that the clients have received. As noted in Section 6.6.2, the underlying risk of the clients by activity type received is roughly in-line with the design of each program activity, with clients receiving Targeted Support having the only significant reduction in concern reports.

In addition, we note that the modelled impact in OOHC rate for children not initially in OOHC appears to be roughly in line with the relative situations of the cohorts receiving the activity types, with the most favourable impact observed for clients who have received Community Centres, who have the lowest rate to begin with, and the least favourable impact observed for clients who have received Intensive Support. This may be due to an underlying difference in the unobserved risk factors which could not be controlled by the model as further discussed in the limitations Section below.

Figure H.17 – Observed outcomes rate one quarter after entry by activity type received (HSDS)

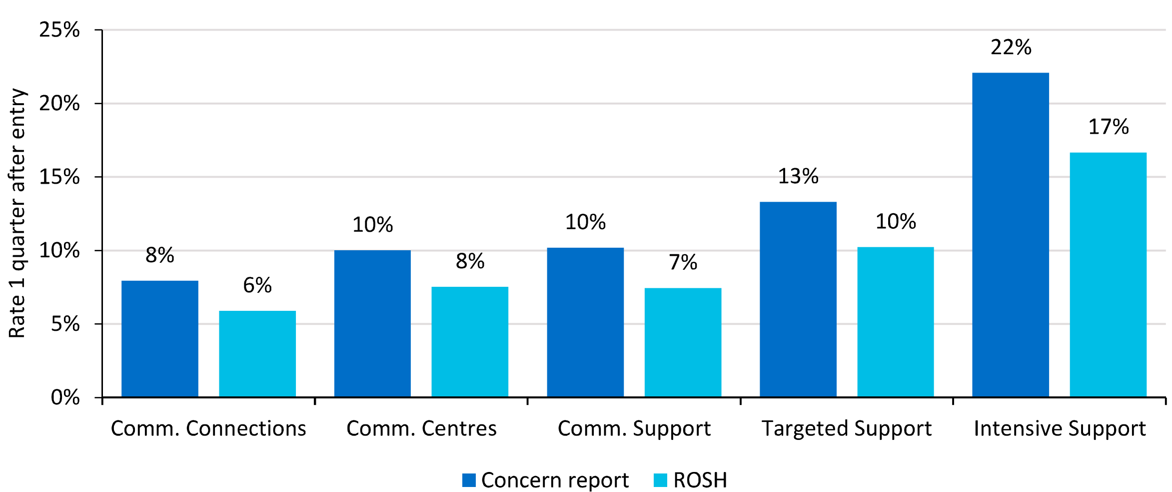
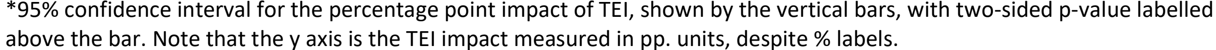
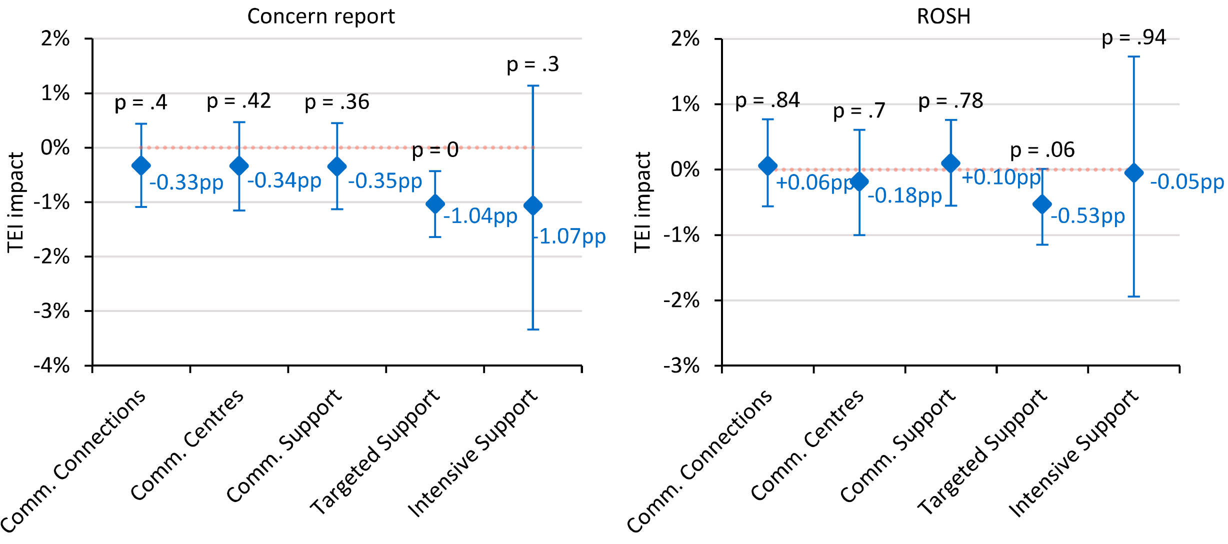



Figure H.18 – Modelled TEI impact six quarters after entry by activity type received (HSDS)


*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.



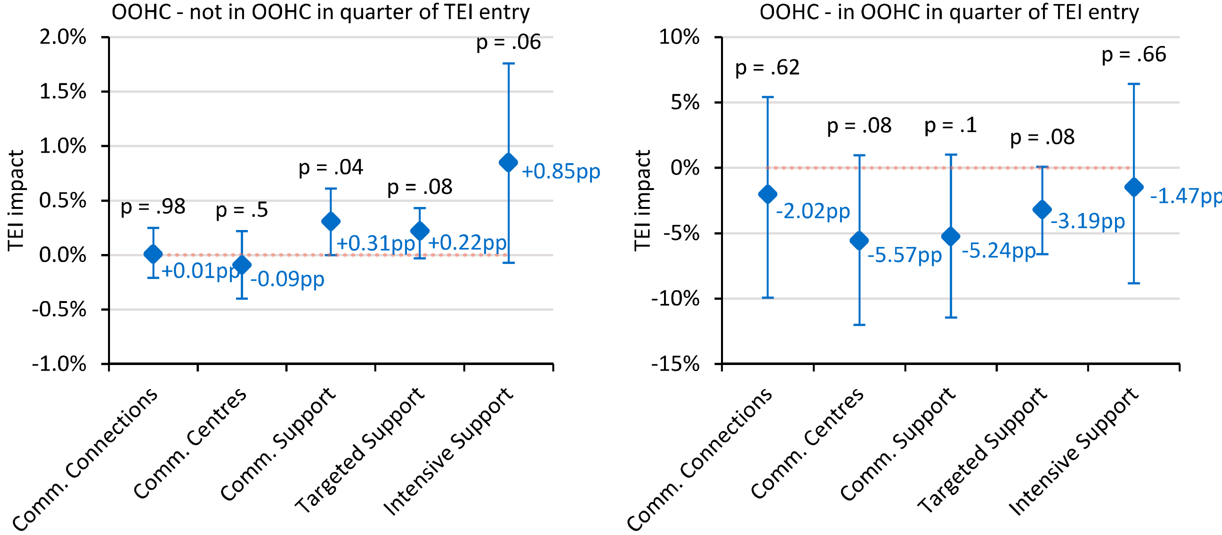



Figure H.19 and Figure H.20 below compares results by the service types that the clients have received. Consistent with the observations from the activity type comparison above, clients who received service types from the Community Strengthening stream such as Social Participation and Community Engagement tend to have lower risks, while clients who received services from the Wellbeing and Safety stream such as Counselling and Family Capacity building tend to have higher risks. Clients who received Specialist Support have the highest risk (note that some of the service types such as Education and Skills Training can fall under multiple activity types as shown in Appendix B). One notable exception is Supported Playgroups, which falls under Targeted Support activity type but clients who received the service have much lower risk compared to the other service types under Targeted Support.

As discussed in the results from Section 6.6.2, Counselling and Specialist Support stand out as services that have contributed to the most reduction in concern reports, which are helping the clients with the highest risks. Note that the confidence interval around the results for Specialist Support is wide due to the low volume of clients who have received the service.

Also note that in the charts below the Indigenous specific service types have been grouped into one broad category as the number of clients who have received the services are small and does not satisfy data privacy requirements. The service type Facilitating Employment Pathways is excluded from all models, while Community Engagement and Specialist Support are excluded from the OOHC model for children not initially in OOHC, again due to small data volume.

Figure H.19 – Observed outcomes rate one quarter after entry by service type received (HSDS)

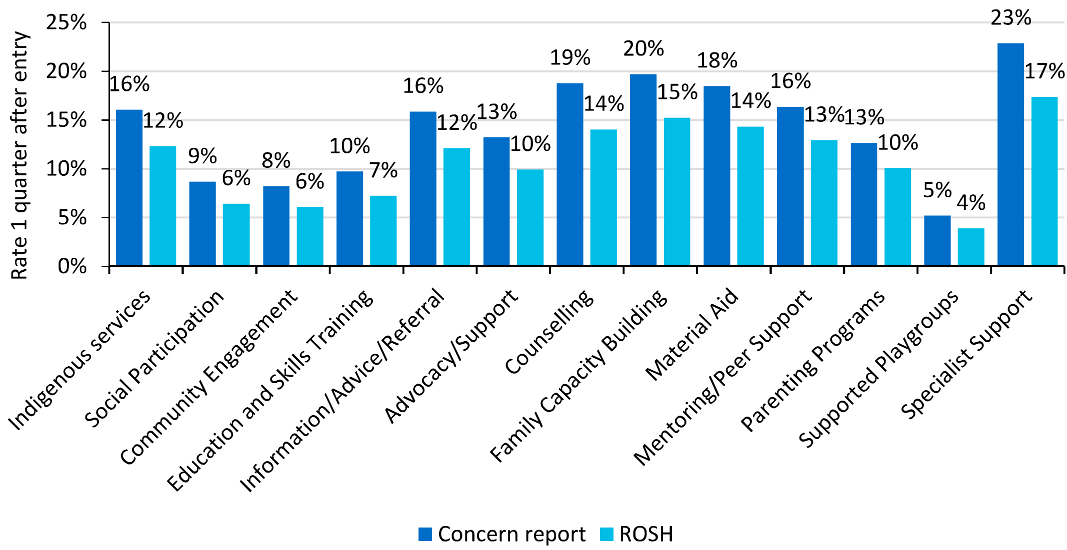
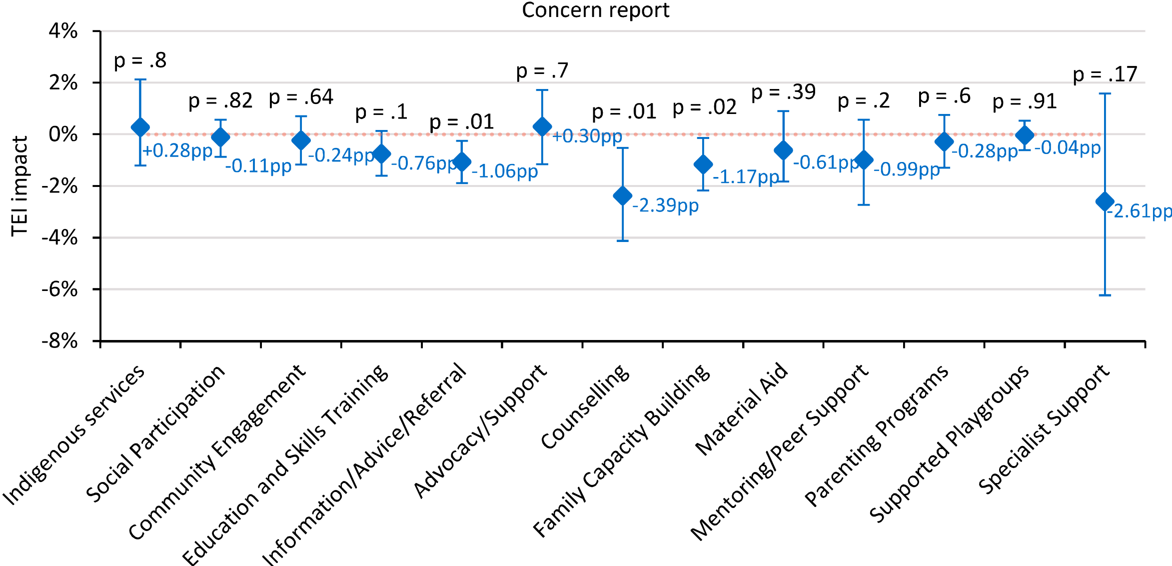
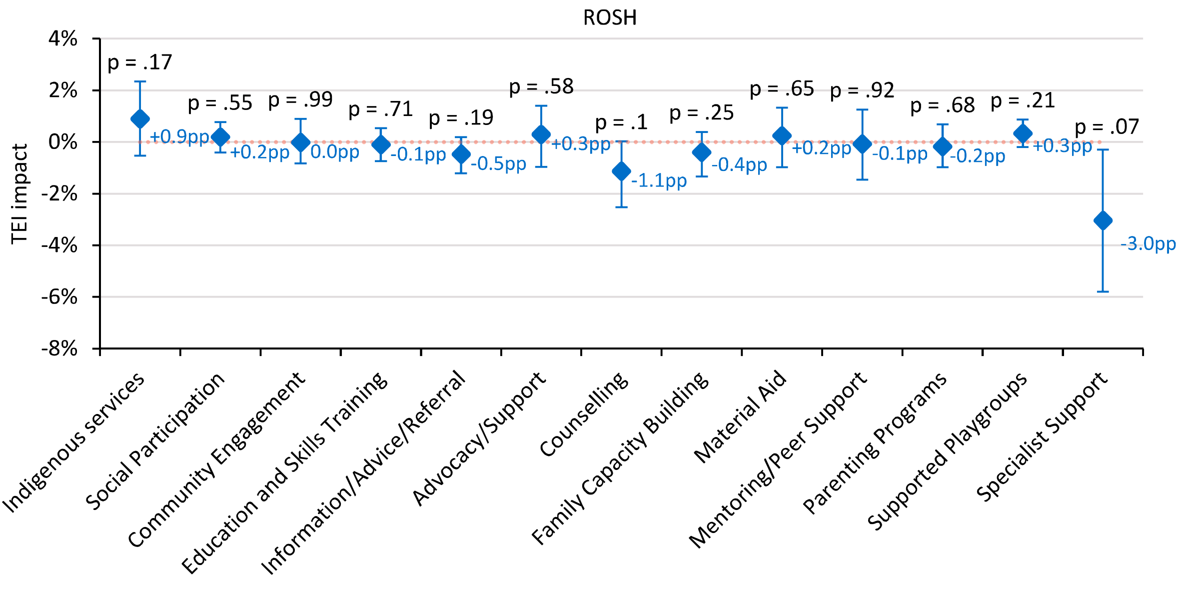
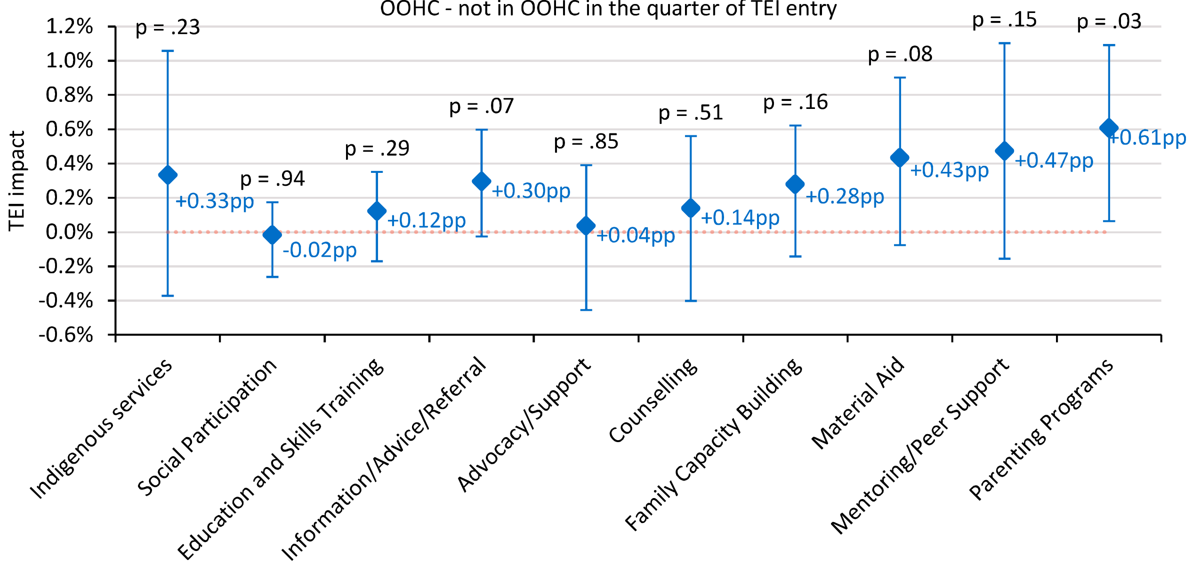


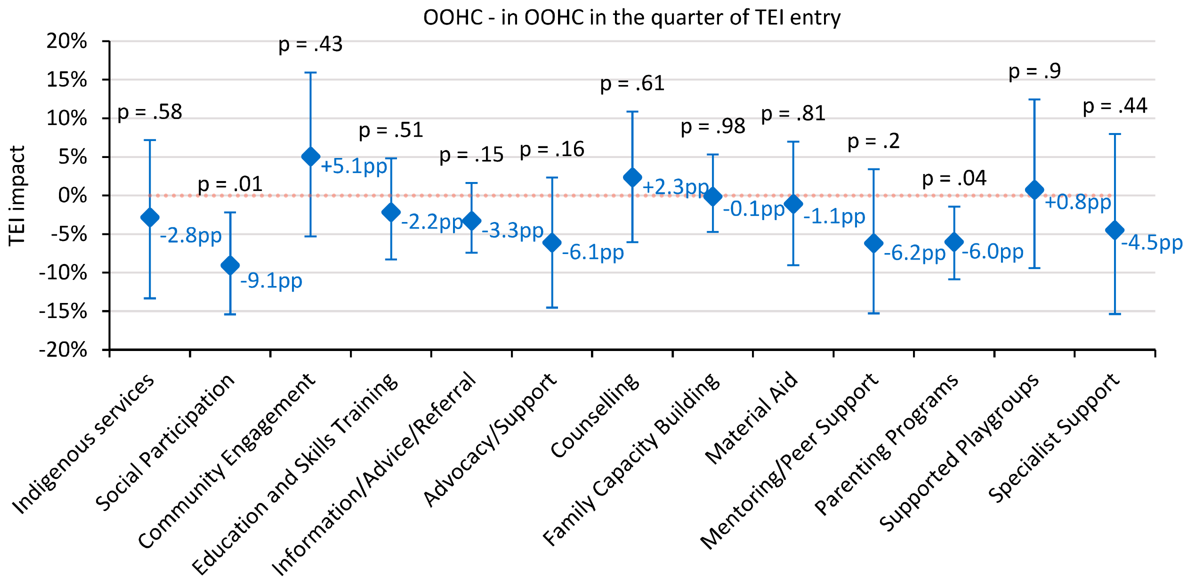

Figure H.20 – Modelled TEI impact six quarters after entry by service type received (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.






In

addition to the test of all the service types, we tested specifically for the impact of the Indigenous specific service types for Aboriginal children as first discussed in Section 8.3.1, with further breakdowns shown in Figure H.21 and Figure H.22 below. It is notable that the Aboriginal children who received the Indigenous specific service types appear to have lower risk than those who did not, possibly due to the service types having a greater focus in the Community Strengthening stream. The services have contributed to a statistically significant reduction (p-value = 0.05) in the rate of remaining in OOHC rate, while the impact on the other modelled outcomes are less conclusive.

Figure H.21 – Observed outcomes rate for Aboriginal children one quarter after entry by whether they received the Indigenous specific service types (HSDS)

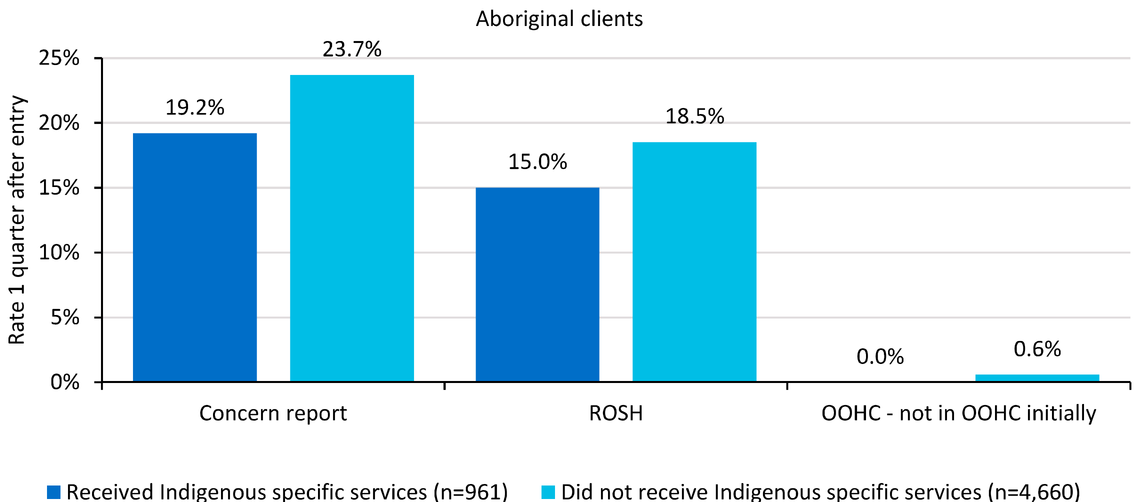
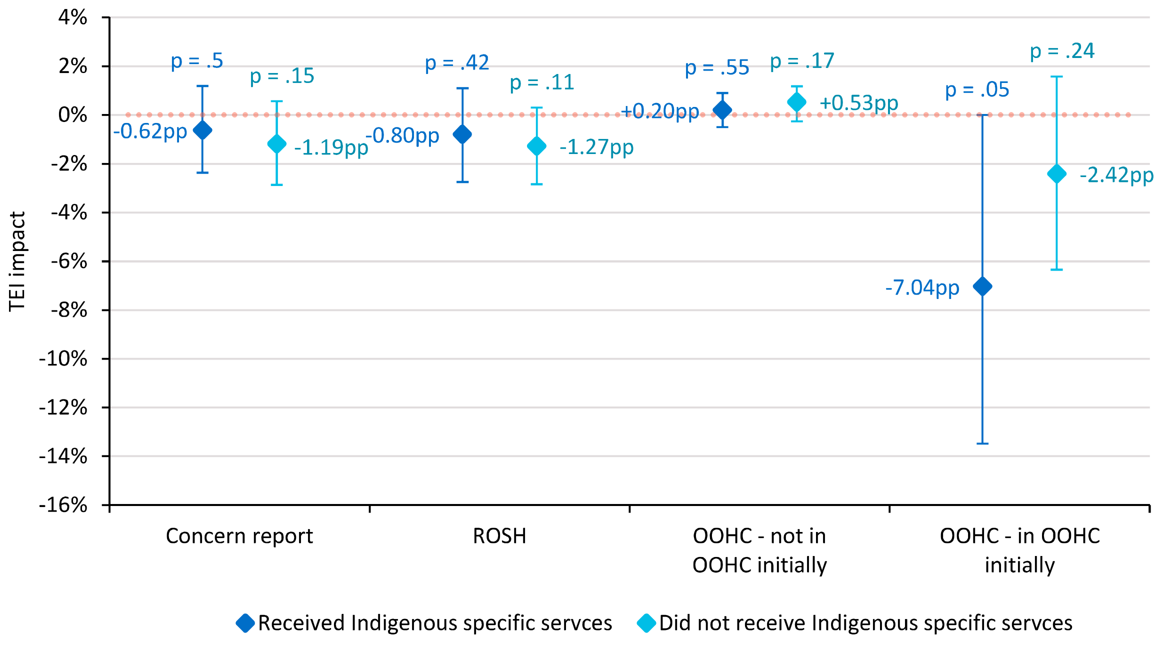



Figure H.22 – Modelled TEI impact for Aboriginal children six quarters after entry by whether they received the Indigenous specific service types (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.




Finally, we compared results by the total number of sessions that the client has attended in Figure H.23 and Figure H.24 below. Clients with higher risk were able to receive more sessions, which have

contributed to a more significant reduction in the child protection outcomes from the higher starting base. The groupings used were determined by first fitting the model without number of sessions as a predictor, then we compared the difference between the model predicted rate and observed rate by number of sessions and grouping by regions where the difference is similar. The grouped session variable was then added to the model as a predictor and the difference between model predicted rate and observed rate was re-examined to ensure that the difference have been corrected.

Figure H.23 – Observed outcomes rate one quarter after entry by total number of sessions attended (HSDS)

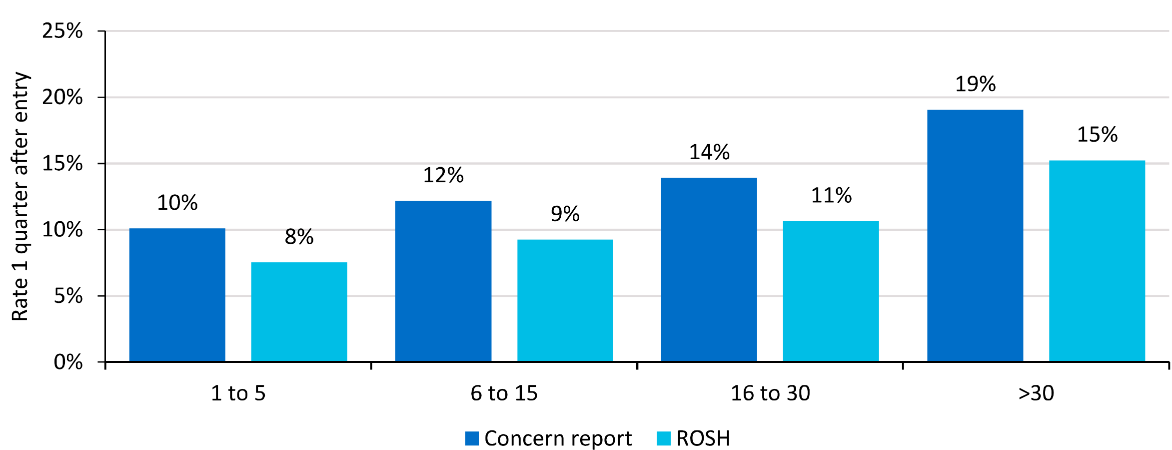
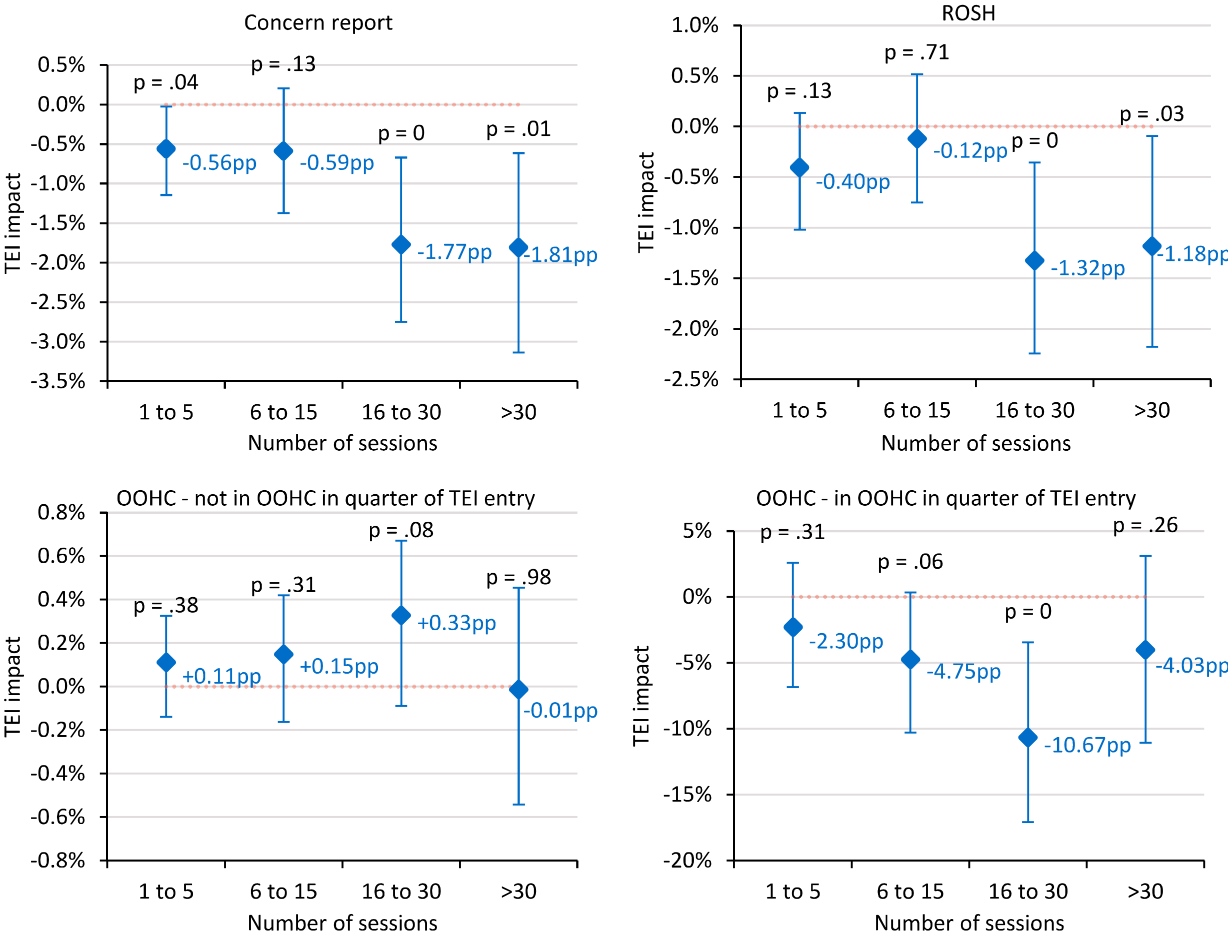



Figure H.24 – Modelled TEI impact six quarters after entry by total number of sessions attended (HSDS)

*95% confidence interval for the percentage point impact of TEI, shown by the vertical bars, with two-sided p-value labelled above the bar. Note that the y axis is the TEI impact measured in pp. units, despite % labels.



### H.1.7 Uncertainties and Limitations

In addition to the data limitations regarding the linked dataset as discussed in Section 3.4, there are additional uncertainties and limitations specific to the regression design as discussed below:

- The primary uncertainty of this modelling approach, like other approaches, is that we can only control for risk factors that are observable from the data and cannot control for unobservable risk factors. We have assumed the size of the residual selection effect for the TEI cohort to be the difference between the observed rate and the model predicted rate without TEI support using the observable risk factors as at one quarter after entry, and applied this across all quarters. This approach:
  - Ignores any immediate benefit brought by TEI in the quarter of entry and the quarter after entry – if there is immediate positive impact from the TEI support, then the size of the TEI selection effect would be underestimated and the estimate of TEI estimate in subsequent quarters would also be understated.
  - Does not account for how the selection effect from unobserved risk factors will naturally progress over time and how this impacts the modelled outcomes. As seen from the results from previous sections, conditions for individuals in high-risk situations may naturally improve even in the absence of TEI support. In addition, part of the selection effect in the first quarter after entry might be due to a temporary increase in child protection interaction due to the family becoming more visible to the child protection system as a result of the participation in TEI. We expect these two effects to somewhat offset the potential underestimation described in the previous paragraph. However, for the rate of entry into OOHC, the impact of present risk factors leading to OOHC may be more delayed as it is the most severe form of child protection and takes time to be assessed, as opposed to concern report and ROSH which can occur more instantly. Given this, the controlling of unobserved risk factors using the gap in the first quarter after entry is possibly inadequate. This could be a contributor to the result of the increase in OOHC rate from participation in TEI for children not initially in OOHC at entry.
- The model uses client characteristics and service interaction history as at the end of the quarter of entry to predict future outcomes. This is different to the client's risk profile as at the point entry if TEI had brought immediate change to the client's situations between program entry and the end of the quarter. To quantify the potential impact of this limitation we have refitted the model using individuals who entered in the third month of the quarter only (i.e. a short time between program entry and the end of the quarter) – the result was consistent with those from the main model.
- Service use history would be limited for children who are very young which limits the model's ability to accurately assess their risk profile. We do use the service use history of parents in the model to help assess their risk profile, however their predictiveness is not as strong as the service use from the children themselves.
- The TEI population available for assessing the longer-term impact of TEI is relatively low and is currently limited to seven quarters. Future updates with additional data would improve the robustness of the analysis.
- Unlike the propensity model discussed in the subsequent Section, separate regression models are required for each outcome and the process of variable selection and model building is time-consuming. Hence we have only tested the three of the most important target outcomes of TEI using this approach.
- The analysis only utilises individual TEI clients who can be linked to the HSDS data, which only covers a small proportion of clients in the Community Strengthening stream. We have attempted to address this limitation via the aggregate analysis described in Appendix H.3 below.

## H.2 Propensity matched comparison for broader outcomes

### H.2.1 Introduction and process

In addition to child safety outcomes, the individual-level linkage of TEI service use (including indirect clients) to the HSDS allows us to test a range of other outcomes that are expected to be influenced by TEI services. While this could be tested using the regression framework of Appendix H.1, the wide range of outcomes means its more efficient to set up as a propensity-matched comparison, so that a set of outcomes can be tested quickly for the TEI group and another group who do not interact with TEI but otherwise have similar characteristics. This can be done for up to seven quarters experience (post TEI entry), given the relevant time period July 2020 (start of TEI) through to June 2022 (end of HSDS linked data availability).

The propensity-matching process involves the following steps:

1. A propensity model is fit, predicting the likelihood (propensity) of a person commencing TEI services in a given quarter, given their demographic characteristics and service use up to that quarter (Appendix H.2.2).
2. A 1 in 4 sample of the NSW population is taken and each person is assigned a propensity score based on the propensity model. Note that all TEI clients (direct and indirect) are included. This represents the predicted likelihood of TEI entry based on historical risk factors. The underlying dataset is again one row per person per quarter (similar to Appendix H.1), so the model assigns a propensity score to observations of individuals in each quarter from 30th September 2020 to 30th June 2022.
3. Each TEI entrant is matched to a non-TEI person with the nearest propensity score (without replacement). Some risk factors are forced to be the same. If a non-TEI person can't be found within 0.1 standard deviations of the propensity score, the TEI entrant is left unmatched. The matched cohorts are compared at an aggregate level to diagnose risk factor balance (Appendix H.2.3)
4. The outcome rates of the matched cohorts are extracted and compared (Appendix H.2.4).

### H.2.2 Propensity model details and diagnostics

The propensity models were fit using the XGBoost package in R. There were two models fit, the first predicting direct entries into TEI (i.e. the person themselves is a TEI client), and the second predicting indirect entries into TEI (i.e. their parent is a TEI client). Initial models were fit using all available service history and one year of data, which was cut to top 50 for the final model due to computational limits. We have preferred to provide more variables to achieve highest predictivity, noting that some variables are given relatively little weight by the GBM. Both final models used 8 quarters of data. The hyperparameters and options used to fit the final propensity models are in the table below.

| **Hyperparameter / option** | **Value** |
|---|---|
| Tree method | Faster optimized approximate greedy algorithm |
| Objective function | Logistic |
| Evaluation metric | Log loss |
| Learning rate | 0.2 |
| Maximum depth (maximum n-way interactions) | 5 |
| Minimum child weight | 500 |

| Hyperparameter / option | Value |
|---|---|
| Test dataset proportion (for the purposes of propensity modelling only) | 30% of modelling dataset (7 million observations) |

### H.2.2.1 Direct entry model

Below is a list of all variables included in the model. Note that there are some variables included that include information about services used in the quarter of TEI entry. This creates some information leakage as the service usage in the quarter of TEI entry may include services used after intervention. The inclusion of these variables was required to match the strong peak in service usage observed in the TEI cohort during the quarter of intervention.

- ABS 2016 Remoteness Area class
- Age at entry quarter
- Age of mother at quarter of entry
- Appeared at Children's, Drug, Local, District or Supreme Court in quarter of entry
- DCJ district
- Domestic violence police incidents experienced as victim in quarter of entry
- Had a concern report in quarter of entry
- Has achieved an ATAR as at quarter of entry
- Has completed the HSC at quarter of entry
- Is a parent
- Is Aboriginal
- Last NAPLAN exam year sat
- Number of concern reports within 1 year prior to entry
- Number of days in hospital within 1 year prior to entry
- Number of days in hospital within 5 years prior to entry
- Number of days in which ambulatory mental health services were accessed in quarter of entry
- Number of days in which ambulatory mental health services were accessed within 5 years prior to entry
- Number of parents in the HSDS
- Number of police incidents experienced as victim in the quarter of entry
- Number of quarters presented as at risk of homelessness to Specialist Homelessness Services within 5 years prior to entry quarter
- Number of quarters since last accessing mental health ambulatory services (excluding access in the quarter of entry)
- Number of quarters since last accessing private rental assistance (excluding access in the quarter of entry)
- Number of quarters since last accessing public housing (excluding access in the quarter of entry)
- Number of quarters since last admitted to hospital (excluding admissions in the quarter of entry)
- Number of quarters since last concern report (excluding any in the quarter of entry)
- Number of quarters since last experienced a non-domestic violence incident as victim (excluding incidents in the quarter of entry)
- Number of quarters since last experiencing a domestic violence police incident as victim (excluding incidents in the quarter of entry)
- Number of quarters since last in custody (excluding time in custody in quarter of entry)
- Number of quarters since last in Out Of Home Care (excluding time in OOHC in quarter of entry)
- Number of quarters since last presenting as at risk of homelessness to SHS (excluding presentations in quarter of entry)
- Number of quarters since last presenting as homeless to SHS (excluding presentations in quarter of entry)
- Number of quarters since last ROSH report (excluding any in the quarter of entry)
- Number of quarters since parent last accessed mental health services (excluding access in the quarter of entry)*
- Number of quarters since parent last appeared at Children's', Drug, Local, District or Supreme Court (excluding appearances in the quarter of entry)
- Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry)*
- Number of quarters since parent last had service experience in justice domain (excluding experience in the quarter of entry)*
- Number of ROSH reports within 5 years prior to entry
- Presented to Specialist Homelessness Services in quarter of entry

- Proportion of enrolled school days attended within 1 year prior to entry
- Proportion of enrolled school days attended within 5 years prior to entry
- Proportion of enrolled school days suspended within 1 year prior to entry
- Proportion of enrolled school days with unexplained absence within 1 year prior to entry
- Quarter of entry
- SEIFA Advantage decile
- Sex
- Time spent in Out Of Home Care within the 1 year prior to entry
- Weight at birth
- Whether individual was born in NSW, or outside of NSW, or a relative of NSW-born, or a relative of non-NSW-born

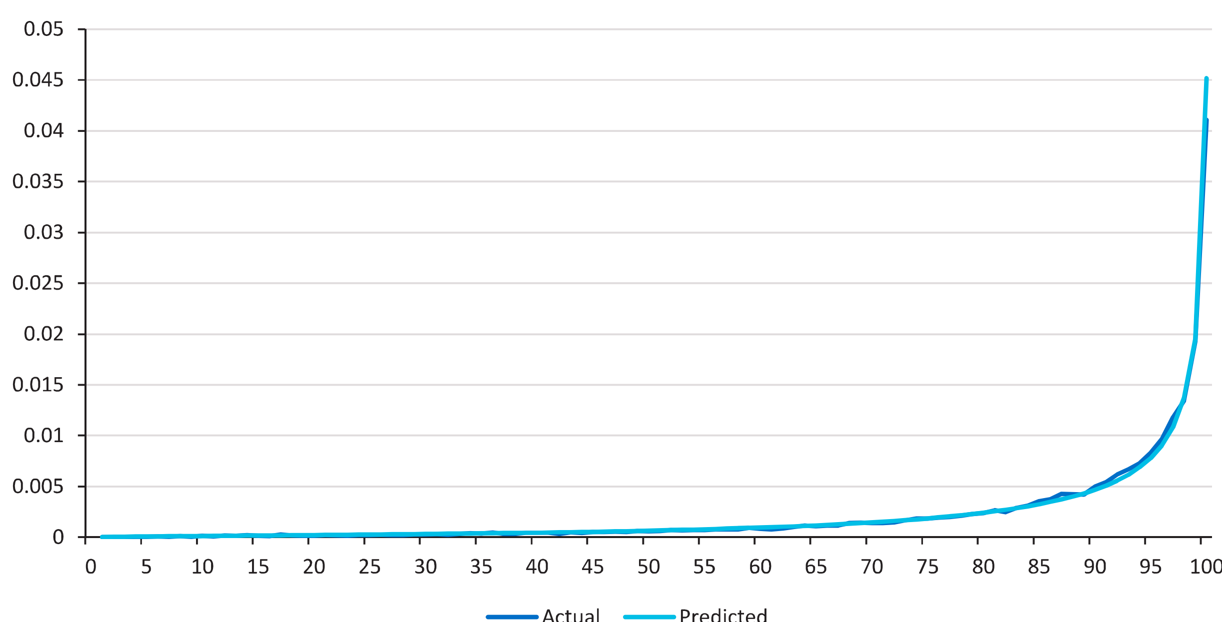
*For a list of services considered in establishing parental history with a particular domain, see the domain definitions used to define client complexity in Appendix G.2.

Figure H.25 shows the relative variable importance of the top 30 most important variables. As one would expect, child safety variables are given high importance by the model, with both long-term and short-term history having high importance. Housing stability (homelessness) and geographic/socio-economic variables are also highly important.

Figure H.25 – Relative variable importance, top 30 variables in the direct entry model

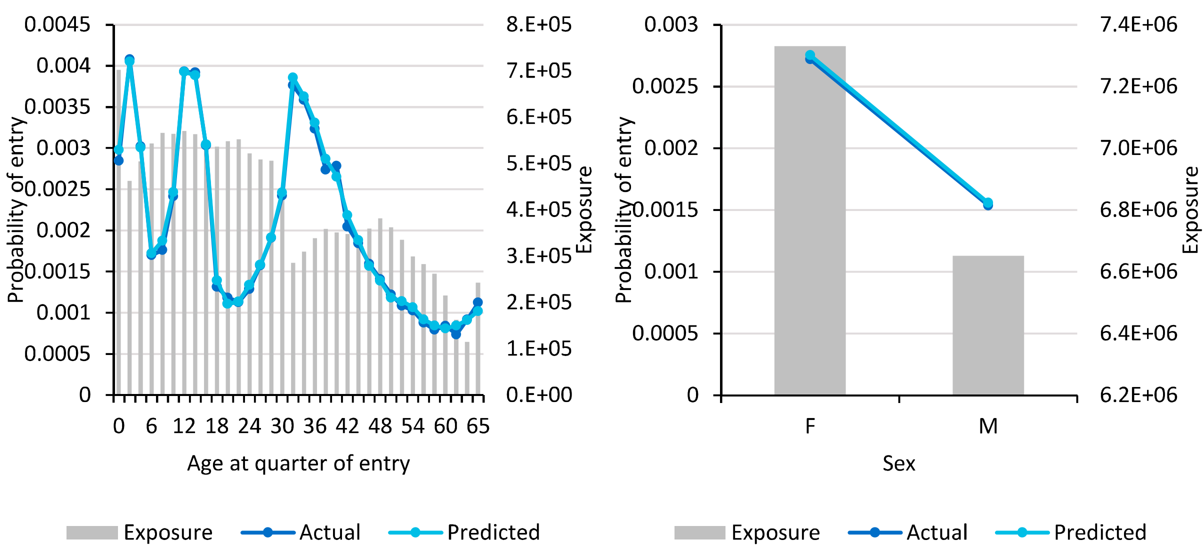
The plot in Figure H.26 sorts people-quarters in the test dataset into percentile bands based on model prediction, then compares the average prediction for each band with the actual rate of TEI entry in the band. Firstly, we note that since the lines are closely aligned, there are no large areas of misprediction. Secondly, the plot shows that the model was able to identify a top 1% of people-quarters with a probability of TEI entry of 4.5%, 21 times higher than the population average and 1,500 times higher than those assigned with the least probability.

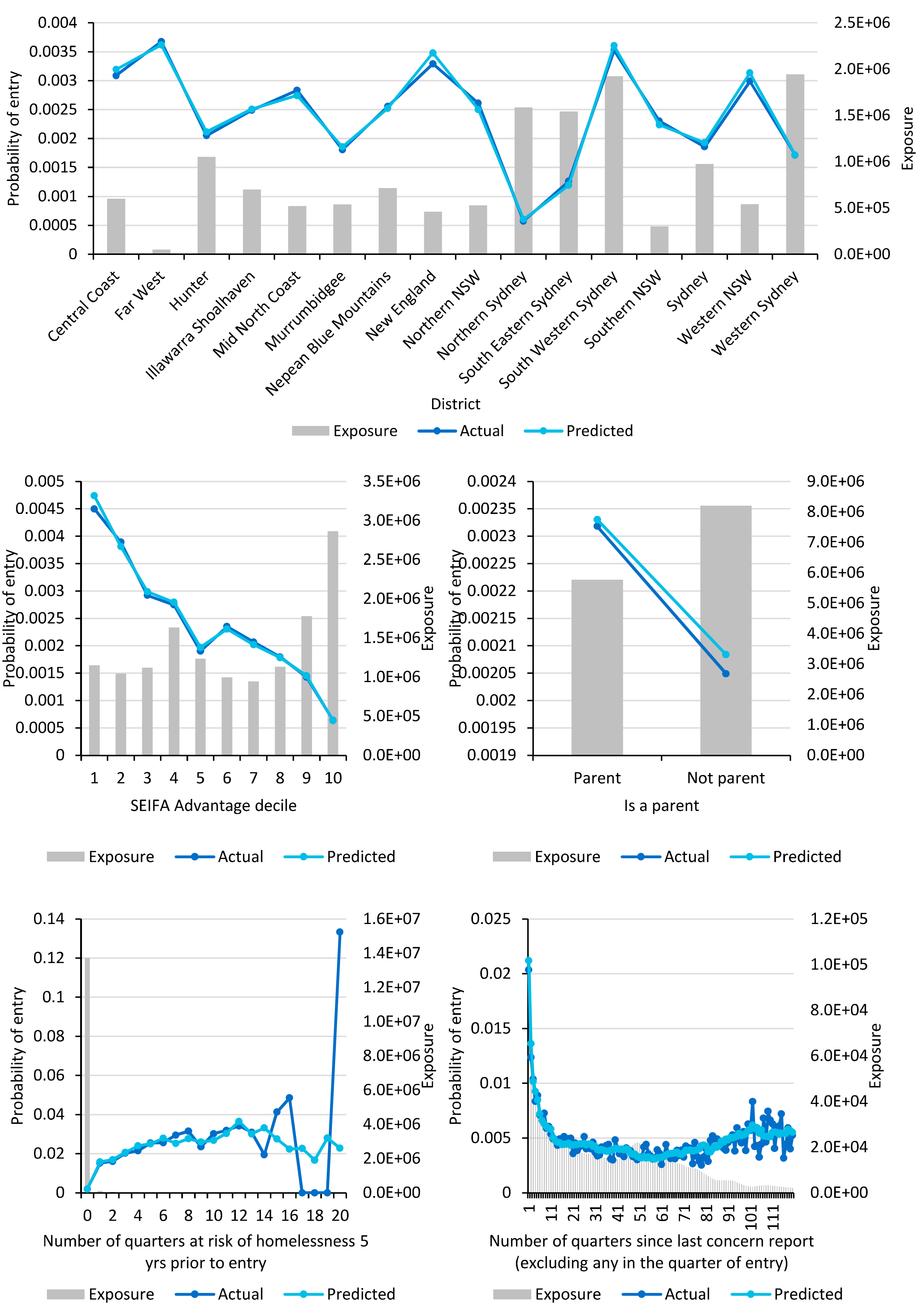
Figure H.26 – Actual versus expected probability of entry by prediction percentile (test dataset), direct entry model

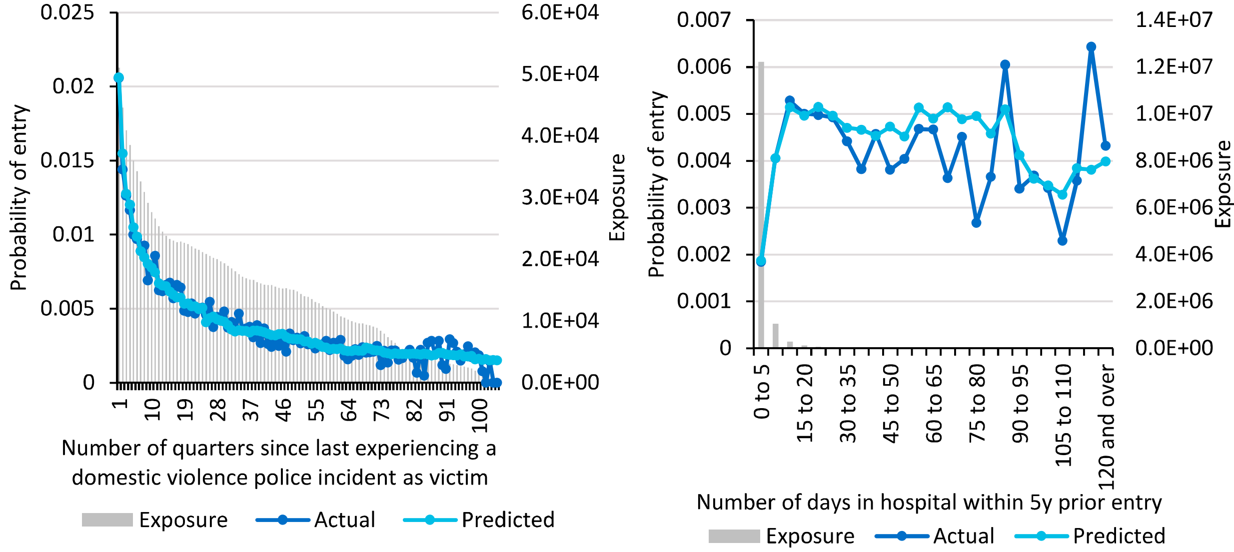



The plots in Figure H.27 show average predictions verses actual targets for the test dataset by key variables. The lack of significant and consistent deviations indicate the model predictions are unbiased.

