Queensland Government

evolve
THERAPEUTIC SERVICES

working together, maximising potential

Evolve Therapeutic Services (ETS) Performance Review

March 2015

Thanks and acknowledgement is given to the following contributors:

- Janet Martin, Acting Director, Clinical Governance, Office of the Chief Psychiatrist, Mental Health Alcohol and Other Drugs Branch.
- Judi Krause, Divisional Director, Child and Youth Mental Health Service (CYMHS) Children's Health Queensland Hospital and Health Service (CHQ HSS).
- Judith Piccone, Program Manager - Specialist Teams, Child and Youth Mental Health Service (CYMHS), Children's Health Queensland Hospital and Health Service (CHQ HHS).
- Warren Bergh, State-wide Program Manager, Evolve Therapeutic Services, Child and Youth Mental Health Service (CYMHS), Children's Health Queensland Hospital and Health Service (CHQ HHS).
- Kathy Eadie, State-wide Senior Service Evaluation and Research Coordinator, Evolve Therapeutic Services, Child and Youth Mental Health Service (CYMHS), Children's Health Queensland Hospital and Health Service (CHQ HHS).
- Information and Performance Unit, Mental Health Alcohol and Other Drugs Branch.

Table of Contents

List of Tables

1.0 Executive Summary

Background and Purpose

The *Protecting Children: An Inquiry Into Abuse of Children in Foster Care* report (2004) indicated that children/young people (C/YP) in out-of-home care needed therapeutic services. This led to the development of the Evolve Interagency Services (Evolve) program. Evolve aims to enhance the mental health, behaviour support and participation in education for C/YP in the care of the Department of Communities, Child Safety and Disability Services (DCCSDS) through a collaborative interdepartmental response by DCCSDS, Queensland Health (QH) and the Department of Education and Training. The QH component of the collaborative, Evolve Therapeutic Services (ETS) sits within a continuum of service delivery by Child and Youth Mental Health Services (CYMHS) provided by Hospital and Health Services and works within the overarching interagency model to provide specialist intensive trauma informed mental health interventions for C/YP in out-of-home care with severe and complex mental health support needs.

There are ten multi-disciplinary, multi-specialist integrated ETS CYMHS teams over 17 sites under 14 Local Service Agreements with a 2014-2015 financial year budget allocation of just over $19.3 million to fund up to 134 full time equivalent staff. To obtain consistent positive outcomes over multiple sites, consistency in eligibility criteria, processes, and services offered is critical. ETS has met this challenge of maintaining program integrity across the state while being flexible to local/regional needs through a number of factors and co-ordination by the state-wide ETS Program Manager and Senior Service Evaluation and Research Coordinator.

ETS is a specialised mental health model of service involving intensive work using outreach and systemic interventions with a range of services and stakeholders including the C/YP. The program and model of service takes into account the acuity and severity of presenting issues resulting from exposure to trauma. Consequently there is a strong focus on direct clinical therapeutic work and capacity building provided by highly qualified and experienced staff.

The Queensland Child Protection Commission of Inquiry report *Taking Responsibility: A Roadmap for Queensland Child Protection* (2013) stated “the Commission is impressed by the reported outcomes of the Evolve programs, especially in terms of placement stability, and considers that if the interventions were available earlier as proposed, then more children might be able to be kept at home, returned home, or kept in more stable out-of-home care” (p.241). Recommendation 7.8 stated that “the DCCSDS negotiate with QH and other partner agencies to develop a service model for earlier intervention specialist services for children in the statutory child protection system, including those still at home. This may require the expansion of the Evolve program or the development of other services to meet their needs, or a combination of both approaches” (p.242). Consequently, DCCSDS requested this ETS Performance Review Report in order to inform negotiations regarding the development of earlier intervention specialist services.

Due to the tight timeframes for the completion of this report, only a snapshot of findings from 2012 and 2013 ETS Annual Outcome Reports were able to be included. Brief information from the 2009, 2010 and 2011 ETS Annual Outcome Reports has also been included to illustrate changes in relation to the demographics of C/YP accepted to the ETS program over time.