Figure H.27 – Actual verses expected by key variables (test dataset), direct entry model




Probability of entry
Exposure
Central Coast
Far West
Hunter
Illawarra Shoalhaven
Mid North Coast
Murrumbidgee
Nepean Blue Mountains
New England
Northern NSW
Northern Sydney
South Eastern Sydney
South Western Sydney
Southern NSW
Sydney
Western NSW
Western Sydney
District
Exposure
Actual
Predicted
SEIFA Advantage decile
Parent
Not parent
Is a parent
Number of quarters at risk of homelessness 5 yrs prior to entry
Number of quarters since last concern report (excluding any in the quarter of entry)




### H.2.2.2 Indirect entry model

Below is a list of all variables included in the model. For similar reasons as the direct entry model, the variables include some quarter of entry information.

- ABS 2016 Remoteness Area class
- Age at entry quarter
- Age of father at birth
- Age of father at quarter of entry
- Age of mother at birth
- Age of mother at quarter of entry
- At risk of homelessness within 5 years prior to entry quarter
- Count of mother's previous pregnancies
- DCJ district
- Gestational age
- Had a concern report in quarter of entry
- Has had a concern report within the 1 year prior to entry
- Has had a concern report within the 5 years prior to entry
- Is a parent
- Is Aboriginal
- Number of days in hospital within 1 year prior to entry
- Number of days in hospital within 5 years prior to entry
- Number of days in which ambulatory mental health services were accessed within 5 years prior to entry
- Number of parents in the HSDS
- Number of quarters since last accessing private rental assistance (excluding access in the quarter of entry)
- Number of quarters since last admitted to hospital (excluding admissions in the quarter of entry)*
- Number of quarters since last concern report (excluding any in the quarter of entry)
- Number of quarters since last experienced a non-domestic violence incident as victim (excluding incidents in the quarter of entry)
- Number of quarters since last in custody (excluding time in custody in quarter of entry)
- Number of quarters since last in Out Of Home Care (excluding time in OOHC in quarter of entry)
- Number of quarters since last presenting as at risk of homelessness to SHS (excluding presentations in quarter of entry)
- Number of quarters since last presenting as homeless to SHS (excluding presentations in quarter of entry)
- Number of quarters since last ROSH report (excluding any in the quarter of entry)
- Number of quarters since last substantiated ROSH report (excluding any in the quarter of entry)
- Number of quarters since parent last accessed mental health services (excluding access in the quarter of entry)*
- Number of quarters since parent last accessed public housing (excluding access in the quarter of entry)*
- Number of quarters since parent last accessed services related to drug/alcohol use (excluding access in the quarter of entry)*
- Number of quarters since parent last appeared at Children's', Drug, Local, District or Supreme Court (excluding appearances in the quarter of entry)

- Number of quarters since parent last had domestic violence experience (excluding experience in the quarter of entry)*
- Number of quarters since parent last had service experience in justice domain (excluding experience in the quarter of entry)*
- Number of quarters since parent last spent time in custody (excluding time in the quarter of entry)*
- Parent number of quarters in which had service history related to domestic violence within the 5 years prior to entry*
- Parent number of quarters in which had service history related to drug/alcohol use within the 5 years prior to entry*
- Presented as homeless to SHS within the 5 years prior to entry
- Presented to Specialist Homelessness Services in quarter of entry
- Proportion of enrolled school days attended within 1 year prior to entry
- Proportion of enrolled school days attended within 5 years prior to entry
- Proportion of enrolled school days suspended within 1 year prior to entry
- Proportion of enrolled school days with unexplained absence within 1 year prior to entry
- Quarter of entry
- SEIFA Advantage decile
- Sex
- Time spent in Out Of Home Care within the 1 year prior to entry
- Time spent in Out Of Home Care within the 5 years prior to entry
- Weight at birth
- Whether mother is Aboriginal

*For a list of services considered in establishing parental history with a particular domain, see the domain definitions used to define client complexity in Appendix G.2

Figure H.28 shows the relative variable importance of the top 30 most important variables. As one would expect, parental risk factor variables are much more prominent, since entries are linked from a child's parents.

Figure H.28 – Relative variable importance, top 30 variables in the indirect entry model

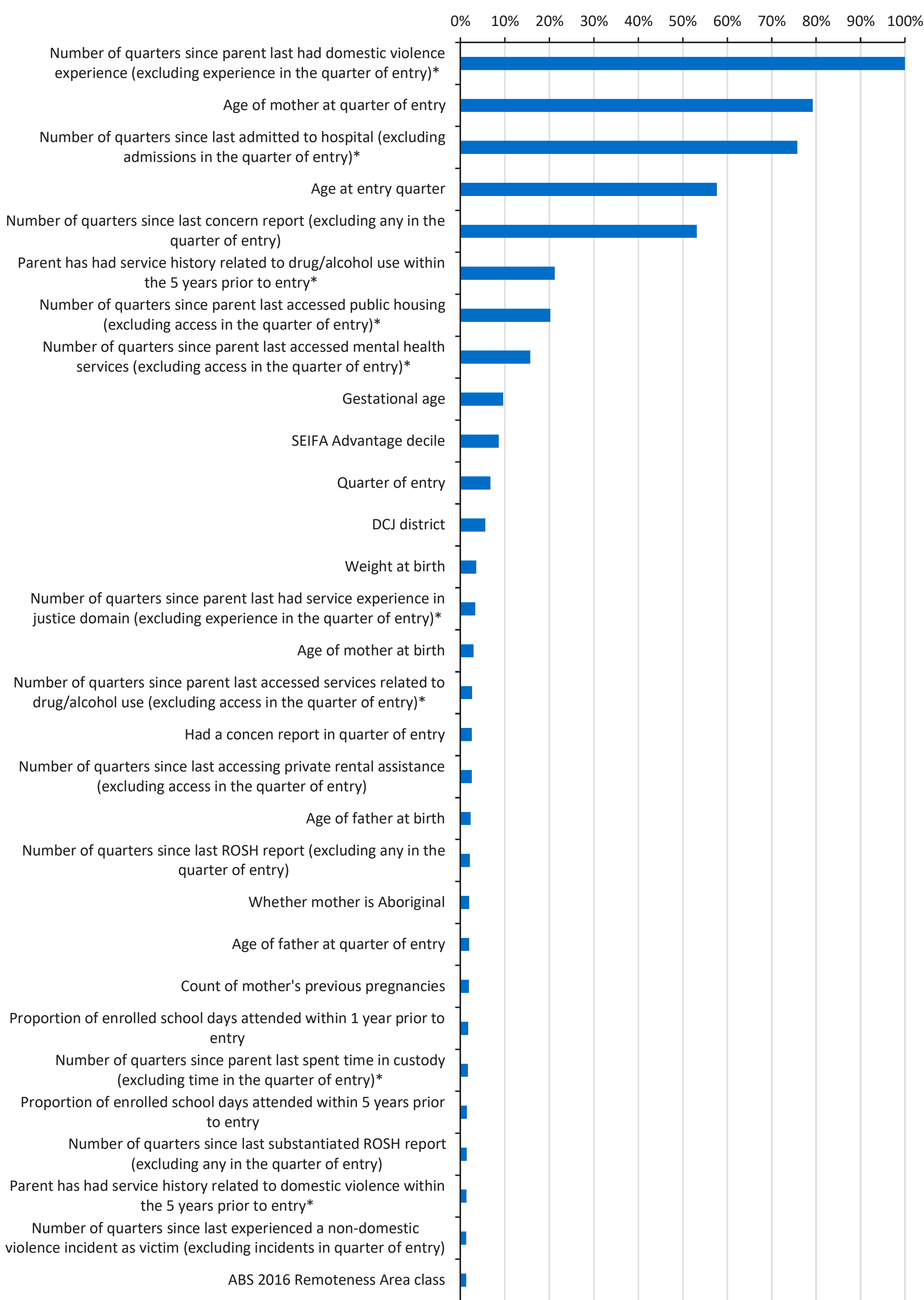
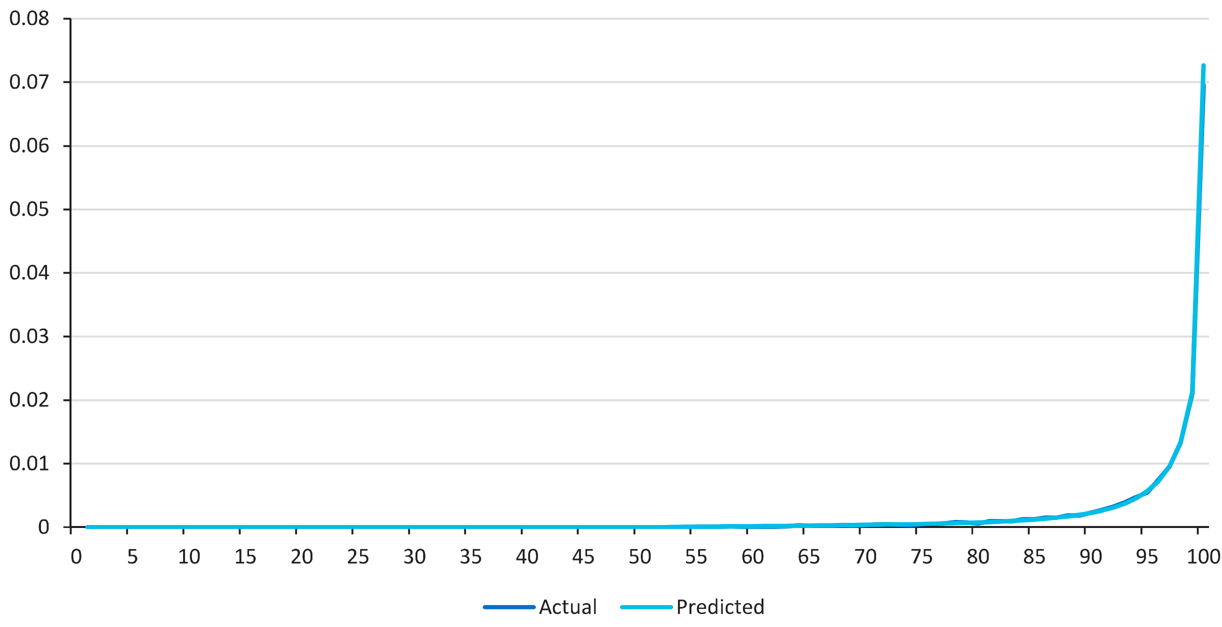



Figure H.29 shows the actual verses expected by predicted band plot on the test dataset for the indirect

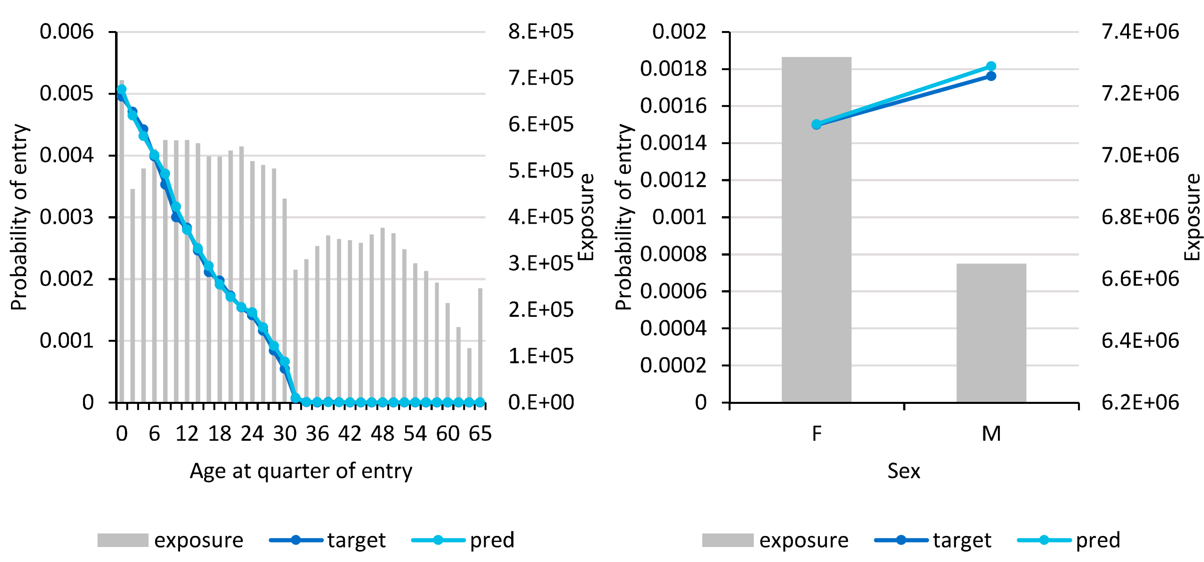
entry model. Similarly to the direct entry model, we note that since the lines are closely aligned, there are no large areas of misprediction. The model was able to identify a top 1% of people-quarters with a probability of TEI entry of 7.3%, 44 times higher than the population average and 600,000 times higher than those assigned with the least probability.

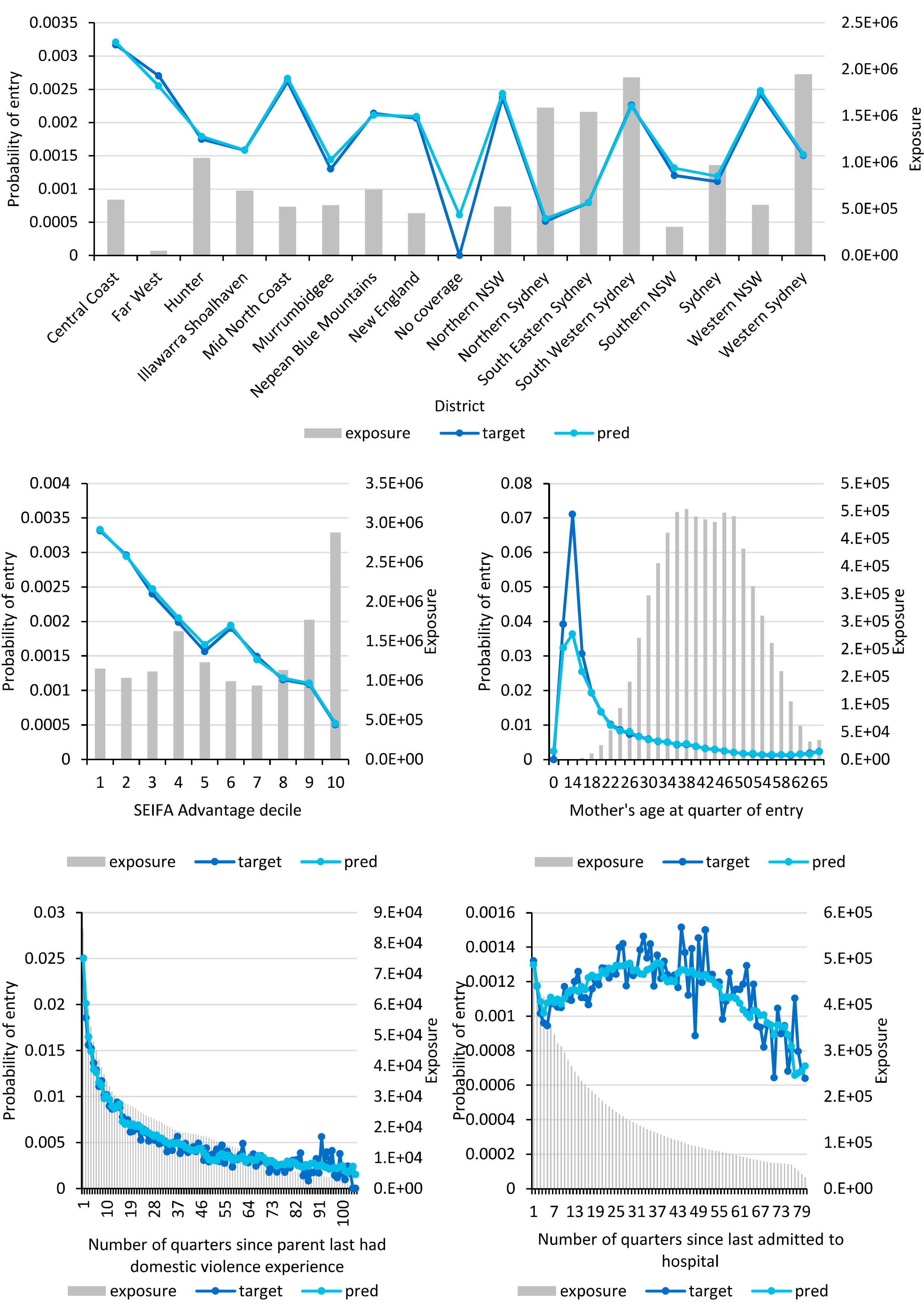
Figure H.29 – Actual verses expected probability of entry by prediction percentile (test dataset), indirect entry model

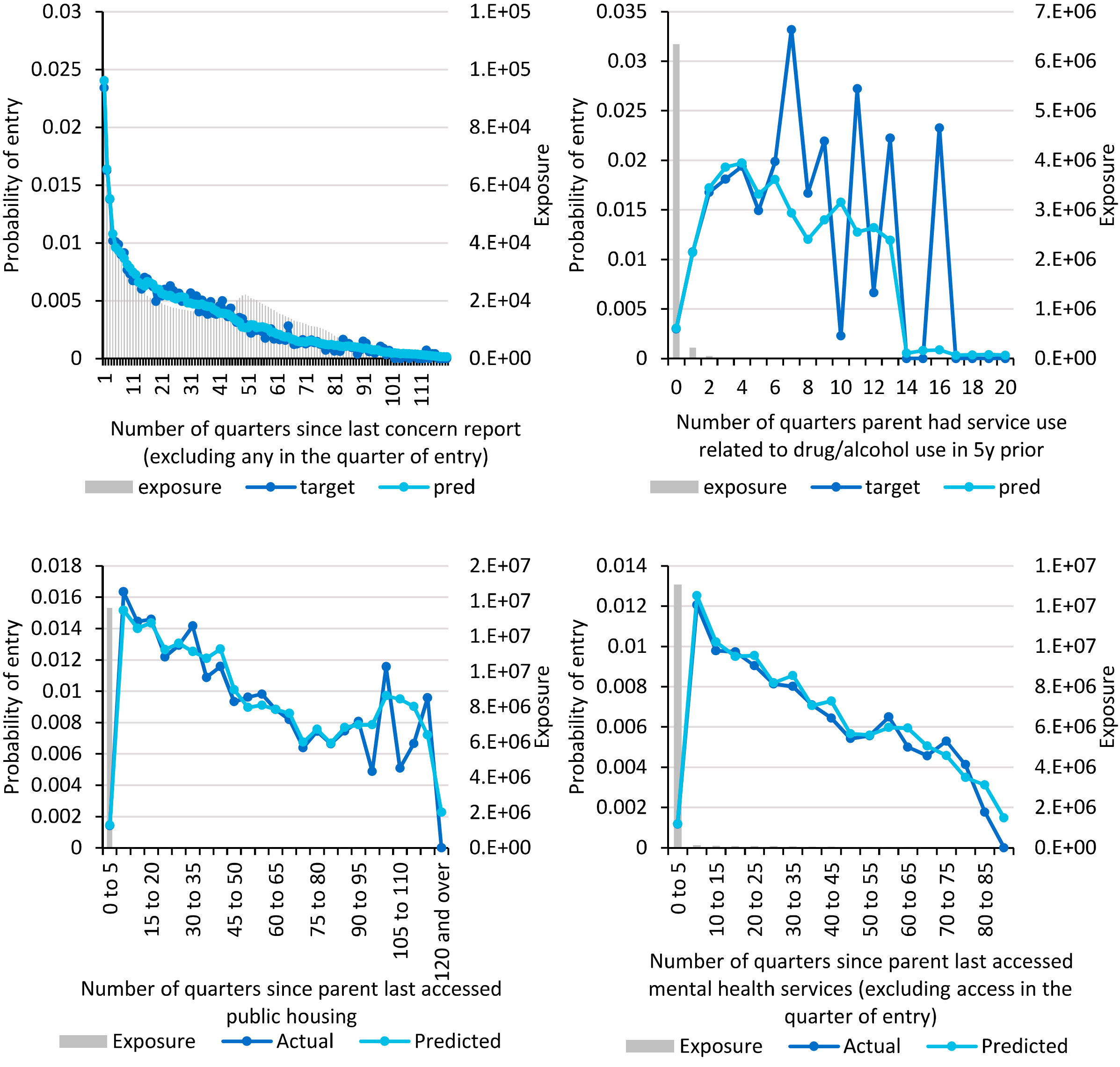



The plots in Figure H.30 show average predictions verses actual targets by key variables. The lack of significant and consistent deviations indicate the model predictions are unbiased.

Figure H.30 – Actual verses expected by key variables (test dataset), indirect entry model




Probability of entry
Exposure
District
Central Coast
Far West
Hunter
Illawarra Shoalhaven
Mid North Coast
Murrumbidgee
Nepean Blue Mountains
New England
No coverage
Northern NSW
Northern Sydney
South Eastern Sydney
South Western Sydney
Southern NSW
Sydney
Western NSW
Western Sydney
exposure
target
pred
SEIFA Advantage decile
Mother's age at quarter of entry
Number of quarters since parent last had domestic violence experience
Number of quarters since last admitted to hospital




### H.2.3 Propensity matching details and diagnostics

We performed the 1 to 1 nearest match using the MatchIt R package. The following variables were force matched (i.e. required to be the same):

- Age of individual in the quarter of entry (in 2-year bands)
- Sex of individual
- Whether individual identifies as Aboriginal
- DCJ District the individual resides in
- Whether the individual is a parent.

In addition, to remove differences between TEI clients and the comparison group owing to visibility of individual service use in the data, time trends in the data and data processing changes or issues:

- A force match was required on the following descriptions for an individual:
  - born in NSW
  - born outside of NSW

- a relative of somebody born in NSW
- a relative of somebody born outside of NSW

Observations of each TEI client's outcomes by quarter were compared against the matched individual's outcomes in the same quarter. Table H.8 summarises the match cohorts. Most (77%) of entrants were able to be matched with a member of the non-TEI population. 60% of the matched TEI cohort were direct entrants into TEI, 47% of the unmatched cohort were direct entrants, and overall, 57% of all TEI clients were direct entrants.

Table H.8 – Match summary

| Entry type | Matched TEI | Unmatched TEI | All TEI |
|---|---|---|---|
| Direct entry | 81,864 | 19,093 | **100,957** |
| Indirect entry | 53,683 | 21,574 | **75,257** |
| **All** | **135,547** | **40,667** | **176,214** |

Table H.9 tabulates the risk profile of the comparison group and TEI matched group, as well as the TEI unmatched cohort. The table shows that the comparison group has a similar risk profile to matched TEI client group. For the 23% of TEI clients for which a match was not found, risk factors were far higher.

Figure H.31 displays the average client complexity (as defined in Appendix G.2) for each of the cohorts. On average, each unmatched TEI client used services from 0.8 domains in the quarter of entry and from 1.2 domains in the year prior to entering TEI. By contrast, the TEI matched group and comparison group used services from just 0.3 domains in the quarter of entry and 0.5 in the year prior. About 55% of unmatched TEI clients who used services in at least one domain also used services from a different domain, compared to only 33% of matched TEI clients and 35% of those in the comparison group.

Failure to find a match for 23% of the TEI population could be due to several factors, such as:

- The severity of this group's risk profile due to intensity of service history found limited matches amongst non-TEI people
- The complexity, or use of services across multiple domains, of these clients found limited matches amongst non-TEI people
- The size of the available pool of comparison people diminished once constraints from force-matched characteristics were applied, further limiting the ability to find a match.

Table H.9 – Risk profile of 2020-21 and 2021-22 Comparison (n=135,547), TEI matched (n=135,547) and TEI unmatched (n=40,667) cohorts (HSDS)

| Risk factor[a] | **Comparis-on** (within 1 year prior to entry) | **TEI matched** (within 1 year prior to entry) | **TEI unmatched** (within 1 year prior to entry) | **Comparis-on** (within 5 years prior to entry) | **TEI matched** (within 5 years prior to entry) | **TEI unmatched** (within 5 years prior to entry) |
|---|---|---|---|---|---|---|
| **Concern report** (of clients aged under 18) | 23.3% | 21.9% | 39.9% | 39.0% | 37.7% | 47.5% |
| **ROSH report** (of clients aged under 18) | 19.2% | 17.9% | 35.5% | 34.2% | 32.9% | 45.2% |
| **Substantiated ROSH report** (of clients aged under 18) | 3.9% | 3.8% | 10.8% | 10.7% | 10.1% | 21.5% |
| **Out of home care** (of clients aged under 18) | 3.5% | 3.3% | 6.1% | 4.7% | 4.4% | 7.8% |
| **Domestic violence victim** | 4.1% | 4.0% | 14.2% | 10.9% | 10.7% | 26.8% |
| **Proven domestic violence offence** (of clients aged 11 or over) | 0.8% | 0.8% | 3.2% | 2.4% | 2.5% | 8.7% |
| **Proven drug or alcohol related offence** (of clients aged 11 or over) | 0.6% | 0.5% | 1.9% | 2.5% | 2.3% | 6.6% |
| **Time in custody** (of clients aged 11 or over) | 1.4% | 1.4% | 5.3% | 3.1% | 3.0% | 10.6% |
| **Interaction with criminal justice system** (of clients aged 11 or over) | 3.6% | 3.5% | 12.3% | 9.0% | 9.0% | 25.4% |
| **Youth cautions** (of clients aged 11 or over and under 18) | 1.7% | 1.8% | 4.2% | 3.7% | 3.5% | 9.0% |
| **School suspension**[b] (of clients aged between 5 and 18 with at least one day of school enrolment) | 24.5% | 24.2% | 29.2% | - | - | - |
| **Did not achieve NAPLAN minimum standard at last NAPLAN** (as at quarter of entry, of those with a NAPLAN record) | 17.0% | 17.7% | 25.8% | - | - | - |
| **SHS homeless presentation** | 3.9% | 3.7% | 19.2% | 10.2% | 9.7% | 33.6% |
| **Mental health ambulatory services** | 3.7% | 3.6% | 11.5% | 8.6% | 8.3% | 21.1% |
| **Opioid treatment support** (of clients aged 15 or over) | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| **Hospital admission for mental health** | 0.9% | 0.9% | 2.8% | 2.5% | 2.5% | 6.8% |
| **Hospital admission for alcohol or drug use** (of clients aged 15 or over) | 0.9% | 0.8% | 4.2% | 3.0% | 2.6% | 11.2% |
| **Parental history**[c] **with custody** (of clients with at | 5.2% | 5.2% | 8.4% | 11.5% | 11.3% | 18.0% |

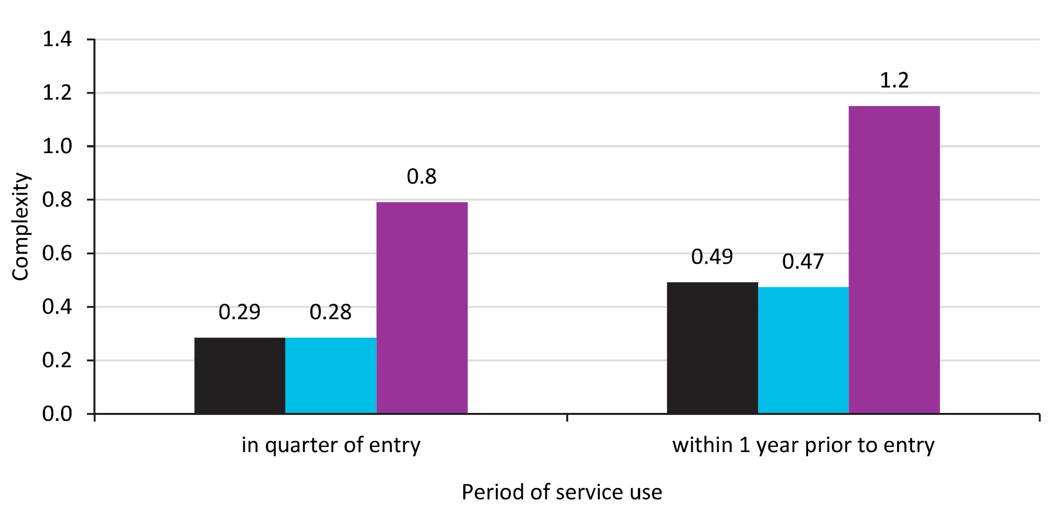
| Risk factor[a] | **Comparis-on** (within 1 year prior to entry) | **TEI matched** (within 1 year prior to entry) | **TEI unmatched** (within 1 year prior to entry) | **Comparis-on** (within 5 years prior to entry) | **TEI matched** (within 5 years prior to entry) | **TEI unmatched** (within 5 years prior to entry) |
|---|---|---|---|---|---|---|
| least one parent in linked data) | | | | | | |
| **Parental history[c] with drug/alcohol related services** (of clients with at least one parent in linked data) | 3.5% | 3.4% | 6.6% | 13.2% | 12.9% | 21.0% |
| **Parental history[c] with domestic violence** (of clients with at least one parent in linked data) | 16.9% | 15.9% | 31.2% | 37.3% | 36.3% | 54.5% |
| **Parental history[c] with justice** (of clients with at least one parent in linked data) | 11.4% | 10.9% | 18.9% | 28.9% | 28.2% | 40.9% |
| **Parental history[c] with mental health** (of clients with at least one parent in linked data) | 9.2% | 8.7% | 18.6% | 22.9% | 22.1% | 36.8% |
| **Parental history[c] with public housing** (of clients with at least one parent in linked data) | 15.8% | 15.3% | 26.8% | 18.2% | 17.7% | 30.8% |

(a) Bracketed conditions after risk factor are included when we restrict the client group for a more relevant comparison. For example, we only report the rate of concern reports for the subset of TEI and matched general population that are under 18. This means different rows will reflect different sub-cohorts.

(b) Suspension data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible data processing changes. Moreover, school data is not available from June 2020 due to covid or prior to 2018 due to data quality issues, so the 'within 5 years prior to entry' measure is less than the true measure, and excluded. At least one day of school enrolment is applied to exclude children who are never recorded as attending an NSW public school.

(c) For a list of services considered in establishing parental history with a particular domain, see the domain definitions used to define client complexity in Appendix G.2.

Figure H.31 – Average count of 9 domains utilised prior to TEI entry for comparison group (n=135,547), TEI matched group (n=135,547) and TEI unmatched group (n=40,667) (HSDS)




### H.2.3.1 Propensity match balance

Figure H.32 and Figure H.33 display balance statistics for important variables. The charts are split by demographic factors (Figure H.32) and government service use indicators from a range of service sectors (Figure H.33). The values plotted are the difference in mean of the general population of NSW from (subtracting) the mean of the TEI population ('before match'), and the difference in mean of the comparison group formed by propensity matching from (subtracting) the mean of the TEI population ('after match'). Overall, the balance between the matched cohorts is a significant improvement on the balance between the TEI population and the NSW population prior to matching. However, there remain some variables with slight differences between the matched and comparison populations.

Figure H.32 – Difference in mean of population (n=1,164,154 sample before match, n=135,547 after match) from mean of TEI population (n=135,547) before and after propensity match (HSDS) (demographic characteristics)

Figure H.33 – Difference in mean of population (n=1,164,154 sample before match, n=135,547 after match) from mean of TEI population (n=135,547) before and after propensity match (HSDS) (government service use)

## H.2.4 Observed outcomes before and after commencing TEI services as an individual client

The charts in Figure H.34 track outcome rates in each of the eight quarters prior to intervention (commencing TEI) and in the eight quarters afterwards for four cohorts:

- In **blue, the entire TEI cohort**
- In **light blue, the matched TEI cohort**
- In **black, the comparison cohort**
- In **purple, the unmatched TEI cohort**

Note that the number of people observed from the point of intervention onwards decrease by quarter due to outcomes being observed to June 2022 only. Entrants in September 2020 had 7 quarters of post-intervention data available whereas entrants in June 2022 had only the quarter of intervention observable.

It is observed that leading up to the point of intervention:

- Most outcomes trend upwards leading up to the point of intervention. This aligns with qualitative survey findings in which providers reported that participants entered TEI at crisis points in their lives.
- Pre-intervention behaviour is similar between the **TEI matched** and **comparison** cohorts, with service use often increasing in the lead up to intervention.
- The **unmatched TEI cohort** has higher service use than other cohorts across all services and often displays a sharper peak of service usage at intervention compared to the other cohorts. This suggests that a larger proportion of this cohort are at a crisis point compared to the **matched** TEI cohort.

From the point of intervention onwards:

- In aggregate, the **TEI cohort** shows decreases in service usage post-intervention for most outcomes, 'reverting to the mean'. Natural reversion to the mean is not unexpected from such participants regardless of intervention, as evidenced by the same reversion to the mean observed amongst the **comparison cohort**.
- Service usage tends to decrease dramatically (although off a higher starting point), for the **unmatched TEI cohort.**
- The **TEI matched cohort** tends to have a higher rate of service use from the point of intervention across most outcomes compared to the **comparison cohort**.
  - Note that an increase in service use is not strictly an adverse effect; it may represent a participant receiving services they were in need of but were not aware of prior to being informed through TEI. It may also reflect increased interactions with mandatory reporters resulting in more concern reports being made. A notable example is the large increase in homelessness service usage from the point of intervention. Many TEI providers are also Specialist Homelessness Service providers, so the referral pathway is natural and not an indication that participation in TEI has resulted in more housing instability.

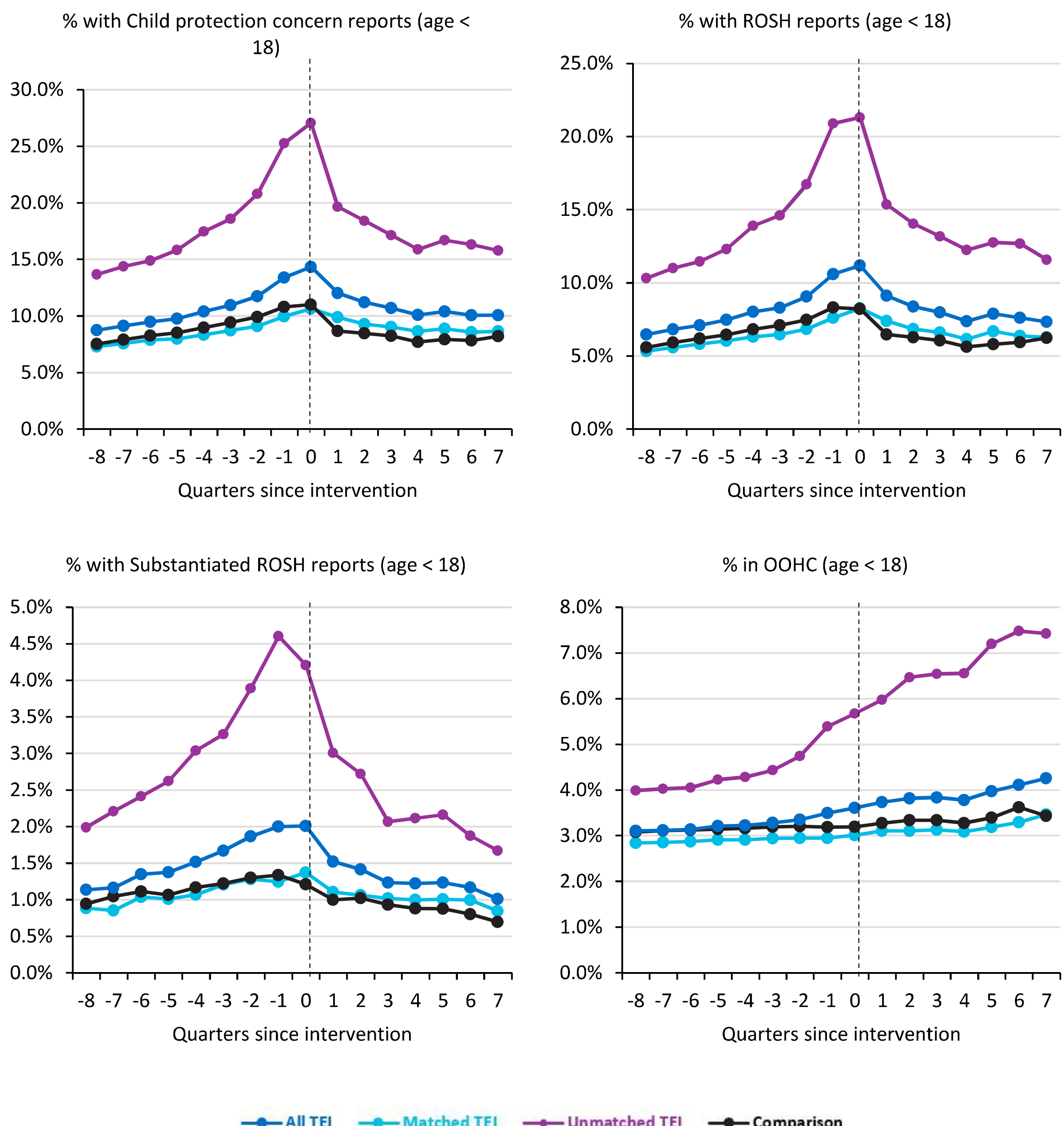
Between the effects of natural reversion to the mean, information gain leading to increased service use post-intervention, and genuine improvements or deterioration in outcomes, a limitation of this analysis is the difficulty to disentangle the relative prevalence of each effect for each outcome.

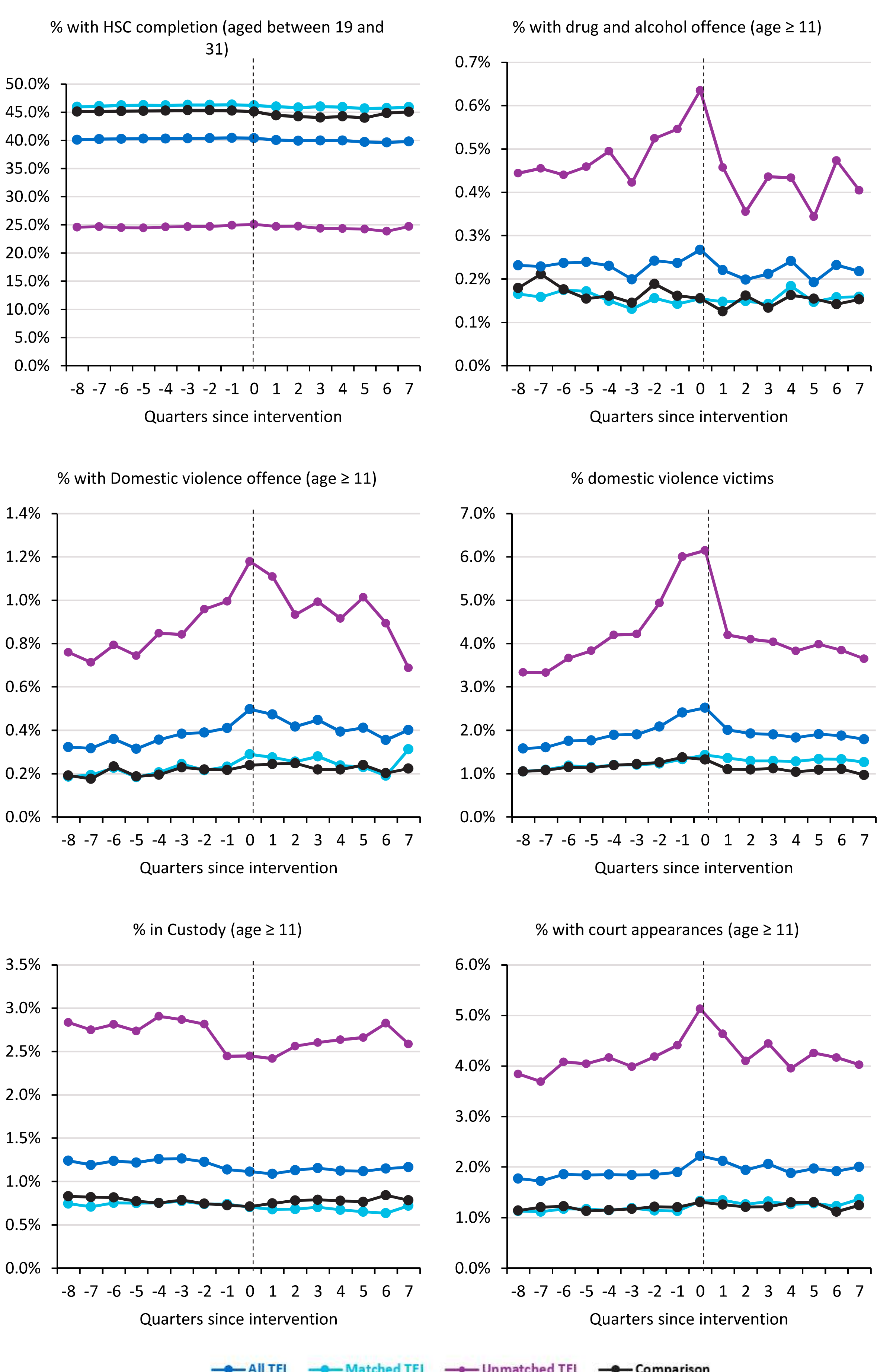
Nuances in individual service pathways also led to matched cohorts with differing behaviour leading up to intervention despite the propensity match significantly improving on the balance between the matched cohorts compared to the broader NSW population, further limiting comparison. In addition, intensity of service use amongst TEI clients meant that a comparison was not able to be obtained for some of the highest-risk and most complex TEI clients, a large drawback of this analysis. Other analyses in this evaluation include all participants, providing a more holistic measure of impact across the entire TEI population.

Nevertheless, the analysis allows us to observe many outcomes at once and see upticks in service use around the quarter of intervention, evidencing referral pathways into TEI or from TEI across many services (particularly child protection safety and homelessness services). For some outcomes, service use remains elevated from the point of intervention for the duration observed (not strictly an adverse effect).

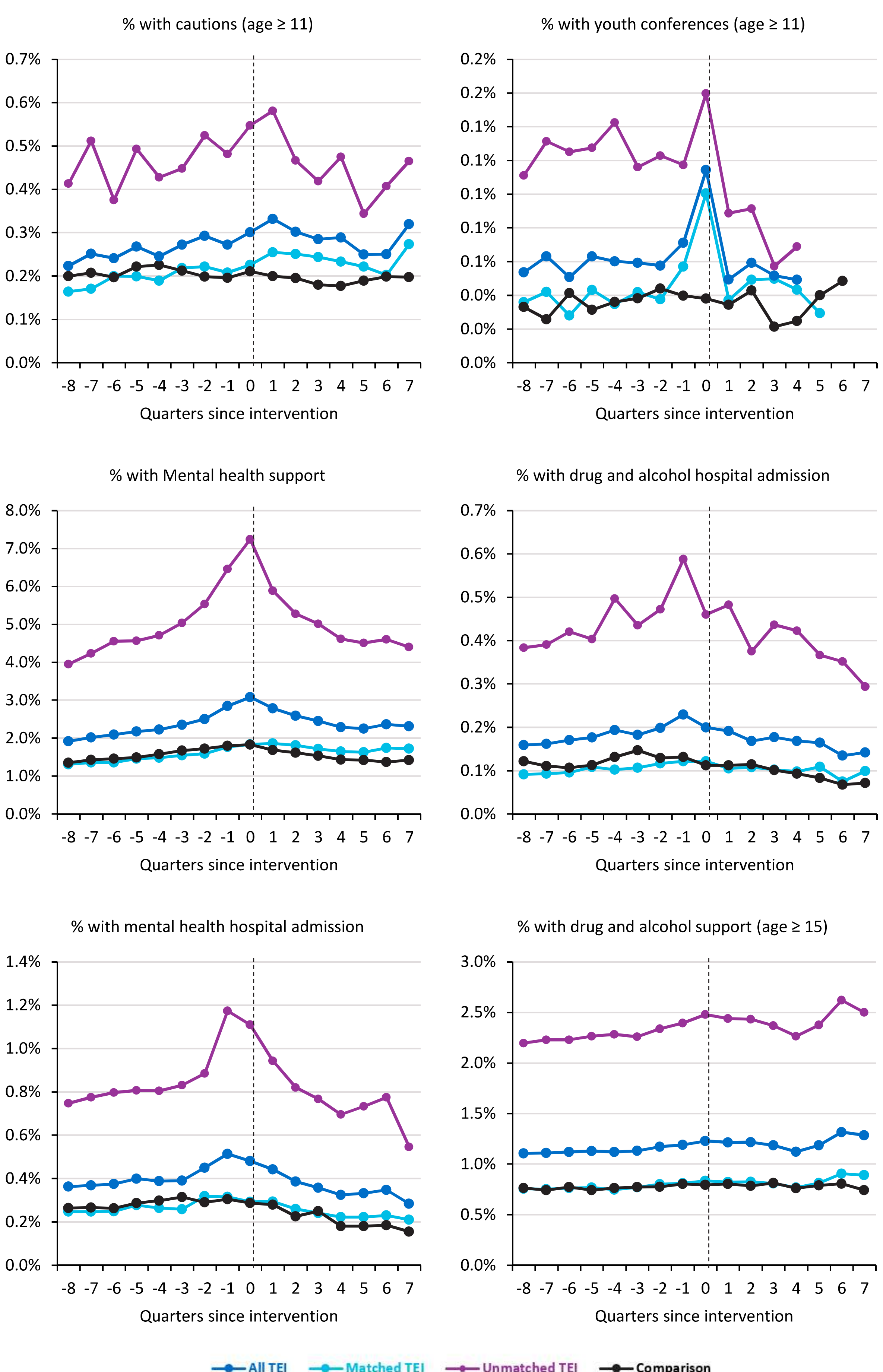
Figure H.34 – Outcomes comparison charts before and after intervention (HSDS)

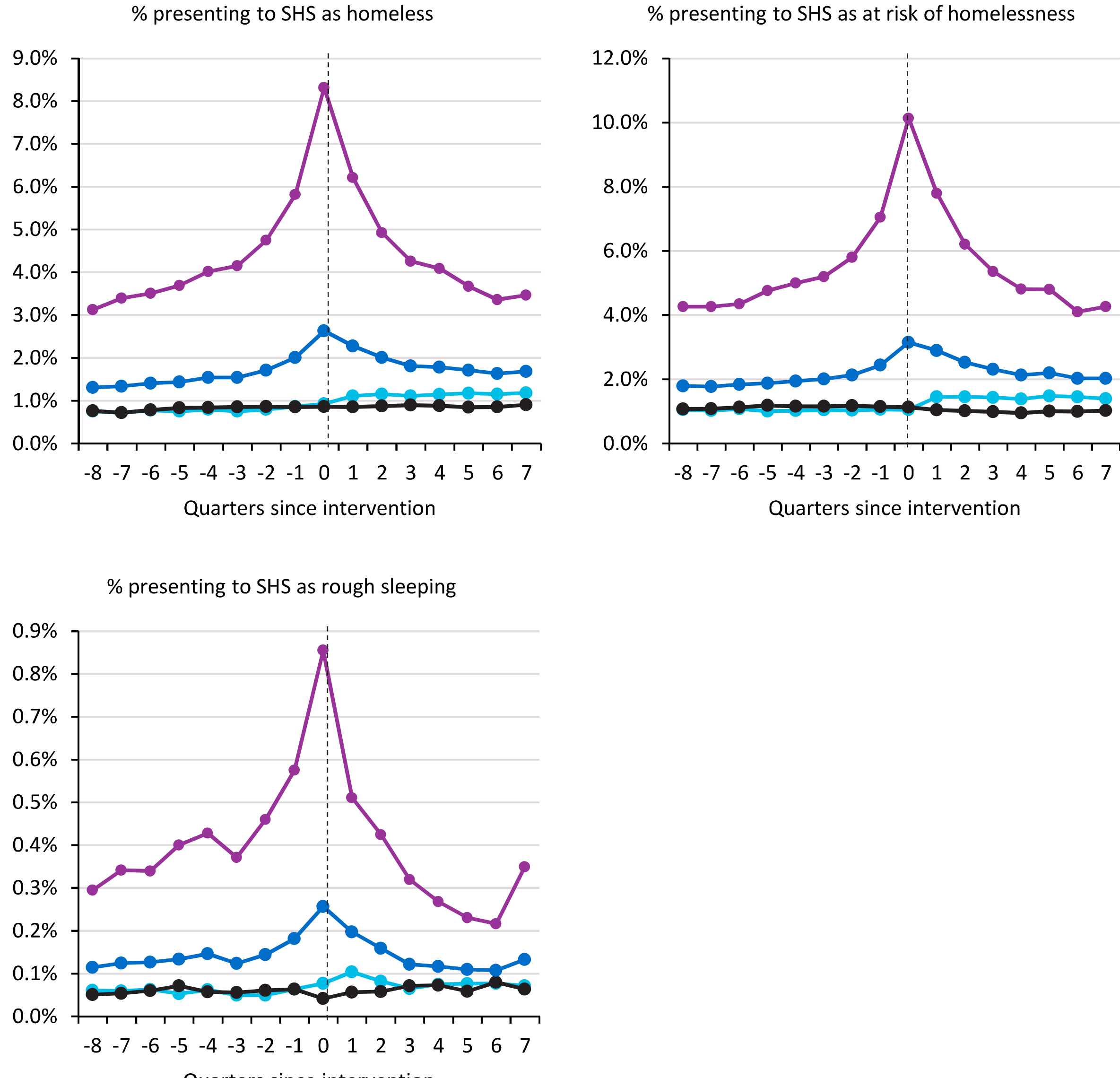
Note: points where the data volume is insufficient to satisfy the data privacy requirements are excluded.


% with Child protection concern reports (age < 18)
Quarters since intervention
% with ROSH reports (age < 18)
Quarters since intervention
% with Substantiated ROSH reports (age < 18)
Quarters since intervention
% in OOHC (age < 18)
Quarters since intervention
All TEI
Matched TEI
Unmatched TEI
Comparison



% with HSC completion (aged between 19 and 31)
% with drug and alcohol offence (age ≥ 11)
% with Domestic violence offence (age ≥ 11)
% domestic violence victims
% in Custody (age ≥ 11)
% with court appearances (age ≥ 11)
Quarters since intervention
All TEI
Matched TEI
Unmatched TEI
Comparison


% with cautions (age ≥ 11)
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with youth conferences (age ≥ 11)
0.2%
0.2%
0.1%
0.1%
0.1%
0.1%
0.1%
0.0%
0.0%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with Mental health support
8.0%
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with drug and alcohol hospital admission
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with mental health hospital admission
1.4%
1.2%
1.0%
0.8%
0.6%
0.4%
0.2%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with drug and alcohol support (age ≥ 15)
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
All TEI
Matched TEI
Unmatched TEI
Comparison




## H.3 Aggregate analysis of child protection safety outcomes

The individual-level analysis of safety outcomes in Appendix H.1 includes only those people (either children or children of parents) who are identified in the DEX collection and in turn linked successfully to the HSDS. This is skewed heavily towards the Wellbeing and Safety stream, and represents a minority of individuals. A natural question is whether there is other evidence that supports broader impacts including non-identified people in TEI group sessions. An 'aggregate' analysis looks at impacts at a non-individual (e.g. outcome rate for a region), seeking evidence of change over time. We have performed an aggregate analysis of key outcomes at a Local Government Areas (LGA) level to test whether LGAs with more intense TEI service provision have seen more improvement compared to others. The outcomes and intensity measures analysed were:

**Intensity measures**

- Number of group clients
- Number of group sessions
- Number of individual clients
- Number of individual sessions
- Total funding

**Outcomes**

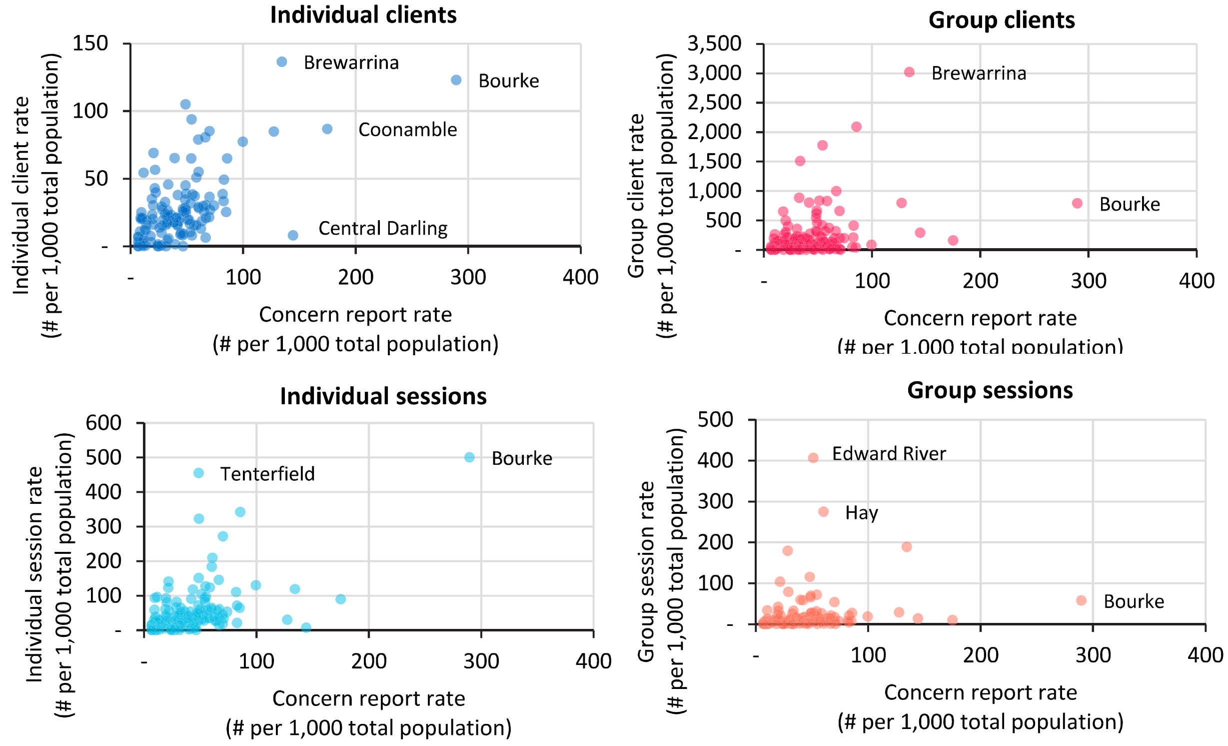
- Concern reports
- ROSH reports
- SARAs
- Time in OOHC

The aggregate approach is expected to be less sensitive than individual-level impacts. TEI would need to reach a sizeable fraction of at-risk children and see a substantial decrease in child protection interactions to be detected. It is also complicated by the relative lack of funding changes over time (many funding amounts are similar to those prior 2021). This provides less chance of detecting a change in patterns with the rollout of TEI.

### H.3.1 Volume of TEI services by LGA

Figure H.35 examines the relationship between the volume of TEI participants and services provided in 2020/21 compared to the concern report rate in each LGA. We expect to see alignment between the two, since TEI is targeted towards areas with greater support needs.

Figure H.35 – Relationship between TEI volume and concern report rate by LGA, 2020-21 (DEX and HSDS)




LGAs with higher concern report rates generally also received higher rates of TEI services, and these were also more likely have lower populations. This relationship is strongest for individual clients and individual sessions, with the group client relationship potentially being convoluted by rate of identification and repeat attendances differing by location.

Figure H.36 – TEI service volume in 2021-22 compared to 2020-21 (DEX)

Note: See Appendix K.9 for the underlying statistics on the full list of LGAs. Only the outliers have been labelled in the chart.

Figure H.36 shows that the volume of TEI services was relatively unchanged between 2021-22 and 2020-21, with most LGAs receiving a similar amount of services in the two years (lying close to the dotted line). The LGAs with the largest movements in these charts are those with small populations as the same nominal increases in clients or sessions represent larger portions of the population.

### H.3.2 TEI funding by LGA

One step of our aggregate approach tests outcomes as a function of per capita funding in an LGA. Data provided lists the primary LGA of a contract as well as secondary LGAs expected to be served by that contract. We have allocated funding to providers that operate across multiple LGAs by:

1. Allocating 40% of the total funding to the primary LGA
2. Evenly distributing the remaining funding to all listed LGAs (including the primary LGA)

Figure H.37 examines the relationship between the volume of funding provided for the first year of TEI (2020-21) compared to the concern report rate in each LGA. LGAs with higher concern report rates generally also received higher rates of TEI funding. Note that Murrumbidgee has been excluded from the chart as it received well above any other LGA in funding, however this is a function of the allocation process above and the fact that it is primarily served by a single provider.

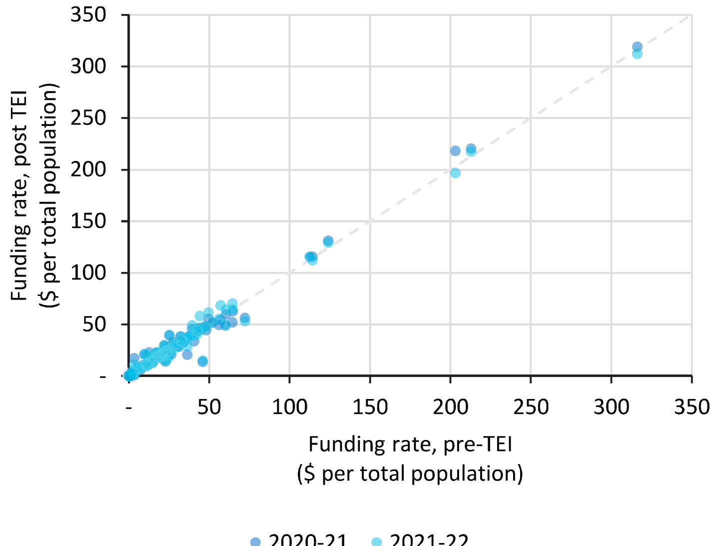
Figure H.37 – Funding rate vs concern report rate, 2020-21 (Funding data and DEX)

Brewarrina
Bourke
Funding rate
($ per total population)
Concern report rate
(# per 1,000 total population)

Note: See Appendix K.9 for the underlying statistics on the full list of LGAs. Only the districts that are most different have been labelled in the chart.

Figure H.38 shows that there has been minimal change in funding by LGA over time, with most funding rolling over within organisations.

Figure H.38 – Comparison of pre-TEI funding levels by LGA (x-axis) to TEI funding rates in 2020-21 and 2021-22 (Funding data)




This lack of change between pre and post TEI implementation reduces the ability to see aggregate-level impacts. We would expect to see larger changes in outcomes for regions with large increases or decreases in funding, as a type of natural experiment.

### H.3.3 Safety Outcome Trends over time

To assist with presentation of time trends in this Section, we have split LGAs into 'high', 'medium' and 'low' groups of about 40 LGAs each, based on where they rank in terms of rate of TEI service provision and funding. Additionally, we have classified the change in funding from pre-TEI levels to be 'Small change' if there was a <10% change (85 LGAs) or 'Large decrease/increase' if there was a >10% change in funding (21/22 LGAs respectively).

### H.3.3.1 By level of funding

Figure H.39 shows the average rate of concern reports, ROSH reports, SARA reports and OOHC in each of the LGA groups by funding, relative to the 2 year pre-TEI rates. We have presented the trends by funding group as it provides a more holistic measure of TEI service provision, including allowance for how intense services provided to each client or in each session are. Outcomes for each group are volatile quarter to quarter and mostly follow state-wide trends. There does not seem to be any difference in behaviour between the three categories for any of the outcomes.

Figure H.39 – Safety outcomes over time by LGA funding group (Funding data and HSDS)

*Rate per 1,000 total population, relative to the average rate in the 2018-19 and 2019-20 years.

### H.3.3.2 By change in funding

As discussed in H.3.2, there was minimal change in funding to each LGA upon introduction of TEI. After allowing for inflation, 22 LGAs (representing 11% of funding) saw increases of more than 10%, while 21 LGAs (representing 17% of funding) saw decrease of more than 10%. The remaining 85 LGAs saw changes in funding of less than 10%.

Figure H.40 shows the average rate of child protection reports and OOHC usage in each of these LGA groups by change in funding, relative to the rates in the two years prior to TEI. Once again, outcomes for each group are volatile quarter to quarter and mostly follow state-wide trends. There is no evidence that LGAs with larger increases in funding perform differently from those with smaller changes or decreases in funding.

Figure H.40 – Safety outcomes over time by LGA change in funding group (Funding data and HSDS)

*Rate per 1000 total population, relative to the average rate in the 2018-19 and 2019-20 years.

### H.3.4 Regression models of LGA-level trends

We have constructed LGA level models for each of the safety outcomes predicting the next quarter's safety outcome rate using historical levels as predictors to assess if there is any systematic misfit by any of the TEI intensity measure variables (which are not included as predictors). The quasi-poisson family was used and the parameter tables for these models are summarised in Table 10.1 to Table 10.4 below.

Table 10.1 – LGA level model parameters – Concern reports

| Term | Coefficient |
|---|---|
| Intercept | -6.20 |
| Rate of concern reports in the 2 years prior, linear spline from 0 to 0.1 | 19.99 |
| Rate of concern reports in the 2 years prior, linear spline from 0.1 to 0.5 | 3.77 |
| 2020/21 indicator | 0.11 |

Table 10.2 – LGA level model parameters – ROSH reports

| Term | Coefficient |
|---|---|
| Intercept | -6.70 |
| Rate of ROSH reports in the 2 years prior to TEI, linear spline from 0 to 0.05 | 37.72 |
| Rate of ROSH reports in the 2 years prior to TEI, linear spline from 0.05 to 0.12 | 11.00 |
| Rate of ROSH reports in the 2 years prior to TEI, linear spline from 0.12 to 0.3 | 5.56 |
| 2020/21 indicator | 0.16 |

Table 10.3 – LGA level model parameters – SARA reports

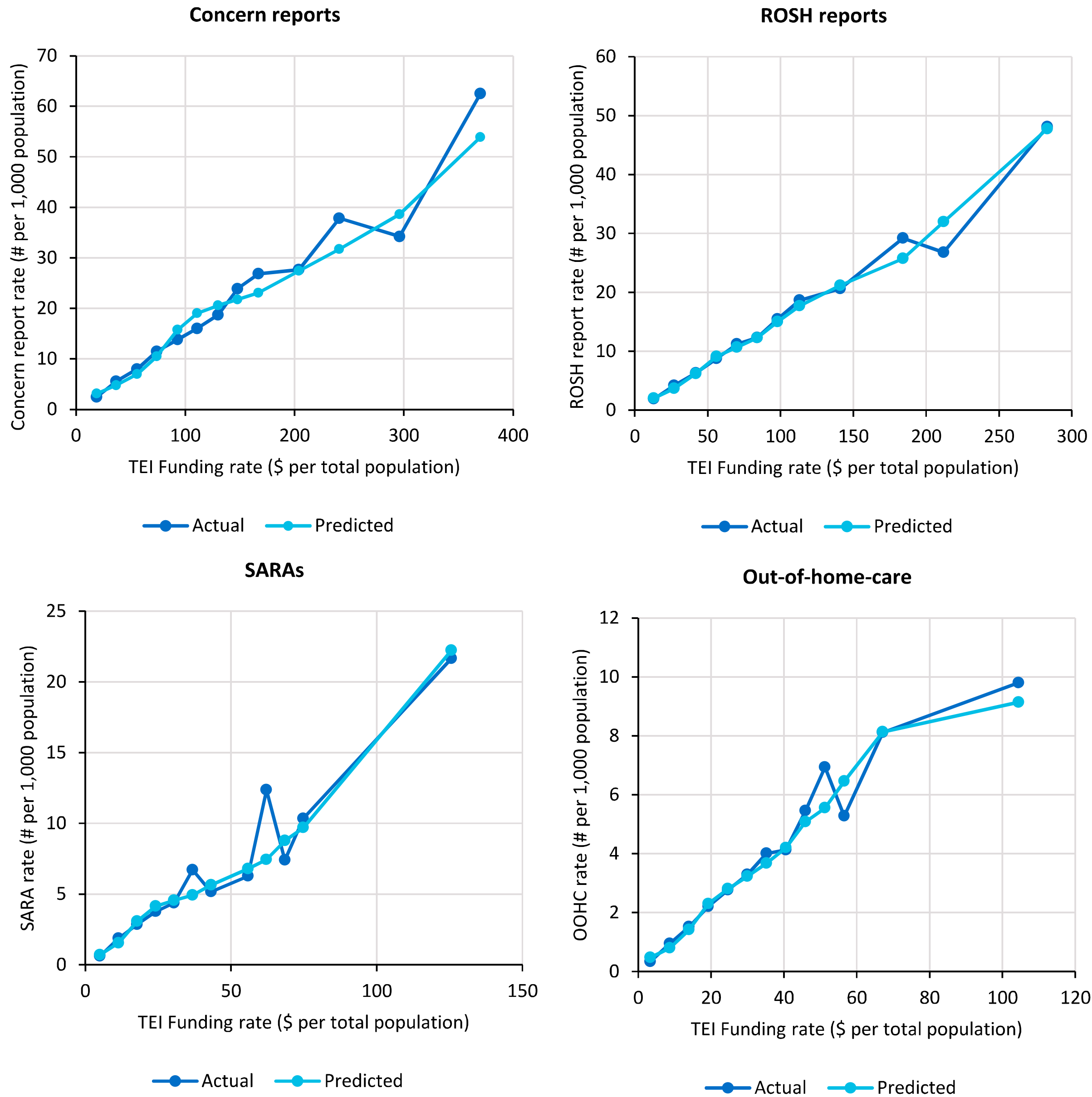
| Term | Coefficient |
|---|---|
| Intercept | -7.75 |
| Rate of SARA reports in the 2 years prior to TEI, linear spline from 0 to 0.02 | 111.41 |
| Rate of SARA reports in the 2 years prior to TEI, linear spline from 0.02 to 0.2 | 16.01 |
| Quarters since June 2020 | -0.02 |

Table 10.4 – LGA level model parameters – OOHC

| Term | Coefficient |
|---|---|
| Intercept | -6.62 |
| Rate of OOHC in the 2 years prior to TEI, linear spline from 0 to 0.02 | 97.20 |
| Rate of OOHC reports in the 2 years prior to TEI, linear spline from 0.02 to 0.2 | 25.84 |
| Quarters since June 2020 | -0.01 |

We did not observe a systematic misfit by any of the TEI intensity measure predictors on any of the modelled outcomes, implying that there was no significant measurable impact of TEI intensity on safety outcome rates at an LGA level. This is shown for the funding rate variable in Figure H.41.

Figure H.41 – Actual versus expected by TEI funding rate for safety outcome LGA level models (Funding data and HSDS)




This is consistent with the exploratory analysis in earlier sections, which suggest that formal hypothesis testing via regression modelling would be unlikely to provide convincing results since:

- There is minimal variation within the TEI intensity measure predictors, and
- The intensity measure predictors are correlated with the historical outcome predictors, which are already included as control variables.

### H.3.5 Conclusion

We found that there was no evidence of LGA level outcomes being related to the level of TEI service provision. This is not unexpected; the variation of the intensity measures over time and by LGA has not been large and therefore very strong relative improvements would have been necessary for a relationship to be established. Additionally, the outcomes by LGA were volatile quarter to quarter, particularly for smaller LGAs, and mostly followed state-wide trends.

Combining with the results of Appendix H.1, this means that we see small but material improvements in safety outcomes for children interacting with TEI, but little evidence that the TEI program has improved safety outcomes relative to pre-TEI support programs. If substantial funding reallocations occur with the 2025 recommission there may be the opportunity to re-examine, but for now the results demonstrate the value of having individual-level identification to test outcomes precisely.

## H.4 SCORE relationship with client outcomes

### H.4.1 List of Circumstances and Goals SCORE domains

For Circumstances SCORE assessments, clients are asked to rank from 1 – Negative impact, 2 – Moderate negative impact, 3 – Middle ground, 4 – Adequate over the short term, 5 – Adequate and stable over the medium term. The full list of Circumstances SCORE domains are (abbreviated domain names in brackets are used for chart legends in the subsequent sections):

- Physical health
- Mental health, wellbeing and self-care (Mental)
- Personal and family safety (Personal)
- Age-appropriate development
- Community participation and networks
- Family functioning (Family)
- Financial resilience
- Material wellbeing and basic necessities
- Employment
- Education and skills training (Training)
- Housing

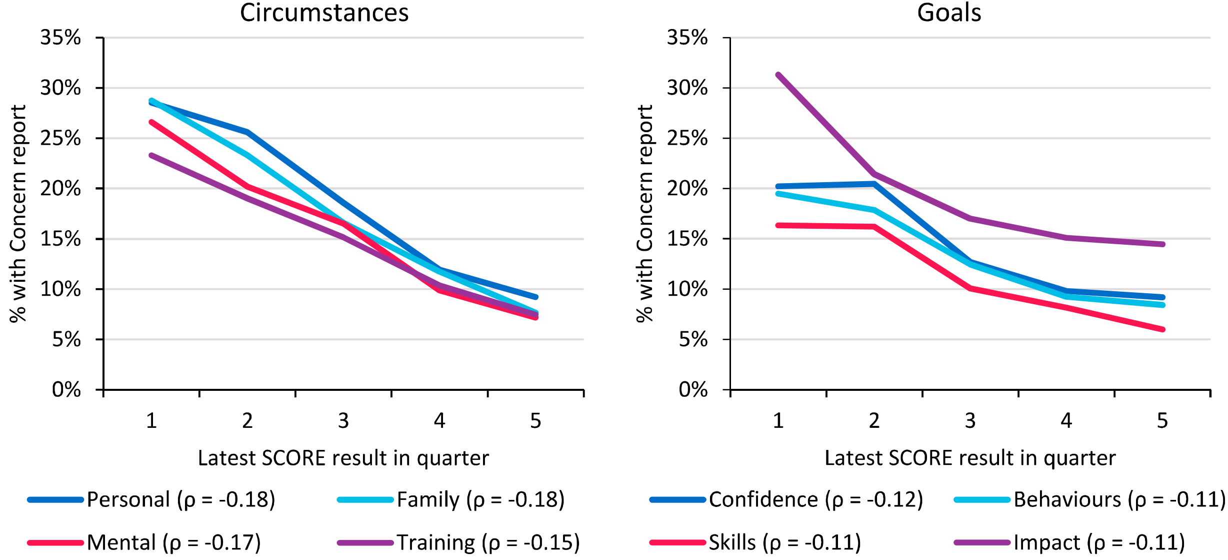
For Goals SCORE assessments, clients are asked to rank from 1 – No progress, 2 – Limited progress with emerging engagement, 3 – Limited progress with strong engagement, 4 – Moderate progress, 5 – Fully achieved. The full list of Goals SCORE domains are

- Increasing knowledge and access to information (abbreviated domain names in brackets are used for chart legends in the subsequent sections):
- Increasing Skills (Skills)
- Changing behaviours (Behaviours)
- Empowerment, choice and control to make own decisions (Confidence)
- Increasing engagement with support services
- Reducing the negative impact of the immediate crisis (Impact)

### H.4.2 Direct correlation between SCORE result and client outcomes

Figure H.42 to Figure H.45 below shows the probability of client experiencing each of the modelled outcomes in the following quarter given their SCORE results. The charts include the result from the top four Circumstances SCORE and top four Goals SCORE domains that have the strongest correlation with the modelled outcome, with the corresponding value of correlation shown in the chart legend. These charts support the observations described in Section 6.8.

Figure H.42 – Concern report rate by last SCORE result in the previous quarter (HSDS)




*Note: the abbreviated SCORE domains in the chart legend are (same applies for Figure H.43 to Figure H.45 below):

- Personal – Personal and family safety
- Family – Family functioning
- Mental – Mental health, wellbeing and self-care
- Training – Education and skills training
- Confidence – Empowerment, choice and control to make own decisions
- Behaviours – Changing behaviours
- Skills – Increasing Skills
- Impact – Reducing the impact of immediate crisis

Figure H.43 – ROSH rate by last SCORE result in the previous quarter (HSDS)

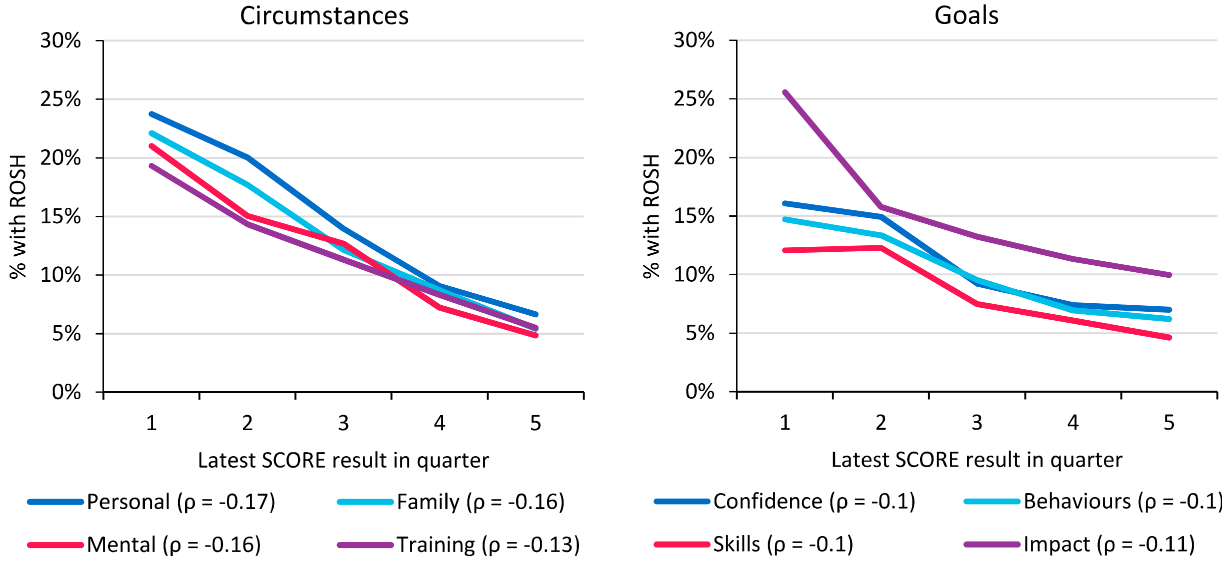


Figure H.44 – Rate of being victim of domestic violence by last SCORE result in the previous quarter (HSDS)

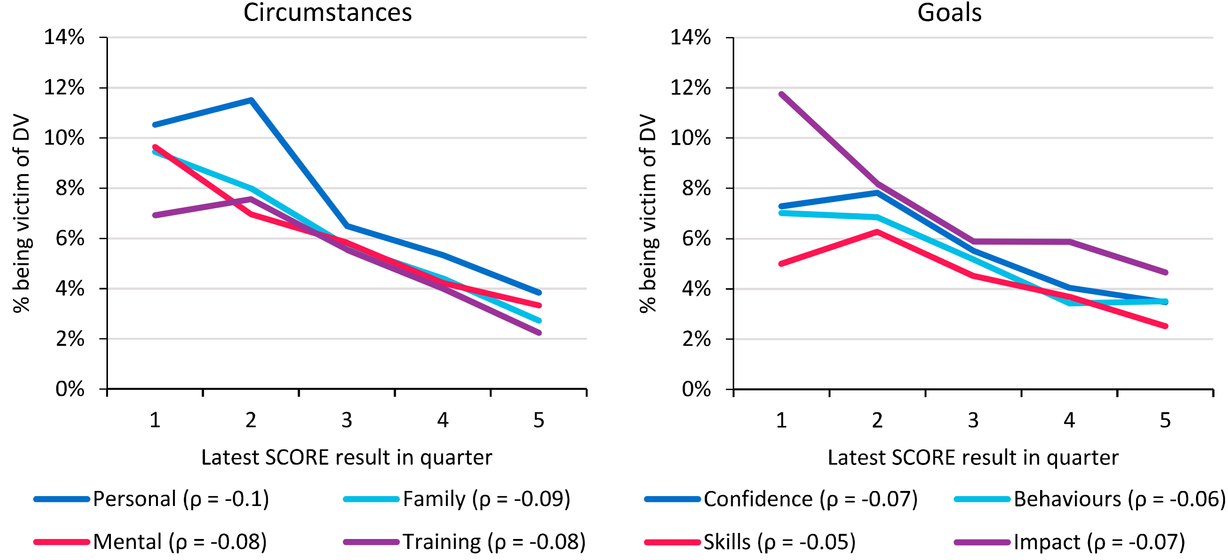
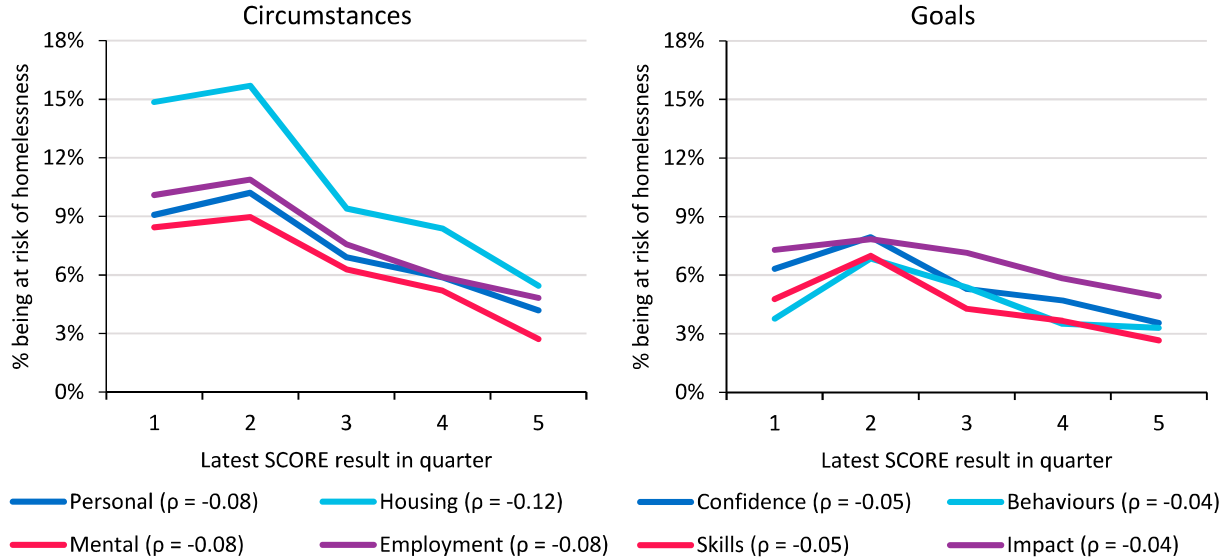
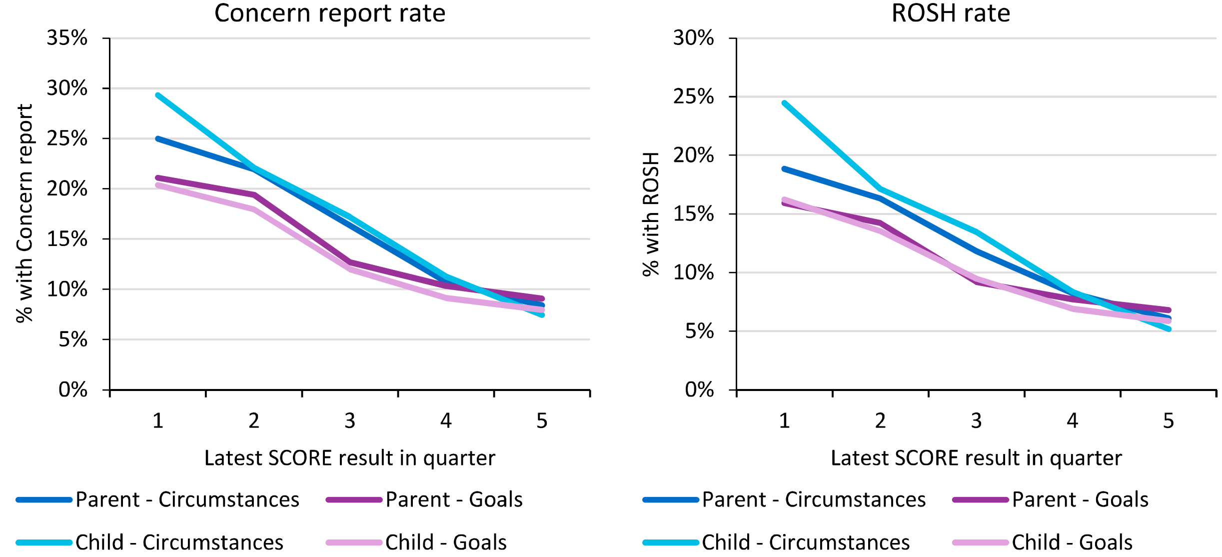



Figure H.45 – Rate of being at risk of homelessness by last SCORE result in the previous quarter (HSDS)




Using the same four Circumstances and four Goals SCORE domains from the figures above, we investigated whether the SCORE relationship with concern report and ROSH outcomes for the child are different depending on whether the assessment was completed for the child or the parent. Figure H.46 below shows that the observed relationship is mostly consistent between the two groups.

Figure H.46 – Relationship between SCORE result and client outcome by who the assessment was completed for (HSDS)

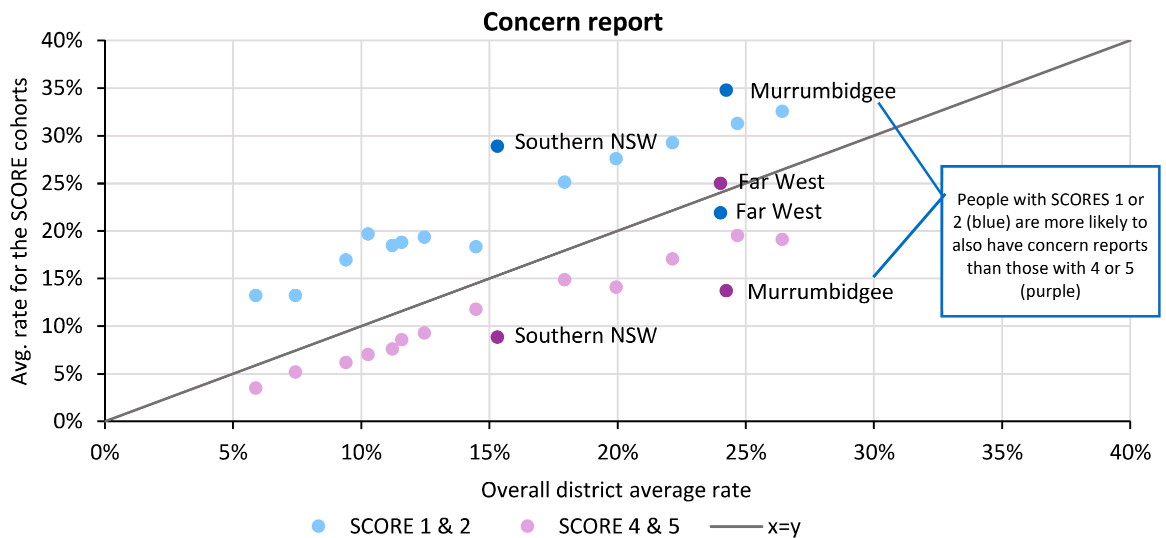


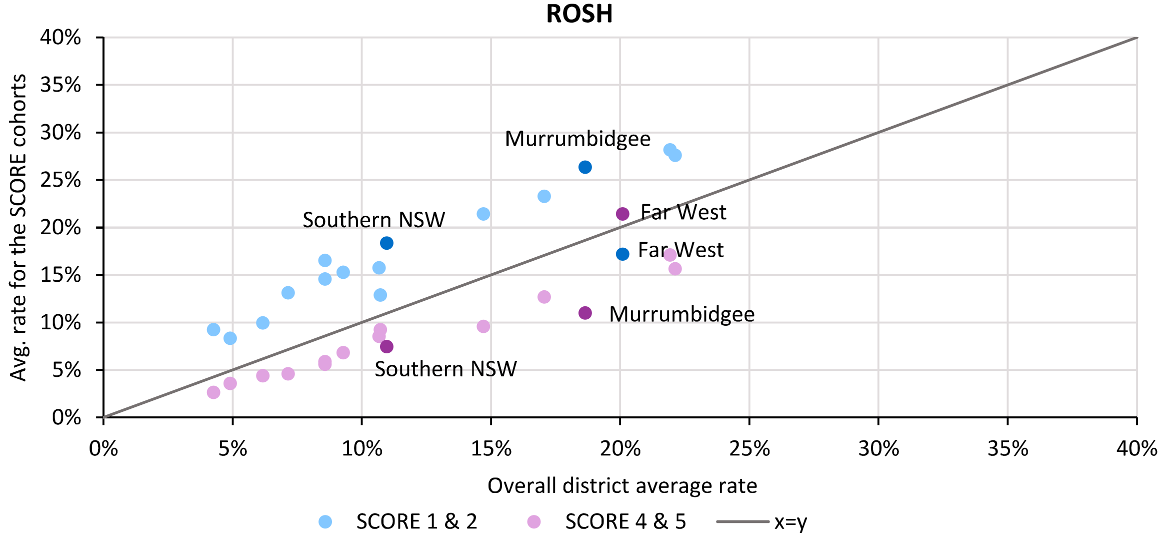

Lastly, we investigated whether the SCORE relationship with each of the modelled outcomes is consistent across DCJ districts, again using the SCORE domains identified in the charts above. The results are shown in Figure H.47 below which plots each district by the outcome rate for clients with SCORE rating of 1 or 2 and the rate for clients with SCORE rating of 4 or 5 against the overall average of clients with SCORE in the district. Points higher than the line x=y means that the outcomes rate for the cohort of clients as defined by their specific SCORE rating is higher than the average of all clients with SCORE rating, and vice versa for points lower than the line x=y.

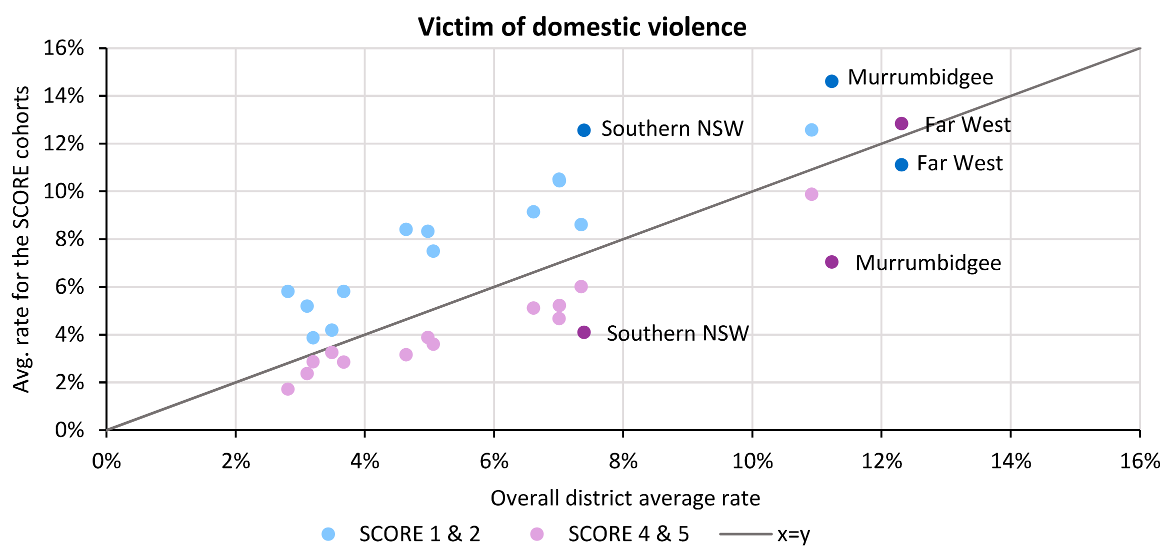
The chart shows that purple points representing clients with SCORE rating of 4 or 5 (more positive results) are generally below the line x=y, which correspond to lower than average likelihood of experiencing the modelled outcomes. This is observed across all districts except for Far West, where the volume of SCORE surveys completed is low and hence the results are less reliable. Similarly, the blue points representing clients with SCORE rating of 1 or 2 correspond to higher than average likelihood of experiencing the modelled outcomes.

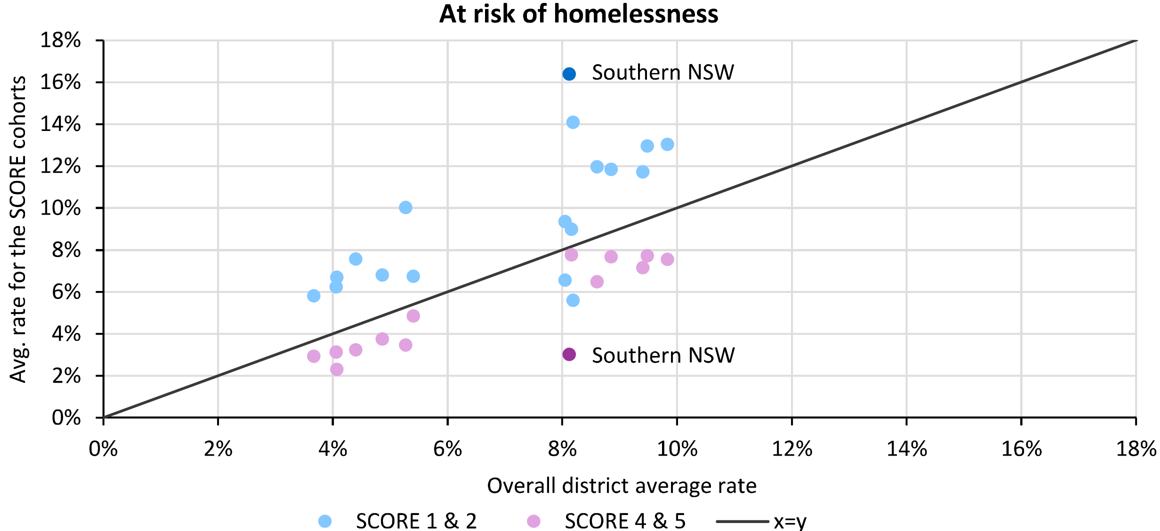
Across all the safety outcomes, the observed relationship between SCORE and outcome is particularly strong in Murrumbidgee and Southern NSW. For example, the chart for concern report shows that in Murrumbidgee, 35% of clients with SCORE rating of 1 or 2 experience concern report in the following quarter, compared to only 14% for clients with SCORE rating of 4 or 5 and 24% for all clients with SCORE assessment. For the housing outcome, clients with a SCORE rating of 1 or 2 is over five times more likely to be at risk of homelessness compared to clients with a SCORE rating of 4 or 5. These districts of interest are shown using a darker colour in the charts below and separately labelled.

Figure H.47 – Relationship between SCORE result and client outcome by DCJ district (HSDS)






### H.4.3 Predictiveness of change in SCORE with change in client outcomes

The regression models described in Section 6.8 use a range of client characteristics and service interaction history to control for the clients' risk profile. These are summarised in the table below for each of the four models. Note that the model structures adopted in these models are simpler with less predictors used than the regression models assessing the impact of TEI as described in Appendix H.1.2. This is because the volume of data used in this analysis is much smaller as it only includes clients with SCORE assessments.

Table H.10 – List of predictors used for each change in SCORE model

| Predictor | Concern report | ROSH | Victim of D.V. | At risk of homelessness |
|---|---|---|---|---|
| Age | ✓ | ✓ | ✓ | ✓ |
| Mother age at birth | | ✓ | | |
| Sex | ✓ | ✓ | ✓ | ✓ |
| Indigenous status | ✓ | ✓ | ✓ | ✓ |
| SEIFA Economic Advantage decile | ✓ | ✓ | ✓ | |
| Concern report history | ✓ | ✓ | | |
| ROSH report history | ✓ | ✓ | | |
| Mental health service history | ✓ | ✓ | ✓ | ✓ |
| Hospitalisation history | ✓ | ✓ | ✓ | ✓ |
| Police cautions history | ✓ | ✓ | ✓ | |
| Court history | | | | ✓ |
| Victim of domestic violence incidence history | ✓ | ✓ | ✓ | ✓ |
| Parent being victim of domestic violence incidence history* | ✓ | ✓ | | |
| Victim of non-domestic violence incidence history | | | ✓ | ✓ |

| Predictor | Concern report | ROSH | Victim of D.V. | At risk of homelessness |
|---|---|---|---|---|
| Private rental assistance receipt history | ✓ | ✓ | ✓ | ✓ |
| Homelessness history | | | ✓ | ✓ |
| At risk of homelessness history | | | | ✓ |
| Proportion of school days attended in the last year | ✓ | ✓ | | |
| Mother was smoking at birth | | ✓ | | |
| Calendar quarter | ✓ | ✓ | ✓ | ✓ |
| Earliest SCORE result | ✓ | ✓ | ✓ | ✓ |
| Outcome type | ✓ | ✓ | ✓ | ✓ |
| Quarters between first and last SCORE | ✓ | ✓ | ✓ | ✓ |
| Change between first and last SCORE | ✓ | ✓ | ✓ | ✓ |

*Note: For a list of services considered in establishing parental history with a particular domain, see the domain definitions used to define client complexity in Appendix G.2.

The number of clients included in each model are summarised in the charts below. For the concern report and ROSH models, it includes children aged 0-17 who have at least two SCORE assessments completed in the same domain that can be either for themselves or for their parents. For the victim of domestic violence and at risk of homelessness models, it includes adults aged 18+ and only assessments for themselves are considered.

Figure H.48 – Volume of clients included in concern report and ROSH models by SCORE domain (HSDS)

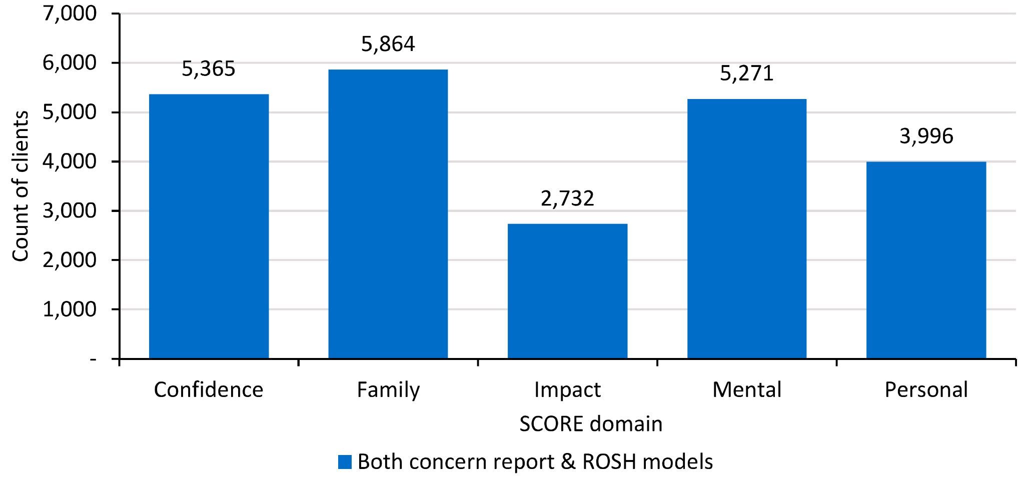


Figure H.49 – Volume of clients included in victim of domestic violence and at risk of homelessness models by SCORE domain (HSDS)

Count of clients
6,000
5,000
4,000
3,000
2,000
1,000
-
4,382
5,470
2,702
4,297
3,373
1,761
5,235
Confidence
Family
Impact
Mental
Personal
Housing
Skills
SCORE domain
DV model only
Both models
Homelessness model only

The table below summarises the p-value of the change in SCORE coefficient for individual domains in predicting client outcomes. This corresponds to a hypothesis test with the null hypothesis that there is no relationship between the change in SCORE coefficient and client outcome. A low p-value means there is strong evidence of the SCORE result from the domain being predictive of client outcome.