ETS Outcomes, Activity Data and Economic Returns

In 2009, seven ETS teams were operational with a caseload of 283 C/YP. The program's caseload increased significantly to 595 in 2013 with all ten teams (with an additional position being hosted in Mt Isa) operational. C/YP seen by ETS are on average 9.5 years of age, male (60%), and a third are of Aboriginal and/or Torres Strait Islander descent.

Service duration average is consistent with the Evolve Interagency Services manual recommendation of 18 months and the majority of C/YP exit ETS due to achievement of Evolve

Plan goals. Half of all C/YP seen in 2013 had a primary diagnosis, at admission, of Reactive Attachment Disorder, Post Traumatic Stress Disorder, or Behaviour and Emotional Disorder.

The ETS program objectives are measured by a range of Key Performance Indicators. Statistically significant improvements have been found from pre to post treatment on measures of overall functioning and wellbeing, engagement in educational activities, and relationships with carers, peers and the larger community. The majority of C/YP were involved in the development of their care plan but less than half were actively involved in the stakeholder process perhaps due to either being too young to participate or unable to manage the setting. Carer wellbeing measures have provided mixed outcomes possibly because different response rates and different collection processes over the years make comparisons difficult. There has been a reduction in placement changes from pre to post treatment and measures of stakeholder collaboration and communication have been rated highly by carers and clinicians alike.

ETS staff have provided training to over 8000 carers, government and non-government stakeholders, and key partner agency staff.

The average number of hours of clinical intervention provided per week per C/YP was 4.25 which includes direct contact with the C/YP, stakeholder meetings and face to face / phone contact with stakeholders or carers. This equates to 25.5 hours of clinical intervention per clinician per week out of a standard 38 hour working week. These hours however do not include travel time (for intensive support provided during home/school visits and stakeholder meetings), session and meeting preparation, documentation, staff meetings, case review and professional development.

Past benefit-cost analyses modelling has indicated that the Net Present Value of Evolve (which represents benefits minus the costs of the program) can be estimated at around $360,238 per C/YP, with benefits being realised over the duration of a decade. It further indicated a positive reduction in average C/YP related costs when a C/YP is open to the Evolve Program and receiving a provision of service at a conservative saving of $47,000 per annum per C/YP.

Conclusion

The findings in this report illustrate the complexity of the ETS model of service delivery with multiple interventions occurring simultaneously and reinforcing one another to achieve positive outcomes. Individual therapeutic work with the child, psycho-education for the carer, dyadic work involving the child and carer together, and work with the broader system of ‘stakeholders’ are all important characteristics of the ETS model. All of these components can contribute to successful outcomes.

Overall, the findings detail a wide range of converging evidence demonstrating that ETS continues to provide an effective treatment program for C/YP in out-of-home care with severe and complex mental health needs. The evidence of positive changes being achieved in both C/YP’s well-being and functioning and other important mediating variables (such as carer well-being, placement stability and stakeholder communication) across the course of treatment provides strong support of the ETS program across all Key Performance Indicators.

6 March 2015

2.0 Purpose

In June 2013, the Queensland Child Protection Commission of Inquiry report *Taking Responsibility: A Roadmap for Queensland Child Protection* was released. Section 7.8 of the report, 'Planning for the education and health needs of children in out-of-home care', stated that "the Commission is impressed by the reported outcomes of the Evolve programs, especially in terms of placement stability, and considers that if the interventions were available earlier as proposed, then more children might be able to be kept at home, returned home, or kept in more stable out-of-home care" (p.241). The Commission defined earlier in terms of:

- the severity of the emotional and behavioural problems experienced by the child or young person
- the age at which the child or young person can access the specialist services
- the stage in the statutory process that the child or young person has reached.

The Commission however noted that the Evolve program has been providing services to an increasingly younger client group and at an earlier stage of the child protection intervention as it has developed.

Recommendation 7.8 of the Taking Responsibility report was that "the Department of Communities, Child Safety and Disability Services (DCCSDS) negotiate with Queensland Health and other partner agencies to develop a service model for earlier intervention specialist services for children in the statutory child protection system, including those still at home. This may require the expansion of the Evolve program or the development of other services to meet their needs, or a combination of both approaches" (p.242).