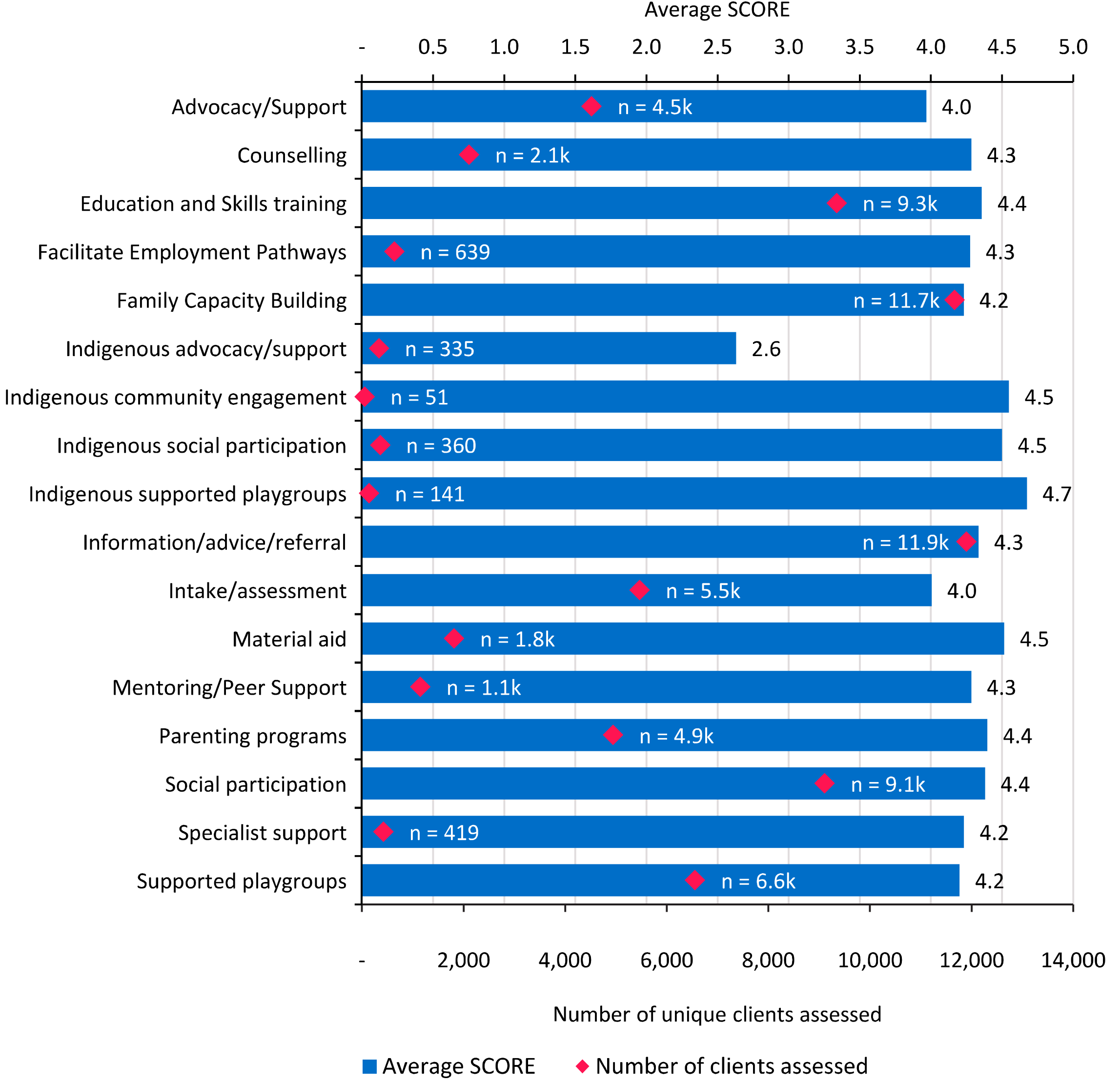
Table H.11 – p-values for change in SCORE variables from individual domains

| SCORE domain (C = Circumstance, G = Goal) | Concern report | ROSH | Victim of D.V. | At risk of homelessness |
|---|---|---|---|---|
| Personal and Family safety (C) | <0.0001 | <0.0001 | 0.012 | 0.004 |
| Family Functioning (C) | <0.0001 | <0.0001 | 0.002 | N/A |
| Mental health (C) | <0.0001 | <0.0001 | 0.0003 | 0.087 |
| Housing (C) | N/A | N/A | N/A | 0.004 |
| Empowerment, choice and control (G) | <0.0001 | 0.028 | 0.011 | N/A |
| Impact of immediate crisis (G) | 0.0003 | 0.047 | 0.008 | 0.820 |
| Increasing Skills (G) | N/A | N/A | N/A | 0.385 |

## H.5 Client satisfaction

Figure H.50 below shows the average SCORE rating from the domain "I am better able to deal with issues that I sought help with" for each service type. As discussed in Section 6.8.1, the low rating for Advocacy/Support and Indigenous Advocacy/Support is driven by one outlet in Nepean Blue Mountains, who accounts of around a quarter of the total SCORE assessments collected for Advocacy/Support and two-thirds of the assessments collected for Indigenous Advocacy/Support and have average rating of close to one for both service types. This may be driven by a data submission issue. Excluding this outlet, the average rating is much higher at 4.5 for Advocacy/Support and 4.2 for Indigenous Advocacy/Support.

Figure H.50 – Satisfaction SCORE for "I am better able to deal with issues that I sought help with" by service type (DEX, all years)*




*Note: Business Planning, Community sector coordination, Community sector planning are excluded as they are mainly aimed at support persons instead of clients, Indigenous healing workshop is excluded due to low volume of SCORE surveys collected.

Figure H.51 to Figure H.53 below show that there is some variation across districts in the average satisfaction SCORE rating for each of the three domains as well as percentage of clients with a SCORE result in each domain. Again, we have excluded SCORE results from the one outlet in Nepean Blue Mountains due to the potential data issue mentioned at the start of this Section and described in Section 6.6.2 for these figures.

Figure H.51 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district for outcome domain “I am better able to deal with issues that I sought help with” (DEX, all years)

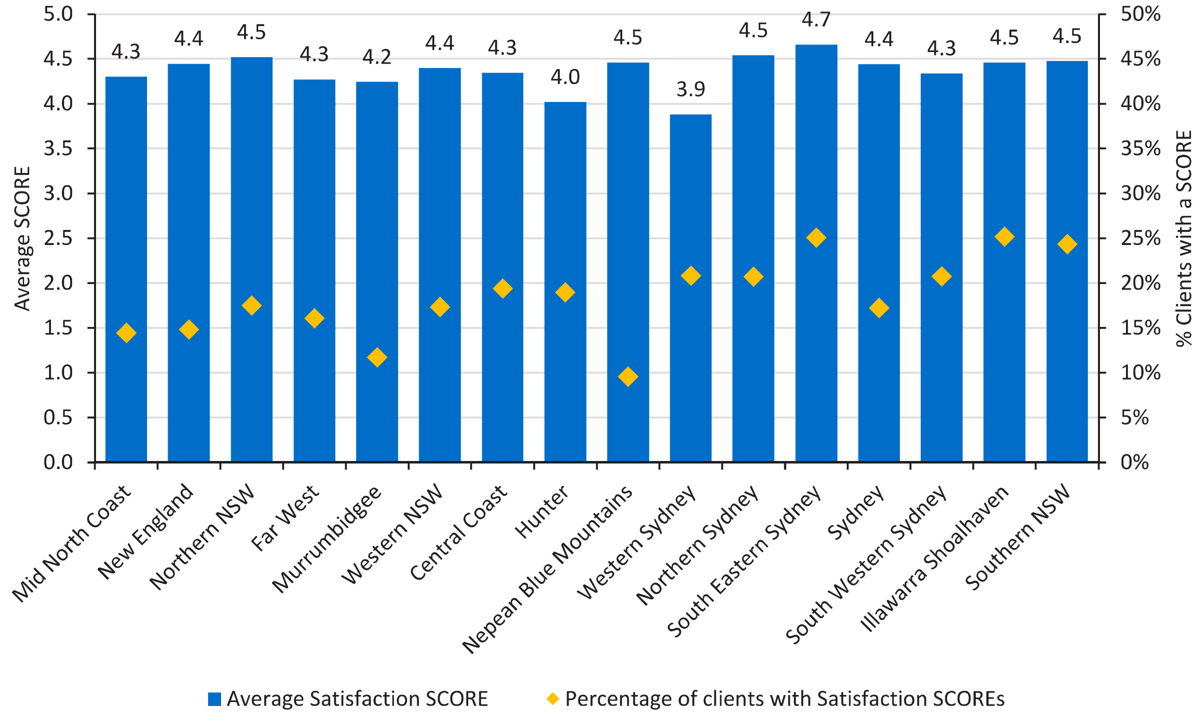



Figure H.52 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district for outcome domain “I am satisfied with the services I have received” (DEX, all years)

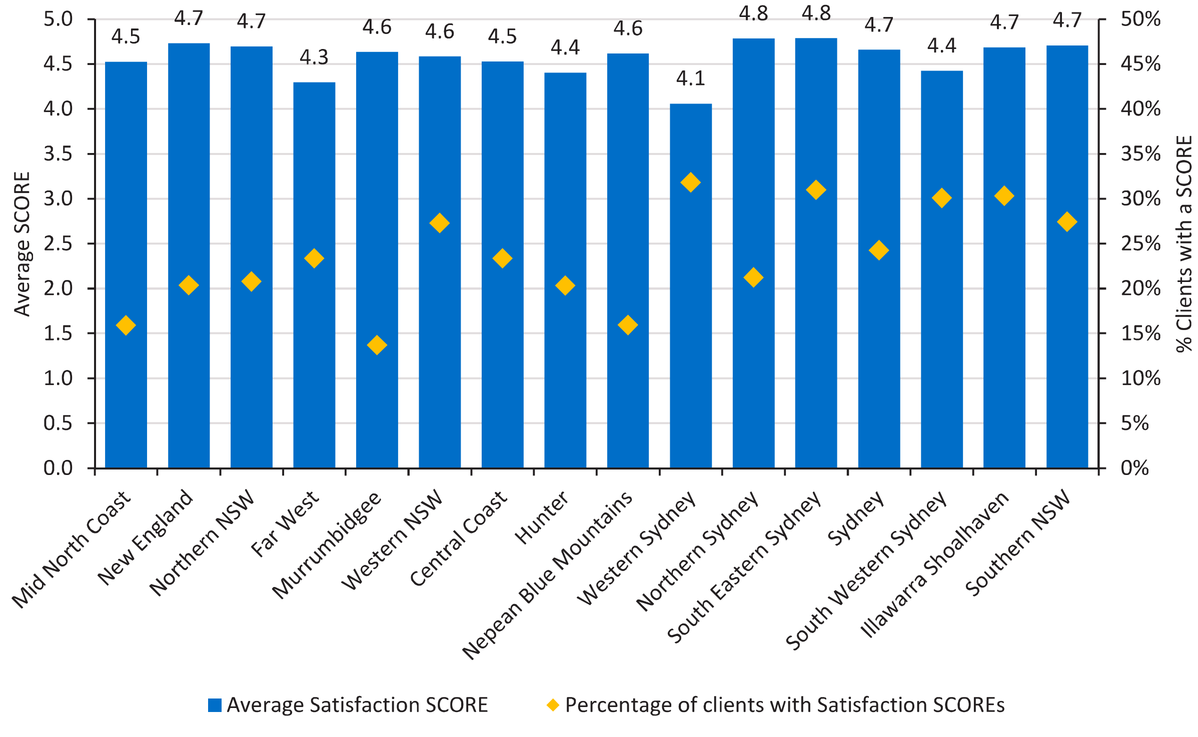


Figure H.53 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district for outcome domain “The service listened to me and understood my issues” (DEX, all years)

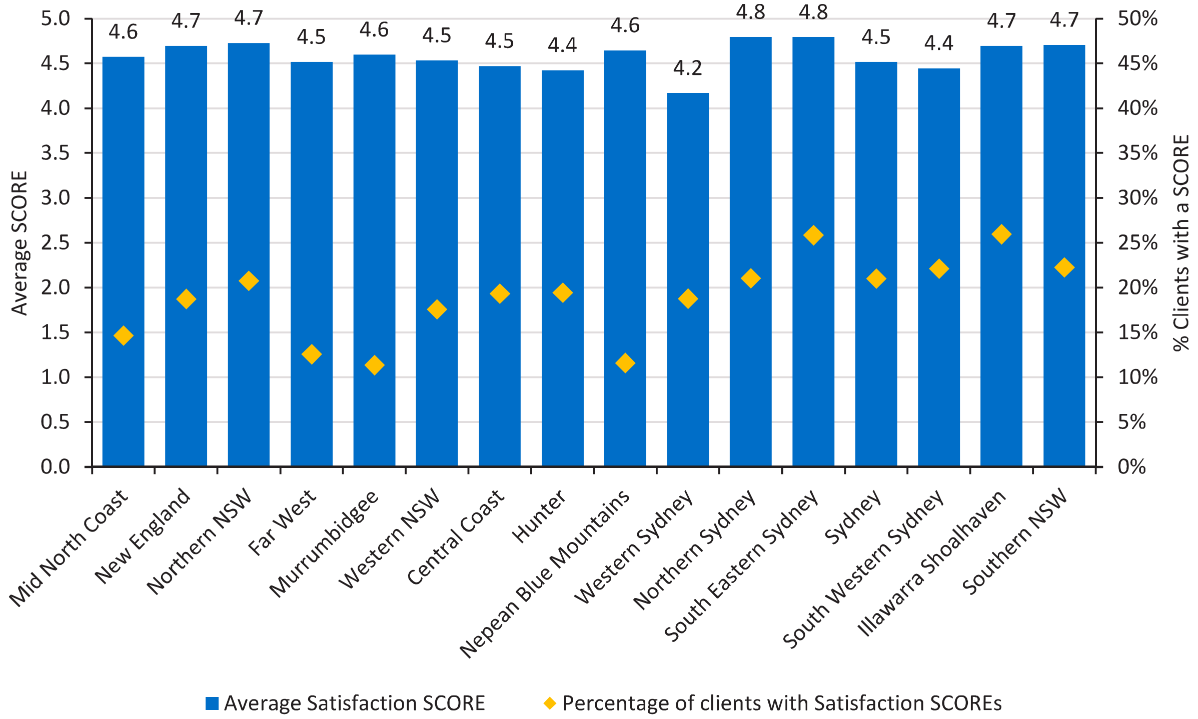



Figure H.54 to Figure H.56 below breaks down the average satisfaction SCORE from each domain by district for Aboriginal and Non-Aboriginal clients. The results across the three domains are very similar to the overall average shown in Section 8.3.3.

Figure H.54 – Average satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district for outcome domain “I am better able to deal with issues that I sought help with” (DEX, all years)

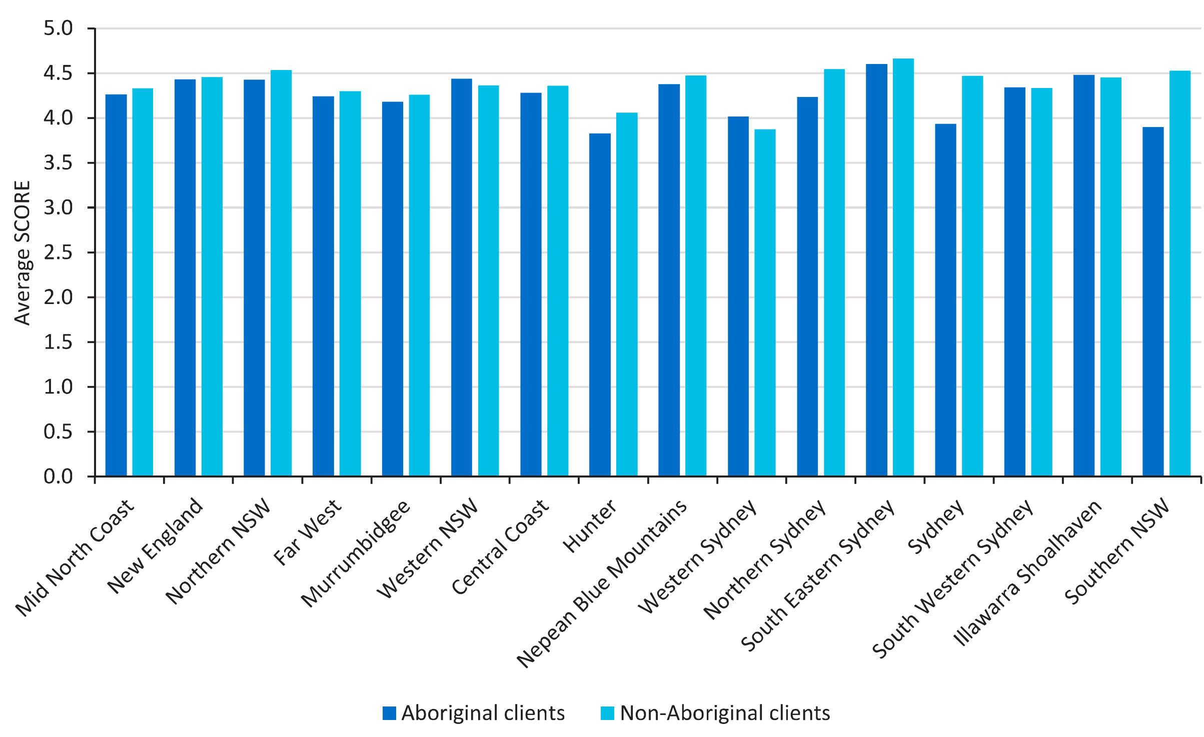


Figure H.55 – Average satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district for outcome domain "I am satisfied with the services I have received" (DEX, all years)

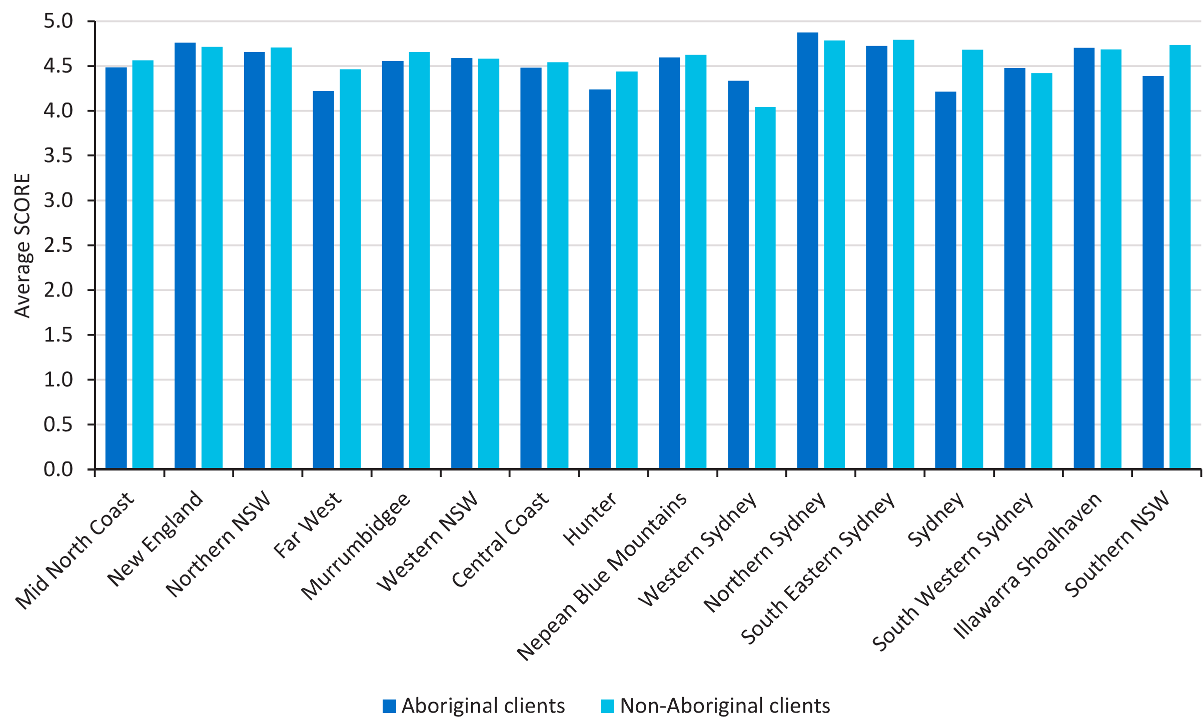
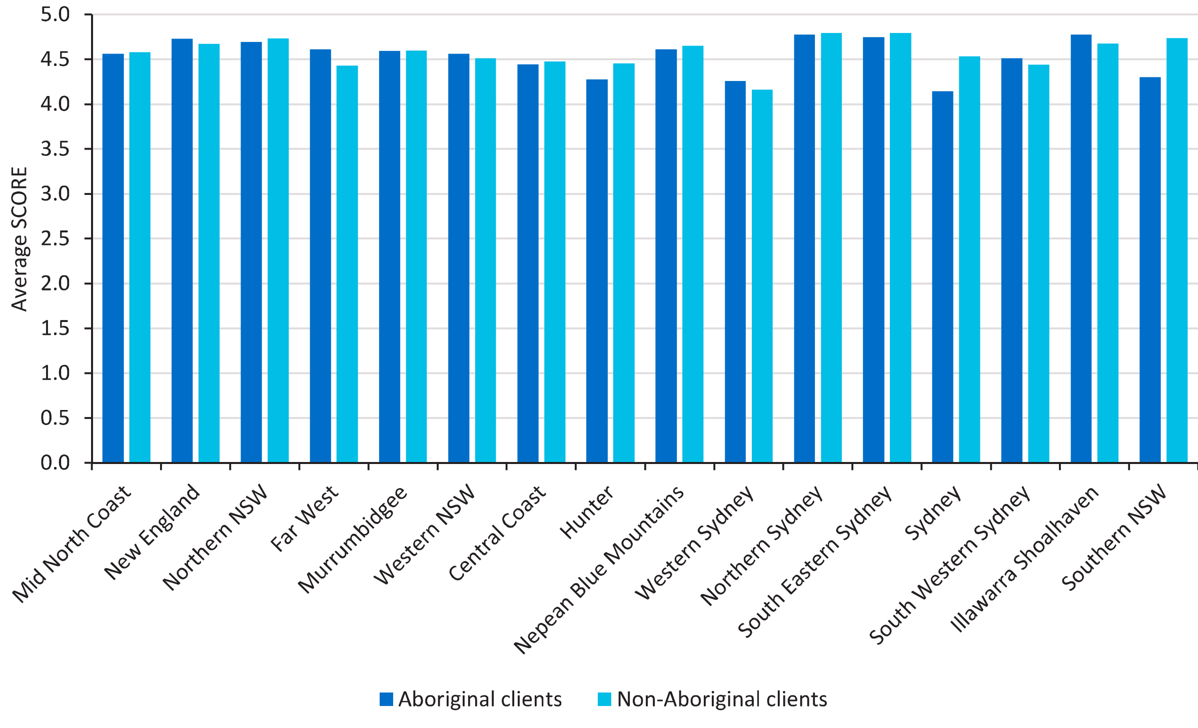



Figure H.56 – Average satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district for outcome domain "The service listened to me and understood my issues" (DEX, all years)



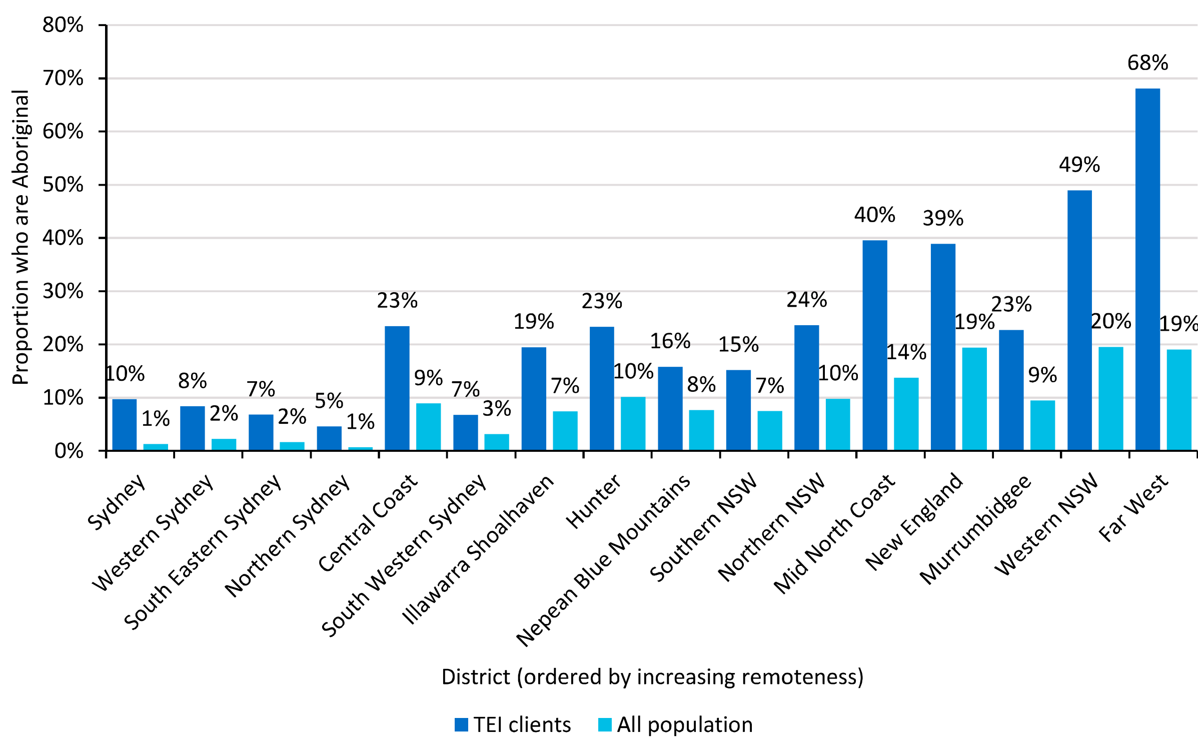
# Appendix I Service delivery for Aboriginal Children and Families (additional analysis)

## I.1 TEI program reach to Aboriginal Children and Families

Aboriginal children, young people, families and communities are a priority group for the TEI program. In NSW, Aboriginal children make up 42% of the out of home care population despite representing just 8% of the child population.[110] In 2022-23, 25,056 or 16% of all individual clients and 19% of individual clients aged 0-17 identified as Aboriginal and or Torres Strait Islander. The TEI program is one of the NSW Government's key initiatives aiming to reduce entries into out of home care.

In Figure I.1 below we compare the Aboriginal people's share of TEI clients to their share of the general population in 2022-23. We limit the comparison to people aged 0-44 as it is a better reflection of the target cohorts of TEI and it covers the bulk of the TEI clients. Overall, the Aboriginal people's share of TEI clients is about 2.5 times their share of the general population. The over-representation is consistently at around 2 to 3 times across all districts except those in the metropolitan Sydney region, where Aboriginal people as a proportion of population is very low and the share of Aboriginal TEI clients is 4 to 8 times the share of overall population.

Figure I.1 – Aboriginal people's share of TEI clients compared to their share of the general population (Age 0-44) (DEX, 2022-23)




[110] See Productivity Commission information repository: https://www.pc.gov.au/closing-the-gap-data/dashboard/socioeconomic/outcome-area12/out-of-home care.

## I.2 Past government service interactions for Aborginal Children and Families in TEI

The analyses in Sections I.2 and I.3 involve analysis of linked data using the HSDS. Throughout these sections, TEI clients refers to clients who attended TEI sessions and who were able to be linked to the HSDS, as well as children visible through the HSDS. Altogether, there are 36,121 such clients where 18,232 (49%) directly attended TEI sessions and 17,798 (51%) were children of TEI attendees.

As introduced in Section 5.3.1, TEI clients have heightened historical service usage compared to the general population. Even amongst TEI clients, Aboriginal clients tended to have more complex circumstances than non-Aboriginal clients, a reflection of many contributing factors, including historical injustices experienced. As we see in Figure 8.1, Aboriginal TEI clients generally have twice the likelihood of having service history across a range of outcomes chosen from safety, justice, education, housing and health domains.

For each TEI client, five people in the general NSW population with the same age, sex and parental status (being a parent or not) was sampled to form the general population group for comparison purposes [111]. Both Aboriginal and non-Aboriginal clients used services at a higher proportion than the general population.

Table I.1 contains a full list of services across different domains and the proportion of the Aboriginal TEI population compared to their sampled general population comparison group. Figure I.2 and Figure I.3 reveal additional educational history.

Table I.1 – Risk profile of 2020-21 and 2021-22 Aboriginal TEI population compared to the general population sample, n=36,121 (TEI), n=180,440 (General).

| Risk factor[(a)] | **TEI Aboriginal** (in quarter of entry) | **General** (in quarter of entry) | **TEI Aboriginal** (within 1 year prior to entry) | **General** (within 1 year prior to entry) | **TEI Aboriginal** (ever prior to entry) | **General** (ever prior to entry) |
|---|---|---|---|---|---|---|
| **Concern report** (of clients aged under 18) | 26.5% | 2.0% | 47.3% | 5.2% | 73.4% | 16.1% |
| **ROSH report** (of clients aged under 18) | 20.9% | 1.5% | 40.3% | 4.0% | 69.8% | 13.4% |
| **Substantiated ROSH report** (of clients aged under 18) | 4.2% | 0.2% | 11.3% | 0.6% | 38.8% | 3.8% |
| **Out of home care** (of clients aged under 18) | 8.6% | 0.6% | 9.2% | 0.7% | 15.4% | 1.3% |
| **Domestic violence victim** | 4.3% | 0.3% | 11.2% | 1.0% | 34.1% | 6.6% |
| **Proven domestic violence offence** (of clients aged 11 or over) | 1.1% | 0.1% | 3.2% | 0.2% | 12.4% | 1.1% |
| **Proven drug or alcohol related offence** (of clients aged 11 or over) | 0.5% | 0.1% | 1.6% | 0.2% | 12.4% | 2.9% |

[111] Additionally, to remove differences between TEI clients and the comparison group owing to visibility of individual service use in the data, time trends in the data and data processing changes or issues, TEI client service use in a given quarter was compared to general population service use in the same quarter. Further, those born in NSW were matched to those born in NSW and those born outside NSW were matched to those born outside NSW.

| Risk factor[a] | TEI Aboriginal (in quarter of entry) | General (in quarter of entry) | TEI Aboriginal (within 1 year prior to entry) | General (within 1 year prior to entry) | TEI Aboriginal (ever prior to entry) | General (ever prior to entry) |
|---|---|---|---|---|---|---|
| **Time in custody** (of clients aged 11 or over) | 2.9% | 0.2% | 5.7% | 0.4% | 16.3% | 1.4% |
| **Interaction with criminal justice system** (of clients aged 11 or over) | 5.0% | 0.4% | 12.6% | 1.2% | 36.0% | 6.9% |
| **Youth cautions** (of clients aged 11 or over and under 18) | 1.6% | 0.2% | 5.2% | 0.6% | 11.6% | 1.1% |
| **School suspension**[b] (of clients aged between 5 and 18 with at least one day of school enrolment) | 19.0% | 11.6% | 31.7% | 19.0% | - | - |
| **Did not achieve NAPLAN minimum standard at last NAPLAN**[c] (of those with a NAPLAN record) | 35.4% | 7.8% | - | - | - | - |
| **HSC completion** (of NSW born clients aged between 19 and 31) | 23.7% | 63.9% | - | - | - | - |
| **SHS homeless presentation** | 9.9% | 0.3% | 15.0% | 0.7% | 33.2% | 2.4% |
| **Mental health ambulatory services** | 4.2% | 0.6% | 7.7% | 1.3% | 22.5% | 5.6% |
| **Opioid treatment support** (of clients aged 15 or over) | 2.5% | 0.2% | 2.7% | 0.2% | 4.2% | 0.4% |
| **Hospital admission for mental health** | 0.6% | 0.1% | 1.5% | 0.4% | 7.5% | 2.2% |
| **Hospital admission for alcohol or drug use** (of clients aged 15 or over) | 0.7% | 0.1% | 2.3% | 0.3% | 13.7% | 2.6% |
| **Parental history**[d] **with custody** (of clients with at least one parent in linked data) | - | - | 12.8% | 1.2% | 45.0% | 6.7% |
| **Parental history**[d] **with drug/alcohol related services** (of clients with at least one parent in linked data) | - | - | 7.8% | 1.0% | 57.2% | 18.1% |
| **Parental history**[d] **with domestic violence** (of clients with at least one parent in linked data) | - | - | 35.3% | 4.0% | 88.2% | 27.1% |
| **Parental history**[d] **with justice** (of clients with at least one parent in linked data) | - | - | 25.7% | 3.1% | 84.0% | 33.1% |
| **Parental history**[d] **with mental health** (of clients with at least one parent in linked data) | - | - | 16.8% | 2.5% | 61.0% | 16.0% |

| Risk factor[a] | TEI Aboriginal (in quarter of entry) | General (in quarter of entry) | TEI Aboriginal (within 1 year prior to entry) | General (within 1 year prior to entry) | TEI Aboriginal (ever prior to entry) | General (ever prior to entry) |
|---|---|---|---|---|---|---|
| **Parental history[d] with public housing** (of clients with at least one parent in linked data) | - | - | 35.7% | 3.9% | 65.3% | 9.2% |

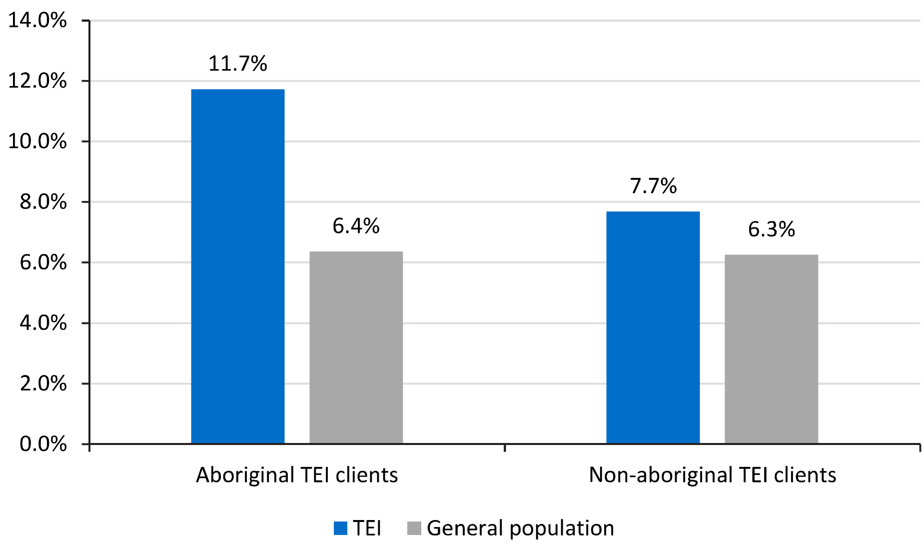
(a) Bracketed conditions after risk factor are included when we restrict the client group for a more relevant comparison. For example, we only report the rate of concern reports for the subset of TEI and matched general population that are under 18. This means different rows will reflect different sub-cohorts.

(b) Suspension data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible data processing changes. Moreover, school data is not available from June 2020 due to covid or prior to 2018 due to data quality issues, so the 'ever prior to entry' measure is less than the true measure, and excluded. At least one day of school enrolment is applied to exclude children who are never recorded as attending an NSW public school.

(c) The mix of last NAPLAN exam year sat amongst the TEI population is different to that amongst the general population, with 62% of TEI clients with a last NAPLAN having last NAPLAN year 9, compared to 67% of the general population. See Figure I.3 for minimum standard achievement rates for the TEI population and the general population by last NAPLAN exam year sat.

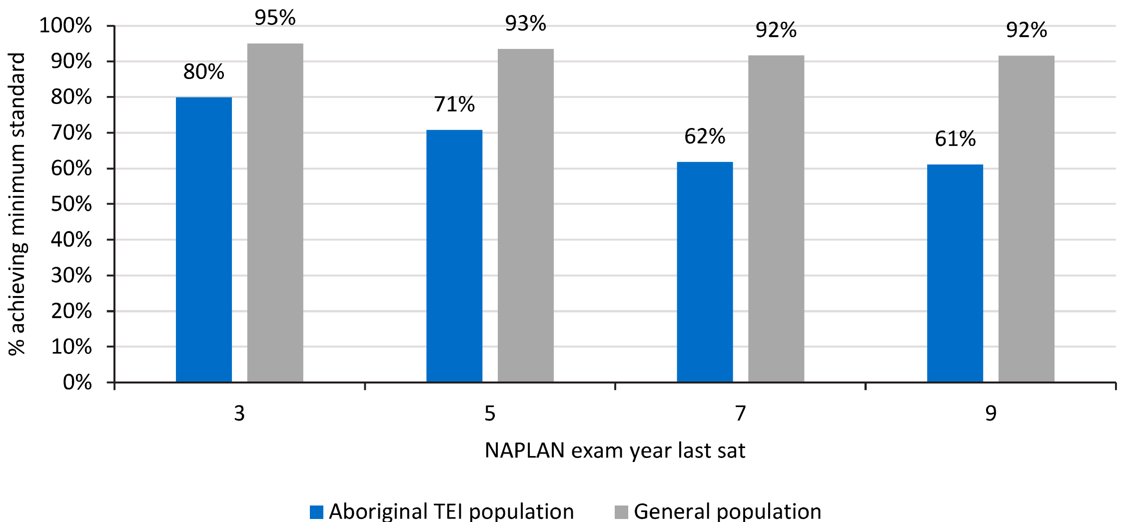
(d) For a list of services considered in establishing parental history with a particular domain, see the domain definitions used to define client complexity in Appendix G.2.

Figure I.2 – Average proportion of enrolled school days in the 1 year prior to entering TEI not attended for Aboriginal and non-Aboriginal TEI clients compared to the general population (HSDS)[112]




[112] Attendance data from calendar years 2020 onwards is not comparable to previous years, or each other, due to the COVID-19 pandemic and possible changes in data processing. Students were encouraged to learn from home, where possible, for large periods of time during 2020 and 2021. There was also some evidence of varied attendance marking practices across schools in the period.

Figure I.3 – Proportion of Aboriginal TEI population and general population achieving the NAPLAN minimum standard by NAPLAN exam year last sat (HSDS)




As a measure of client complexity, services were grouped into 9 selected domains and the count of domains from which services were used counted. For the full definition of each domain, refer to Appendix G.2. Figure I.4 shows the average number of domains out of the 9 selected domains a TEI client used services in over different time periods. The figure shows that Aboriginal TEI clients used services across more domains than the general population. Figure I.5 reveals that Aboriginal TEI clients used services across 5 to 9 times more domains than the general population, compared to 2 to 4 times for non-Aboriginal clients.

Figure I.4 – Average count of 9 domains utilised prior to TEI entry for Aboriginal TEI individual clients and the general population (HSDS)

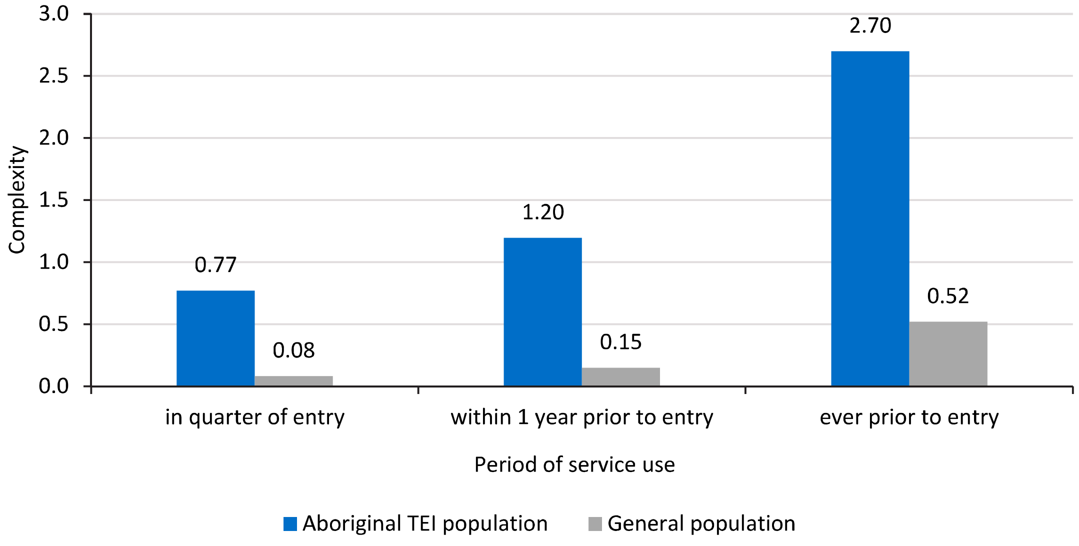
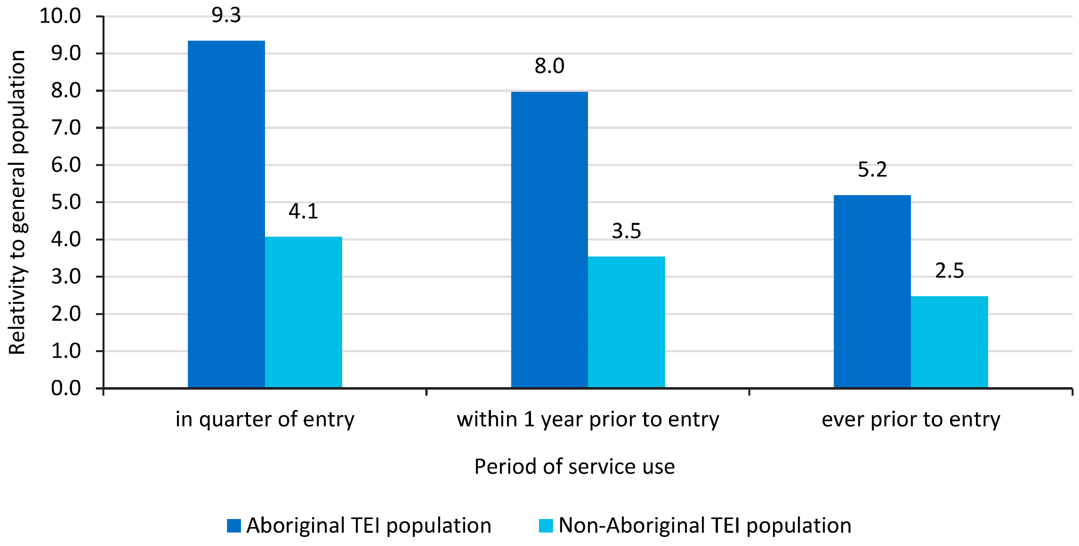


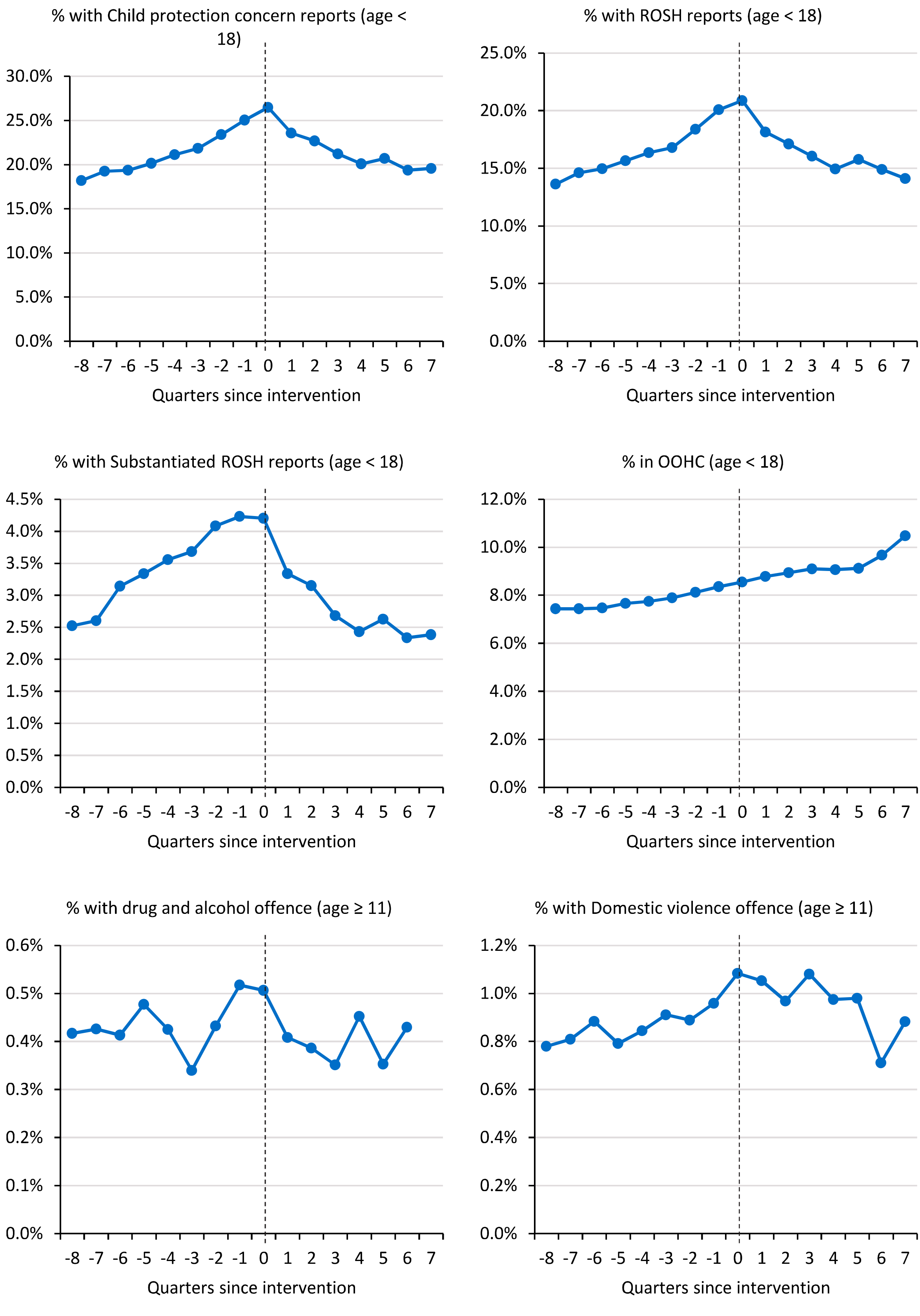
Figure I.5 – Relativity of client complexity compared to the general population, for Aboriginal TEI individual clients and non-Aboriginal Individual TEI clients (HSDS)

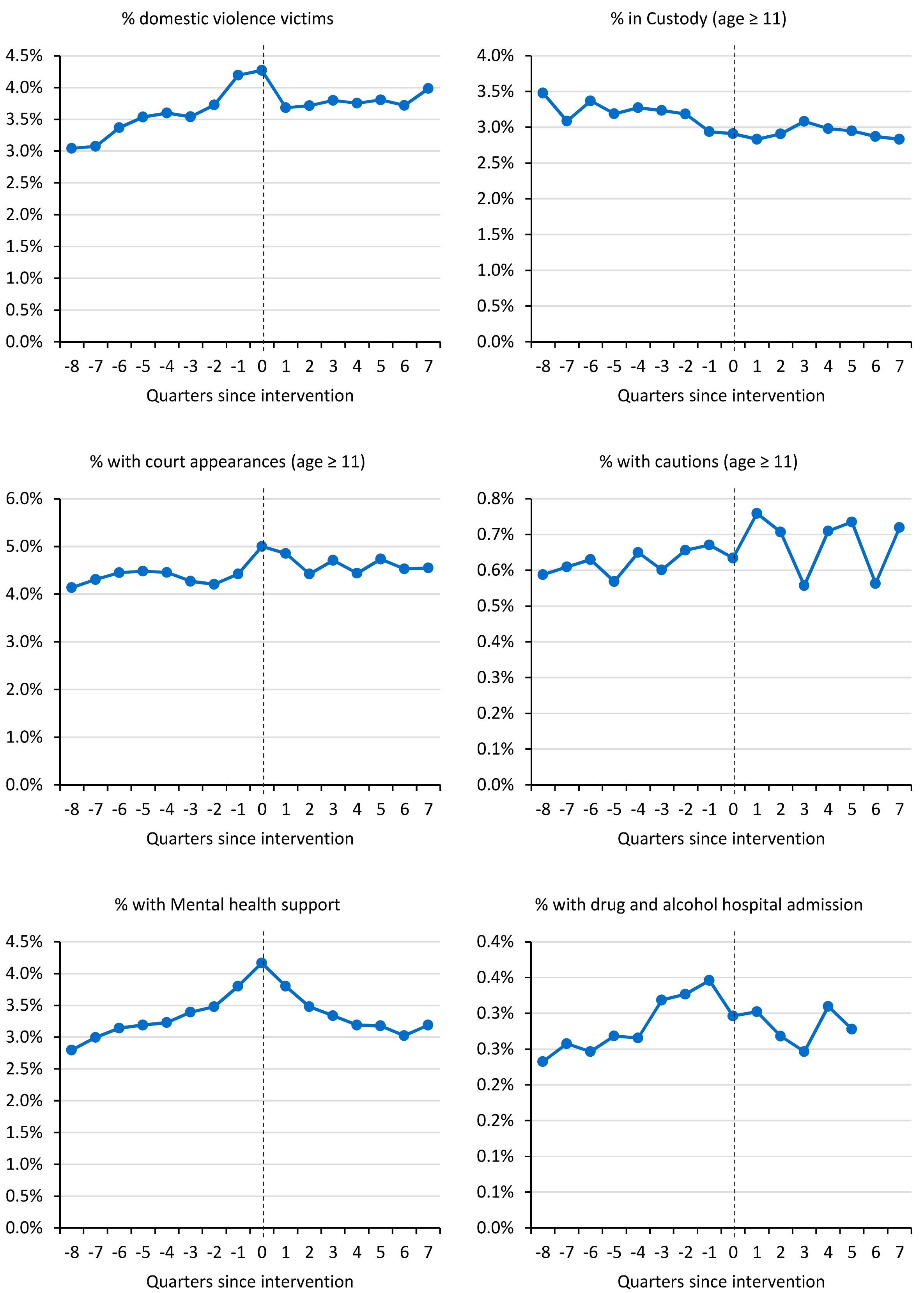



## I.3 TEI outcomes for Aboriginal children and families

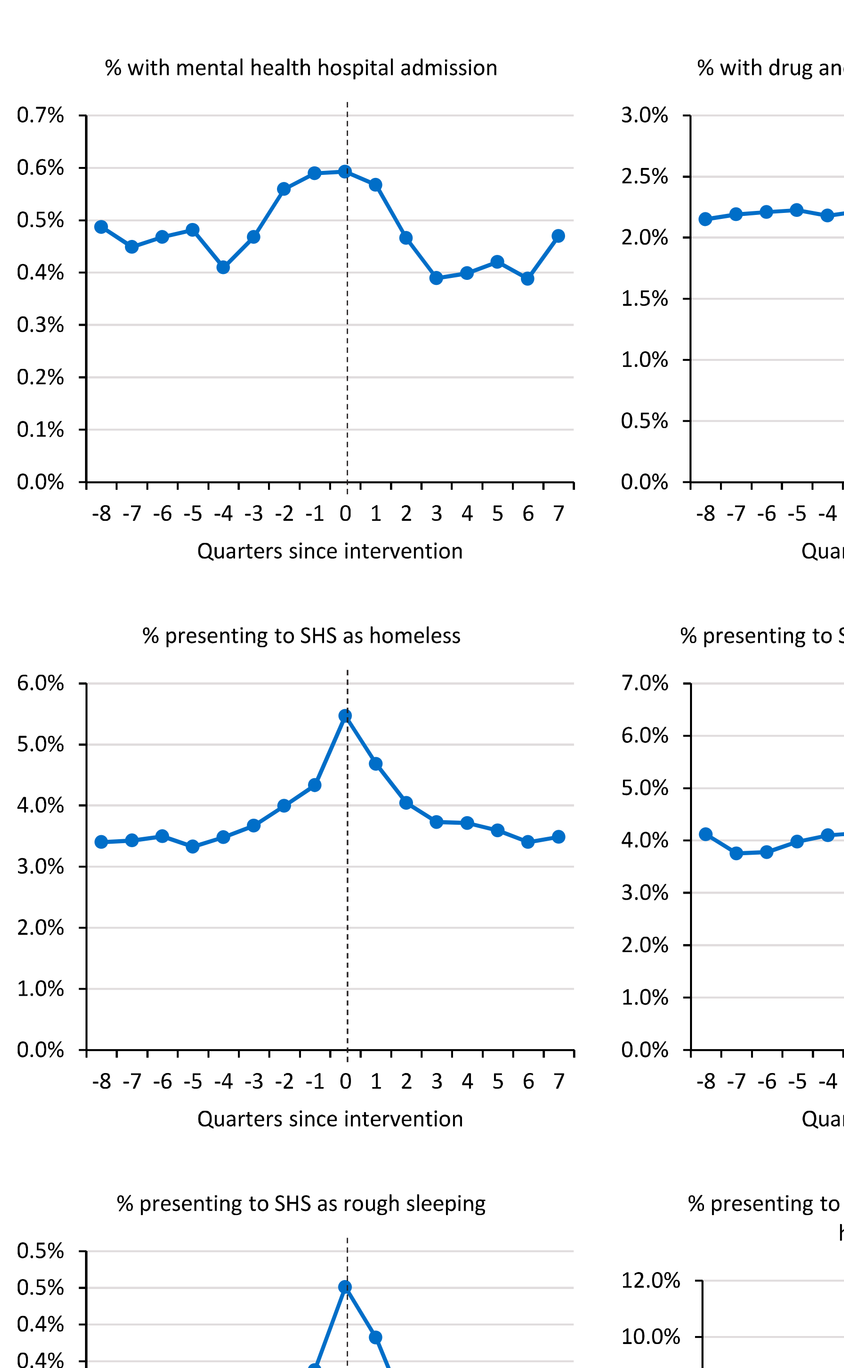
The charts in Figure I.6 track outcome rates in each of the eight quarters prior to intervention and in the eight quarters afterwards for Aboriginal TEI clients. The charts show that experience is generally volatile, but most follow the trend of upwards service usage until the quarter of TEI intervention, then a reduction afterwards.

Figure I.6 – Outcomes charts for Aboriginal TEI clients (HSDS)

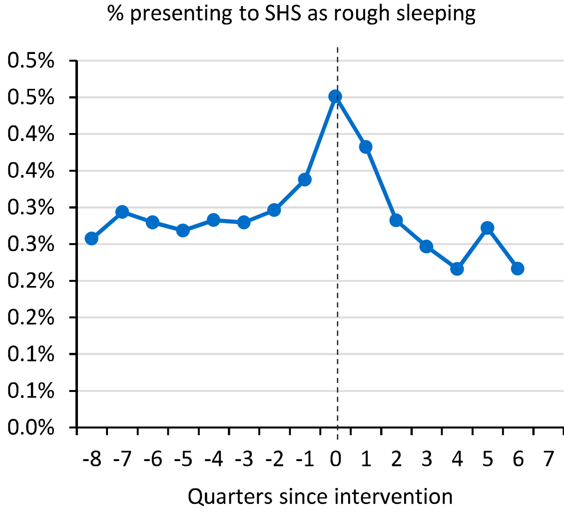




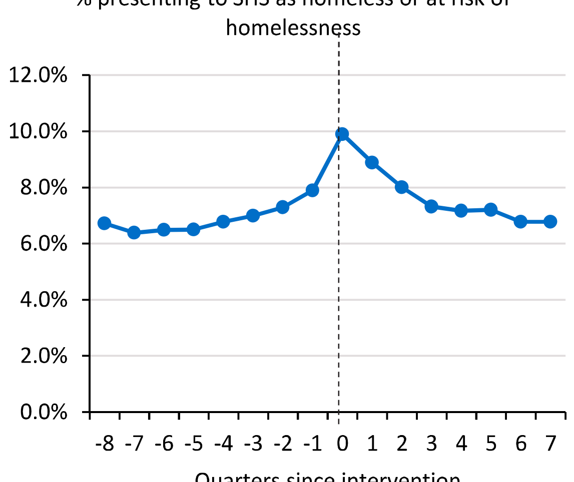
% domestic violence victims
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% in Custody (age ≥ 11)
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with court appearances (age ≥ 11)
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with cautions (age ≥ 11)
0.8%
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with Mental health support
4.5%
4.0%
3.5%
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with drug and alcohol hospital admission
0.4%
0.4%
0.3%
0.3%
0.2%
0.2%
0.1%
0.1%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention



% with mental health hospital admission
0.7%
0.6%
0.5%
0.4%
0.3%
0.2%
0.1%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% with drug and alcohol support (age ≥ 15)
3.0%
2.5%
2.0%
1.5%
1.0%
0.5%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% presenting to SHS as homeless
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention
% presenting to SHS as at risk of homelessness
7.0%
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention

% presenting to SHS as rough sleeping
0.5%
0.5%
0.4%
0.4%
0.3%
0.3%
0.2%
0.2%
0.1%
0.1%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention

% presenting to SHS as homeless or at risk of homelessness
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
-8 -7 -6 -5 -4 -3 -2 -1 0 1 2 3 4 5 6 7
Quarters since intervention

# Appendix J Economic/Cost benefit results (full analysis)

## J.1 Methodology

This Section will set out the methodology for estimation of economic benefits associated with improvement in safety outcomes for TEI clients. Although the TEI impacts were found to be not statistically significant between activity types, the estimation is split by activity type due to differences in client recording behaviour and mix between streams. The applied TEI impacts are similar and the results are not reported at the stream level due to the lack of statistical significance. As discussed in Section 9.1, the key steps are:

1. Extract the total identified client-quarters under 18 in DEX, split by quarters since entry in 2022-23. Note that since our benefit model is quarterly, a single client will be counted (at most) four times. The client need not necessarily have used TEI in 2022-23, we consider all TEI clients and measure the benefit estimated to accrue in the four quarters of 2022-23. This is diagrammatically represented in the Figure below.
2. Scale up to allow for effect of children not recorded in the DEX, but are impacted by TEI through their parents. This factor was selected based on HSDS analysis and differs by activity type.
3. Multiply by proportion of TEI entrants in OOHC, or not in OOHC depending on outcome.
4. Apply regression estimates of TEI impact to calculate the number of quarters with service episodes avoided or additional clients exiting OOHC.
5. Multiply improvement outcomes changes per-event dollar savings/benefits.

Figure J.1 – Diagrammatic representation of measured benefit for each entry quarter cohort, each number represents the quarters since entry.

| | Benefit quarter | | | | | | | | 22-23 Benefit | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Entry quarter | Sep-20 | Dec-20 | Mar-21 | Jun-21 | Sep-21 | Dec-21 | Mar-22 | Jun-22 | Sep-22 | Dec-22 | Mar-23 | Jun-23 |
| Sep-20 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| Dec-20 | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Mar-21 | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
| Jun-21 | | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| Sep-21 | | | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| Dec-21 | | | | | | 0 | 1 | 2 | 3 | 4 | 5 | 6 |
| Mar-22 | | | | | | | 0 | 1 | 2 | 3 | 4 | 5 |
| Jun-22 | | | | | | | | 0 | 1 | 2 | 3 | 4 |
| Sep-22 | | | | | | | | | 0 | 1 | 2 | 3 |
| Dec-22 | | | | | | | | | | 0 | 1 | 2 |
| Mar-23 | | | | | | | | | | | 0 | 1 |
| Jun-23 | | | | | | | | | | | | 0 |

We provide an example calculation on the following page.

**Example calculation – increased OOHC exits**

An example calculation for the increased exits from OOHC for the Targeted Support program activity is set out below. Note that there may be some differences due to rounding.

Table J.1 – Example benefit calculation for increased exits from OOHC for the Targeted Support program activity

| Quarters since TEI entry | Step 1: Client-quarters recorded in DEX in 2022-23 | Step 2: Scale up for children not recorded in DEX | Step 3: Multiply by proportion of TEI children in OOHC | = Total children-quarters impacted by TEI, in OOHC | Step 4: multiply by modelled incremental decrease due to TEI | = Number of additional OOHC exits |
|---|---|---|---|---|---|---|
| 0 | 27,184 | x2.14 | 3.5% | **2,049** | - | **0** |
| 1 | 27,837[(a)] | x2.14 | 3.5% | **2,098** | 0.0% | **0** |
| 2 | 26,263 | x2.14 | 3.5% | **1,979** | 0.0% | **0** |
| 3 | 24,093 | x2.14 | 3.5% | **1,816** | 0.0% | **0** |
| 4 | 20,318 | x2.14 | 3.5% | **1,531** | 0.7% | **11** |
| 5 | 20,495 | x2.14 | 3.5% | **1,544** | 0.9% | **14** |
| 6 | 23,314 | x2.14 | 3.5% | **1,757** | 1.1% | **19** |
| 7 | 24,653 | x2.14 | 3.5% | **1,858** | 1.4% | **26** |
| 8 | 29,413 | x2.14 | 3.5% | **2,217** | 0.0% | **0** |
| 9 | 22,736 | x2.14 | 3.5% | **1,713** | 0.0% | **0** |
| 10 | 14,135 | x2.14 | 3.5% | **1,065** | 0.0% | **0** |
| 11 | 8,951[(b)] | x2.14 | 3.5% | **675** | 0.0% | **0** |
| **Total** | | | | | | **69** |

(a) For example, this total is the sum of clients recorded to have entered TEI in the four quarters spanning 1 April 2022 to 31 March 2023, with minor adjustments for clients being reclassified to other activity types.

(b) These are entrants from the September 2020 quarter.

**Step 5: Apply dollar savings per OOHC restoration**

69 * $376,143 = $25,985,324 in estimated benefit.

**Example calculation – ROSH reports**

An example calculation for the reduction in ROSH reports for the Targeted Support program activity is set out below. Note that there may be some differences due to rounding.

Table J.2 – Example benefit calculation for avoided ROSH reports for the Targeted Support program activity

| Quarters since TEI entry | Step 1: Client-quarters recorded in DEX in 2022-23 | Step 2: Scale up for children not recorded in DEX | Step 3: Multiply by proportion of TEI children not in OOHC | = Total children-quarters impacted by TEI, not in OOHC | Step 4: multiply by modelled decrease due to TEI | = Number of avoided ROSH reports |
|---|---|---|---|---|---|---|
| 0 | 27,184 | x2.14 | 96.5% | **56,125** | - | **0** |
| 1 | 27,837[(a)] | x2.14 | 96.5% | **57,473** | 0.0% | **0** |
| 2 | 26,263 | x2.14 | 96.5% | **54,224** | 0.2% | **91** |
| 3 | 24,093 | x2.14 | 96.5% | **49,743** | 0.3% | **160** |
| 4 | 20,318 | x2.14 | 96.5% | **41,949** | 0.4% | **188** |
| 5 | 20,495 | x2.14 | 96.5% | **42,315** | 0.4% | **177** |
| 6 | 23,314 | x2.14 | 96.5% | **48,135** | 0.4% | **189** |
| 7 | 24,653 | x2.14 | 96.5% | **50,900** | 0.4% | **198** |
| 8 | 29,413 | x2.14 | 96.5% | **60,727** | 0.4% | **236** |
| 9 | 22,736 | x2.14 | 96.5% | **46,942** | 0.4% | **182** |
| 10 | 14,135 | x2.14 | 96.5% | **29,184** | 0.4% | **113** |
| 11 | 8,951[(b)] | x2.14 | 96.5% | **18,481** | 0.4% | **72** |
| **Total** | | | | | | **1,605** |

(a) For example, this total is the sum of clients recorded to have entered TEI in the four quarters spanning 1 April 2022 to 31 March 2023, with minor adjustments for clients being reclassified to other activity types.

(b) These are entrants from the September 2020 quarter.

**Step 5: Apply dollar savings per avoided ROSH report**

1,605 * $18,496 = $29,692,936 in estimated benefit.

## J.2 Full assumptions

Table J.3 – Scaling factors for children not recorded in DEX and proportion in OOHC

| Activity Type | Scaling factor | Proportion in OOHC |
|---|---|---|
| Intensive Support | 2.17 | 7.5% |
| Targeted Support | 2.14 | 3.5% |
| Community Support | 2.61 | 3.9% |
| Community Connections | 2.15 | 2.5% |

| Activity Type | Scaling factor | Proportion in OOHC |
|---|---|---|
| Community Centres | 4.17 | 3.6% |

These selections are based on HSDS analysis on the count of clients when including only children identified in the TEI data, compared to when also including children whose parents are in the TEI data and the OOHC split. The implicit assumption is that the distribution is similar between HSDS and the DEX. The scale-up factors account for the fact that:

- Some programs may be held for parents only
- Some providers may only record the parents

For reasons discussed in Section 9.1.1, we have not allowed for any other scaling to account for impact on group clients and only focus on benefit to identified clients and their children. This is a relatively conservative assumption – it is reasonable to expect some impact for unidentified group clients, although it is also plausible that any outcome improvement is less marked for the group.

Table J.4 – Modelled change in concern report rate, for children not in OOHC

| Quarters since TEI entry | Intensive Support | Targeted Support | Community Support | Community Connections | Community Centres |
|---|---|---|---|---|---|
| 1 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 2 | -0.2% | -0.2% | -0.1% | -0.1% | -0.1% |
| 3 | -0.6% | -0.3% | -0.3% | -0.2% | -0.2% |
| 4 | -0.8% | -0.4% | -0.4% | -0.2% | -0.3% |
| 5 | -1.0% | -0.6% | -0.5% | -0.3% | -0.4% |
| 6 | -1.2% | -0.7% | -0.6% | -0.4% | -0.5% |
| 7 | -1.2% | -0.7% | -0.5% | -0.4% | -0.5% |
| 8+ | -1.2% | -0.7% | -0.5% | -0.4% | -0.5% |

Table J.5 – Modelled change in ROSH report rate, for children not in OOHC

| Quarters since TEI entry | Intensive Support | Targeted Support | Community Support | Community Connections | Community Centres |
|---|---|---|---|---|---|
| 1 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 2 | -0.3% | -0.2% | -0.1% | -0.1% | -0.1% |
| 3 | -0.5% | -0.3% | -0.2% | -0.1% | -0.2% |
| 4 | -0.8% | -0.4% | -0.4% | -0.2% | -0.3% |
| 5 | -0.7% | -0.4% | -0.3% | -0.2% | -0.3% |
| 6 | -0.6% | -0.4% | -0.3% | -0.2% | -0.3% |
| 7 | -0.6% | -0.4% | -0.3% | -0.2% | -0.3% |
| 8+ | -0.6% | -0.4% | -0.3% | -0.2% | -0.3% |

Table J.6 – Modelled change in OOHC rate, for children in OOHC

| Quarters since TEI entry | Intensive Support | Targeted Support | Community Support | Community Connections | Community Centres |
|---|---|---|---|---|---|
| 1 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 2 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 3 | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |
| 4 | -0.7% | -0.7% | -0.7% | -0.8% | -0.7% |
| 5 | -1.0% | -0.9% | -1.0% | -1.0% | -1.0% |
| 6 | -1.2% | -1.1% | -1.1% | -1.3% | -1.2% |
| 7 | -1.5% | -1.4% | -1.5% | -1.7% | -1.5% |
| 8+ | 0.0% | 0.0% | 0.0% | 0.0% | 0.0% |

Note: This shows the incremental change in each quarter and doesn't include exits from prior quarters to avoid double counting.

Table J.7 – Dollar savings per avoided event

| Outcome | Government savings (avoided cost) | Savings (to the individual) | Justification/Source |
|---|---|---|---|
| Concern Report avoided | $270 | - | DCJ unit costing guide for the cost of a concern report (SCRPT and initial assessment at Helpline) [$310] divided by the number of CYP per concern report [2.1] multiplied by the average number of concern reports per person per quarter [1.8]. |
| ROSH Report avoided | $10,583 | $5,275 | Government savings based on item SA19 of the DCJ Benefits Menu (2024) – "A client who is the subject of a ROSH report is not re-reported at ROSH in the following year (per person)" [$10,583].<br>Individual savings based on item SA9 of the DCJ Benefits Menu (2024) – "Reduced trauma resulting in incident of ROSH being either avoided or prevented (per episode avoided)" [$5,275] |
| Out of home care exit | $376,143 | - | Item SA22 of the DCJ Benefits Menu (2024) – "A client in OOHC is successfully restored with their family (per person)" [$376,143]. |

# Appendix K Detailed data for graphs used throughout this document

## K.1 Section 5

Table K.1 – Figure 5.1 – Number of individual clients by DCJ district (DEX)

| District | Number of individual clients in 2021-22 | Number of individual clients in 2022-23 |
|---|---|---|
| Mid North Coast | 6,219 | 7,764 |
| New England | 5,558 | 6,567 |
| Northern NSW | 5,374 | 6,725 |
| Far West | 563 | 612 |
| Murrumbidgee | 3,984 | 4,639 |
| Western NSW | 6,550 | 7,779 |
| Central Coast | 7,798 | 9,539 |
| Hunter | 8,516 | 10,162 |
| Nepean Blue Mountains | 8,029 | 10,250 |
| Western Sydney | 13,605 | 18,536 |
| Northern Sydney | 3,840 | 4,114 |
| South Eastern Sydney | 9,046 | 11,973 |
| Sydney | 9,292 | 12,512 |
| South Western Sydney | 29,502 | 38,081 |
| Illawarra Shoalhaven | 6,693 | 8,365 |
| Southern NSW | 2,928 | 3,660 |

Table K.2 – Figure 5.2 – Average number of sessions per client by client's year of entry (DEX)

| District | Average number of sessions per client in 2021-22 | Average number of sessions per client in 2022-23 |
|---|---|---|
| Mid North Coast | 10.3 | 9.4 |
| New England | 13.7 | 12.2 |
| Northern NSW | 9.5 | 8.1 |
| Far West | 12.3 | 7.7 |
| Murrumbidgee | 13.3 | 9.8 |
| Western NSW | 13.5 | 12.6 |
| Central Coast | 10.5 | 8.1 |
| Hunter | 12.9 | 10.1 |
| Nepean Blue Mountains | 10.2 | 7.7 |
| Western Sydney | 11.7 | 9.2 |
| Northern Sydney | 8.3 | 7.6 |
| South Eastern Sydney | 9.8 | 7.9 |
| Sydney | 11.2 | 11.4 |
| South Western Sydney | 12.8 | 8.4 |
| Illawarra Shoalhaven | 13.1 | 12.0 |
| Southern NSW | 14.3 | 10.4 |

Table K.3 – Figure 5.3 – Risk profile of individual clients in 2021-22 and 2022-23 by first program activity (HSDS)

| Risk factor | Community Connections | Community Centres | Community Support | Targeted Support | Intensive Support |
|---|---|---|---|---|---|
| Concern report (of clients aged under 18) | 32.9% | 44.1% | 45.9% | 46.2% | 69.8% |
| Victim of domestic violence | 16.9% | 24.8% | 23.3% | 21.2% | 31.1% |
| Interaction with criminal justice system (of clients aged 11 or over) | 16.9% | 23.3% | 21.0% | 18.5% | 22.5% |
| School suspension (of clients aged between 5 and 18 with at least one day of school enrolment) | 32.0% | 34.0% | 34.3% | 35.5% | 37.1% |
| SHS homeless presentation | 12.0% | 15.0% | 16.7% | 16.5% | 25.8% |
| Mental health ambulatory services | 11.6% | 17.2% | 16.8% | 15.4% | 23.2% |

Table K.4 – Figure 5.4 – Average count of 9 domains utilised prior to TEI entry for TEI individual clients (n=176,214) and the general population (n=878,743) (HSDS)

| Population | in quarter of entry | within 1 year prior to entry | ever prior to entry |
|---|---|---|---|
| TEI population | 0.402 | 0.630 | 1.527 |
| General population | 0.077 | 0.140 | 0.500 |

Table K.5 – Figure 5.5 – Proportion of TEI individual clients and general population in priority groups (HSDS)

| Priority group | TEI clients | General population | Relativity of TEI to general population | Count of TEI clients | Count of general population |
|---|---|---|---|---|---|
| 0 to 5 years old | 23.25% | 9.94% | 2.34 | 40976 | 670255 |
| Aboriginal | 20.50% | 4.07% | 5.04 | 36121 | 274038 |
| Young person at risk of school disengagement | 27.33% | 18.02% | 1.52 | 14848 | 155170 |
| Young parent with risk factors | 1.22% | 0.16% | 7.79 | 2146 | 10545 |
| Any priority group | 45.12% | 15.40% | 2.93 | 79507 | 1038158 |

Table K.6 – Figure 5.6 – Proportion of TEI individual clients in priority groups by first program activity (HSDS)

| Priority group | Community Connections | Community Centres | Community Support | Targeted Support | Intensive Support |
|---|---|---|---|---|---|
| 0 to 5 years old | 17.75% | 15.80% | 15.48% | 28.63% | 19.89% |
| Aboriginal | 18.05% | 17.54% | 20.66% | 21.34% | 28.51% |
| Young person at risk of school disengagement | 19.04% | 22.99% | 25.39% | 30.52% | 31.94% |

| Priority group | Community Connections | Community Centres | Community Support | Targeted Support | Intensive Support |
|---|---|---|---|---|---|
| Young parent with risk factors | 0.72% | 0.77% | 0.87% | 1.49% | 2.16% |
| Any priority group | 37.49% | 35.43% | 39.09% | 50.58% | 51.03% |
| Relativity to general population | 2.45 | 2.32 | 2.55 | 3.27 | 3.27 |

Table K.7 – Figure 5.7 – Proportion of TEI individual clients in any priority group and relativity to general population (HSDS)

| Statistic | Community Connections | Community Centres | Community Support | Targeted Support | Intensive Support |
|---|---|---|---|---|---|
| Proportion of TEI in any priority group | 37.49% | 35.43% | 39.09% | 50.58% | 51.03% |
| Proportion of general population in any priority group | 15.28% | 15.24% | 15.34% | 15.46% | 15.60% |
| Relativity of TEI to general population in any priority group | 2.45 | 2.32 | 2.55 | 3.27 | 3.27 |

## K.2 Section 6

Table K.8 – Figure 6.1 - Proportion of TEI participants under 18 with concern reports (left) and ROSH reports (right) (HSDS)

| Quarters since intervention | % with concern report | % with ROSH report |
|---|---|---|
| -8 | 5.7% | 4.2% |
| -7 | 5.9% | 4.4% |
| -6 | 6.1% | 4.6% |
| -5 | 6.2% | 4.8% |
| -4 | 6.6% | 5.1% |
| -3 | 6.9% | 5.2% |
| -2 | 7.4% | 5.7% |
| -1 | 8.3% | 6.6% |
| 0 | 8.8% | 6.9% |
| 1 | 7.3% | 5.6% |
| 2 | 6.8% | 5.1% |
| 3 | 6.5% | 4.8% |
| 4 | 6.1% | 4.5% |
| 5 | 6.2% | 4.7% |
| 6 | 5.9% | 4.5% |
| 7 | 5.9% | 4.3% |

Table K.9 – Figure 6.2 – Provider survey results: "From your perspective, how effective is the Targeted Earlier Intervention (TEI) in reducing the risk of children entering into the child protection system over the short term (i.e. over the first 12 months)?", n = 337

| Response | Number of responses |
|---|---|
| Not effective at all | 4 |
| Slightly effective | 29 |
| Moderately effective | 112 |
| Very effective | 114 |
| Extremely effective | 35 |
| I'm not sure | 43 |

Table K.10 – Figure 6.3 – Provider survey results: "From your perspective, how effective is the Targeted Earlier Intervention (TEI) in reducing the risk of children entering into the child protection system over the short term (i.e. over the first 12 months)?", n = 26 (Providers identifying as Aboriginal Controlled)

| Response | Number of responses |
|---|---|
| Not effective at all | 0 |
| Slightly effective | 2 |
| Moderately effective | 7 |
| Very effective | 11 |
| Extremely effective | 4 |
| I'm not sure | 2 |

Table K.11 – Figure 6.4 - Proportion of TEI participants presenting to Specialist Homelessness Services as homeless or at risk of homelessness (left) or using mental health services (right) (HSDS)

| Quarters since intervention | % presenting to SHS at risk of homelessness or homeless | % using mental health ambulatory services |
|---|---|---|
| -8 | 2.8% | 1.9% |
| -7 | 2.8% | 2.0% |
| -6 | 2.9% | 2.1% |
| -5 | 3.0% | 2.2% |
| -4 | 3.1% | 2.2% |
| -3 | 3.2% | 2.4% |
| -2 | 3.4% | 2.5% |
| -1 | 4.0% | 2.8% |
| 0 | 5.1% | 3.1% |
| 1 | 4.6% | 2.8% |
| 2 | 4.1% | 2.6% |
| 3 | 3.7% | 2.5% |
| 4 | 3.5% | 2.3% |
| 5 | 3.5% | 2.3% |

| Quarters since intervention | % presenting to SHS at risk of homelessness or homeless | % using mental health ambulatory services |
|---|---|---|
| 6 | 3.3% | 2.4% |
| 7 | 3.4% | 2.3% |

Table K.12 – Figure 6.5 – Provider survey results – “The TEI program is designed around the TEI Outcomes Framework, which includes the following long term client outcomes. For each outcome, how much of an effect do you believe that the overall TEI program is having on individual clients?”, n = 339

| Response | Not sure / not applicable | Large negative effect | Small negative effect | No effect | Small positive effect | Large positive effect |
|---|---|---|---|---|---|---|
| Sense of belonging to their community | 3.2% | 0.3% | 0.0% | 1.5% | 31.9% | 63.1% |
| Participation in community events | 5.3% | 0.3% | 0.0% | 2.4% | 33.0% | 59.0% |
| Health of children and young people | 7.1% | 0.6% | 0.0% | 2.1% | 46.9% | 43.4% |
| Client reported self-determination | 8.3% | 0.0% | 1.2% | 2.7% | 44.8% | 43.1% |
| Parental health | 10.6% | 0.3% | 0.3% | 6.8% | 49.3% | 32.7% |
| School attendance and achievement | 15.6% | 0.3% | 1.5% | 7.1% | 48.4% | 27.1% |
| Sustained participation in employment | 27.1% | 0.3% | 1.2% | 15.6% | 45.1% | 10.6% |
| Sustained safe and stable housing | 21.2% | 0.9% | 1.8% | 23.9% | 41.0% | 11.2% |

Table K.13 – Figure 6.6 – Average satisfaction SCORE for each outcome domain by year (DEX)

| Outcome Domain | 2021 | 2022 | 2023 |
|---|---|---|---|
| I am better able to deal with issues that I sought help with | 4.4 | 4.2 | 4.3 |
| I am satisfied with the services I have received | 4.5 | 4.4 | 4.5 |
| The service listened to me and understood my issues | 4.6 | 4.5 | 4.5 |

Table K.14 – Figure 6.7 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district (DEX, all years)

| District | Average Satisfaction SCORE | Percentage of clients with Satisfaction SCOREs |
|---|---|---|
| Mid North Coast | 4.5 | 16% |
| New England | 4.7 | 22% |
| Northern NSW | 4.7 | 22% |
| Far West | 4.2 | 27% |
| Murrumbidgee | 4.5 | 15% |
| Western NSW | 4.6 | 28% |
| Central Coast | 4.5 | 24% |
| Hunter | 4.3 | 21% |
| Nepean Blue Mountains | 4.6 | 19% |
| Western Sydney | 4.0 | 33% |
| Northern Sydney | 4.7 | 23% |
| South Eastern Sydney | 4.8 | 32% |
| Sydney | 4.5 | 28% |
| South Western Sydney | 4.4 | 31% |
| Illawarra Shoalhaven | 4.6 | 31% |
| Southern NSW | 4.5 | 30% |

Table K.15 – Figure 6.8 – Average Community SCORE rating by year and domain (DEX, all years)

| Year | Group / community knowledge, skills, attitudes and behaviours | Social cohesion |
|---|---|---|
| 2020-21 | 3.6 | 3.8 |
| 2021-22 | 3.7 | 3.9 |
| 2022-23 | 3.8 | 4.0 |

Table K.16 – Figure 6.9 – Average Community SCORE rating by domain and overall proportion of Community Strengthening sessions assessed for each district (DEX, all years)

| District | Group / community knowledge, skills, attitudes and behaviours | Social cohesion | % of Community Strengthening sessions assessed |
|---|---|---|---|
| Mid North Coast | 4.0 | 4.0 | 2.4% |
| New England | 3.4 | 3.4 | 5.9% |
| Northern NSW | 3.3 | 3.3 | 1.7% |
| Far West | 4.0 | 3.9 | 2.5% |
| Murrumbidgee | 3.6 | 3.7 | 0.7% |
| Western NSW | 3.8 | 3.7 | 10.7% |
| Central Coast | 3.7 | 4.2 | 0.5% |
| Hunter | 3.5 | 3.7 | 1.5% |
| Nepean Blue Mountains | 3.9 | 4.1 | 3.5% |
| Western Sydney | 3.4 | 3.7 | 4.9% |
| Northern Sydney | 4.0 | 3.7 | 5.2% |

| District | Group / community knowledge, skills, attitudes and behaviours | Social cohesion | % of Community Strengthening sessions assessed |
|---|---|---|---|
| South Eastern Sydney | 3.7 | 3.9 | 4.1% |
| Sydney | 3.8 | 3.8 | 11.5% |
| South Western Sydney | 3.9 | 4.4 | 6.2% |
| Illawarra Shoalhaven | 4.0 | 4.1 | 5.2% |
| Southern NSW | 3.8 | 3.7 | 1.5% |

## K.3 Section 8

Table K.17 – Figure 8.1 – Service interaction history of Aboriginal and non-Aboriginal TEI clients prior to TEI entry (HSDS)

| Service interaction | Proportion of Non-Aboriginal clients with service interaction | Proportion of Aboriginal clients with service interaction |
|---|---|---|
| Concern report (of clients aged under 18) | 37.5% | 73.4% |
| Victim survivor of domestic violence | 18.7% | 34.1% |
| Interaction with criminal justice system (of clients aged 11 or over) | 15.7% | 36.0% |
| School suspension (of clients aged between 5 and 18 with at least one day of school enrolment) | 31.1% | 46.0% |
| SHS homeless presentation | 11.6% | 33.2% |
| Mental health ambulatory services | 13.9% | 22.5% |
| Did not achieve NAPLAN minimum standard at last NAPLAN (of those with a NAPLAN record) | 15.3% | 35.4% |

Table K.18 – Figure 8.2 – Relativity of service interaction compared to the general population prior to TEI entry, for Aboriginal TEI clients and non-Aboriginal TEI clients (HSDS)

| Service interaction | Non-Aboriginal | Aboriginal |
|---|---|---|
| Concern report (of clients aged under 18) | 2.45 | 4.56 |
| Victim survivor of domestic violence | 2.51 | 5.14 |
| Interaction with criminal justice system (of clients aged 11 or over) | 2.10 | 5.22 |
| School suspension (of clients aged between 5 and 18 with at least one day of school enrolment) | 1.34 | 2.02 |
| SHS homeless presentation | 5.15 | 13.74 |
| Mental health ambulatory services | 2.66 | 4.02 |
| Did not achieve NAPLAN minimum standard at last NAPLAN (of those with a NAPLAN record) | 2.05 | 4.54 |

Table K.19 – Figure 8.3 – Proportion of individual clients who are Aboriginal and Proportion of funding for ACCO providers in each DCJ District (DEX, 2022-23)

| District | % of TEI clients | % of funding to ACCOs |
|---|---|---|
| Sydney | 8.9% | 6.2% |
| Western Sydney | 7.6% | 1.6% |
| South Eastern Sydney | 6.5% | 0.0% |
| Northern Sydney | 3.6% | 0.0% |
| Central Coast | 21.2% | 11.5% |
| South Western Sydney | 6.3% | 3.4% |
| Illawarra Shoalhaven | 17.5% | 6.9% |
| Hunter | 19.7% | 8.3% |
| Nepean Blue Mountains | 13.6% | 6.3% |
| Southern NSW | 14.3% | 0.0% |
| Northern NSW | 23.1% | 15.0% |
| Mid North Coast | 34.9% | 14.6% |
| New England | 38.4% | 18.7% |
| Murrumbidgee | 21.0% | 30.6% |
| Western NSW | 45.4% | 5.8% |
| Far West | 68.5% | 43.1% |

Table K.20 – Figure 8.4 – Number of individual and group clients served by ACCO providers (DEX)

| Year | Group clients | Individual clients |
|---|---|---|
| 2020-21 | 10,231 | 3,102 |
| 2021-22 | 16,200 | 4,750 |
| 2022-23 | 36,795 | 6,756 |

Table K.21 – Figure 8.5 – Proportion of Aboriginal clients who have received TEI services from ACCO providers compared to total number of Aboriginal clients in the district (DEX)

| District | 2021-22 | 2022-23 | Total Aboriginal clients (2021-22 and 2022-23) |
|---|---|---|---|
| Sydney | 5% | 2% | 1,950 |
| Western Sydney | 1% | 1% | 2,440 |
| South Eastern Sydney* | 0% | 0% | 1,313 |
| Northern Sydney* | 0% | 0% | 219 |
| Central Coast | 10% | 14% | 3,650 |
| South Western Sydney | 10% | 18% | 4,308 |
| Illawarra Shoalhaven | 12% | 17% | 2,602 |
| Hunter | 11% | 17% | 3,543 |
| Nepean Blue Mountains | 7% | 8% | 2,428 |
| Southern NSW* | 0% | 0% | 973 |
| Northern NSW | 18% | 25% | 2,806 |
| Mid North Coast | 34% | 25% | 4,905 |
| New England | 10% | 11% | 4,589 |
| Murrumbidgee | 13% | 17% | 1,846 |

| District | 2021-22 | 2022-23 | Total Aboriginal clients (2021-22 and 2022-23) |
|---|---|---|---|
| Western NSW | 2% | 6% | 6,301 |
| Far West | 29% | 53% | 654 |

Table K.22 – Figure 8.6 - Proportion of Aboriginal TEI participants under 18 with concern reports (left) and ROSH reports (right) (HSDS)

| Quarters since intervention | % with concern report Aboriginal | % with concern report Non-Aboriginal | % with ROSH report Aboriginal | % with ROSH report Non-Aboriginal |
|---|---|---|---|---|
| -8 | 12.5% | 3.9% | 9.4% | 2.9% |
| -7 | 13.2% | 4.0% | 10.0% | 3.0% |
| -6 | 13.1% | 4.3% | 10.1% | 3.1% |
| -5 | 13.5% | 4.4% | 10.5% | 3.3% |
| -4 | 14.1% | 4.7% | 10.9% | 3.6% |
| -3 | 14.5% | 5.0% | 11.1% | 3.7% |
| -2 | 15.4% | 5.3% | 12.1% | 4.0% |
| -1 | 16.3% | 6.3% | 13.0% | 4.9% |
| 0 | 17.0% | 6.7% | 13.4% | 5.2% |
| 1 | 15.1% | 5.3% | 11.6% | 4.0% |
| 2 | 14.5% | 4.8% | 10.9% | 3.5% |
| 3 | 13.4% | 4.6% | 10.2% | 3.4% |
| 4 | 12.7% | 4.4% | 9.4% | 3.1% |
| 5 | 13.1% | 4.3% | 10.0% | 3.3% |
| 6 | 12.0% | 4.3% | 9.2% | 3.2% |
| 7 | 12.0% | 4.2% | 8.6% | 3.1% |

Table K.23 – Figure 8.7 - Proportion of Aboriginal TEI clients under 18 in OOHC in quarters before and after entry to TEI, split by whether or not clients were in OOHC in quarter of intervention (HSDS)

| Quarters since intervention | In OOHC at entry | Not in OOHC at entry |
|---|---|---|
| -8 | 66.7% | 2.2% |
| -7 | 68.9% | 2.0% |
| -6 | 71.5% | 1.7% |
| -5 | 74.9% | 1.6% |
| -4 | 77.9% | 1.4% |
| -3 | 81.3% | 1.2% |
| -2 | 86.4% | 0.9% |
| -1 | 92.6% | 0.5% |
| 0 | 100.0% | 0.0% |
| 1 | 95.7% | 0.6% |
| 2 | 93.3% | 0.9% |
| 3 | 90.0% | 1.3% |
| 4 | 86.9% | 1.5% |
| 5 | 84.2% | 1.7% |
| 6 | 82.1% | 2.1% |

| Quarters since intervention | In OOHC at entry | Not in OOHC at entry |
|---|---|---|
| 7 | 79.4% | 2.5% |

Table K.24 – Figure 8.8 – Provider survey results – “From your perspective, how effectively do you think (Aboriginal Children, Young People, Families and Communities) are being supported by the TEI services you provide under this contract?”, n = 13 (Providers identifying as Aboriginal Controlled)

| Response | Number of responses |
|---|---|
| Not sure / not applicable | 0 |
| Very Poorly Supported | 0 |
| Somewhat Poorly Supported | 1 |
| Neither Poorly nor Effectively Supported | 1 |
| Somewhat Effectively Supported | 7 |
| Very Effectively Supported | 4 |

Table K.25 – Figure 8.9 – Provider survey results – “From your perspective, how effectively do you think (Aboriginal Children, Young People, Families and Communities) are being supported by the TEI services you provide under this contract?”, n = 308

| Response | Number of responses |
|---|---|
| Not sure / not applicable | 41 |
| Very Poorly Supported | 3 |
| Somewhat Poorly Supported | 14 |
| Neither Poorly nor Effectively Supported | 39 |
| Somewhat Effectively Supported | 148 |
| Very Effectively Supported | 63 |

Table K.26 – Figure 8.10 - Proportion of Aboriginal TEI participants presenting to Specialist Homelessness Services as homeless or at risk of homelessness (left) or using mental health services (right) (HSDS)

| Quarters since intervention | % presenting to SHS at risk of homelessness or homeless Aboriginal | % presenting to SHS at risk of homelessness or homeless Non-Aboriginal | % using mental health ambulatory services Aboriginal | % using mental health ambulatory services Non-Aboriginal |
|---|---|---|---|---|
| -8 | 6.7% | 1.8% | 2.8% | 1.7% |
| -7 | 6.4% | 1.9% | 3.0% | 1.8% |
| -6 | 6.5% | 2.0% | 3.1% | 1.8% |
| -5 | 6.5% | 2.0% | 3.2% | 1.9% |
| -4 | 6.8% | 2.2% | 3.2% | 2.0% |
| -3 | 7.0% | 2.2% | 3.4% | 2.1% |
| -2 | 7.3% | 2.5% | 3.5% | 2.3% |
| -1 | 7.9% | 2.9% | 3.8% | 2.6% |
| 0 | 9.9% | 3.9% | 4.2% | 2.8% |
| 1 | 8.9% | 3.5% | 3.8% | 2.5% |
| 2 | 8.0% | 3.0% | 3.5% | 2.4% |

| Quarters since intervention | % presenting to SHS at risk of homelessness or homeless Aboriginal | % presenting to SHS at risk of homelessness or homeless Non-Aboriginal | % using mental health ambulatory services Aboriginal | % using mental health ambulatory services Non-Aboriginal |
|---|---|---|---|---|
| 3 | 7.3% | 2.7% | 3.3% | 2.2% |
| 4 | 7.2% | 2.5% | 3.2% | 2.0% |
| 5 | 7.2% | 2.5% | 3.2% | 2.0% |
| 6 | 6.8% | 2.4% | 3.0% | 2.2% |
| 7 | 6.8% | 2.5% | 3.2% | 2.1% |

Table K.27 – Figure 8.11 – Average Satisfaction SCORE for Aboriginal and non-Aboriginal clients by each outcome domain (DEX, all years)

| SCORE Domain | Aboriginal clients | Non-aboriginal clients |
|---|---|---|
| I am better able to deal with issues that I sought help with | 4.29 | 4.34 |
| I am satisfied with the services I have received | 4.53 | 4.50 |
| The service listened to me and understood my issues | 4.55 | 4.52 |

Table K.28 – Figure 8.12 – Average Satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district (DEX, all years)

| Provider District | Aboriginal clients | Non-Aboriginal clients |
|---|---|---|
| Mid North Coast | 4.4 | 4.5 |
| New England | 4.7 | 4.7 |
| Northern NSW | 4.6 | 4.7 |
| Far West | 4.1 | 4.4 |
| Murrumbidgee | 4.5 | 4.5 |
| Western NSW | 4.6 | 4.6 |
| Central Coast | 4.4 | 4.5 |
| Hunter | 4.1 | 4.3 |
| Nepean Blue Mountains | 4.6 | 4.6 |
| Western Sydney | 4.3 | 4.0 |
| Northern Sydney | 4.7 | 4.7 |
| South Eastern Sydney | 4.7 | 4.8 |
| Sydney | 4.2 | 4.5 |
| South Western Sydney | 4.4 | 4.4 |
| Illawarra Shoalhaven | 4.6 | 4.6 |
| Southern NSW | 4.1 | 4.6 |

Table K.29 – Figure 8.13 – Average Satisfaction SCORE for Aboriginal clients from ACCO and non-ACCO providers by each outcome domain (DEX, all years)

| SCORE Domain | ACCO | Non-ACCO |
|---|---|---|
| I am better able to deal with issues that I sought help with | 4.48 | 4.28 |
| I am satisfied with the services I have received | 4.47 | 4.53 |
| The service listened to me and understood my issues | 4.64 | 4.54 |

Table K.30 – Figure 8.14 - Proportion of funding to ACCOs over time

| Year | ACCO funding | Non-ACCO funding | Proportion of funding to ACCOs |
|---|---|---|---|
| 2020-21 | $ 10,467,709.59 | $ 168,574,939.40 | 5.85% |
| 2021-22 | $ 12,551,301.15 | $ 169,622,663.13 | 6.89% |
| 2022-23 | $ 13,786,745.77 | $ 165,954,898.10 | 7.67% |

Table K.31 – Figure 8.15 - Proportion of funding to ACCOs compared to proportion of children that are Aboriginal, by DCJ District, 2022-23

| Districts | Aboriginal children proportion | ACCO funding % |
|---|---|---|
| Sydney | 2% | 6% |
| Western Sydney | 3% | 2% |
| South Eastern Sydney | 2% | 0% |
| Northern Sydney | 1% | 0% |
| Central Coast | 11% | 12% |
| South Western Sydney | 4% | 3% |
| Illawarra Shoalhaven | 10% | 7% |
| Hunter | 13% | 8% |
| Nepean Blue Mountains | 10% | 6% |
| Southern NSW | 10% | 0% |
| Northern NSW | 12% | 15% |
| Mid North Coast | 17% | 15% |
| New England | 25% | 19% |
| Murrumbidgee | 12% | 31% |
| Western NSW | 24% | 6% |
| Far West | 23% | 43% |

Table K.32 – Figure 8.16 - Average cost per session, by ACCO classification (DEX and Funding data)

| Year | ACCOs | Non-ACCOs |
|---|---|---|
| 2020-21 | $1,584 | $436 |
| 2021-22 | $1,204 | $386 |
| 2022-23 | $963 | $354 |

Table K.33 – Figure 8.17 - Average number of sessions per organisation (DEX and Funding data)

| Year | ACCOs | Non-ACCOs |
|---|---|---|
| 2020-21 | 165 | 738 |
| 2021-22 | 227 | 848 |
| 2022-23 | 292 | 920 |

## K.4 Section 9

Table K.34 – Figure 9.1 – Service provider funding costs, in 2022-23 dollars

| Financial Year | Community | Wellbeing and Safety |
|---|---|---|
| 2021 | $71 M | $107 M |
| 2022 | $73 M | $109 M |

| Financial Year | Community | Wellbeing and Safety |
|---|---|---|
| 2023 | $72 M | $108 M |

Table K.35 – Figure 9.2 - 2022-23 funding costs, by DCJ District and stream

| District | Community | Wellbeing and Safety |
|---|---|---|
| South Western Sydney | $11.7 M | $15.9 M |
| Western Sydney | $11.0 M | $10.4 M |
| Hunter | $4.3 M | $12.2 M |
| Nepean/Blue Mountains | $8.2 M | $6.7 M |
| Sydney | $4.6 M | $9.1 M |
| South Eastern Sydney | $4.7 M | $7.9 M |
| Illawarra Shoalhaven | $5.5 M | $5.9 M |
| Murrumbidgee | $4.1 M | $5.3 M |
| Western NSW | $3.6 M | $5.3 M |
| Mid North Coast | $3.0 M | $6.1 M |
| Central Coast | $2.8 M | $5.7 M |
| Northern NSW | $3.6 M | $5.0 M |
| New England | $1.6 M | $4.5 M |
| Northern Sydney | $1.5 M | $4.4 M |
| Southern NSW | $1.2 M | $2.5 M |
| Far West | $0.5 M | $0.8 M |

Table K.36 – Figure 9.3 - Average cost per session (LHS) and average number of sessions per organisation (RHS) over time (DEX and Funding data)

| Year | Average cost per session (LHS) | Average number of sessions per organisation (RHS) |
|---|---|---|
| 2020-21 | $455 | 698 |
| 2021-22 | $405 | 798 |
| 2022-23 | $372 | 865 |

Table K.37 – Figure 9.4 - Cost per session (LHS) and sessions per organisation (RHS) by DCJ District, 2022-23 (DEX and Funding data)

| District | Average cost per session (LHS) | Average sessions per organisation (RHS) |
|---|---|---|
| Nepean Blue Mountains | $650 | 573 |
| Far West | $558 | 333 |
| Western Sydney | $475 | 738 |
| Western NSW | $452 | 508 |
| Southern NSW | $418 | 520 |
| South Eastern Sydney | $416 | 706 |
| Illawarra Shoalhaven | $396 | 652 |

| District | Average cost per session (LHS) | Average sessions per organisation (RHS) |
|---|---|---|
| Sydney | $364 | 1,020 |
| Mid North Coast | $359 | 792 |
| South Western Sydney | $358 | 1,401 |
| Northern NSW | $348 | 956 |
| Northern Sydney | $331 | 988 |
| Hunter/New England | $326 | 866 |
| Murrumbidgee | $273 | 1,232 |
| Central Coast | $223 | 1,364 |

Table K.38 – Figure 9.5 - Distribution of funding per session by activity stream, 2022-23 (DEX and Funding data)

| Funding per session ($) | % of organisations (Wellbeing and Safety) | % of organisations (Community Strengthening) |
|---|---|---|
| 0 - 100 | 4% | 22% |
| 100 - 200 | 11% | 17% |
| 200 - 300 | 15% | 12% |
| 300 - 400 | 14% | 12% |
| 400 - 500 | 10% | 6% |
| 500 - 600 | 7% | 4% |
| 600 - 700 | 8% | 2% |
| 700 - 800 | 3% | 2% |
| 800 - 900 | 6% | 3% |
| 900 - 1000 | 3% | 4% |
| 1000 - 1100 | 4% | 1% |
| 1100 - 1200 | 2% | 3% |
| 1200 - 1300 | 2% | 1% |
| 1300 - 1400 | 2% | 1% |
| 1400 - 1500 | 1% | 1% |
| 1500 - 1600 | 1% | 1% |
| 1600 - 1700 | 1% | 1% |
| 1700 - 1800 | 1% | 1% |
| 1800 - 1900 | 2% | 1% |
| 1900 - 2000 | 2% | 2% |

Table K.39 – Figure 9.6 – Cost-benefit summary

| | Cost ($ M) | Identifiable Benefits ($ M) |
|---|---|---|
| Govt. Benefit - Reduction in Concern Reports | - | 1 |
| Govt. Benefit - Reduction in ROSH Reports | - | 27 |
| Individual Benefit - Reduction in ROSH Reports | - | 13 |
| Govt. Benefit - OOHC Restorations | - | 51 |
| Cost - Individual session funding | 139 | - |
| Cost - Group session funding | 41 | - |

| | Cost ($ M) | Identifiable Benefits ($ M) |
|---|---|---|
| Cost - Program administration costs | 1 | - |

## K.5 Appendix B

Table K.40 – Figure B.1 – Number of sessions delivered by service type in 2022-23 for service types in the Community Strengthening stream (DEX)

| Service type | Community Centres | Community Connections | Community Support |
|---|---|---|---|
| Advocacy/Support | 0 | 0 | 17,323 |
| Business Planning | 0 | 0 | 26 |
| Community Engagement | 3,246 | 5,007 | 0 |
| Community sector coordination | 0 | 3,237 | 0 |
| Community sector planning | 0 | 2,843 | 0 |
| Education and Skills training | 2,367 | 1,651 | 14,664 |
| Facilitate Employment Pathways | 0 | 0 | 3,336 |
| Indigenous Advocacy/Support | 0 | 0 | 1,544 |
| Indigenous community engagement | 0 | 828 | 0 |
| Indigenous healing workshop | 0 | 0 | 133 |
| Indigenous social participation | 0 | 1,055 | 0 |
| Information/Advice/Referral | 41,556 | 13,773 | 12,274 |
| Social participation | 27,176 | 10,394 | 9,885 |

Table K.41 – Figure B.2 – Number of sessions delivered by service type in 2022-23 for service types in the Wellbeing and Safety stream (DEX)

| Service type | Intensive or Specialist Support | Targeted Support |
|---|---|---|
| Counselling | 6,958 | 26,438 |
| Education and Skills training | 407 | 9,064 |
| Family Capacity Building | 12,916 | 127,353 |
| Indigenous social participation | 0 | 556 |
| Indigenous supported playgroups | 0 | 1,881 |
| Information/Advice/Referral | 3,423 | 44,994 |
| Intake/assessment | 0 | 32,235 |
| Material aid (multiple items, parcels or vouchers) | 0 | 4,468 |
| Mentoring/Peer Support | 0 | 7,950 |
| Parenting Programs | 0 | 14,009 |
| Specialist Support | 3,556 | 0 |
| Supported playgroups | 0 | 19,122 |

## K.6 Appendix D

Table K.42 – Figure D.1 – Proportion of clients with assessments collected directly from SCORE and from other validated tools (DEX, all years, n = 116,728)

| SCORE type | SCORE directly | Validated outcomes tool |
|---|---|---|
| Circumstances | 96% | 6% |
| Goals | 95% | 7% |
| Satisfaction | 96% | 5% |

Table K.43 – Figure D.2 – Average SCORE rating from SCORE directly and from other validated tools (DEX, all years)

| SCORE type | SCORE directly | Validated outcomes tool |
|---|---|---|
| Circumstances | 3.2 | 3.0 |
| Goals | 3.3 | 3.5 |
| Satisfaction | 4.4 | 4.8 |

Table K.44 – Figure D.3 – Proportion of clients with SCORE assessments completed by each party for each outcome type (DEX, all years)

| SCORE type | client | joint | practitioner | support person |
|---|---|---|---|---|
| Circumstances | 36% | 25% | 50% | 7% |
| Goals | 37% | 24% | 48% | 8% |
| Satisfaction | 48% | 23% | 33% | 8% |

Table K.45 – Figure D.4 – Average SCORE rating by who completed the SCORE assessment for each outcome type (DEX, all years)

| SCORE type | client | joint | practitioner | support person |
|---|---|---|---|---|
| Circumstances | 3.4 | 3.3 | 3.0 | 3.3 |
| Goals | 3.5 | 3.5 | 3.0 | 3.5 |
| Satisfaction | 4.6 | 4.4 | 4.2 | 4.7 |

Table K.46 – Figure D.5 – Proportion of individual clients with any SCORE assessment completed in the year by SCORE type (DEX, all years)

| Year | Circumstances | Goals | Satisfaction |
|---|---|---|---|
| 2020-21 | 26% | 25% | 20% |
| 2021-22 | 32% | 31% | 24% |
| 2022-23 | 36% | 34% | 29% |

Table K.47 – Figure D.6 – SCORE collection rate by District after controlling for differences in client characteristics and risk factors (HSDS)

| District (ordered by increasing remoteness) | Circumstances | Goals | Satisfaction |
|---|---|---|---|
| Sydney | 48% | 41% | 37% |
| Western Sydney | 50% | 47% | 36% |
| South Eastern Sydney | 44% | 37% | 36% |

| District (ordered by increasing remoteness) | Circumstances | Goals | Satisfaction |
|---|---|---|---|
| Northern Sydney | 43% | 42% | 24% |
| Central Coast | 36% | 32% | 27% |
| South Western Sydney | 46% | 47% | 33% |
| Illawarra Shoalhaven | 36% | 34% | 32% |
| Hunter | 32% | 30% | 25% |
| Nepean Blue Mountains | 40% | 32% | 34% |
| Southern NSW | 32% | 34% | 28% |
| Northern NSW | 37% | 32% | 26% |
| Mid North Coast | 33% | 27% | 18% |
| New England | 31% | 28% | 24% |
| Murrumbidgee | 36% | 32% | 21% |
| Western NSW | 38% | 34% | 26% |
| Far West | 40% | 27% | 23% |
| State average | 41% | 38% | 30% |

Table K.48 – Figure D.7 – SCORE collection rate by Indigenous status after controlling for differences in client characteristics and risk factors (HSDS)

| SCORE type | Aboriginal | Non-Aboriginal |
|---|---|---|
| Circumstances | 37% | 42% |
| Goals | 33% | 39% |
| Satisfaction | 27% | 31% |

Table K.49 – Figure D.8 – SCORE collection rate by CALD status after controlling for differences in client characteristics and risk factors (HSDS)

| SCORE type | CALD | Not CALD |
|---|---|---|
| Circumstances | 45% | 40% |
| Goals | 43% | 37% |
| Satisfaction | 34% | 30% |

Table K.50 – Figure D.9 – Number of sessions assessed (left) compared to proportion of sessions assessed (right) (DEX, Community Strengthening sessions only)

| Year | Number of sessions assessed | Proportion of sessions assessed |
|---|---|---|
| 2020-21 | 7,246 | 6.6% |
| 2021-22 | 8,146 | 6.0% |
| 2022-23 | 10,000 | 5.8% |

Table K.51 – Figure D.10 – Count of the number of clients in sessions with Community SCORE by the number of clients in each session

| Number of clients (banded) | Group / community knowledge, skills, attitudes and behaviours | Social cohesion |
|---|---|---|
| 1 to 5 | 1,717 | 793 |
| 6 to 10 | 1,308 | 874 |

| Number of clients (banded) | Group / community knowledge, skills, attitudes and behaviours | Social cohesion |
|---|---|---|
| 11 to 20 | 1,591 | 1,014 |
| 21 to 30 | 715 | 506 |
| 31 to 60 | 875 | 682 |
| 61 to 100 | 490 | 436 |
| 101 to 200 | 441 | 397 |
| >200 | 524 | 521 |

## K.7 Appendix E

Table K.52 – Figure E.1 – Total number of TEI clients (DEX)

| Year | Individual Clients | Unidentified Clients |
|---|---|---|
| 2020-21 | 113,520 | 712,416 |
| 2021-22 | 127,831 | 977,815 |
| 2022-23 | 161,602 | 1,133,760 |

Table K.53 – Figure E.2 – Number of individual clients by program activity (DEX)

| Program activity | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|
| Community Centres | 18,769 | 25,300 | 32,991 |
| Community Connections | 18,352 | 24,058 | 33,727 |
| Community Support | 22,473 | 27,301 | 35,695 |
| Targeted Support | 66,520 | 68,809 | 83,513 |
| Intensive or Specialist Support | 3,540 | 3,324 | 3,928 |

Table K.54 – Figure E.3 – Number of unidentified group clients by program activity (DEX)

| Program activity | 2020-21 | 2021-22 | 2022-23 |
|---|---|---|---|
| Community Centres | 295,066 | 357,446 | 376,679 |
| Community Connections | 251,931 | 445,924 | 530,110 |
| Community Support | 84,175 | 106,995 | 143,468 |
| Targeted Support | 60,461 | 47,201 | 60,059 |
| Intensive or Specialist Support | 333 | 639 | 454 |

Table K.55 – Figure E.4 – Number of individual clients by DCJ district (DEX)

| District | 2021-22 | 2022-23 |
|---|---|---|
| Mid North Coast | 6,219 | 7,764 |
| New England | 5,558 | 6,567 |
| Northern NSW | 5,374 | 6,725 |
| Far West | 563 | 612 |
| Murrumbidgee | 3,984 | 4,639 |
| Western NSW | 6,550 | 7,779 |
| Central Coast | 7,798 | 9,539 |
| Hunter | 8,516 | 10,162 |
| Nepean Blue Mountains | 8,029 | 10,250 |
| Western Sydney | 13,605 | 18,536 |

| District | 2021-22 | 2022-23 |
|---|---|---|
| Northern Sydney | 3,840 | 4,114 |
| South Eastern Sydney | 9,046 | 11,973 |
| Sydney | 9,292 | 12,512 |
| South Western Sydney | 29,502 | 38,081 |
| Illawarra Shoalhaven | 6,693 | 8,365 |
| Southern NSW | 2,928 | 3,660 |

Table K.56 – Figure E.5 – Number of unidentified group clients by DCJ district (DEX)

| District | 2021-22 | 2022-23 |
|---|---|---|
| Mid North Coast | 54,235 | 58,900 |
| New England | 48,135 | 49,035 |
| Northern NSW | 63,128 | 63,942 |
| Far West | 2,709 | 2,914 |
| Murrumbidgee | 38,054 | 39,277 |
| Western NSW | 39,821 | 47,104 |
| Central Coast | 38,222 | 60,244 |
| Hunter | 62,080 | 72,316 |
| Nepean Blue Mountains | 92,435 | 161,678 |
| Western Sydney | 91,254 | 117,568 |
| Northern Sydney | 22,203 | 22,106 |
| South Eastern Sydney | 174,152 | 192,130 |
| Sydney | 89,736 | 73,556 |
| South Western Sydney | 102,085 | 82,021 |
| Illawarra Shoalhaven | 45,457 | 78,281 |
| Southern NSW | 14,109 | 12,688 |

Table K.57 – Figure E.6 – Individual client growth rate compared to population growth rate from 2021-22 to 2022-23 by district (DEX)

| District | Individual client growth rate | Population growth rate |
|---|---|---|
| Mid North Coast | 25% | 1.0% |
| New England | 18% | 0.8% |
| Northern NSW | 25% | 0.8% |
| Far West | 9% | 0.5% |
| Murrumbidgee | 16% | 0.7% |
| Western NSW | 19% | 0.5% |
| Central Coast | 22% | 0.8% |
| Hunter | 19% | 1.7% |
| Nepean Blue Mountains | 28% | 1.1% |
| Western Sydney | 36% | 3.7% |
| Northern Sydney | 7% | 2.4% |
| South Eastern Sydney | 32% | 3.0% |
| Sydney | 35% | 3.3% |
| South Western Sydney | 29% | 2.7% |
| Illawarra Shoalhaven | 25% | 1.0% |

| District | Individual client growth rate | Population growth rate |
|---|---|---|
| Southern NSW | 25% | 1.1% |

Table K.58 – Figure E.7 – Number of sessions delivered by program activity (DEX)

| Program activity | 2021-22 | 2022-23 |
|---|---|---|
| Community Centres | 60,076 | 74,306 |
| Community Connections | 29,040 | 38,450 |
| Community Support | 46,372 | 58,985 |
| Targeted Support | 299,076 | 287,438 |
| Intensive or Specialist Support | 24,883 | 27,075 |

Table K.59 – Figure E.8 – Number of sessions delivered in each DCJ District in 2022-23 (DEX)

| District | Community Centres | Community Connections | Community Support | Targeted Support | Intensive or Specialist Support |
|---|---|---|---|---|---|
| Mid North Coast | 3,605 | 868 | 5,213 | 14,452 | 1,265 |
| New England | 1,958 | 1,789 | 2,621 | 19,411 | 365 |
| Northern NSW | 3,492 | 10,014 | 3,856 | 7,459 | 37 |
| Far West | <10 | 39 | 113 | 2,182 | <10 |
| Murrumbidgee | 15,830 | 579 | 2,992 | 14,393 | 850 |
| Western NSW | 2,479 | 1,814 | 2,601 | 11,103 | 1,822 |
| Central Coast | 14,616 | 1,259 | 2,230 | 20,177 | 28 |
| Hunter | 5,344 | 837 | 3,704 | 29,204 | 4,034 |
| Nepean Blue Mountains | 3,378 | 2,897 | 4,865 | 9,563 | 2,313 |
| Western Sydney | 5,026 | 6,363 | 9,329 | 21,800 | 2,615 |
| Northern Sydney | 170 | 380 | 3,373 | 13,441 | 529 |
| South Eastern Sydney | 3,594 | 2,003 | 2,959 | 21,004 | 856 |
| Sydney | 1,789 | 2,186 | 4,135 | 28,332 | 4,045 |
| South Western Sydney | 8,059 | 4,739 | 5,699 | 55,893 | 2,743 |
| Illawarra Shoalhaven | 4,906 | 1,550 | 4,450 | 12,300 | 5,494 |
| Southern NSW | 56 | 1,133 | 845 | 6,724 | 79 |

Table K.60 – Figure E.9 – Average number of sessions per client by client's year of entry (DEX)

| District | 2020-21 | 2021-22 |
|---|---|---|
| Mid North Coast | 10.3 | 9.4 |
| New England | 13.7 | 12.2 |
| Northern NSW | 9.5 | 8.1 |
| Far West | 12.3 | 7.7 |
| Murrumbidgee | 13.3 | 9.8 |

| District | 2020-21 | 2021-22 |
|---|---|---|
| Western NSW | 13.5 | 12.6 |
| Central Coast | 10.5 | 8.1 |
| Hunter | 12.9 | 10.1 |
| Nepean Blue Mountains | 10.2 | 7.7 |
| Western Sydney | 11.7 | 9.2 |
| Northern Sydney | 8.3 | 7.6 |
| South Eastern Sydney | 9.8 | 7.9 |
| Sydney | 11.2 | 11.4 |
| South Western Sydney | 12.8 | 8.4 |
| Illawarra Shoalhaven | 13.1 | 12.0 |
| Southern NSW | 14.3 | 10.4 |

Table K.61 – Figure E.10 – Proportion of funding for organisations without client data recorded in DEX (DEX and funding data)

| District | 2021-22 | 2022-23 |
|---|---|---|
| Mid North Coast | 1.7% | 9.2% |
| New England | 2.3% | 2.6% |
| Northern NSW | 0.0% | 0.0% |
| Far West | 0.0% | 9.5% |
| Murrumbidgee | 0.0% | 0.0% |
| Western NSW | 3.4% | 5.2% |
| Central Coast | 1.4% | 1.4% |
| Hunter | 1.2% | 0.4% |
| Nepean Blue Mountains | 1.2% | 0.6% |
| Western Sydney | 0.7% | 6.4% |
| Northern Sydney | 1.4% | 0.0% |
| South Eastern Sydney | 0.0% | 0.1% |
| Sydney | 0.4% | 4.9% |
| South Western Sydney | 1.1% | 0.0% |
| Illawarra Shoalhaven | 1.9% | 0.2% |
| Southern NSW | 2.8% | 0.1% |

Table K.62 – Figure E.11 – Distribution of the amount of funding per session for organisations by district (DEX and funding data)

| District | Year | Q1 | Median | Q3 |
|---|---|---|---|---|
| All districts | 2021 | $350 | $662 | $1,642 |
| All districts | 2022 | $315 | $649 | $1,347 |
| All districts | 2023 | $307 | $532 | $1,141 |
| Mid North Coast | 2021 | $404 | $576 | $1,830 |
| Mid North Coast | 2022 | $338 | $526 | $1,173 |
| Mid North Coast | 2023 | $247 | $473 | $1,146 |
| Northern NSW | 2021 | $389 | $707 | $1,784 |
| Northern NSW | 2022 | $319 | $687 | $1,162 |
| Northern NSW | 2023 | $412 | $606 | $1,507 |
| Far West | 2021 | $1,569 | $5,005 | $7,357 |
| Far West | 2022 | $189 | $782 | $3,664 |

| District | Year | Q1 | Median | Q3 |
|---|---|---|---|---|
| Far West | 2023 | $708 | $994 | $1,232 |
| Murrumbidgee | 2021 | $239 | $502 | $1,941 |
| Murrumbidgee | 2022 | $213 | $731 | $1,780 |
| Murrumbidgee | 2023 | $208 | $475 | $1,064 |
| Western NSW | 2021 | $340 | $645 | $1,773 |
| Western NSW | 2022 | $298 | $702 | $2,030 |
| Western NSW | 2023 | $324 | $783 | $1,705 |
| Central Coast | 2021 | $307 | $584 | $1,027 |
| Central Coast | 2022 | $214 | $335 | $832 |
| Central Coast | 2023 | $246 | $308 | $506 |
| Hunter/New England | 2021 | $341 | $609 | $1,082 |
| Hunter/New England | 2022 | $251 | $561 | $1,089 |
| Hunter/New England | 2023 | $269 | $476 | $821 |
| Nepean Blue Mountains | 2021 | $562 | $941 | $1,878 |
| Nepean Blue Mountains | 2022 | $577 | $1,032 | $1,565 |
| Nepean Blue Mountains | 2023 | $502 | $810 | $1,238 |
| Western Sydney | 2021 | $417 | $798 | $1,537 |
| Western Sydney | 2022 | $373 | $816 | $2,215 |
| Western Sydney | 2023 | $326 | $455 | $1,564 |
| Northern Sydney | 2021 | $358 | $736 | $2,084 |
| Northern Sydney | 2022 | $307 | $576 | $1,218 |
| Northern Sydney | 2023 | $313 | $580 | $995 |
| South Eastern Sydney | 2021 | $265 | $680 | $3,482 |
| South Eastern Sydney | 2022 | $456 | $681 | $1,980 |
| South Eastern Sydney | 2023 | $315 | $719 | $1,456 |
| Sydney | 2021 | $331 | $801 | $1,752 |
| Sydney | 2022 | $433 | $736 | $1,373 |
| Sydney | 2023 | $344 | $777 | $1,276 |
| South Western Sydney | 2021 | $294 | $553 | $1,036 |
| South Western Sydney | 2022 | $314 | $544 | $843 |
| South Western Sydney | 2023 | $321 | $554 | $930 |
| Illawarra Shoalhaven | 2021 | $359 | $635 | $1,390 |
| Illawarra Shoalhaven | 2022 | $349 | $663 | $1,181 |
| Illawarra Shoalhaven | 2023 | $331 | $488 | $1,054 |
| Southern NSW | 2021 | $284 | $616 | $1,325 |
| Southern NSW | 2022 | $274 | $368 | $658 |
| Southern NSW | 2023 | $235 | $393 | $1,194 |

Table K.63 – Figure E.12 – Funding per session against total funding for each organisation (DEX and Funding data)

*Omitted due to too many points.*

## K.8 Appendix F

Table K.64 – Figure F.1 – Scatterplots of number of sessions per 100,000 children, and funding per child, against SEIFA. Line of best fits shown (DEX and funding data)

| District | SEIFA | Session per 100,000 children in district | Funding per child |
|---|---|---|---|
| Sydney | 991 | 36,787 | $118 |
| Western Sydney | 999 | 15,321 | $75 |
| South Eastern Sydney | 1,046 | 17,196 | $74 |
| Northern Sydney | 1,086 | 9,885 | $31 |
| Central Coast | 994 | 44,624 | $108 |
| South Western Sydney | 930 | 31,003 | $101 |
| Illawarra Shoalhaven | 996 | 29,956 | $124 |
| Hunter | 995 | 31,525 | $118 |
| Nepean Blue Mountains | 1,006 | 21,266 | $157 |
| Southern NSW | 1,016 | 19,314 | $81 |
| Northern NSW | 978 | 34,814 | $134 |
| Mid North Coast | 958 | 32,784 | $134 |
| New England | 960 | 46,148 | $101 |
| Murrumbidgee | 972 | 48,202 | $130 |
| Western NSW | 975 | 30,100 | $130 |
| Far West | 931 | 46,473 | $189 |

Table K.65 – Figure F.2 – Scatterplot of proportion of TEI funding going to Wellbeing Stream, against SEIFA

| District | SEIFA | % Wellbeing |
|---|---|---|
| Sydney | 991 | 66% |
| Western Sydney | 999 | 47% |
| South Eastern Sydney | 1,046 | 62% |
| Northern Sydney | 1,086 | 73% |
| Central Coast | 994 | 68% |
| South Western Sydney | 930 | 57% |
| Illawarra Shoalhaven | 996 | 52% |
| Hunter | 995 | 74% |
| Nepean Blue Mountains | 1,006 | 45% |
| Southern NSW | 1,016 | 67% |
| Northern NSW | 978 | 56% |
| Mid North Coast | 958 | 66% |
| New England | 960 | 74% |
| Murrumbidgee | 972 | 57% |
| Western NSW | 975 | 59% |

| District | SEIFA | % Wellbeing |
|---|---|---|
| Far West | 931 | 62% |

Table K.66 – Figure F.3 – Past and future population growth in people aged under 20

| District | 2014 to 2024 | 2024 to 2034 |
|---|---|---|
| Mid North Coast | 4% | 0% |
| New England | -2% | -1% |
| Northern NSW | 0% | -3% |
| Far West | -9% | -17% |
| Murrumbidgee | 1% | 1% |
| Western NSW | 0% | 0% |
| Central Coast | 4% | 2% |
| Hunter | 7% | 5% |
| Nepean Blue Mountains | 1% | -1% |
| Western Sydney | 13% | 11% |
| Northern Sydney | 4% | -3% |
| South Eastern Sydney | -1% | -2% |
| Sydney | 3% | 1% |
| South Western Sydney | 9% | 7% |
| Illawarra Shoalhaven | 7% | 10% |
| Southern NSW | 4% | 3% |

Table K.67 – Figure F.4 – Proportion of population entering TEI (individual clients), by DCJ District relative to the NSW average, 2020-21 and 2021-22 (HSDS)

| District | Community Strengthening entries | Wellbeing and Safety entries |
|---|---|---|
| Mid North Coast | 0.65 | 0.76 |
| New England | 0.27 | 1.16 |
| Northern NSW | 0.65 | 0.63 |
| Far West | 0.34 | 1.24 |
| Murrumbidgee | 0.30 | 0.53 |
| Western NSW | 0.52 | 0.92 |
| Central Coast | 0.88 | 0.76 |
| Hunter | 0.27 | 0.75 |
| Nepean Blue Mountains | 0.64 | 0.59 |
| Western Sydney | 0.36 | 0.48 |
| Northern Sydney | 0.05 | 0.25 |
| South Eastern Sydney | 0.21 | 0.32 |
| Sydney | 0.30 | 0.50 |
| South Western Sydney | 0.77 | 0.77 |

| District | Community Strengthening entries | Wellbeing and Safety entries |
|---|---|---|
| Illawarra Shoalhaven | 0.47 | 0.60 |
| Southern NSW | 0.24 | 0.69 |

Table K.68 – Figure F.5 – Risk-controlled rates of entry into TEI (individual client entries) by DCJ District, relative to median District (HSDS)

| District | Risk controlled rate of entry, relative to median district |
|---|---|
| Mid North Coast | 0.85 |
| New England | 0.92 |
| Northern NSW | 1.01 |
| Far West | 0.78 |
| Murrumbidgee | 0.67 |
| Western NSW | 0.87 |
| Central Coast | 1.34 |
| Hunter | 0.76 |
| Nepean Blue Mountains | 1.08 |
| Western Sydney | 0.94 |
| Northern Sydney | 1.00 |
| South Eastern Sydney | 1.00 |
| Sydney | 1.19 |
| South Western Sydney | 1.28 |
| Illawarra Shoalhaven | 0.87 |
| Southern NSW | 0.89 |

Table K.69 – Figure F.6 – Risk-controlled rates of entry into the Wellbeing and Safety stream (individual client entries) by DCJ District, relative to median District (HSDS)*

| District | Risk controlled rate of entry, relative to median district |
|---|---|
| Mid North Coast | 0.80 |
| New England | 1.22 |
| Northern NSW | 0.93 |
| Far West | 1.07 |
| Murrumbidgee | 0.74 |
| Western NSW | 0.89 |
| Central Coast | 1.10 |
| Hunter | 1.00 |
| Nepean Blue Mountains | 0.89 |
| Western Sydney | 0.92 |
| Northern Sydney | 1.13 |
| South Eastern Sydney | 1.00 |

| District | Risk controlled rate of entry, relative to median district |
|---|---|
| Sydney | 1.29 |
| South Western Sydney | 1.22 |
| Illawarra Shoalhaven | 0.91 |
| Southern NSW | 1.14 |

Table K.70 – Figure F.9 – Average distance (km) travelled by individual clients by DCJ District (DEX, 2021-22 and 2022-23)

| District | Community Centres | Community Connections | Community Support | Targeted Support |
|---|---|---|---|---|
| Sydney | 2.6 | 3.4 | 3.3 | 3.4 |
| Western Sydney | 4.8 | 5.1 | 4.9 | 4.8 |
| South Eastern Sydney | 4.0 | 4.7 | 5.2 | 4.6 |
| Northern Sydney | 10.5 | 13.3 | 7.3 | 6.3 |
| Central Coast | 5.9 | 8.7 | 8.4 | 11.5 |
| South Western Sydney | 4.3 | 3.8 | 5.4 | 6.2 |
| Illawarra Shoalhaven | 4.2 | 7.0 | 5.7 | 8.5 |
| Hunter | 6.7 | 13.5 | 7.9 | 11.1 |
| Nepean Blue Mountains | 14.4 | 7.0 | 13.0 | 8.3 |
| Southern NSW | 7.2 | 8.7 | 10.5 | 22.4 |
| Northern NSW | 35.3 | 27.2 | 24.0 | 23.2 |
| Mid North Coast | 8.1 | 17.3 | 9.8 | 9.6 |
| New England | 22.8 | 32.2 | 17.6 | 16.1 |
| Murrumbidgee | 11.4 | 24.5 | 26.1 | 25.1 |
| Western NSW | 16.2 | 43.3 | 27.7 | 27.1 |

Table K.71 – Figure F.11 – Average distance travelled by individual clients compared to proportion of clients receiving virtual sessions in each LGA (DEX, 2021-22 and 2022-23)

*Omitted due to too many points.*

## K.9 Appendix H

Table K.72 – Figure H.1 – Study population by quarters since entry for children not in OOHC in the initial quarter (HSDS)*

| Quarters since entry | TEI | Non-TEI |
|---|---|---|
| 1 | 0.08M | 1.6M |
| 2 | 0.07M | 1.4M |
| 3 | 0.06M | 1.1M |
| 4 | 0.05M | 0.9M |
| 5 | 0.04M | 0.6M |
| 6 | 0.03M | 0.4M |
| 7 | 0.02M | 0.2M |

Table K.73 – Figure H.2 – Observed proportion of children with concern report, ROSH, and OOHC for children not in OOHC in the initial quarter (HSDS)

| Metric | Quarters since entry | TEI | Non-TEI |
|---|---|---|---|
| Concern report | 1 | 11.65% | 1.68% |
| Concern report | 2 | 10.88% | 1.67% |
| Concern report | 3 | 10.38% | 1.68% |
| Concern report | 4 | 9.76% | 1.61% |
| Concern report | 5 | 10.03% | 1.64% |
| Concern report | 6 | 9.76% | 1.64% |
| Concern report | 7 | 9.61% | 1.67% |
| ROSH | 1 | 8.99% | 1.22% |
| ROSH | 2 | 8.21% | 1.20% |
| ROSH | 3 | 7.76% | 1.22% |
| ROSH | 4 | 7.17% | 1.15% |
| ROSH | 5 | 7.68% | 1.19% |
| ROSH | 6 | 7.39% | 1.20% |
| ROSH | 7 | 7.12% | 1.19% |
| OOHC (for children not in OOHC in initial quarter) | 1 | 0.21% | 0.02% |
| OOHC (for children not in OOHC in initial quarter) | 2 | 0.34% | 0.03% |
| OOHC (for children not in OOHC in initial quarter) | 3 | 0.48% | 0.04% |
| OOHC (for children not in OOHC in initial quarter) | 4 | 0.54% | 0.05% |
| OOHC (for children not in OOHC in initial quarter) | 5 | 0.68% | 0.05% |
| OOHC (for children not in OOHC in initial quarter) | 6 | 0.82% | 0.06% |
| OOHC (for children not in OOHC in initial quarter) | 7 | 0.95% | 0.06% |

Table K.74 – Figure H.3 – Study population by quarters since entry for children in OOHC in the initial quarter (HSDS)

| Quarters since entry | TEI | Non-TEI |
|---|---|---|
| 1 | 3.3k | 8.3k |
| 2 | 2.9k | 7.2k |
| 3 | 2.6k | 6.0k |
| 4 | 2.3k | 4.8k |
| 5 | 1.8k | 3.6k |
| 6 | 1.2k | 2.4k |
| 7 | 0.8k | 1.2k |

Table K.75 – Figure H.4 – Observed proportion of children with OOHC by quarters since entry for children already in OOHC in the entry quarter (HSDS)

| Quarters since entry | TEI | Non-TEI |
|---|---|---|
| 1 | 95.6% | 95.8% |

| Quarters since entry | TEI | Non-TEI |
|---|---|---|
| 2 | 92.1% | 93.1% |
| 3 | 88.9% | 89.9% |
| 4 | 84.9% | 88.0% |
| 5 | 82.7% | 85.9% |
| 6 | 79.7% | 82.7% |
| 7 | 76.0% | 81.5% |

Table K.76 – Figure H.5 – Predicted concern report rate by quarter since entry (HSDS)

| Quarters since entry | Non-TEI - Raw | TEI - Raw | Non-TEI - risk adjusted | TEI - without TEI support |
|---|---|---|---|---|
| 1 | 1.68% | 11.64% | 10.17% | 11.64% |
| 2 | 1.67% | 10.88% | 9.50% | 11.03% |
| 3 | 1.67% | 10.48% | 9.25% | 10.80% |
| 4 | 1.63% | 9.72% | 8.64% | 10.14% |
| 5 | 1.63% | 9.75% | 8.75% | 10.30% |
| 6 | 1.65% | 9.85% | 8.95% | 10.55% |
| 7 | 1.65% | 9.98% | 9.07% | 10.68% |

Table K.77 – Figure H.6 – Predicted ROSH rate by quarter since entry (HSDS)

| Quarters since entry | Non-TEI - Raw | TEI - Raw | Non-TEI - risk adjusted | TEI - without TEI support |
|---|---|---|---|---|
| 1 | 1.22% | 8.84% | 7.76% | 8.84% |
| 2 | 1.21% | 8.43% | 7.49% | 8.58% |
| 3 | 1.19% | 7.87% | 7.07% | 8.17% |
| 4 | 1.17% | 7.14% | 6.48% | 7.56% |
| 5 | 1.18% | 7.26% | 6.53% | 7.65% |
| 6 | 1.20% | 7.45% | 6.65% | 7.82% |
| 7 | 1.20% | 7.54% | 6.73% | 7.91% |

Table K.78 – Figure H.7 – Predicted OOHC rate by quarter since entry for children not in OOHC upon TEI entry (HSDS)

| Quarters since entry | Non-TEI - Raw | TEI - Raw | Non-TEI - risk adjusted | TEI - without TEI support |
|---|---|---|---|---|
| 1 | 0.02% | 0.23% | 0.21% | 0.23% |
| 2 | 0.03% | 0.33% | 0.32% | 0.35% |
| 3 | 0.04% | 0.47% | 0.47% | 0.51% |
| 4 | 0.05% | 0.54% | 0.51% | 0.56% |
| 5 | 0.05% | 0.66% | 0.59% | 0.64% |
| 6 | 0.06% | 0.82% | 0.69% | 0.74% |
| 7 | 0.06% | 0.98% | 0.77% | 0.83% |

Table K.79 – Figure H.8 – Predicted OOHC rate by quarter since entry for children in OOHC upon TEI entry (HSDS)

| Quarters since entry | Non-TEI - Raw | TEI - Raw | Non-TEI - risk adjusted | TEI - without TEI support |
|---|---|---|---|---|
| 1 | 95.9% | 95.7% | 94.9% | 95.6% |
| 2 | 93.1% | 92.1% | 91.5% | 92.8% |
| 3 | 89.8% | 88.3% | 87.6% | 89.5% |
| 4 | 87.9% | 85.8% | 85.5% | 87.7% |
| 5 | 85.8% | 82.7% | 83.2% | 85.6% |
| 6 | 83.4% | 79.7% | 81.1% | 83.7% |
| 7 | 80.7% | 75.3% | 77.8% | 80.6% |

Table K.80 – Figure H.9 – Observed outcomes rate one quarter after entry for children with and without child protection interaction prior to TEI entry (HSDS)

| Model | Had past concern report | Never had concern report |
|---|---|---|
| Concern report | 23.5% | 1.5% |
| ROSH | 17.9% | 1.1% |
| OOHC - not in OOHC initially | 0.5% | 0.0% |

Table K.81 – Figure H.10 – Modelled TEI impact six quarters after entry for children with and without child protection interaction prior to TEI entry (HSDS)

| Model | Had past concern report? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support | expected rate without TEI support |
|---|---|---|---|---|---|---|---|
| Concern report | Yes | -1.34% | -2.3% | -0.4% | 0.01 | 18.22% | 19.55% |
| Concern report | No | -0.11% | -0.3% | 0.1% | 0.40 | 1.83% | 1.94% |
| ROSH | Yes | -0.72% | -1.7% | 0.2% | 0.15 | 13.83% | 14.55% |
| ROSH | No | -0.09% | -0.3% | 0.2% | 0.47 | 1.33% | 1.42% |
| OOHC - not in OOHC initially | Yes | 0.14% | -0.4% | 0.6% | 0.50 | 1.64% | 1.51% |
| OOHC - not in OOHC initially | No | 0.00% | 0.0% | 0.0% | 1.00 | 0.00% | 0.00% |

Table K.82 – Figure H.11 – Observed outcomes rate one quarter after entry for children in the priority cohorts (HSDS)

| Priority cohort | Model | In the priority cohort | Not in the priority cohort |
|---|---|---|---|
| Aboriginal clients | Concern Report | 23% | 9% |
| Aboriginal clients | ROSH | 18% | 6% |
| Age 0-5 | Concern Report | 9% | 14% |
| Age 0-5 | ROSH | 7% | 10% |
| At risk of school disengagement | Concern Report | 23% | 10% |
| At risk of school disengagement | ROSH | 17% | 8% |

| Priority cohort | Model | In the priority cohort | Not in the priority cohort |
|---|---|---|---|
| Young parent with risk factors | Concern Report | 18% | 12% |
| Young parent with risk factors | ROSH | 14% | 9% |

Table K.83 – Figure H.12 – Modelled TEI impact six quarters after entry for children in the priority cohorts (HSDS)

| Model | Aboriginal client? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Yes | -1.13% | -2.8% | 0.4% | 0.16 | 19.09% |
| Concern report | No | -0.62% | -1.1% | -0.1% | 0.01 | 7.25% |
| ROSH | Yes | -1.24% | -2.8% | 0.4% | 0.13 | 14.52% |
| ROSH | No | -0.22% | -0.6% | 0.2% | 0.30 | 5.43% |
| OOHC - not in OOHC initially | Yes | 0.50% | -0.3% | 1.1% | 0.20 | 1.94% |
| OOHC - not in OOHC initially | No | 0.05% | -0.1% | 0.2% | 0.57 | 0.50% |
| OOHC - in OOHC initially | Yes | -2.78% | -6.3% | 1.8% | 0.18 | 82.11% |
| OOHC - in OOHC initially | No | -5.42% | -9.8% | -0.1% | 0.05 | 76.97% |

| Model | Age 0 to 5? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Yes | -0.48% | -1.3% | 0.1% | 0.19 | 7.85% |
| Concern report | No | -0.90% | -1.6% | -0.2% | 0.02 | 11.49% |
| ROSH | Yes | -0.19% | -0.8% | 0.3% | 0.57 | 5.82% |
| ROSH | No | -0.47% | -1.1% | 0.2% | 0.16 | 8.77% |
| OOHC - not in OOHC initially | Yes | 0.24% | -0.1% | 0.6% | 0.19 | 1.10% |
| OOHC - not in OOHC initially | No | 0.02% | -0.2% | 0.2% | 0.74 | 0.59% |
| OOHC - in OOHC initially | Yes | -4.85% | -9.7% | 0.5% | 0.06 | 80.88% |
| OOHC - in OOHC initially | No | -3.70% | -7.4% | 0.3% | 0.07 | 79.07% |

| Model | With school disengagement risk? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Yes | -0.56% | -2.2% | 1.0% | 0.49 | 17.35% |
| Concern report | No | -0.72% | -1.2% | -0.2% | 0.02 | 8.14% |

| Model | With school disengagement risk? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| ROSH | Yes | 0.18% | -1.4% | 1.5% | 0.82 | 13.25% |
| ROSH | No | -0.47% | -0.9% | 0.0% | 0.05 | 6.11% |
| OOHC - not in OOHC initially | Yes | 0.08% | -0.5% | 0.5% | 0.69 | 0.92% |
| OOHC - not in OOHC initially | No | 0.16% | -0.1% | 0.4% | 0.15 | 0.80% |
| OOHC - in OOHC initially | Yes | -2.26% | -10.2% | 4.6% | 0.51 | 76.30% |
| OOHC - in OOHC initially | No | -4.40% | -7.6% | -0.8% | 0.02 | 80.40% |

| Model | Has young parent with risk factors? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Yes | 1.53% | -4.1% | 5.7% | 0.52 | 12.96% |
| Concern report | No | -0.72% | -1.2% | -0.2% | 0.01 | 9.81% |
| ROSH | Yes | 1.51% | -3.7% | 5.8% | 0.47 | 8.95% |
| ROSH | No | -0.38% | -0.9% | 0.2% | 0.11 | 7.43% |
| OOHC - not in OOHC initially | Yes | 2.97% | 0.8% | 4.5% | 0.01 | 4.43% |
| OOHC - not in OOHC initially | No | 0.07% | -0.1% | 0.3% | 0.53 | 0.74% |
| OOHC - in OOHC initially | Yes | 7.28% | -10.3% | 26.0% | 0.52 | 74.78% |
| OOHC - in OOHC initially | No | -4.47% | -7.2% | -1.0% | 0.01 | 79.90% |

Table K.84 – Figure H.13 – Observed outcomes rate one quarter after entry by client age band at entry (HSDS)

| Age band | Concern report | ROSH |
|---|---|---|
| 0 to 5 | 8.8% | 6.8% |
| 6 to 11 | 13.1% | 10.1% |
| 12 to 17 | 14.6% | 10.7% |

Table K.85 – Figure H.14 – Modelled TEI impact six quarters after entry by client age band at entry (HSDS)

| Model | Age band | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | 0 to 5 | -0.53% | -1.2% | 0.3% | 0.16 | 7.83% |
| Concern report | 6 to 11 | -1.16% | -2.0% | -0.2% | 0.02 | 11.24% |

| Model | Age band | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | 12 to 17 | -0.63% | -1.7% | 0.4% | 0.22 | 11.81% |
| ROSH | 0 to 5 | -0.22% | -0.9% | 0.4% | 0.53 | 5.82% |
| ROSH | 6 to 11 | -0.89% | -1.8% | -0.1% | 0.04 | 8.71% |
| ROSH | 12 to 17 | -0.01% | -1.0% | 0.9% | 0.98 | 8.83% |
| OOHC - not in OOHC initially | 0 to 5 | 0.21% | -0.2% | 0.5% | 0.24 | 1.10% |
| OOHC - not in OOHC initially | 6 to 11 | 0.07% | -0.3% | 0.4% | 0.59 | 0.76% |
| OOHC - not in OOHC initially | 12 to 17 | -0.03% | -0.3% | 0.2% | 0.85 | 0.39% |
| OOHC - in OOHC initially | 0 to 5 | -4.45% | -9.7% | 1.1% | 0.09 | 80.86% |
| OOHC - in OOHC initially | 6 to 11 | -3.58% | -8.1% | 1.1% | 0.19 | 79.50% |
| OOHC - in OOHC initially | 12 to 17 | -3.61% | -8.7% | 2.1% | 0.16 | 78.60% |

Table K.86 – Figure H.15 – Observed outcomes rate one quarter after entry by client residential DCJ district at entry (HSDS)

| DCJ district | Concern report | ROSH |
|---|---|---|
| Mid North Coast | 18% | 14% |
| New England | 18% | 14% |
| Northern NSW | 14% | 9% |
| Murrumbidgee | 20% | 16% |
| Western NSW | 18% | 14% |
| Central Coast | 13% | 10% |
| Hunter | 19% | 15% |
| Nepean Blue Mountains | 10% | 9% |
| Western Sydney | 8% | 6% |
| Northern Sydney | 7% | 5% |
| South Eastern Sydney | 7% | 6% |
| Sydney | 7% | 6% |
| South Western Sydney | 8% | 6% |
| Illawarra Shoalhaven | 14% | 8% |
| Southern NSW | 13% | 10% |

Table K.87 – Figure H.16 – Modelled TEI impact six quarters after entry by client residential DCJ district at entry (HSDS)

| Model | DCJ district | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Mid North Coast | -2.65% | -5.5% | -0.1% | 0.04 | 15.11% |
| Concern report | New England | -1.69% | -4.2% | 1.0% | 0.18 | 14.23% |
| Concern report | Northern NSW | 1.33% | -1.0% | 3.4% | 0.21 | 10.20% |
| Concern report | Murrumbidgee | -1.98% | -5.8% | 1.6% | 0.26 | 16.99% |
| Concern report | Western NSW | -0.93% | -3.5% | 1.6% | 0.49 | 16.76% |
| Concern report | Central Coast | 0.62% | -1.6% | 2.7% | 0.57 | 11.31% |
| Concern report | Hunter | -2.23% | -4.6% | -0.2% | 0.03 | 14.78% |
| Concern report | Nepean Blue Mountains | -1.48% | -3.4% | 0.3% | 0.09 | 7.99% |
| Concern report | Western Sydney | 0.08% | -1.0% | 1.1% | 0.92 | 7.26% |
| Concern report | Northern Sydney | -2.23% | -3.7% | -0.9% | 0.01 | 3.79% |
| Concern report | South Eastern Sydney | -1.44% | -2.9% | -0.1% | 0.04 | 5.10% |
| Concern report | Sydney | -0.80% | -2.9% | 1.1% | 0.35 | 6.15% |
| Concern report | South Western Sydney | 0.64% | -0.3% | 1.5% | 0.21 | 7.57% |
| Concern report | Illawarra Shoalhaven | -1.13% | -3.3% | 1.3% | 0.34 | 12.06% |
| Concern report | Southern NSW | -3.26% | -7.2% | -0.1% | 0.05 | 9.56% |
| ROSH | Mid North Coast | -0.97% | -3.5% | 1.5% | 0.47 | 12.70% |
| ROSH | New England | -0.36% | -2.8% | 1.7% | 0.83 | 10.96% |
| ROSH | Northern NSW | 0.21% | -1.8% | 2.0% | 0.82 | 5.40% |
| ROSH | Murrumbidgee | -1.09% | -4.6% | 2.0% | 0.52 | 13.50% |
| ROSH | Western NSW | -0.36% | -2.7% | 2.0% | 0.75 | 13.07% |
| ROSH | Central Coast | 0.10% | -1.9% | 2.3% | 0.92 | 8.54% |
| ROSH | Hunter | -0.19% | -2.1% | 1.5% | 0.85 | 11.87% |
| ROSH | Nepean Blue Mountains | -1.76% | -3.5% | -0.2% | 0.03 | 6.38% |
| ROSH | Western Sydney | 0.56% | -0.5% | 1.6% | 0.26 | 5.74% |
| ROSH | Northern Sydney | -1.69% | -3.0% | -0.5% | 0.01 | 2.75% |
| ROSH | South Eastern Sydney | -0.88% | -2.2% | 0.3% | 0.17 | 3.95% |
| ROSH | Sydney | -1.18% | -3.0% | 0.6% | 0.18 | 4.68% |
| ROSH | South Western Sydney | 0.01% | -0.9% | 0.8% | 0.94 | 5.59% |
| ROSH | Illawarra Shoalhaven | 0.14% | -1.8% | 1.9% | 0.87 | 7.28% |
| ROSH | Southern NSW | -2.86% | -6.6% | 0.6% | 0.09 | 7.42% |
| OOHC - in OOHC initially | Mid North Coast | -14.95% | -26.1% | -3.5% | 0.01 | 64.01% |
| OOHC - in OOHC initially | New England | 10.11% | -3.3% | 24.7% | 0.19 | 76.76% |
| OOHC - in OOHC initially | Northern NSW | -0.76% | -11.9% | 11.2% | 0.88 | 82.71% |

| Model | DCJ district | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| OOHC - in OOHC initially | Murrumbidgee | -8.64% | -24.4% | 6.4% | 0.25 | 72.00% |
| OOHC - in OOHC initially | Western NSW | 1.03% | -8.7% | 11.4% | 0.84 | 80.41% |
| OOHC - in OOHC initially | Central Coast | -15.63% | -23.4% | -7.6% | 0.00 | 78.32% |
| OOHC - in OOHC initially | Hunter | 9.67% | 1.6% | 18.2% | 0.02 | 86.29% |
| OOHC - in OOHC initially | Nepean Blue Mountains | -2.90% | -12.3% | 8.4% | 0.56 | 83.00% |
| OOHC - in OOHC initially | Western Sydney | -11.07% | -16.2% | -4.8% | 0.00 | 79.71% |
| OOHC - in OOHC initially | Northern Sydney | -6.65% | -15.3% | -0.5% | 0.02 | 93.35% |
| OOHC - in OOHC initially | South Eastern Sydney | -6.15% | -20.1% | 11.0% | 0.44 | 78.13% |
| OOHC - in OOHC initially | Sydney | -12.24% | -25.2% | 3.5% | 0.12 | 75.07% |
| OOHC - in OOHC initially | South Western Sydney | -4.86% | -9.9% | 1.3% | 0.10 | 88.16% |
| OOHC - in OOHC initially | Illawarra Shoalhaven | 3.52% | -8.0% | 16.5% | 0.60 | 75.97% |
| OOHC - in OOHC initially | Southern NSW | -11.28% | -26.6% | 5.4% | 0.22 | 78.24% |

Table K.88 – Figure H.17 – Observed outcomes rate one quarter after entry by activity type received (HSDS)

| Program activity | Concern report | ROSH |
|---|---|---|
| Comm. Connections | 8% | 6% |
| Comm. Centres | 10% | 8% |
| Comm. Support | 10% | 7% |
| Targeted Support | 13% | 10% |
| Intensive Support | 22% | 17% |

Table K.89 – Figure H.18 – Modelled TEI impact six quarters after entry by activity type received (HSDS)

| Model | Program activity | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Comm. Connections | -0.33% | -1.1% | 0.4% | 0.40 | 7.57% |
| Concern report | Comm. Centres | -0.34% | -1.2% | 0.5% | 0.42 | 9.02% |
| Concern report | Comm. Support | -0.35% | -1.1% | 0.5% | 0.36 | 9.56% |
| Concern report | Targeted Support | -1.04% | -1.6% | -0.4% | 0.00 | 10.66% |
| Concern report | Intensive Support | -1.07% | -3.3% | 1.1% | 0.30 | 18.22% |
| ROSH | Comm. Connections | 0.06% | -0.6% | 0.8% | 0.84 | 5.80% |
| ROSH | Comm. Centres | -0.18% | -1.0% | 0.6% | 0.70 | 6.65% |
| ROSH | Comm. Support | 0.10% | -0.6% | 0.8% | 0.78 | 7.15% |

| Model | Program activity | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| ROSH | Targeted Support | -0.53% | -1.2% | 0.0% | 0.06 | 8.17% |
| ROSH | Intensive Support | -0.05% | -1.9% | 1.7% | 0.94 | 13.88% |
| OOHC - not in OOHC initially | Comm. Connections | 0.01% | -0.2% | 0.3% | 0.98 | 0.40% |
| OOHC - not in OOHC initially | Comm. Centres | -0.09% | -0.4% | 0.2% | 0.50 | 0.52% |
| OOHC - not in OOHC initially | Comm. Support | 0.31% | 0.0% | 0.6% | 0.04 | 0.79% |
| OOHC - not in OOHC initially | Targeted Support | 0.22% | 0.0% | 0.4% | 0.08 | 0.94% |
| OOHC - not in OOHC initially | Intensive Support | 0.85% | -0.1% | 1.8% | 0.06 | 1.99% |
| OOHC - in OOHC initially | Comm. Connections | -2.02% | -9.9% | 5.4% | 0.62 | 78.12% |
| OOHC - in OOHC initially | Comm. Centres | -5.57% | -12.0% | 1.0% | 0.08 | 80.93% |
| OOHC - in OOHC initially | Comm. Support | -5.24% | -11.4% | 1.0% | 0.10 | 76.72% |
| OOHC - in OOHC initially | Targeted Support | -3.19% | -6.6% | 0.1% | 0.08 | 80.38% |
| OOHC - in OOHC initially | Intensive Support | -1.47% | -8.8% | 6.4% | 0.66 | 78.65% |

Table K.90 – Figure H.19 – Observed outcomes rate one quarter after entry by service type received (HSDS)

| Service type | Concern report | ROSH |
|---|---|---|
| Indigenous services | 16% | 12% |
| Social Participation | 9% | 6% |
| Community Engagement | 8% | 6% |
| Education and Skills Training | 10% | 7% |
| Information/Advice/Referral | 16% | 12% |
| Advocacy and Support | 13% | 10% |
| Counselling | 19% | 14% |
| Family Capacity Building | 20% | 15% |
| Material Aid | 18% | 14% |
| Mentoring/Peer Support | 16% | 13% |
| Parenting Programs | 13% | 10% |
| Supported Playgroups | 5% | 4% |
| Specialist Support | 23% | 17% |

Table K.91 – Figure H.20 – Modelled TEI impact six quarters after entry by service type received (HSDS)

| Model | Service type | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Indigenous services | 0.28% | -1.2% | 2.1% | 0.80 | 14.26% |
| Concern report | Social Participation | -0.11% | -0.9% | 0.6% | 0.82 | 8.06% |
| Concern report | Community Engagement | -0.24% | -1.2% | 0.7% | 0.64 | 7.43% |
| Concern report | Education and Skills Training | -0.76% | -1.6% | 0.1% | 0.10 | 8.40% |
| Concern report | Information/Advice/Referral | -1.06% | -1.9% | -0.3% | 0.01 | 13.25% |
| Concern report | Advocacy and Support | 0.30% | -1.2% | 1.7% | 0.70 | 12.59% |
| Concern report | Counselling | -2.39% | -4.1% | -0.5% | 0.01 | 14.27% |
| Concern report | Family Capacity Building | -1.17% | -2.2% | -0.1% | 0.02 | 15.26% |
| Concern report | Material Aid | -0.61% | -1.8% | 0.9% | 0.39 | 14.12% |
| Concern report | Mentoring/Peer Support | -0.99% | -2.7% | 0.6% | 0.20 | 13.47% |
| Concern report | Parenting Programs | -0.28% | -1.3% | 0.7% | 0.60 | 11.13% |
| Concern report | Supported Playgroups | -0.04% | -0.6% | 0.5% | 0.91 | 5.34% |
| Concern report | Specialist Support | -2.61% | -6.2% | 1.6% | 0.17 | 17.18% |
| ROSH | Indigenous services | 0.90% | -0.5% | 2.3% | 0.17 | 11.25% |
| ROSH | Social Participation | 0.19% | -0.4% | 0.8% | 0.55 | 6.09% |
| ROSH | Community Engagement | -0.01% | -0.8% | 0.9% | 0.99 | 5.50% |
| ROSH | Education and Skills Training | -0.11% | -0.7% | 0.5% | 0.71 | 6.51% |
| ROSH | Information/Advice/Referral | -0.47% | -1.2% | 0.2% | 0.19 | 10.05% |
| ROSH | Advocacy and Support | 0.29% | -1.0% | 1.4% | 0.58 | 9.29% |
| ROSH | Counselling | -1.13% | -2.5% | 0.0% | 0.10 | 10.77% |
| ROSH | Family Capacity Building | -0.40% | -1.3% | 0.4% | 0.25 | 11.75% |
| ROSH | Material Aid | 0.24% | -1.0% | 1.3% | 0.65 | 11.16% |
| ROSH | Mentoring/Peer Support | -0.08% | -1.5% | 1.3% | 0.92 | 10.84% |
| ROSH | Parenting Programs | -0.18% | -1.0% | 0.7% | 0.68 | 8.62% |
| ROSH | Supported Playgroups | 0.33% | -0.2% | 0.9% | 0.21 | 4.23% |
| ROSH | Specialist Support | -3.04% | -5.8% | -0.3% | 0.07 | 11.23% |
| OOHC - not in OOHC initially | Indigenous services | 0.33% | -0.4% | 1.1% | 0.23 | 1.12% |
| OOHC - not in OOHC initially | Social Participation | -0.02% | -0.3% | 0.2% | 0.94 | 0.36% |
| OOHC - not in OOHC initially | Education and Skills Training | 0.12% | -0.2% | 0.4% | 0.29 | 0.57% |
| OOHC - not in OOHC initially | Information/Advice/Referral | 0.30% | 0.0% | 0.6% | 0.07 | 1.15% |
| OOHC - not in OOHC initially | Advocacy and Support | 0.04% | -0.5% | 0.4% | 0.85 | 0.62% |
| OOHC - not in OOHC initially | Counselling | 0.14% | -0.4% | 0.6% | 0.51 | 0.77% |

| Model | Service type | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| OOHC - not in OOHC initially | Family Capacity Building | 0.28% | -0.1% | 0.6% | 0.16 | 1.37% |
| OOHC - not in OOHC initially | Material Aid | 0.43% | -0.1% | 0.9% | 0.08 | 1.32% |
| OOHC - not in OOHC initially | Mentoring/Peer Support | 0.47% | -0.2% | 1.1% | 0.15 | 1.48% |
| OOHC - not in OOHC initially | Parenting Programs | 0.61% | 0.1% | 1.1% | 0.03 | 1.75% |
| OOHC - not in OOHC initially | Supported Playgroups | 0.43% | 0.2% | 0.6% | 1.00 | 0.56% |
| OOHC - in OOHC initially | Indigenous services | -2.83% | -13.3% | 7.2% | 0.58 | 81.41% |
| OOHC - in OOHC initially | Social Participation | -9.07% | -15.4% | -2.2% | 0.01 | 77.42% |
| OOHC - in OOHC initially | Community Engagement | 5.06% | -5.3% | 16.0% | 0.43 | 85.52% |
| OOHC - in OOHC initially | Education and Skills Training | -2.18% | -8.3% | 4.8% | 0.51 | 80.01% |
| OOHC - in OOHC initially | Information/Advice/Referral | -3.29% | -7.4% | 1.6% | 0.15 | 79.06% |
| OOHC - in OOHC initially | Advocacy and Support | -6.11% | -14.5% | 2.3% | 0.16 | 74.92% |
| OOHC - in OOHC initially | Counselling | 2.33% | -6.1% | 10.9% | 0.61 | 81.50% |
| OOHC - in OOHC initially | Family Capacity Building | -0.12% | -4.7% | 5.3% | 0.98 | 81.83% |
| OOHC - in OOHC initially | Material Aid | -1.09% | -9.0% | 7.0% | 0.81 | 83.43% |
| OOHC - in OOHC initially | Mentoring/Peer Support | -6.20% | -15.3% | 3.4% | 0.20 | 80.74% |
| OOHC - in OOHC initially | Parenting Programs | -6.02% | -10.8% | -1.4% | 0.04 | 79.40% |
| OOHC - in OOHC initially | Supported Playgroups | 0.75% | -9.4% | 12.5% | 0.90 | 76.14% |
| OOHC - in OOHC initially | Specialist Support | -4.49% | -15.4% | 8.0% | 0.44 | 79.39% |

Table K.92 – Figure H.21 – Observed outcomes rate for Aboriginal children one quarter after entry by whether they received the Indigenous specific service types (HSDS)

| Model | Received Indigenous specific servces | Did not receive Indigenous specific servces |
|---|---|---|
| Concern report | 19.2% | 23.7% |
| ROSH | 15.0% | 18.5% |
| OOHC - not in OOHC initially | 0.0% | 0.6% |

Table K.93 – Figure H.22 – Modelled TEI impact for Aboriginal children six quarters after entry by whether they received the Indigenous specific service types (HSDS)

| Model | Received indigenous specific services? | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | Yes | -0.62% | -2.4% | 1.2% | 0.50 | 16.86% |
| Concern report | No | -1.19% | -2.9% | 0.6% | 0.15 | 19.53% |
| ROSH | Yes | -0.80% | -2.7% | 1.1% | 0.42 | 12.93% |
| ROSH | No | -1.27% | -2.8% | 0.3% | 0.11 | 14.84% |
| OOHC - not in OOHC initially | Yes | 0.20% | -0.5% | 0.9% | 0.55 | 1.36% |
| OOHC - not in OOHC initially | No | 0.53% | -0.3% | 1.2% | 0.17 | 2.06% |
| OOHC - in OOHC initially | Yes | -7.04% | -13.5% | 0.0% | 0.05 | 78.85% |
| OOHC - in OOHC initially | No | -2.42% | -6.3% | 1.6% | 0.24 | 82.52% |

Table K.94 – Figure H.23 – Observed outcomes rate one quarter after entry by total number of sessions attended (HSDS)

| Number of sessions | Concern report | ROSH |
|---|---|---|
| 1 to 5 | 10% | 8% |
| 6 to 15 | 12% | 9% |
| 16 to 30 | 14% | 11% |
| >30 | 19% | 15% |

Table K.95 – Figure H.24 – Modelled TEI impact six quarters after entry by total number of sessions attended (HSDS)

| Model | Number of sessions | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| Concern report | 1 to 5 | -0.56% | -1.1% | 0.0% | 0.04 | 8.89% |
| Concern report | 6 to 15 | -0.59% | -1.4% | 0.2% | 0.13 | 9.97% |
| Concern report | 16 to 30 | -1.77% | -2.7% | -0.7% | 0.00 | 9.52% |
| Concern report | >30 | -1.81% | -3.1% | -0.6% | 0.01 | 13.19% |
| ROSH | 1 to 5 | -0.40% | -1.0% | 0.1% | 0.13 | 6.53% |
| ROSH | 6 to 15 | -0.12% | -0.8% | 0.5% | 0.71 | 7.72% |
| ROSH | 16 to 30 | -1.32% | -2.2% | -0.4% | 0.00 | 7.04% |
| ROSH | >30 | -1.18% | -2.2% | -0.1% | 0.03 | 10.33% |
| OOHC - not in OOHC initially | 1 to 5 | 0.11% | -0.1% | 0.3% | 0.38 | 0.77% |
| OOHC - not in OOHC initially | 6 to 15 | 0.15% | -0.2% | 0.4% | 0.31 | 0.80% |
| OOHC - not in OOHC initially | 16 to 30 | 0.33% | -0.1% | 0.7% | 0.08 | 0.89% |
| OOHC - not in OOHC initially | >30 | -0.01% | -0.5% | 0.5% | 0.98 | 0.94% |

| Model | Number of sessions | Mean effect | Confidence interval - lower | Confidence interval - upper | p-value | rate with TEI support |
|---|---|---|---|---|---|---|
| OOHC - in OOHC initially | 1 to 5 | -2.30% | -6.9% | 2.6% | 0.31 | 78.93% |
| OOHC - in OOHC initially | 6 to 15 | -4.75% | -10.3% | 0.3% | 0.06 | 80.54% |
| OOHC - in OOHC initially | 16 to 30 | -10.67% | -17.1% | -3.5% | 0.00 | 78.32% |
| OOHC - in OOHC initially | >30 | -4.03% | -11.1% | 3.1% | 0.26 | 81.72% |

Table K.96 – Figure H.34 – Outcomes comparison charts before and after intervention (HSDS)

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| **% with Child protection concern reports (age < 18)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 7.3% | 7.5% | 13.7% | 8.8% |
| -7 | 7.6% | 7.9% | 14.4% | 9.1% |
| -6 | 7.9% | 8.3% | 14.9% | 9.5% |
| -5 | 8.0% | 8.5% | 15.8% | 9.8% |
| -4 | 8.3% | 9.0% | 17.5% | 10.4% |
| -3 | 8.7% | 9.4% | 18.6% | 11.0% |
| -2 | 9.1% | 9.9% | 20.8% | 11.7% |
| -1 | 10.0% | 10.8% | 25.3% | 13.4% |
| 0 | 10.6% | 11.0% | 27.1% | 14.3% |
| 1 | 9.9% | 8.7% | 19.6% | 12.0% |
| 2 | 9.3% | 8.5% | 18.4% | 11.2% |
| 3 | 9.0% | 8.2% | 17.1% | 10.7% |
| 4 | 8.6% | 7.7% | 15.9% | 10.1% |
| 5 | 8.9% | 7.9% | 16.7% | 10.4% |
| 6 | 8.6% | 7.8% | 16.3% | 10.1% |
| 7 | 8.6% | 8.2% | 15.8% | 10.1% |
| **% with ROSH reports (age < 18)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 5.3% | 5.6% | 10.3% | 6.5% |
| -7 | 5.6% | 5.9% | 11.0% | 6.8% |
| -6 | 5.8% | 6.2% | 11.5% | 7.1% |
| -5 | 6.0% | 6.5% | 12.3% | 7.5% |
| -4 | 6.3% | 6.8% | 13.9% | 8.0% |
| -3 | 6.5% | 7.1% | 14.6% | 8.3% |
| -2 | 6.8% | 7.5% | 16.7% | 9.1% |
| -1 | 7.6% | 8.3% | 20.9% | 10.6% |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| 0 | 8.3% | 8.2% | 21.3% | 11.2% |
| 1 | 7.4% | 6.5% | 15.3% | 9.1% |
| 2 | 6.8% | 6.3% | 14.0% | 8.4% |
| 3 | 6.6% | 6.1% | 13.2% | 8.0% |
| 4 | 6.1% | 5.6% | 12.2% | 7.4% |
| 5 | 6.7% | 5.8% | 12.8% | 7.9% |
| 6 | 6.4% | 5.9% | 12.7% | 7.6% |
| 7 | 6.3% | 6.2% | 11.6% | 7.3% |
| **% with Substantiated ROSH reports (age < 18)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.9% | 0.9% | 2.0% | 1.1% |
| -7 | 0.9% | 1.0% | 2.2% | 1.2% |
| -6 | 1.0% | 1.1% | 2.4% | 1.3% |
| -5 | 1.0% | 1.1% | 2.6% | 1.4% |
| -4 | 1.1% | 1.2% | 3.0% | 1.5% |
| -3 | 1.2% | 1.2% | 3.3% | 1.7% |
| -2 | 1.3% | 1.3% | 3.9% | 1.9% |
| -1 | 1.2% | 1.3% | 4.6% | 2.0% |
| 0 | 1.4% | 1.2% | 4.2% | 2.0% |
| 1 | 1.1% | 1.0% | 3.0% | 1.5% |
| 2 | 1.1% | 1.0% | 2.7% | 1.4% |
| 3 | 1.0% | 0.9% | 2.1% | 1.2% |
| 4 | 1.0% | 0.9% | 2.1% | 1.2% |
| 5 | 1.0% | 0.9% | 2.2% | 1.2% |
| 6 | 1.0% | 0.8% | 1.9% | 1.2% |
| 7 | 0.8% | 0.7% | 1.7% | 1.0% |
| **% in OOHC (age < 18)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 2.8% | 3.1% | 4.0% | 3.1% |
| -7 | 2.9% | 3.1% | 4.0% | 3.1% |
| -6 | 2.9% | 3.1% | 4.1% | 3.1% |
| -5 | 2.9% | 3.1% | 4.2% | 3.2% |
| -4 | 2.9% | 3.2% | 4.3% | 3.2% |
| -3 | 2.9% | 3.2% | 4.4% | 3.3% |
| -2 | 2.9% | 3.2% | 4.7% | 3.4% |
| -1 | 2.9% | 3.2% | 5.4% | 3.5% |
| 0 | 3.0% | 3.2% | 5.7% | 3.6% |
| 1 | 3.1% | 3.3% | 6.0% | 3.7% |
| 2 | 3.1% | 3.3% | 6.5% | 3.8% |
| 3 | 3.1% | 3.3% | 6.5% | 3.8% |
| 4 | 3.1% | 3.3% | 6.6% | 3.8% |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| 5 | 3.2% | 3.4% | 7.2% | 4.0% |
| 6 | 3.3% | 3.6% | 7.5% | 4.1% |
| 7 | 3.5% | 3.4% | 7.4% | 4.3% |
| **% with HSC completion (aged between 19 and 31)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 45.9% | 45.1% | 24.6% | 40.1% |
| -7 | 46.1% | 45.2% | 24.7% | 40.3% |
| -6 | 46.2% | 45.2% | 24.5% | 40.3% |
| -5 | 46.3% | 45.2% | 24.5% | 40.3% |
| -4 | 46.2% | 45.3% | 24.7% | 40.3% |
| -3 | 46.3% | 45.4% | 24.7% | 40.4% |
| -2 | 46.3% | 45.3% | 24.7% | 40.4% |
| -1 | 46.3% | 45.3% | 24.9% | 40.5% |
| 0 | 46.2% | 45.1% | 25.1% | 40.4% |
| 1 | 46.0% | 44.4% | 24.7% | 40.1% |
| 2 | 45.8% | 44.3% | 24.8% | 39.9% |
| 3 | 46.0% | 44.1% | 24.4% | 40.0% |
| 4 | 45.9% | 44.3% | 24.4% | 40.0% |
| 5 | 45.7% | 44.0% | 24.3% | 39.8% |
| 6 | 45.7% | 44.9% | 23.9% | 39.6% |
| 7 | 45.9% | 45.1% | 24.7% | 39.8% |
| **% with drug and alcohol offence (age ≥ 11)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.2% | 0.2% | 0.4% | 0.2% |
| -7 | 0.2% | 0.2% | 0.5% | 0.2% |
| -6 | 0.2% | 0.2% | 0.4% | 0.2% |
| -5 | 0.2% | 0.2% | 0.5% | 0.2% |
| -4 | 0.1% | 0.2% | 0.5% | 0.2% |
| -3 | 0.1% | 0.1% | 0.4% | 0.2% |
| -2 | 0.2% | 0.2% | 0.5% | 0.2% |
| -1 | 0.1% | 0.2% | 0.5% | 0.2% |
| 0 | 0.2% | 0.2% | 0.6% | 0.3% |
| 1 | 0.1% | 0.1% | 0.5% | 0.2% |
| 2 | 0.1% | 0.2% | 0.4% | 0.2% |
| 3 | 0.1% | 0.1% | 0.4% | 0.2% |
| 4 | 0.2% | 0.2% | 0.4% | 0.2% |
| 5 | 0.1% | 0.2% | 0.3% | 0.2% |
| 6 | 0.2% | 0.1% | 0.5% | 0.2% |
| 7 | 0.2% | 0.2% | 0.4% | 0.2% |
| **% with Domestic violence offence (age ≥ 11)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| -8 | 0.2% | 0.2% | 0.8% | 0.3% |
| -7 | 0.2% | 0.2% | 0.7% | 0.3% |
| -6 | 0.2% | 0.2% | 0.8% | 0.4% |
| -5 | 0.2% | 0.2% | 0.7% | 0.3% |
| -4 | 0.2% | 0.2% | 0.8% | 0.4% |
| -3 | 0.2% | 0.2% | 0.8% | 0.4% |
| -2 | 0.2% | 0.2% | 1.0% | 0.4% |
| -1 | 0.2% | 0.2% | 1.0% | 0.4% |
| 0 | 0.3% | 0.2% | 1.2% | 0.5% |
| 1 | 0.3% | 0.2% | 1.1% | 0.5% |
| 2 | 0.3% | 0.2% | 0.9% | 0.4% |
| 3 | 0.3% | 0.2% | 1.0% | 0.4% |
| 4 | 0.2% | 0.2% | 0.9% | 0.4% |
| 5 | 0.2% | 0.2% | 1.0% | 0.4% |
| 6 | 0.2% | 0.2% | 0.9% | 0.4% |
| 7 | 0.3% | 0.2% | 0.7% | 0.4% |
| **% domestic violence victims** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 1.1% | 1.0% | 3.3% | 1.6% |
| -7 | 1.1% | 1.1% | 3.3% | 1.6% |
| -6 | 1.2% | 1.2% | 3.7% | 1.8% |
| -5 | 1.1% | 1.1% | 3.8% | 1.8% |
| -4 | 1.2% | 1.2% | 4.2% | 1.9% |
| -3 | 1.2% | 1.2% | 4.2% | 1.9% |
| -2 | 1.2% | 1.3% | 4.9% | 2.1% |
| -1 | 1.3% | 1.4% | 6.0% | 2.4% |
| 0 | 1.4% | 1.3% | 6.1% | 2.5% |
| 1 | 1.4% | 1.1% | 4.2% | 2.0% |
| 2 | 1.3% | 1.1% | 4.1% | 1.9% |
| 3 | 1.3% | 1.1% | 4.0% | 1.9% |
| 4 | 1.3% | 1.0% | 3.8% | 1.8% |
| 5 | 1.3% | 1.1% | 4.0% | 1.9% |
| 6 | 1.3% | 1.1% | 3.8% | 1.9% |
| 7 | 1.3% | 1.0% | 3.6% | 1.8% |
| **% in Custody (age ≥ 11)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.7% | 0.8% | 2.8% | 1.2% |
| -7 | 0.7% | 0.8% | 2.7% | 1.2% |
| -6 | 0.8% | 0.8% | 2.8% | 1.2% |
| -5 | 0.8% | 0.8% | 2.7% | 1.2% |
| -4 | 0.8% | 0.8% | 2.9% | 1.3% |
| -3 | 0.8% | 0.8% | 2.9% | 1.3% |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| -2 | 0.7% | 0.7% | 2.8% | 1.2% |
| -1 | 0.7% | 0.7% | 2.4% | 1.1% |
| 0 | 0.7% | 0.7% | 2.4% | 1.1% |
| 1 | 0.7% | 0.7% | 2.4% | 1.1% |
| 2 | 0.7% | 0.8% | 2.6% | 1.1% |
| 3 | 0.7% | 0.8% | 2.6% | 1.2% |
| 4 | 0.7% | 0.8% | 2.6% | 1.1% |
| 5 | 0.7% | 0.8% | 2.7% | 1.1% |
| 6 | 0.6% | 0.8% | 2.8% | 1.2% |
| 7 | 0.7% | 0.8% | 2.6% | 1.2% |
| **% with court appearances (age ≥ 11)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 1.1% | 1.1% | 3.8% | 1.8% |
| -7 | 1.1% | 1.2% | 3.7% | 1.7% |
| -6 | 1.2% | 1.2% | 4.1% | 1.9% |
| -5 | 1.2% | 1.1% | 4.0% | 1.8% |
| -4 | 1.1% | 1.2% | 4.2% | 1.9% |
| -3 | 1.2% | 1.2% | 4.0% | 1.8% |
| -2 | 1.1% | 1.2% | 4.2% | 1.9% |
| -1 | 1.1% | 1.2% | 4.4% | 1.9% |
| 0 | 1.3% | 1.3% | 5.1% | 2.2% |
| 1 | 1.3% | 1.3% | 4.6% | 2.1% |
| 2 | 1.3% | 1.2% | 4.1% | 1.9% |
| 3 | 1.3% | 1.2% | 4.4% | 2.1% |
| 4 | 1.3% | 1.3% | 4.0% | 1.9% |
| 5 | 1.3% | 1.3% | 4.3% | 2.0% |
| 6 | 1.2% | 1.1% | 4.2% | 1.9% |
| 7 | 1.4% | 1.2% | 4.0% | 2.0% |
| **% with cautions (age ≥ 11)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.2% | 0.2% | 0.4% | 0.2% |
| -7 | 0.2% | 0.2% | 0.5% | 0.3% |
| -6 | 0.2% | 0.2% | 0.4% | 0.2% |
| -5 | 0.2% | 0.2% | 0.5% | 0.3% |
| -4 | 0.2% | 0.2% | 0.4% | 0.2% |
| -3 | 0.2% | 0.2% | 0.4% | 0.3% |
| -2 | 0.2% | 0.2% | 0.5% | 0.3% |
| -1 | 0.2% | 0.2% | 0.5% | 0.3% |
| 0 | 0.2% | 0.2% | 0.5% | 0.3% |
| 1 | 0.3% | 0.2% | 0.6% | 0.3% |
| 2 | 0.3% | 0.2% | 0.5% | 0.3% |
| 3 | 0.2% | 0.2% | 0.4% | 0.3% |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| 4 | 0.2% | 0.2% | 0.5% | 0.3% |
| 5 | 0.2% | 0.2% | 0.3% | 0.2% |
| 6 | 0.2% | 0.2% | 0.4% | 0.3% |
| 7 | 0.3% | 0.2% | 0.5% | 0.3% |
| **% with youth conferences (age ≥ 11)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.0% | 0.0% | 0.1% | 0.1% |
| -7 | 0.0% | 0.0% | 0.1% | 0.1% |
| -6 | 0.0% | 0.0% | 0.1% | 0.1% |
| -5 | 0.0% | 0.0% | 0.1% | 0.1% |
| -4 | 0.0% | 0.0% | 0.1% | 0.1% |
| -3 | 0.0% | 0.0% | 0.1% | 0.1% |
| -2 | 0.0% | 0.0% | 0.1% | 0.1% |
| -1 | 0.1% | 0.0% | 0.1% | 0.1% |
| 0 | 0.1% | 0.0% | 0.2% | 0.1% |
| 1 | 0.0% | 0.0% | 0.1% | 0.0% |
| 2 | 0.0% | 0.0% | 0.1% | 0.1% |
| 3 | 0.0% | 0.0% | 0.1% | 0.1% |
| 4 | 0.0% | 0.0% | 0.1% | 0.0% |
| 5 | 0.0% | 0.0% | N/A | N/A |
| 6 | N/A | 0.0% | N/A | N/A |
| 7 | N/A | N/A | N/A | N/A |
| **% with Mental health support** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 1.3% | 1.3% | 4.0% | 1.9% |
| -7 | 1.4% | 1.4% | 4.2% | 2.0% |
| -6 | 1.4% | 1.5% | 4.6% | 2.1% |
| -5 | 1.5% | 1.5% | 4.6% | 2.2% |
| -4 | 1.5% | 1.6% | 4.7% | 2.2% |
| -3 | 1.5% | 1.7% | 5.0% | 2.4% |
| -2 | 1.6% | 1.7% | 5.5% | 2.5% |
| -1 | 1.8% | 1.8% | 6.5% | 2.8% |
| 0 | 1.8% | 1.8% | 7.2% | 3.1% |
| 1 | 1.9% | 1.7% | 5.9% | 2.8% |
| 2 | 1.8% | 1.6% | 5.3% | 2.6% |
| 3 | 1.7% | 1.5% | 5.0% | 2.5% |
| 4 | 1.6% | 1.4% | 4.6% | 2.3% |
| 5 | 1.6% | 1.4% | 4.5% | 2.3% |
| 6 | 1.7% | 1.4% | 4.6% | 2.4% |
| 7 | 1.7% | 1.4% | 4.4% | 2.3% |
| **% with drug and alcohol hospital admission** | | | | |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.1% | 0.1% | 0.4% | 0.2% |
| -7 | 0.1% | 0.1% | 0.4% | 0.2% |
| -6 | 0.1% | 0.1% | 0.4% | 0.2% |
| -5 | 0.1% | 0.1% | 0.4% | 0.2% |
| -4 | 0.1% | 0.1% | 0.5% | 0.2% |
| -3 | 0.1% | 0.1% | 0.4% | 0.2% |
| -2 | 0.1% | 0.1% | 0.5% | 0.2% |
| -1 | 0.1% | 0.1% | 0.6% | 0.2% |
| 0 | 0.1% | 0.1% | 0.5% | 0.2% |
| 1 | 0.1% | 0.1% | 0.5% | 0.2% |
| 2 | 0.1% | 0.1% | 0.4% | 0.2% |
| 3 | 0.1% | 0.1% | 0.4% | 0.2% |
| 4 | 0.1% | 0.1% | 0.4% | 0.2% |
| 5 | 0.1% | 0.1% | 0.4% | 0.2% |
| 6 | 0.1% | 0.1% | 0.4% | 0.1% |
| 7 | 0.1% | 0.1% | 0.3% | 0.1% |
| **% with mental health hospital admission** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.2% | 0.3% | 0.7% | 0.4% |
| -7 | 0.2% | 0.3% | 0.8% | 0.4% |
| -6 | 0.2% | 0.3% | 0.8% | 0.4% |
| -5 | 0.3% | 0.3% | 0.8% | 0.4% |
| -4 | 0.3% | 0.3% | 0.8% | 0.4% |
| -3 | 0.3% | 0.3% | 0.8% | 0.4% |
| -2 | 0.3% | 0.3% | 0.9% | 0.5% |
| -1 | 0.3% | 0.3% | 1.2% | 0.5% |
| 0 | 0.3% | 0.3% | 1.1% | 0.5% |
| 1 | 0.3% | 0.3% | 0.9% | 0.4% |
| 2 | 0.3% | 0.2% | 0.8% | 0.4% |
| 3 | 0.2% | 0.2% | 0.8% | 0.4% |
| 4 | 0.2% | 0.2% | 0.7% | 0.3% |
| 5 | 0.2% | 0.2% | 0.7% | 0.3% |
| 6 | 0.2% | 0.2% | 0.8% | 0.3% |
| 7 | 0.2% | 0.2% | 0.5% | 0.3% |
| **% with drug and alcohol support (age ≥ 15)** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.8% | 0.8% | 2.2% | 1.1% |
| -7 | 0.8% | 0.7% | 2.2% | 1.1% |
| -6 | 0.8% | 0.8% | 2.2% | 1.1% |
| -5 | 0.8% | 0.7% | 2.3% | 1.1% |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| -4 | 0.7% | 0.8% | 2.3% | 1.1% |
| -3 | 0.8% | 0.8% | 2.3% | 1.1% |
| -2 | 0.8% | 0.8% | 2.3% | 1.2% |
| -1 | 0.8% | 0.8% | 2.4% | 1.2% |
| 0 | 0.8% | 0.8% | 2.5% | 1.2% |
| 1 | 0.8% | 0.8% | 2.4% | 1.2% |
| 2 | 0.8% | 0.8% | 2.4% | 1.2% |
| 3 | 0.8% | 0.8% | 2.4% | 1.2% |
| 4 | 0.8% | 0.8% | 2.3% | 1.1% |
| 5 | 0.8% | 0.8% | 2.4% | 1.2% |
| 6 | 0.9% | 0.8% | 2.6% | 1.3% |
| 7 | 0.9% | 0.7% | 2.5% | 1.3% |
| **% presenting to SHS as homeless** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.8% | 0.8% | 3.1% | 1.3% |
| -7 | 0.7% | 0.7% | 3.4% | 1.3% |
| -6 | 0.8% | 0.8% | 3.5% | 1.4% |
| -5 | 0.8% | 0.8% | 3.7% | 1.4% |
| -4 | 0.8% | 0.8% | 4.0% | 1.5% |
| -3 | 0.8% | 0.9% | 4.2% | 1.5% |
| -2 | 0.8% | 0.9% | 4.7% | 1.7% |
| -1 | 0.9% | 0.9% | 5.8% | 2.0% |
| 0 | 0.9% | 0.9% | 8.3% | 2.6% |
| 1 | 1.1% | 0.9% | 6.2% | 2.3% |
| 2 | 1.2% | 0.9% | 4.9% | 2.0% |
| 3 | 1.1% | 0.9% | 4.3% | 1.8% |
| 4 | 1.1% | 0.9% | 4.1% | 1.8% |
| 5 | 1.2% | 0.9% | 3.7% | 1.7% |
| 6 | 1.2% | 0.9% | 3.4% | 1.6% |
| 7 | 1.2% | 0.9% | 3.5% | 1.7% |
| **% presenting to SHS as at risk of homelessness** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 1.1% | 1.1% | 4.3% | 1.8% |
| -7 | 1.0% | 1.1% | 4.3% | 1.8% |
| -6 | 1.1% | 1.1% | 4.3% | 1.8% |
| -5 | 1.0% | 1.2% | 4.8% | 1.9% |
| -4 | 1.0% | 1.2% | 5.0% | 1.9% |
| -3 | 1.0% | 1.2% | 5.2% | 2.0% |
| -2 | 1.0% | 1.2% | 5.8% | 2.1% |
| -1 | 1.1% | 1.1% | 7.0% | 2.4% |
| 0 | 1.1% | 1.1% | 10.1% | 3.2% |
| 1 | 1.4% | 1.0% | 7.8% | 2.9% |

| Quarters since intervention | Matched TEI rate of outcome | Comparison rate of outcome | Unmatched TEI rate of outcome | All TEI rate of outcome |
|---|---|---|---|---|
| 2 | 1.5% | 1.0% | 6.2% | 2.5% |
| 3 | 1.4% | 1.0% | 5.4% | 2.3% |
| 4 | 1.4% | 1.0% | 4.8% | 2.1% |
| 5 | 1.5% | 1.0% | 4.8% | 2.2% |
| 6 | 1.5% | 1.0% | 4.1% | 2.0% |
| 7 | 1.4% | 1.0% | 4.3% | 2.0% |
| **% presenting to SHS as rough sleeping** | | | | |
| Quarters since intervention | Matched TEI | Comparison | Unmatched TEI | All TEI |
| -8 | 0.1% | 0.1% | 0.3% | 0.1% |
| -7 | 0.1% | 0.1% | 0.3% | 0.1% |
| -6 | 0.1% | 0.1% | 0.3% | 0.1% |
| -5 | 0.1% | 0.1% | 0.4% | 0.1% |
| -4 | 0.1% | 0.1% | 0.4% | 0.1% |
| -3 | 0.0% | 0.1% | 0.4% | 0.1% |
| -2 | 0.0% | 0.1% | 0.5% | 0.1% |
| -1 | 0.1% | 0.1% | 0.6% | 0.2% |
| 0 | 0.1% | 0.0% | 0.9% | 0.3% |
| 1 | 0.1% | 0.1% | 0.5% | 0.2% |
| 2 | 0.1% | 0.1% | 0.4% | 0.2% |
| 3 | 0.1% | 0.1% | 0.3% | 0.1% |
| 4 | 0.1% | 0.1% | 0.3% | 0.1% |
| 5 | 0.1% | 0.1% | 0.2% | 0.1% |
| 6 | 0.1% | 0.1% | 0.2% | 0.1% |
| 7 | 0.1% | 0.1% | 0.3% | 0.1% |

Table K.97 – Figure H.35 – Relationship between TEI volume and concern report rate by LGA, 2020-21 (DEX and HSDS), Figure H.36 – TEI service volume in 2021-22 compared to 2020-21 (DEX)

| LGA | Concern report rate (# per 1,000 total population) | Group client rate (# per 1,000 total population, 2020-21) | Group client rate (# per 1,000 total population, 2021-22) | Group session rate (# per 1,000 total population, 2020-21) | Group session rate (# per 1,000 total population, 2021-22) | Individual client rate (# per 1,000 total population, 2020-21) | Individual client rate (# per 1,000 total population, 2021-22) | Individual session rate (# per 1,000 total population, 2020-21) | Individual session rate (# per 1,000 total population, 2021-22) |
|---|---|---|---|---|---|---|---|---|---|
| Albury | 53 | 219 | 256 | 20 | 25 | 32 | 41 | 55 | 111 |
| Armidale Regional | 57 | 134 | 311 | 13 | 31 | 15 | 27 | 35 | 45 |
| Ballina | 26 | 54 | 32 | 2 | 5 | 14 | 13 | 22 | 23 |
| Balranald | 40 | 111 | 403 | 59 | 403 | 1 | 1 | 2 | 1 |
| Bathurst Regional | 55 | 137 | 201 | 17 | 14 | 38 | 38 | 97 | 89 |

| LGA | Concern report rate (# per 1,000 total population) | Group client rate (# per 1,000 total population, 2020-21) | Group client rate (# per 1,000 total population, 2021-22) | Group session rate (# per 1,000 total population, 2020-21) | Group session rate (# per 1,000 total population, 2021-22) | Individual client rate (# per 1,000 total population, 2020-21) | Individual client rate (# per 1,000 total population, 2021-22) | Individual session rate (# per 1,000 total population, 2020-21) | Individual session rate (# per 1,000 total population, 2021-22) |
|---|---|---|---|---|---|---|---|---|---|
| Bayside (NSW) | 10 | 260 | 813 | 12 | 14 | 21 | 27 | 25 | 22 |
| Bega Valley | 36 | 134 | 155 | 16 | 10 | 19 | 22 | 53 | 57 |
| Bellingen | 33 | 881 | 1,659 | 25 | 60 | 18 | 45 | 48 | 87 |
| Berrigan | 29 | 200 | 223 | 180 | 189 | 15 | 35 | 66 | 115 |
| Blacktown | 35 | 182 | 166 | 6 | 6 | 19 | 19 | 29 | 38 |
| Bland | 42 | 800 | 3,150 | 15 | 28 | 15 | 30 | 4 | 11 |
| Blayney | 47 | - | - | - | - | - | - | - | - |
| Blue Mountains | 22 | 401 | 375 | 20 | 18 | 40 | 56 | 56 | 67 |
| Bogan | 83 | 411 | 442 | 21 | 18 | 49 | 71 | 20 | 21 |
| Bourke | 290 | 788 | 436 | 58 | 52 | 123 | 172 | 500 | 597 |
| Brewarrina | 134 | 3,013 | 613 | 189 | 88 | 137 | 235 | 118 | 109 |
| Broken Hill | 82 | 44 | 49 | 8 | 8 | 39 | 45 | 110 | 144 |
| Burwood | 10 | 122 | 66 | 33 | 4 | 21 | 8 | 38 | 12 |
| Byron | 20 | 302 | 233 | 32 | 34 | 16 | 14 | 37 | 32 |
| Cabonne | 27 | 4 | 1 | 1 | 0 | 0 | - | 0 | - |
| Camden | 28 | 44 | 31 | 4 | 4 | 10 | 9 | 6 | 4 |
| Campbelltown (NSW) | 49 | 112 | 223 | 7 | 7 | 45 | 45 | 151 | 165 |
| Canada Bay | 8 | 12 | 32 | 0 | 0 | 3 | 2 | 1 | 1 |
| Canterbury-Bankstown | 19 | 261 | 212 | 7 | 5 | 35 | 38 | 60 | 69 |
| Carrathool | 24 | - | - | - | - | - | - | - | - |
| Central Coast (NSW) | 36 | 217 | 242 | 14 | 17 | 23 | 36 | 42 | 74 |
| Central Darling | 144 | 290 | 265 | 13 | 9 | 8 | 14 | 6 | 9 |
| Cessnock | 52 | 230 | 137 | 26 | 33 | 20 | 17 | 32 | 28 |
| Clarence Valley | 53 | 115 | 155 | 12 | 9 | 10 | 11 | 27 | 19 |
| Cobar | 67 | 315 | 265 | 14 | 19 | 81 | 62 | 145 | 114 |
| Coffs Harbour | 43 | 275 | 265 | 9 | 23 | 18 | 24 | 36 | 50 |
| Coolamon | 32 | - | - | - | - | - | - | - | - |
| Coonamble | 175 | 158 | 18 | 9 | 6 | 87 | 98 | 89 | 132 |
| Cootamundra-Gundagai Regional | 48 | 315 | 277 | 115 | 131 | 26 | 21 | 50 | 44 |

| LGA | Concern report rate (# per 1,000 total population) | Group client rate (# per 1,000 total population, 2020-21) | Group client rate (# per 1,000 total population, 2021-22) | Group session rate (# per 1,000 total population, 2020-21) | Group session rate (# per 1,000 total population, 2021-22) | Individual client rate (# per 1,000 total population, 2020-21) | Individual client rate (# per 1,000 total population, 2021-22) | Individual session rate (# per 1,000 total population, 2020-21) | Individual session rate (# per 1,000 total population, 2021-22) |
|---|---|---|---|---|---|---|---|---|---|
| Cowra | 54 | 1,773 | 1,554 | 72 | 60 | 94 | 84 | 81 | 118 |
| Cumberland | 20 | 98 | 77 | 11 | 14 | 30 | 38 | 27 | 34 |
| Dubbo Regional | 65 | 198 | 183 | 14 | 14 | 26 | 27 | 56 | 77 |
| Dungog | 22 | 79 | 72 | 7 | 14 | 57 | 37 | 141 | 80 |
| Edward River | 51 | 833 | 522 | 406 | 496 | 19 | 17 | 104 | 67 |
| Eurobodalla | 42 | 101 | 95 | 9 | 6 | 16 | 11 | 26 | 21 |
| Fairfield | 20 | 498 | 364 | 11 | 8 | 69 | 87 | 81 | 117 |
| Federation | 29 | 183 | 66 | 78 | 58 | 19 | 27 | 82 | 120 |
| Forbes | 70 | 10 | 8 | 6 | 6 | 22 | 22 | 45 | 59 |
| Georges River | 14 | 103 | 191 | 9 | 9 | 16 | 15 | 27 | 22 |
| Gilgandra | 70 | 659 | 225 | 53 | 37 | 36 | 78 | 18 | 62 |
| Glen Innes Severn | 59 | 830 | 516 | 26 | 50 | 51 | 72 | 123 | 218 |
| Goulburn Mulwaree | 53 | 16 | 67 | 5 | 7 | 17 | 28 | 44 | 60 |
| Greater Hume Shire | 33 | - | 2 | - | 0 | 5 | 5 | 12 | 6 |
| Griffith | 47 | 49 | 115 | 3 | 5 | 9 | 18 | 48 | 64 |
| Gunnedah | 61 | 15 | 110 | 1 | 30 | 55 | 106 | 59 | 168 |
| Gwydir | 39 | 1 | 138 | 1 | 5 | 65 | 99 | 39 | 66 |
| Hawkesbury | 31 | 355 | 491 | 13 | 14 | 33 | 53 | 28 | 42 |
| Hay | 60 | 369 | 398 | 275 | 262 | 79 | 96 | 184 | 172 |
| Hilltops | 49 | 538 | 392 | 18 | 19 | 35 | 38 | 72 | 82 |
| Hornsby | 11 | 4 | 0 | 0 | 0 | 3 | 4 | 5 | 7 |
| Hunters Hill | 7 | - | 6 | - | 1 | - | 6 | - | 5 |
| Inner West | 12 | 62 | 116 | 5 | 3 | 54 | 43 | 96 | 65 |
| Inverell | 71 | 0 | 6 | 0 | 0 | 27 | 28 | 33 | 38 |
| Junee | 49 | 308 | 673 | 4 | 18 | 25 | 10 | 28 | 10 |
| Kempsey | 74 | 195 | 193 | 7 | 9 | 30 | 39 | 53 | 69 |
| Kiama | 13 | 148 | 51 | 3 | 3 | 0 | 1 | 1 | 3 |
| Ku-ring-gai | 11 | 3 | 1 | 0 | 0 | 0 | 0 | 0 | 0 |
| Kyogle | 34 | 1,506 | 1,464 | 32 | 54 | 46 | 28 | 27 | 27 |
| Lachlan | 70 | 196 | 63 | 17 | 8 | 85 | 70 | 271 | 209 |
| Lake Macquarie | 39 | 196 | 325 | 12 | 16 | 18 | 27 | 33 | 59 |
| Lane Cove | 7 | 50 | 40 | 4 | 3 | 3 | 2 | 6 | 2 |

| LGA | Concern report rate (# per 1,000 total population) | Group client rate (# per 1,000 total population, 2020-21) | Group client rate (# per 1,000 total population, 2021-22) | Group session rate (# per 1,000 total population, 2020-21) | Group session rate (# per 1,000 total population, 2021-22) | Individual client rate (# per 1,000 total population, 2020-21) | Individual client rate (# per 1,000 total population, 2021-22) | Individual session rate (# per 1,000 total population, 2020-21) | Individual session rate (# per 1,000 total population, 2021-22) |
|---|---|---|---|---|---|---|---|---|---|
| Leeton | 67 | 11 | 2 | 0 | 0 | 6 | 12 | 14 | 13 |
| Lismore | 57 | 315 | 487 | 9 | 7 | 37 | 72 | 57 | 185 |
| Lithgow | 49 | 457 | 508 | 28 | 22 | 39 | 50 | 58 | 87 |
| Liverpool | 28 | 147 | 127 | 7 | 4 | 27 | 30 | 41 | 42 |
| Liverpool Plains | 46 | 9 | 1 | 6 | 1 | 8 | 4 | 11 | 3 |
| Lockhart | 34 | - | - | - | - | 6 | - | 24 | - |
| Maitland | 59 | 58 | 63 | 6 | 9 | 16 | 16 | 34 | 39 |
| Mid-Coast | 47 | 89 | 159 | 4 | 9 | 26 | 32 | 41 | 43 |
| Mid-Western Regional | 47 | 27 | 28 | 11 | 13 | 28 | 33 | 40 | 51 |
| Moree Plains | 100 | 84 | 76 | 18 | 4 | 77 | 69 | 130 | 115 |
| Mosman | 7 | - | - | - | - | - | - | - | - |
| Murray River | 18 | 0 | 4 | 0 | 0 | 3 | 6 | 20 | 18 |
| Murrumbidgee | 55 | - | - | - | - | 8 | 36 | 127 | 182 |
| Muswellbrook | 86 | 2,087 | 2,463 | 27 | 25 | 65 | 52 | 342 | 288 |
| Nambucca Valley | 49 | 53 | 44 | 26 | 16 | 27 | 13 | 47 | 32 |
| Narrabri | 60 | 102 | 138 | 7 | 8 | 29 | 49 | 64 | 63 |
| Narrandera | 61 | 11 | 13 | 7 | 4 | 28 | 42 | 209 | 195 |
| Narromine | 85 | 42 | 48 | 7 | 4 | 25 | 37 | 64 | 85 |
| Newcastle | 32 | 74 | 85 | 6 | 5 | 16 | 23 | 44 | 64 |
| North Sydney | 9 | 13 | 15 | 0 | 2 | 3 | 5 | 2 | 24 |
| Northern Beaches | 11 | 72 | 54 | 5 | 3 | 4 | 4 | 11 | 10 |
| Oberon | 19 | 90 | 103 | 22 | 33 | 23 | 27 | 43 | 39 |
| Orange | 63 | 137 | 201 | 14 | 14 | 19 | 32 | 27 | 29 |
| Parkes | 65 | 113 | 221 | 9 | 10 | 30 | 36 | 26 | 21 |
| Parramatta | 13 | 149 | 136 | 6 | 8 | 12 | 17 | 22 | 27 |
| Penrith | 41 | 185 | 163 | 7 | 7 | 21 | 18 | 20 | 18 |
| Port Macquarie-Hastings | 34 | 41 | 95 | 2 | 3 | 22 | 46 | 20 | 30 |
| Port Stephens | 44 | 109 | 146 | 17 | 9 | 21 | 25 | 118 | 109 |

| LGA | Concern report rate (# per 1,000 total population) | Group client rate (# per 1,000 total population, 2020-21) | Group client rate (# per 1,000 total population, 2021-22) | Group session rate (# per 1,000 total population, 2020-21) | Group session rate (# per 1,000 total population, 2021-22) | Individual client rate (# per 1,000 total population, 2020-21) | Individual client rate (# per 1,000 total population, 2021-22) | Individual session rate (# per 1,000 total population, 2020-21) | Individual session rate (# per 1,000 total population, 2021-22) |
|---|---|---|---|---|---|---|---|---|---|
| Queanbeyan-Palerang Regional | 9 | 32 | 80 | 8 | 12 | 21 | 32 | 29 | 33 |
| Randwick | 15 | 36 | 112 | 3 | 3 | 19 | 16 | 10 | 10 |
| Richmond Valley | 67 | 993 | 2,021 | 21 | 18 | 30 | 34 | 61 | 53 |
| Ryde | 10 | 75 | 75 | 4 | 3 | 25 | 25 | 93 | 100 |
| Shellharbour | 42 | 167 | 101 | 58 | 9 | 38 | 30 | 90 | 53 |
| Shoalhaven | 33 | 113 | 145 | 9 | 12 | 22 | 31 | 65 | 89 |
| Singleton | 41 | 84 | 1,250 | 3 | 12 | 21 | 36 | 53 | 69 |
| Snowy Monaro Regional | 33 | 181 | 105 | 10 | 12 | 26 | 51 | 43 | 57 |
| Snowy Valleys | 39 | 33 | 66 | 9 | 10 | 18 | 27 | 42 | 40 |
| Strathfield | 9 | - | - | - | - | 11 | 8 | 4 | 2 |
| Sutherland Shire | 14 | 82 | 67 | 4 | 4 | 12 | 12 | 30 | 28 |
| Sydney | 9 | 193 | 363 | 5 | 9 | 20 | 27 | 58 | 85 |
| Tamworth Regional | 67 | 73 | 92 | 8 | 3 | 21 | 23 | 37 | 38 |
| Temora | 49 | 664 | 652 | 69 | 181 | 105 | 85 | 322 | 345 |
| Tenterfield | 49 | 615 | 872 | 65 | 337 | 28 | 60 | 455 | 763 |
| The Hills Shire | 12 | 16 | 24 | 0 | 1 | 5 | 5 | 3 | 1 |
| Tweed | 28 | 68 | 168 | 4 | 8 | 29 | 30 | 30 | 30 |
| Upper Hunter Shire | 33 | 70 | 150 | 5 | 11 | 23 | 20 | 52 | 30 |
| Upper Lachlan Shire | 18 | 650 | 142 | 10 | 9 | 8 | 4 | 5 | 4 |
| Uralla | 32 | 102 | 485 | 3 | 37 | 17 | 30 | 6 | 22 |
| Wagga Wagga | 63 | 26 | 9 | 7 | 1 | 13 | 9 | 38 | 26 |
| Walcha | 45 | 13 | 541 | 3 | 25 | 10 | 15 | 5 | 19 |
| Walgett | 128 | 794 | 470 | 28 | 25 | 85 | 72 | 30 | 31 |
| Warren | 83 | 211 | 793 | 4 | 19 | 33 | 79 | 71 | 132 |
| Warrumbungle Shire | 54 | 416 | 399 | 31 | 27 | 65 | 123 | 92 | 130 |
| Waverley | 7 | 1 | 6 | 1 | 2 | 7 | 3 | 15 | 8 |

| LGA | Concern report rate (# per 1,000 total population) | Group client rate (# per 1,000 total population, 2020-21) | Group client rate (# per 1,000 total population, 2021-22) | Group session rate (# per 1,000 total population, 2020-21) | Group session rate (# per 1,000 total population, 2021-22) | Individual client rate (# per 1,000 total population, 2020-21) | Individual client rate (# per 1,000 total population, 2021-22) | Individual session rate (# per 1,000 total population, 2020-21) | Individual session rate (# per 1,000 total population, 2021-22) |
|---|---|---|---|---|---|---|---|---|---|
| Weddin | 24 | - | 4 | - | 1 | - | - | - | - |
| Wentworth | 44 | 40 | 89 | 1 | 21 | 9 | 12 | 22 | 33 |
| Willoughby | 7 | 25 | 41 | 1 | 1 | 7 | 8 | 15 | 12 |
| Wingecarribee | 20 | 157 | 76 | 41 | 11 | 20 | 20 | 91 | 68 |
| Wollondilly | 22 | 213 | 150 | 103 | 22 | 43 | 50 | 122 | 134 |
| Wollongong | 31 | 231 | 234 | 11 | 8 | 24 | 28 | 43 | 41 |
| Woollahra | 10 | - | - | - | - | 1 | 1 | 0 | 0 |
| Yass Valley | 24 | - | 11 | - | 1 | 2 | 3 | 3 | 4 |

Table K.98 – Figure H.37 – Funding rate vs concern report rate, 2020-21 (Funding data and DEX)

| LGA | Funding rate ($ per total population) |
|---|---|
| Albury | $21 |
| Armidale Regional | $16 |
| Ballina | $19 |
| Balranald | $0 |
| Bathurst Regional | $20 |
| Bayside (NSW) | $12 |
| Bega Valley | $21 |
| Bellingen | $52 |
| Berrigan | $14 |
| Blacktown | $19 |
| Bland | $24 |
| Blayney | - |
| Blue Mountains | $63 |
| Bogan | $44 |
| Bourke | $220 |
| Brewarrina | $319 |
| Broken Hill | $33 |
| Burwood | $18 |
| Byron | $19 |
| Cabonne | $3 |
| Camden | $11 |
| Campbelltown (NSW) | $26 |

| LGA | Funding rate ($ per total population) |
|---|---|
| Canada Bay | $8 |
| Canterbury-Bankstown | $20 |
| Carrathool | $22 |
| Central Coast (NSW) | $22 |
| Central Darling | $218 |
| Cessnock | $19 |
| Clarence Valley | $21 |
| Cobar | $5 |
| Coffs Harbour | $22 |
| Coolamon | $17 |
| Coonamble | $131 |
| Cootamundra-Gundagai Regional | $38 |
| Cowra | $38 |
| Cumberland | $18 |
| Dubbo Regional | $21 |
| Dungog | $55 |
| Edward River | $14 |
| Eurobodalla | $16 |
| Fairfield | $28 |
| Federation | $11 |
| Forbes | $3 |
| Georges River | $17 |
| Gilgandra | $44 |
| Glen Innes Severn | $37 |
| Goulburn Mulwaree | $13 |
| Greater Hume Shire | $1 |
| Griffith | $12 |
| Gunnedah | $34 |
| Gwydir | $31 |
| Hawkesbury | $39 |
| Hay | $49 |
| Hilltops | $23 |
| Hornsby | $5 |
| Hunters Hill | $20 |
| Inner West | $17 |
| Inverell | $31 |
| Junee | $29 |
| Kempsey | $44 |
| Kiama | $30 |
| Ku-ring-gai | $3 |
| Kyogle | $54 |
| Lachlan | $116 |

| LGA | Funding rate ($ per total population) |
|---|---|
| Lake Macquarie | $18 |
| Lane Cove | $10 |
| Leeton | $11 |
| Lismore | $35 |
| Lithgow | $28 |
| Liverpool | $18 |
| Liverpool Plains | $5 |
| Lockhart | $23 |
| Maitland | $14 |
| Mid-Coast | $24 |
| Mid-Western Regional | $13 |
| Moree Plains | $116 |
| Mosman | $6 |
| Murray River | $4 |
| Murrumbidgee | $679 |
| Muswellbrook | $60 |
| Nambucca Valley | $20 |
| Narrabri | $48 |
| Narrandera | $39 |
| Narromine | $33 |
| Newcastle | $22 |
| North Sydney | $6 |
| Northern Beaches | $7 |
| Oberon | $39 |
| Orange | $12 |
| Parkes | $39 |
| Parramatta | $14 |
| Penrith | $24 |
| Port Macquarie-Hastings | $11 |
| Port Stephens | $17 |
| Queanbeyan-Palerang Regional | $12 |
| Randwick | $13 |
| Richmond Valley | $51 |
| Ryde | $10 |
| Shellharbour | $23 |
| Shoalhaven | $21 |
| Singleton | $31 |
| Snowy Monaro Regional | $19 |
| Snowy Valleys | $13 |
| Strathfield | $21 |
| Sutherland Shire | $11 |
| Sydney | $19 |

| LGA | Funding rate ($ per total population) |
|---|---|
| Tamworth Regional | $11 |
| Temora | $34 |
| Tenterfield | $56 |
| The Hills Shire | $10 |
| Tweed | $15 |
| Upper Hunter Shire | $46 |
| Upper Lachlan Shire | $29 |
| Uralla | $28 |
| Wagga Wagga | $20 |
| Walcha | $45 |
| Walgett | $46 |
| Warren | $49 |
| Warrumbungle Shire | $30 |
| Waverley | $6 |
| Weddin | $25 |
| Wentworth | $43 |
| Willoughby | $5 |
| Wingecarribee | $19 |
| Wollondilly | $46 |
| Wollongong | $25 |
| Woollahra | $9 |
| Yass Valley | $11 |

Table K.99 – Figure H.38 – Comparison of pre-TEI funding levels by LGA (x-axis) to TEI funding rates in 2020-21 and 2021-22 (Funding data) OMITTED

| LGA | Funding rate, pre-TEI ($ per total population) | 2020-21 | 2021-22 |
|---|---|---|---|
| Albury | $21 | $21 | $20 |
| Armidale Regional | $22 | $16 | $17 |
| Ballina | $19 | $19 | $19 |
| Balranald | $1 | $0 | - |
| Bathurst Regional | $19 | $20 | $19 |
| Bayside (NSW) | $13 | $12 | $12 |
| Bega Valley | $21 | $21 | $21 |
| Bellingen | $65 | $52 | $70 |
| Berrigan | $23 | $14 | $15 |
| Blacktown | $21 | $19 | $19 |
| Bland | $24 | $24 | $24 |
| Blayney | - | - | - |
| Blue Mountains | $65 | $63 | $64 |

| LGA | Funding rate, pre-TEI ($ per total population) | 2020-21 | 2021-22 |
|---|---|---|---|
| Bogan | $43 | $44 | $43 |
| Bourke | $213 | $220 | $217 |
| Brewarrina | $316 | $319 | $312 |
| Broken Hill | $28 | $33 | $27 |
| Burwood | $16 | $18 | $18 |
| Byron | $15 | $19 | $20 |
| Cabonne | $3 | $3 | $2 |
| Camden | $12 | $11 | $11 |
| Campbelltown (NSW) | $23 | $26 | $29 |
| Canada Bay | $6 | $8 | $8 |
| Canterbury-Bankstown | $23 | $20 | $21 |
| Carrathool | $18 | $22 | $23 |
| Central Coast (NSW) | $22 | $22 | $22 |
| Central Darling | $203 | $218 | $197 |
| Cessnock | $18 | $19 | $22 |
| Clarence Valley | $21 | $21 | $25 |
| Cobar | $5 | $5 | $4 |
| Coffs Harbour | $21 | $22 | $23 |
| Coolamon | $3 | $17 | $11 |
| Coonamble | $124 | $131 | $129 |
| Cootamundra-Gundagai Regional | $32 | $38 | $38 |
| Cowra | $37 | $38 | $38 |
| Cumberland | $18 | $18 | $18 |
| Dubbo Regional | $24 | $21 | $24 |
| Dungog | $50 | $55 | $62 |
| Edward River | $46 | $14 | $15 |
| Eurobodalla | $16 | $16 | $16 |
| Fairfield | $31 | $28 | $28 |
| Federation | $11 | $11 | $12 |
| Forbes | $3 | $3 | $3 |
| Georges River | $15 | $17 | $17 |
| Gilgandra | $48 | $44 | $47 |
| Glen Innes Severn | $36 | $37 | $36 |
| Goulburn Mulwaree | $13 | $13 | $13 |
| Greater Hume Shire | $4 | $1 | $1 |
| Griffith | $12 | $12 | $11 |
| Gunnedah | $41 | $34 | $39 |
| Gwydir | $31 | $31 | $30 |
| Hawkesbury | $39 | $39 | $40 |
| Hay | $60 | $49 | $50 |
| Hilltops | $23 | $23 | $23 |

| LGA | Funding rate, pre-TEI ($ per total population) | 2020-21 | 2021-22 |
|---|---|---|---|
| Hornsby | $4 | $5 | $4 |
| Hunters Hill | $24 | $20 | $20 |
| Inner West | $20 | $17 | $17 |
| Inverell | $29 | $31 | $30 |
| Junee | $26 | $29 | $25 |
| Kempsey | $43 | $44 | $44 |
| Kiama | $22 | $30 | $29 |
| Ku-ring-gai | $3 | $3 | $3 |
| Kyogle | $57 | $54 | $68 |
| Lachlan | $113 | $116 | $115 |
| Lake Macquarie | $18 | $18 | $18 |
| Lane Cove | $11 | $10 | $10 |
| Leeton | $11 | $11 | $11 |
| Lismore | $33 | $35 | $33 |
| Lithgow | $27 | $28 | $27 |
| Liverpool | $20 | $18 | $18 |
| Liverpool Plains | $5 | $5 | $9 |
| Lockhart | $13 | $23 | $15 |
| Maitland | $15 | $14 | $16 |
| Mid-Coast | $23 | $24 | $24 |
| Mid-Western Regional | $15 | $13 | $14 |
| Moree Plains | $114 | $116 | $112 |
| Mosman | $7 | $6 | $6 |
| Murray River | $2 | $4 | $5 |
| Murrumbidgee | $22 | - | - |
| Muswellbrook | $61 | $60 | $64 |
| Nambucca Valley | $36 | $20 | $29 |
| Narrabri | $47 | $48 | $47 |
| Narrandera | $25 | $39 | $40 |
| Narromine | $34 | $33 | $32 |
| Newcastle | $22 | $22 | $22 |
| North Sydney | $6 | $6 | $6 |
| Northern Beaches | $7 | $7 | $7 |
| Oberon | $39 | $39 | $39 |
| Orange | $12 | $12 | $11 |
| Parkes | $38 | $39 | $38 |
| Parramatta | $14 | $14 | $14 |
| Penrith | $23 | $24 | $24 |
| Port Macquarie-Hastings | $11 | $11 | $11 |
| Port Stephens | $17 | $17 | $19 |
| Queanbeyan-Palerang Regional | $12 | $12 | $11 |

| LGA | Funding rate, pre-TEI ($ per total population) | 2020-21 | 2021-22 |
|---|---|---|---|
| Randwick | $15 | $13 | $13 |
| Richmond Valley | $52 | $51 | $52 |
| Ryde | $11 | $10 | $10 |
| Shellharbour | $17 | $23 | $22 |
| Shoalhaven | $27 | $21 | $23 |
| Singleton | $29 | $31 | $31 |
| Snowy Monaro Regional | $18 | $19 | $18 |
| Snowy Valleys | $13 | $13 | $13 |
| Strathfield | $10 | $21 | $21 |
| Sutherland Shire | $10 | $11 | $11 |
| Sydney | $20 | $19 | $18 |
| Tamworth Regional | $11 | $11 | $11 |
| Temora | $33 | $34 | $34 |
| Tenterfield | $72 | $56 | $53 |
| The Hills Shire | $9 | $10 | $10 |
| Tweed | $15 | $15 | $16 |
| Upper Hunter Shire | $43 | $46 | $47 |
| Upper Lachlan Shire | $30 | $29 | $29 |
| Uralla | $24 | $28 | $18 |
| Wagga Wagga | $25 | $20 | $20 |
| Walcha | $44 | $45 | $58 |
| Walgett | $46 | $46 | $45 |
| Warren | $56 | $49 | $55 |
| Warrumbungle Shire | $28 | $30 | $29 |
| Waverley | $6 | $6 | $5 |
| Weddin | $24 | $25 | $25 |
| Wentworth | $42 | $43 | $40 |
| Willoughby | $5 | $5 | $4 |
| Wingecarribee | $20 | $19 | $22 |
| Wollondilly | $40 | $46 | $49 |
| Wollongong | $25 | $25 | $25 |
| Woollahra | $8 | $9 | $8 |
| Yass Valley | $11 | $11 | $21 |

Table K.100 – Figure H.39 – Safety outcomes over time by LGA funding group (Funding data and HSDS)

Concern report

| Quarter ending | Low | Medium | High |
|---|---|---|---|
| Sep-18 | 0.94 | 0.94 | 0.95 |
| Dec-18 | 0.96 | 0.95 | 0.96 |
| Mar-19 | 0.96 | 0.98 | 0.98 |
| Jun-19 | 1.00 | 0.99 | 1.00 |

| Quarter ending | Low | Medium | High |
|---|---|---|---|
| Sep-19 | 1.07 | 1.07 | 1.04 |
| Dec-19 | 1.03 | 1.04 | 1.03 |
| Mar-20 | 1.03 | 1.01 | 1.03 |
| Jun-20 | 1.01 | 1.03 | 1.01 |
| Sep-20 | 1.19 | 1.17 | 1.18 |
| Dec-20 | 1.13 | 1.14 | 1.16 |
| Mar-21 | 1.12 | 1.13 | 1.10 |
| Jun-21 | 1.20 | 1.19 | 1.16 |
| Sep-21 | 0.95 | 0.92 | 0.96 |
| Dec-21 | 1.06 | 1.04 | 1.04 |
| Mar-22 | 1.01 | 0.98 | 0.96 |
| Jun-22 | 1.04 | 1.01 | 1.00 |

ROSH

| Quarter ending | Low | Medium | High |
|---|---|---|---|
| Sep-18 | 0.94 | 0.92 | 0.94 |
| Dec-18 | 0.93 | 0.92 | 0.93 |
| Mar-19 | 0.95 | 0.98 | 0.95 |
| Jun-19 | 1.00 | 0.99 | 1.01 |
| Sep-19 | 1.09 | 1.08 | 1.07 |
| Dec-19 | 1.04 | 1.05 | 1.04 |
| Mar-20 | 1.02 | 1.00 | 1.03 |
| Jun-20 | 1.03 | 1.05 | 1.03 |
| Sep-20 | 1.22 | 1.23 | 1.25 |
| Dec-20 | 1.18 | 1.21 | 1.22 |
| Mar-21 | 1.17 | 1.19 | 1.16 |
| Jun-21 | 1.21 | 1.19 | 1.17 |
| Sep-21 | 0.96 | 0.88 | 0.97 |
| Dec-21 | 1.12 | 1.04 | 1.09 |
| Mar-22 | 1.05 | 0.99 | 1.00 |
| Jun-22 | 1.07 | 1.01 | 1.02 |

SARA

| Quarter ending | Low | Medium | High |
|---|---|---|---|
| Sep-18 | 0.89 | 0.79 | 0.77 |
| Dec-18 | 0.90 | 0.86 | 0.92 |
| Mar-19 | 0.91 | 0.97 | 0.98 |
| Jun-19 | 0.92 | 0.95 | 0.99 |
| Sep-19 | 1.07 | 1.06 | 1.05 |
| Dec-19 | 1.03 | 1.04 | 0.94 |
| Mar-20 | 1.15 | 1.13 | 1.10 |
| Jun-20 | 1.14 | 1.19 | 1.24 |
| Sep-20 | 1.07 | 1.27 | 1.26 |
| Dec-20 | 1.03 | 1.09 | 1.24 |
| Mar-21 | 1.13 | 1.16 | 1.23 |
| Jun-21 | 1.03 | 1.14 | 1.08 |

| Quarter ending | Low | Medium | High |
|---|---|---|---|
| Sep-21 | 0.91 | 0.87 | 0.98 |
| Dec-21 | 1.03 | 0.99 | 0.90 |
| Mar-22 | 0.93 | 1.01 | 0.91 |
| Jun-22 | 0.83 | 0.95 | 0.78 |

Out of home care

| Quarter ending | Low | Medium | High |
|---|---|---|---|
| Sep-18 | 1.04 | 1.04 | 1.05 |
| Dec-18 | 1.03 | 1.03 | 1.02 |
| Mar-19 | 1.02 | 1.01 | 1.01 |
| Jun-19 | 1.01 | 1.01 | 1.00 |
| Sep-19 | 1.00 | 1.00 | 1.00 |
| Dec-19 | 0.99 | 0.99 | 0.99 |
| Mar-20 | 0.97 | 0.98 | 0.98 |
| Jun-20 | 0.95 | 0.95 | 0.95 |
| Sep-20 | 0.95 | 0.95 | 0.95 |
| Dec-20 | 0.95 | 0.95 | 0.95 |
| Mar-21 | 0.94 | 0.94 | 0.94 |
| Jun-21 | 0.93 | 0.93 | 0.94 |
| Sep-21 | 0.92 | 0.91 | 0.93 |
| Dec-21 | 0.91 | 0.90 | 0.92 |
| Mar-22 | 0.89 | 0.88 | 0.90 |
| Jun-22 | 0.88 | 0.87 | 0.87 |

Table K.101 – Figure H.40 – Safety outcomes over time by LGA change in funding group (Funding data and HSDS)

Concern report

| Quarter ending | Large decrease | Small change | Large increase |
|---|---|---|---|
| Sep-18 | 0.93 | 0.94 | 0.95 |
| Dec-18 | 0.95 | 0.95 | 0.97 |
| Mar-19 | 1.00 | 0.97 | 0.97 |
| Jun-19 | 1.00 | 1.00 | 0.96 |
| Sep-19 | 1.06 | 1.07 | 1.04 |
| Dec-19 | 1.04 | 1.03 | 1.06 |
| Mar-20 | 1.00 | 1.02 | 1.00 |
| Jun-20 | 1.04 | 1.01 | 1.05 |
| Sep-20 | 1.15 | 1.18 | 1.20 |
| Dec-20 | 1.15 | 1.13 | 1.15 |
| Mar-21 | 1.12 | 1.12 | 1.11 |
| Jun-21 | 1.21 | 1.18 | 1.22 |
| Sep-21 | 0.95 | 0.94 | 0.91 |
| Dec-21 | 1.01 | 1.06 | 1.03 |
| Mar-22 | 0.99 | 0.99 | 0.97 |
| Jun-22 | 1.03 | 1.02 | 0.98 |

ROSH

| Quarter ending | Large decrease | Small change | Large increase |
|---|---|---|---|
| Sep-18 | 0.92 | 0.93 | 0.93 |
| Dec-18 | 0.92 | 0.93 | 0.93 |
| Mar-19 | 0.97 | 0.97 | 0.97 |
| Jun-19 | 1.01 | 1.00 | 0.95 |
| Sep-19 | 1.06 | 1.09 | 1.05 |
| Dec-19 | 1.04 | 1.04 | 1.07 |
| Mar-20 | 1.01 | 1.01 | 1.02 |
| Jun-20 | 1.07 | 1.03 | 1.07 |
| Sep-20 | 1.21 | 1.23 | 1.29 |
| Dec-20 | 1.23 | 1.20 | 1.22 |
| Mar-21 | 1.21 | 1.17 | 1.18 |
| Jun-21 | 1.23 | 1.18 | 1.21 |
| Sep-21 | 0.94 | 0.92 | 0.84 |
| Dec-21 | 1.05 | 1.08 | 1.01 |
| Mar-22 | 1.03 | 1.00 | 0.96 |
| Jun-22 | 1.06 | 1.03 | 0.96 |

SARA

| Quarter ending | Large decrease | Small change | Large increase |
|---|---|---|---|
| Sep-18 | 0.89 | 0.88 | 1.05 |
| Dec-18 | 0.92 | 0.88 | 1.00 |
| Mar-19 | 0.99 | 0.97 | 0.97 |
| Jun-19 | 0.94 | 0.96 | 0.96 |
| Sep-19 | 1.03 | 1.06 | 1.04 |
| Dec-19 | 0.98 | 1.01 | 0.94 |
| Mar-20 | 1.07 | 1.09 | 1.00 |
| Jun-20 | 1.18 | 1.14 | 1.04 |
| Sep-20 | 1.20 | 1.15 | 1.21 |
| Dec-20 | 1.09 | 1.04 | 0.96 |
| Mar-21 | 1.05 | 1.09 | 1.09 |
| Jun-21 | 1.03 | 1.05 | 1.05 |
| Sep-21 | 0.91 | 0.88 | 0.84 |
| Dec-21 | 0.90 | 0.96 | 1.00 |
| Mar-22 | 0.88 | 0.94 | 1.02 |
| Jun-22 | 0.87 | 0.90 | 0.95 |

Out of home care

| Quarter ending | Large decrease | Small change | Large increase |
|---|---|---|---|
| Sep-18 | 1.03 | 1.04 | 1.05 |
| Dec-18 | 1.02 | 1.03 | 1.03 |
| Mar-19 | 1.00 | 1.01 | 1.01 |
| Jun-19 | 1.00 | 1.01 | 1.00 |
| Sep-19 | 1.00 | 1.00 | 0.99 |
| Dec-19 | 1.01 | 0.99 | 0.98 |
| Mar-20 | 0.99 | 0.98 | 0.98 |

| Quarter ending | Large decrease | Small change | Large increase |
|---|---|---|---|
| Jun-20 | 0.95 | 0.95 | 0.97 |
| Sep-20 | 0.96 | 0.95 | 0.97 |
| Dec-20 | 0.95 | 0.94 | 1.00 |
| Mar-21 | 0.94 | 0.93 | 0.99 |
| Jun-21 | 0.93 | 0.93 | 0.97 |
| Sep-21 | 0.90 | 0.91 | 0.95 |
| Dec-21 | 0.89 | 0.90 | 0.93 |
| Mar-22 | 0.86 | 0.89 | 0.89 |
| Jun-22 | 0.84 | 0.88 | 0.86 |

Table K.102 – Figure H.41 – Actual versus expected by TEI funding rate for safety outcome LGA level models (Funding data and HSDS)

Concern reports

| Average Funding Rate | Actual | Predicted |
|---|---|---|
| 19 | 2.47 | 3.12 |
| 37 | 5.59 | 4.78 |
| 56 | 7.98 | 6.99 |
| 74 | 11.45 | 10.54 |
| 93 | 13.85 | 15.77 |
| 111 | 16.04 | 19.04 |
| 130 | 18.72 | 20.58 |
| 148 | 23.88 | 21.75 |
| 167 | 26.87 | 23.09 |
| 204 | 27.63 | 27.42 |
| 241 | 37.81 | 31.74 |
| 296 | 34.22 | 38.65 |
| 370 | 62.50 | 53.89 |

ROSH

| Average Funding Rate | Actual | Predicted |
|---|---|---|
| 13 | 1.91 | 2.05 |
| 27 | 4.18 | 3.69 |
| 42 | 6.33 | 6.22 |
| 56 | 8.72 | 9.11 |
| 70 | 11.21 | 10.66 |
| 84 | 12.31 | 12.28 |
| 98 | 15.45 | 15.02 |
| 113 | 18.67 | 17.71 |
| 141 | 20.62 | 21.19 |
| 184 | 29.15 | 25.74 |
| 212 | 26.78 | 31.95 |
| 283 | 48.08 | 47.75 |

SARA

| Average Funding Rate | Actual | Predicted |
|---|---|---|
| 5 | 0.60 | 0.69 |
| 11.4 | 1.86 | 1.54 |
| 17.7 | 2.85 | 3.07 |
| 24.1 | 3.75 | 4.14 |
| 30.4 | 4.37 | 4.54 |
| 36.8 | 6.69 | 4.92 |
| 43.1 | 5.16 | 5.63 |
| 55.8 | 6.26 | 6.78 |
| 62.1 | 12.37 | 7.43 |
| 68.5 | 7.40 | 8.77 |
| 74.8 | 10.33 | 9.68 |
| 125.6 | 21.66 | 22.24 |

Out of home care

| Average Funding Rate | Actual | Predicted |
|---|---|---|
| 3.3 | 0.34 | 0.47 |
| 8.7 | 0.95 | 0.79 |
| 14 | 1.52 | 1.42 |
| 19.3 | 2.21 | 2.30 |
| 24.6 | 2.77 | 2.81 |
| 30 | 3.29 | 3.23 |
| 35.3 | 4.00 | 3.68 |
| 40.6 | 4.13 | 4.20 |
| 45.9 | 5.46 | 5.08 |
| 51.3 | 6.93 | 5.55 |
| 56.6 | 5.27 | 6.46 |
| 67.2 | 8.11 | 8.12 |
| 104.5 | 9.80 | 9.14 |

Table K.103 – Figure H.42 – Concern report rate by last SCORE result in the previous quarter (HSDS)

| SCORE type | SCORE domain | SCORE = 1 | SCORE = 2 | SCORE = 3 | SCORE = 4 | SCORE = 5 |
|---|---|---|---|---|---|---|
| Circumstances | Personal (ρ = -0.18) | 29% | 26% | 19% | 12% | 9% |
| Circumstances | Family (ρ = -0.18) | 29% | 23% | 17% | 12% | 8% |
| Circumstances | Mental (ρ = -0.17) | 27% | 20% | 16% | 10% | 7% |
| Circumstances | Training (ρ = -0.15) | 23% | 19% | 15% | 10% | 7% |
| Goals | Confidence (ρ = -0.12) | 20% | 20% | 13% | 10% | 9% |
| Goals | Behaviours (ρ = -0.11) | 19% | 18% | 12% | 9% | 8% |
| Goals | Skills (ρ = -0.11) | 16% | 16% | 10% | 8% | 6% |
| Goals | Impact (ρ = -0.11) | 31% | 21% | 17% | 15% | 14% |

Table K.104 – Figure H.43 – ROSH rate by last SCORE result in the previous quarter (HSDS)

| SCORE type | SCORE domain | SCORE = 1 | SCORE = 2 | SCORE = 3 | SCORE = 4 | SCORE = 5 |
|---|---|---|---|---|---|---|
| Circumstances | Personal (ρ = -0.17) | 24% | 20% | 14% | 9% | 7% |
| Circumstances | Family (ρ = -0.16) | 22% | 18% | 12% | 9% | 5% |
| Circumstances | Mental (ρ = -0.16) | 21% | 15% | 13% | 7% | 5% |
| Circumstances | Training (ρ = -0.13) | 19% | 14% | 11% | 8% | 5% |
| Goals | Impact (ρ = -0.11) | 26% | 16% | 13% | 11% | 10% |
| Goals | Confidence (ρ = -0.1) | 16% | 15% | 9% | 7% | 7% |
| Goals | Behaviours (ρ = -0.1) | 15% | 13% | 10% | 7% | 6% |
| Goals | Skills (ρ = -0.1) | 12% | 12% | 7% | 6% | 5% |

Table K.105 – Figure H.44 – Rate of being victim of domestic violence by last SCORE result in the previous quarter (HSDS)

| SCORE type | SCORE domain | SCORE = 1 | SCORE = 2 | SCORE = 3 | SCORE = 4 | SCORE = 5 |
|---|---|---|---|---|---|---|
| Circumstances | Personal (ρ = -0.1) | 11% | 11% | 6% | 5% | 4% |
| Circumstances | Family (ρ = -0.09) | 9% | 8% | 6% | 4% | 3% |
| Circumstances | Training (ρ = -0.08) | 7% | 8% | 6% | 4% | 2% |
| Circumstances | Mental (ρ = -0.08) | 10% | 7% | 6% | 4% | 3% |
| Goals | Impact (ρ = -0.07) | 12% | 8% | 6% | 6% | 5% |
| Goals | Confidence (ρ = -0.07) | 7% | 8% | 6% | 4% | 3% |
| Goals | Behaviours (ρ = -0.06) | 7% | 7% | 5% | 3% | 4% |
| Goals | Skills (ρ = -0.05) | 5% | 6% | 5% | 4% | 3% |

Table K.106 – Figure H.45 – Rate of being at risk of homelessness by last SCORE result in the previous quarter (HSDS)

| SCORE type | SCORE domain | SCORE = 1 | SCORE = 2 | SCORE = 3 | SCORE = 4 | SCORE = 5 |
|---|---|---|---|---|---|---|
| Circumstances | Housing (ρ = -0.12) | 15% | 16% | 9% | 8% | 5% |
| Circumstances | Mental (ρ = -0.08) | 8% | 9% | 6% | 5% | 3% |
| Circumstances | Personal (ρ = -0.08) | 9% | 10% | 7% | 6% | 4% |
| Circumstances | Employment (ρ = -0.08) | 10% | 11% | 8% | 6% | 5% |
| Goals | Skills (ρ = -0.05) | 5% | 7% | 4% | 4% | 3% |
| Goals | Confidence (ρ = -0.05) | 6% | 8% | 5% | 5% | 4% |
| Goals | Behaviours (ρ = -0.04) | 4% | 7% | 5% | 4% | 3% |
| Goals | Impact (ρ = -0.04) | 7% | 8% | 7% | 6% | 5% |

Table K.107 – Figure H.46 – Relationship between SCORE result and client outcome by who the assessment was completed for (HSDS)

| Metric | SCORE type | Completed by | SCORE = 1 | SCORE = 2 | SCORE = 3 | SCORE = 4 | SCORE = 5 |
|---|---|---|---|---|---|---|---|
| Concern report | Circumstances | Parent | 25% | 22% | 16% | 11% | 8% |
| Concern report | Circumstances | Child | 29% | 22% | 17% | 11% | 7% |
| Concern report | Goals | Parent | 21% | 19% | 13% | 10% | 9% |
| Concern report | Goals | Child | 20% | 18% | 12% | 9% | 8% |
| ROSH | Circumstances | Parent | 19% | 16% | 12% | 8% | 6% |

| Metric | SCORE type | Completed by | SCORE = 1 | SCORE = 2 | SCORE = 3 | SCORE = 4 | SCORE = 5 |
|---|---|---|---|---|---|---|---|
| ROSH | Circumstances | Child | 24% | 17% | 13% | 8% | 5% |
| ROSH | Goals | Parent | 16% | 14% | 9% | 8% | 7% |
| ROSH | Goals | Child | 16% | 14% | 9% | 7% | 6% |

Table K.108 – Figure H.47 – Relationship between SCORE result and client outcome by DCJ district (HSDS)

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| Mid North Coast | 26% | 33% | 19% |
| New England | 20% | 28% | 14% |
| Northern NSW | 12% | 19% | 9% |
| Far West | 24% | 22% | 25% |
| Murrumbidgee | 24% | 35% | 14% |
| Western NSW | 25% | 31% | 20% |
| Central Coast | 14% | 18% | 12% |
| Hunter | 22% | 29% | 17% |
| Nepean Blue Mountains | 10% | 20% | 7% |
| Western Sydney | 7% | 13% | 5% |
| Northern Sydney | 6% | 13% | 4% |
| South Eastern Sydney | 11% | 19% | 8% |
| Sydney | 9% | 17% | 6% |
| South Western Sydney | 12% | 19% | 9% |
| Illawarra Shoalhaven | 18% | 25% | 15% |
| Southern NSW | 15% | 29% | 9% |

Table K.109 – Figure H.48 – Volume of clients included in concern report and ROSH models by SCORE domain (HSDS)

Concern report

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| Mid North Coast | 26% | 33% | 19% |
| New England | 20% | 28% | 14% |
| Northern NSW | 12% | 19% | 9% |
| Far West | 24% | 22% | 25% |
| Murrumbidgee | 24% | 35% | 14% |
| Western NSW | 25% | 31% | 20% |
| Central Coast | 14% | 18% | 12% |
| Hunter | 22% | 29% | 17% |
| Nepean Blue Mountains | 10% | 20% | 7% |
| Western Sydney | 7% | 13% | 5% |
| Northern Sydney | 6% | 13% | 4% |

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| South Eastern Sydney | 11% | 19% | 8% |
| Sydney | 9% | 17% | 6% |
| South Western Sydney | 12% | 19% | 9% |
| Illawarra Shoalhaven | 18% | 25% | 15% |
| Southern NSW | 15% | 29% | 9% |

ROSH

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| Mid North Coast | 22% | 28% | 16% |
| New England | 15% | 21% | 10% |
| Northern NSW | 6% | 10% | 4% |
| Far West | 20% | 17% | 21% |
| Murrumbidgee | 19% | 26% | 11% |
| Western NSW | 22% | 28% | 17% |
| Central Coast | 11% | 13% | 9% |
| Hunter | 17% | 23% | 13% |
| Nepean Blue Mountains | 9% | 17% | 6% |
| Western Sydney | 5% | 8% | 4% |
| Northern Sydney | 4% | 9% | 3% |
| South Eastern Sydney | 9% | 15% | 6% |
| Sydney | 7% | 13% | 5% |
| South Western Sydney | 9% | 15% | 7% |
| Illawarra Shoalhaven | 11% | 16% | 9% |
| Southern NSW | 11% | 18% | 7% |

Victim of domestic violence

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| Mid North Coast | 7% | 9% | 6% |
| New England | 7% | 11% | 5% |
| Northern NSW | 3% | 5% | 2% |
| Far West | 12% | 11% | 13% |
| Murrumbidgee | 11% | 15% | 7% |
| Western NSW | 11% | 13% | 10% |
| Central Coast | 5% | 7% | 4% |
| Hunter | 7% | 9% | 5% |
| Nepean Blue Mountains | 5% | 8% | 4% |
| Western Sydney | 5% | 8% | 3% |

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| Northern Sydney | 3% | 6% | 2% |
| South Eastern Sydney | 3% | 4% | 3% |
| Sydney | 4% | 6% | 3% |
| South Western Sydney | 3% | 4% | 3% |
| Illawarra Shoalhaven | 7% | 10% | 5% |
| Southern NSW | 7% | 13% | 4% |

At risk of homelessness

| District | Overall rate | Rate for people with SCORE 1 or 2 | Rate for people with SCORE 4 or 5 |
|---|---|---|---|
| Mid North Coast | 9% | 12% | 7% |
| New England | 10% | 13% | 8% |
| Northern NSW | 9% | 12% | 8% |
| Far West | 8% | 14% | 6% |
| Murrumbidgee | 8% | 9% | 7% |
| Western NSW | 9% | 12% | 6% |
| Central Coast | 4% | 7% | 2% |
| Hunter | 5% | 7% | 4% |
| Nepean Blue Mountains | 5% | 10% | 3% |
| Western Sydney | 4% | 6% | 3% |
| Northern Sydney | 4% | 8% | 3% |
| South Eastern Sydney | 8% | 9% | 8% |
| Sydney | 5% | 7% | 5% |
| South Western Sydney | 4% | 6% | 3% |
| Illawarra Shoalhaven | 9% | 13% | 8% |
| Southern NSW | 8% | 16% | 3% |

Table K.110 – Figure H.49 – Volume of clients included in victim of domestic violence and at risk of homelessness models by SCORE domain (HSDS)

| SCORE domain | Count |
|---|---|
| Confidence | 5,365 |
| Family | 5,864 |
| Impact | 2,732 |
| Mental | 5,271 |
| Personal | 3,996 |

Table K.111 – Figure H.50 – Satisfaction SCORE for “I am better able to deal with issues that I sought help with” by service type (DEX, all years)*

| Model | SCORE domain | Count |
|---|---|---|
| DV model only | Confidence | 4382 |
| DV model only | Family | 5470 |

| Model | SCORE domain | Count |
|---|---|---|
| Both models | Impact | 2702 |
| Both models | Mental | 4297 |
| Both models | Personal | 3373 |
| Homelessness model only | Housing | 1761 |
| Homelessness model only | Skills | 5235 |

Table K.112 – Figure H.51 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district for outcome domain "I am better able to deal with issues that I sought help with" (DEX, all years)

| Service Type | Average SCORE | Number of clients assessed |
|---|---|---|
| Advocacy/Support | 4.0 | 4,520 |
| Counselling | 4.3 | 2,108 |
| Education and Skills Training | 4.4 | 9,343 |
| Facilitate Employment Pathways | 4.3 | 639 |
| Family Capacity Building | 4.2 | 11,667 |
| Indigenous Advocacy/Support | 2.6 | 335 |
| Indigenous community engagement | 4.5 | 51 |
| Indigenous social participation | 4.5 | 360 |
| Indigenous supported playgroups | 4.7 | 141 |
| Information/Advice/Referral | 4.3 | 11,899 |
| Intake/assessment | 4.0 | 5,466 |
| Material aid | 4.5 | 1,813 |
| Mentoring/Peer Support | 4.3 | 1,149 |
| Parenting Programs | 4.4 | 4,943 |
| Social participation | 4.4 | 9,107 |
| Specialist Support | 4.2 | 419 |
| Supported playgroups | 4.2 | 6,556 |

Table K.113 – Figure H.52 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district for outcome domain "I am satisfied with the services I have received" (DEX, all years)

| Provider District | Average Satisfaction SCORE | Percentage of clients with Satisfaction SCOREs |
|---|---|---|
| Mid North Coast | 4.3 | 14% |
| New England | 4.4 | 15% |
| Northern NSW | 4.5 | 18% |
| Far West | 4.3 | 16% |
| Murrumbidgee | 4.2 | 12% |
| Western NSW | 4.4 | 17% |
| Central Coast | 4.3 | 19% |
| Hunter | 4.0 | 19% |
| Nepean Blue Mountains | 4.5 | 10% |

| Provider District | Average Satisfaction SCORE | Percentage of clients with Satisfaction SCOREs |
|---|---|---|
| Western Sydney | 3.9 | 21% |
| Northern Sydney | 4.5 | 21% |
| South Eastern Sydney | 4.7 | 25% |
| Sydney | 4.4 | 17% |
| South Western Sydney | 4.3 | 21% |
| Illawarra Shoalhaven | 4.5 | 25% |
| Southern NSW | 4.5 | 24% |

Table K.114 – Figure H.53 – Average satisfaction SCORE and percentage of clients with a SCORE across all three domains by district for outcome domain "The service listened to me and understood my issues" (DEX, all years)

| Provider District | Average Satisfaction SCORE | Percentage of clients with Satisfaction SCOREs |
|---|---|---|
| Mid North Coast | 4.5 | 16% |
| New England | 4.7 | 20% |
| Northern NSW | 4.7 | 21% |
| Far West | 4.3 | 23% |
| Murrumbidgee | 4.6 | 14% |
| Western NSW | 4.6 | 27% |
| Central Coast | 4.5 | 23% |
| Hunter | 4.4 | 20% |
| Nepean Blue Mountains | 4.6 | 16% |
| Western Sydney | 4.1 | 32% |
| Northern Sydney | 4.8 | 21% |
| South Eastern Sydney | 4.8 | 31% |
| Sydney | 4.7 | 24% |
| South Western Sydney | 4.4 | 30% |
| Illawarra Shoalhaven | 4.7 | 30% |
| Southern NSW | 4.7 | 27% |

Table K.115 – Figure H.54 – Average satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district for outcome domain "I am better able to deal with issues that I sought help with" (DEX, all years)

| Provider District | Average Satisfaction SCORE | Percentage of clients with Satisfaction SCOREs |
|---|---|---|
| Mid North Coast | 4.6 | 15% |
| New England | 4.7 | 19% |
| Northern NSW | 4.7 | 21% |
| Far West | 4.5 | 13% |

| Provider District | Average Satisfaction SCORE | Percentage of clients with Satisfaction SCOREs |
|---|---|---|
| Murrumbidgee | 4.6 | 11% |
| Western NSW | 4.5 | 18% |
| Central Coast | 4.5 | 19% |
| Hunter | 4.4 | 19% |
| Nepean Blue Mountains | 4.6 | 12% |
| Western Sydney | 4.2 | 19% |
| Northern Sydney | 4.8 | 21% |
| South Eastern Sydney | 4.8 | 26% |
| Sydney | 4.5 | 21% |
| South Western Sydney | 4.4 | 22% |
| Illawarra Shoalhaven | 4.7 | 26% |
| Southern NSW | 4.7 | 22% |

Table K.116 – Figure H.55 – Average satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district for outcome domain “I am satisfied with the services I have received” (DEX, all years)

| Provider District | Aboriginal clients | Non-Aboriginal clients |
|---|---|---|
| Mid North Coast | 4.3 | 4.3 |
| New England | 4.4 | 4.5 |
| Northern NSW | 4.4 | 4.5 |
| Far West | 4.2 | 4.3 |
| Murrumbidgee | 4.2 | 4.3 |
| Western NSW | 4.4 | 4.4 |
| Central Coast | 4.3 | 4.4 |
| Hunter | 3.8 | 4.1 |
| Nepean Blue Mountains | 4.4 | 4.5 |
| Western Sydney | 4.0 | 3.9 |
| Northern Sydney | 4.2 | 4.5 |
| South Eastern Sydney | 4.6 | 4.7 |
| Sydney | 3.9 | 4.5 |
| South Western Sydney | 4.3 | 4.3 |
| Illawarra Shoalhaven | 4.5 | 4.5 |
| Southern NSW | 3.9 | 4.5 |

Table K.117 – Figure H.56 – Average satisfaction SCORE for Aboriginal clients and non-Aboriginal clients by district for outcome domain “The service listened to me and understood my issues” (DEX, all years)

| Provider District | Aboriginal clients | Non-Aboriginal clients |
|---|---|---|
| Mid North Coast | 4.5 | 4.6 |
| New England | 4.8 | 4.7 |
| Northern NSW | 4.7 | 4.7 |
| Far West | 4.2 | 4.5 |
| Murrumbidgee | 4.6 | 4.7 |
| Western NSW | 4.6 | 4.6 |
| Central Coast | 4.5 | 4.5 |
| Hunter | 4.2 | 4.4 |
| Nepean Blue Mountains | 4.6 | 4.6 |
| Western Sydney | 4.3 | 4.0 |
| Northern Sydney | 4.9 | 4.8 |
| South Eastern Sydney | 4.7 | 4.8 |
| Sydney | 4.2 | 4.7 |
| South Western Sydney | 4.5 | 4.4 |
| Illawarra Shoalhaven | 4.7 | 4.7 |
| Southern NSW | 4.4 | 4.7 |

## K.10 Appendix I

Table K.118 – Figure I.1 – Aboriginal people’s share of TEI clients compared to their share of the general population (Age 0-44) (DEX, 2022-23)

| District | TEI clients | All population |
|---|---|---|
| Sydney | 10% | 1% |
| Western Sydney | 8% | 2% |
| South Eastern Sydney | 7% | 2% |
| Northern Sydney | 5% | 1% |
| Central Coast | 23% | 9% |
| South Western Sydney | 7% | 3% |
| Illawarra Shoalhaven | 19% | 7% |
| Hunter | 23% | 10% |
| Nepean Blue Mountains | 16% | 8% |
| Southern NSW | 15% | 7% |
| Northern NSW | 24% | 10% |
| Mid North Coast | 40% | 14% |

| District | TEI clients | All population |
|---|---|---|
| New England | 39% | 19% |
| Murrumbidgee | 23% | 9% |
| Western NSW | 49% | 20% |
| Far West | 68% | 19% |

Table K.119 – Figure I.2 – Average proportion of enrolled school days in the 1 year prior to entering TEI not attended for Aboriginal and non-Aboriginal TEI clients compared to the general population (HSDS)

| | Aboriginal TEI clients | Non-aboriginal TEI clients |
|---|---|---|
| TEI | 11.7% | 7.7% |
| General population | 6.4% | 6.3% |

Table K.120 – Figure I.3 – Proportion of Aboriginal TEI population and general population achieving the NAPLAN minimum standard by NAPLAN exam year last sat (HSDS)

| NAPLAN exam year | GEN population | TEI All |
|---|---|---|
| 3 | 95.1% | 79.9% |
| 5 | 93.5% | 70.8% |
| 7 | 91.6% | 61.8% |
| 9 | 91.6% | 61.1% |

Table K.121 – Figure I.4 – Average count of 9 domains utilised prior to TEI entry for Aboriginal TEI individual clients and the general population (HSDS)

| | in quarter of entry | within 1 year prior to entry | ever prior to entry |
|---|---|---|---|
| Aboriginal TEI population | 0.77 | 1.20 | 2.70 |
| General population | 0.08 | 0.15 | 0.52 |

Table K.122 – Figure I.5 – Relativity of client complexity compared to the general population, for Aboriginal TEI individual clients and non-Aboriginal Individual TEI clients (HSDS)

| Period of service use | Aboriginal TEI population | Non-Aboriginal TEI population |
|---|---|---|
| in quarter of entry | 9.3419 | 4.0700 |
| within 1 year prior to entry | 7.9751 | 3.5381 |
| ever prior to entry | 5.1919 | 2.4746 |

Table K.123 – Figure I.6 – Outcomes charts for Aboriginal TEI clients (HSDS) (1 of 3)

| Quarters since intervention | % with Child protection concern reports (age < 18) | % with ROSH reports (age < 18) | % with Substantiated ROSH reports (age < 18) | % in OOHC (age < 18) | % with drug and alcohol offence (age ≥ 11) |
|---|---|---|---|---|---|
| -8 | 18.2% | 13.6% | 2.5% | 7.4% | 0.4% |
| -7 | 19.3% | 14.6% | 2.6% | 7.4% | 0.4% |
| -6 | 19.4% | 15.0% | 3.1% | 7.5% | 0.4% |
| -5 | 20.2% | 15.6% | 3.3% | 7.7% | 0.5% |
| -4 | 21.1% | 16.4% | 3.6% | 7.7% | 0.4% |
| -3 | 21.8% | 16.8% | 3.7% | 7.9% | 0.3% |
| -2 | 23.4% | 18.4% | 4.1% | 8.1% | 0.4% |
| -1 | 25.1% | 20.1% | 4.2% | 8.4% | 0.5% |
| 0 | 26.5% | 20.9% | 4.2% | 8.6% | 0.5% |
| 1 | 23.6% | 18.1% | 3.3% | 8.8% | 0.4% |
| 2 | 22.7% | 17.1% | 3.2% | 8.9% | 0.4% |
| 3 | 21.2% | 16.1% | 2.7% | 9.1% | 0.4% |
| 4 | 20.1% | 14.9% | 2.4% | 9.1% | 0.5% |
| 5 | 20.7% | 15.8% | 2.6% | 9.1% | 0.4% |
| 6 | 19.4% | 14.9% | 2.3% | 9.7% | 0.4% |
| 7 | 19.6% | 14.1% | 2.4% | 10.5% | #N/A |

Table K.124 – Figure I.6 – Outcomes charts for Aboriginal TEI clients (HSDS) (2 of 3)

| Quarters since intervention | % with Domestic violence offence (age ≥ 11) | % domestic violence victims | % in Custody (age ≥ 11) | % with court appearances (age ≥ 11) | % with cautions (age ≥ 11) |
|---|---|---|---|---|---|
| -8 | 0.8% | 3.0% | 3.5% | 4.1% | 0.6% |
| -7 | 0.8% | 3.1% | 3.1% | 4.3% | 0.6% |
| -6 | 0.9% | 3.4% | 3.4% | 4.5% | 0.6% |
| -5 | 0.8% | 3.5% | 3.2% | 4.5% | 0.6% |
| -4 | 0.8% | 3.6% | 3.3% | 4.5% | 0.6% |
| -3 | 0.9% | 3.5% | 3.2% | 4.3% | 0.6% |
| -2 | 0.9% | 3.7% | 3.2% | 4.2% | 0.7% |
| -1 | 1.0% | 4.2% | 2.9% | 4.4% | 0.7% |
| 0 | 1.1% | 4.3% | 2.9% | 5.0% | 0.6% |
| 1 | 1.1% | 3.7% | 2.8% | 4.8% | 0.8% |
| 2 | 1.0% | 3.7% | 2.9% | 4.4% | 0.7% |

| Quarters since intervention | % with Domestic violence offence (age ≥ 11) | % domestic violence victims | % in Custody (age ≥ 11) | % with court appearances (age ≥ 11) | % with cautions (age ≥ 11) |
|---|---|---|---|---|---|
| 3 | 1.1% | 3.8% | 3.1% | 4.7% | 0.6% |
| 4 | 1.0% | 3.8% | 3.0% | 4.4% | 0.7% |
| 5 | 1.0% | 3.8% | 2.9% | 4.7% | 0.7% |
| 6 | 0.7% | 3.7% | 2.9% | 4.5% | 0.6% |
| 7 | 0.9% | 4.0% | 2.8% | 4.6% | 0.7% |

Table K.125 – Figure I.6 – Outcomes charts for Aboriginal TEI clients (HSDS) (3 of 3)

| Quarters since interven tion | % with Mental health support | % with drug and alcohol hospital admissio n | % with mental health hospital admissio n | % with drug and alcohol support (age ≥ 15) | % presenti ng to SHS as homeles s | % presenti ng to SHS as homeles s or at risk of homeles sness | % presenti ng to SHS as at risk of homeles sness | % presenti ng to SHS as rough sleeping |
|---|---|---|---|---|---|---|---|---|
| -8 | 2.8% | 0.2% | 0.5% | 2.2% | 3.4% | 6.7% | 4.1% | 0.3% |
| -7 | 3.0% | 0.3% | 0.4% | 2.2% | 3.4% | 6.4% | 3.8% | 0.3% |
| -6 | 3.1% | 0.2% | 0.5% | 2.2% | 3.5% | 6.5% | 3.8% | 0.3% |
| -5 | 3.2% | 0.3% | 0.5% | 2.2% | 3.3% | 6.5% | 4.0% | 0.3% |
| -4 | 3.2% | 0.3% | 0.4% | 2.2% | 3.5% | 6.8% | 4.1% | 0.3% |
| -3 | 3.4% | 0.3% | 0.5% | 2.2% | 3.7% | 7.0% | 4.1% | 0.3% |
| -2 | 3.5% | 0.3% | 0.6% | 2.3% | 4.0% | 7.3% | 4.1% | 0.3% |
| -1 | 3.8% | 0.3% | 0.6% | 2.4% | 4.3% | 7.9% | 4.7% | 0.3% |
| 0 | 4.2% | 0.3% | 0.6% | 2.5% | 5.5% | 9.9% | 5.8% | 0.5% |
| 1 | 3.8% | 0.3% | 0.6% | 2.5% | 4.7% | 8.9% | 5.3% | 0.4% |
| 2 | 3.5% | 0.3% | 0.5% | 2.5% | 4.0% | 8.0% | 4.8% | 0.3% |
| 3 | 3.3% | 0.2% | 0.4% | 2.5% | 3.7% | 7.3% | 4.4% | 0.2% |
| 4 | 3.2% | 0.3% | 0.4% | 2.5% | 3.7% | 7.2% | 4.3% | 0.2% |
| 5 | 3.2% | 0.3% | 0.4% | 2.5% | 3.6% | 7.2% | 4.3% | 0.3% |
| 6 | 3.0% | #N/A | 0.4% | 2.7% | 3.4% | 6.8% | 4.1% | 0.2% |
| 7 | 3.2% | #N/A | 0.5% | 2.5% | 3.5% | 6.8% | 3.9% | #N/A |