To inform the negotiations regarding the development of earlier intervention specialist services, DCCSDS requested an evaluation of the Evolve Therapeutic Services program (ETS). The ETS program has produced annual outcomes reports since 2009. Therefore, this Evolve Therapeutic Services Performance Review is primarily informed by the ETS Annual Outcomes Reports.

3.0 Background & Current Context

In January 2004, the Crime and Misconduct Commission (CMC) released a report *Protecting Children: An Inquiry Into Abuse of Children in Foster Care*. The report stated that there was a clear unmet need for therapeutic services for children in care, including treatment services and therapeutic placements. The CMC considered that it would be necessary for government to look at existing skill bases in the government sector that could provide therapeutic care, rather than from private providers, and that Queensland Health would be one obvious contributor.

Recommendation 7.5 of the CMC report stated 'that more therapeutic treatment programs are made available for children with severe psychological and behavioural problems. Successful programs should be identified, implemented and evaluated' (p. 194) which led to the development of the Evolve Interagency Services (Evolve) program.

The aim of the Evolve Program is to enhance the mental health, behaviour support and participation in education for C/YP in the care of the DCCSDS through a collaborative interdepartmental response by DCCSDS, Queensland Health and the Department of Education and Training (DET). The Queensland Health component of the collaborative, ETS, works within the overarching interagency model to provide mental health therapeutic interventions for children and young people (C/YP) in the target population.

ETS sits within a continuum of service delivery by Child and Youth Mental Health Services (CYMHS) provided by Hospital and Health Services across Queensland which includes acute and sub-acute inpatient services, day programs, consultation-liaison psychiatry, and a range of

specialist (e.g. infant mental health, forensic, early psychosis, children of parents with a mental illness, Ed-LinQ) positions, teams and state-wide services.

In addition, there are a range of general health services provided by Queensland Health which contribute to the mental health service system available to C/YP in out-of-home care. These include School Based Youth Health Nurses, Child Development Services, and Child Health Services (e.g. Triple P Parenting programs). There are also a range of services provided outside of the public health system which contribute to the mental health service system available to children and young people in care. These include Headspace, private practitioners, and mental health guidance officers recently employed within the DET regional offices.

4.0 Service Delivery Model

ETS provides specialist intensive trauma informed mental health interventions for C/YP in out-of-home care with severe and complex mental health support needs. The key focus of ETS is to provide planned and coordinated specialist multidisciplinary mental health assessment and targeted intervention aimed at improving emotional wellbeing and participation in school and community. In addition to direct (individual and systemic) specialist mental health service provision, ETS teams provide psycho-education and skill development to foster/kinship carers, residential care providers, government, non-government and private sector service providers with the aim of strengthening the service system available to meet the multiple and varied mental health needs of children known to the child protection system.

Referrals to ETS can only be made by DCCSDS (Child Safety Services) submitted through a local Evolve Panel. All referrals are assessed against three compulsory criteria:

- the child/young person is under 18 years of age
- the child/young person presents with severe and complex psychological and/or behavioural problems
- the child/young person is in out-of-home care and subject to an interim or finalised Child Protection Order granting custody or guardianship to the Chief Executive of DCCSDS.

ETS teams cover almost the entire state of Queensland. Currently there are ten multi-disciplinary, multi-specialist integrated child and youth mental health teams (with an additional position being hosted in Mt Isa) over 17 sites under 14 Local Service Agreements negotiated between seven DCCSDS (Child Safety Services) and 14 Hospital and Health Services. The 2014-2015 financial year budget allocation was $19,387,235. The entire program was funded to employ up to 134 full-time-equivalent (FTE). Current service agreements expire 30th June, 2015.

5.0 Mental Health Treatment for Children and Young People in Care

Mental health needs of C/YP in out-of-home care can be very different from the needs of C/YP in the general population (Tarren-Sweeney, 2008a; Bellamy et al, 2010; DeJong, 2010), with experts stressing the need for highly specialised trauma and attachment-informed, multi-agency approaches (Golding, 2010; Tarren-Sweeney, 2010).

6.0 Trauma-Informed Care and Practice

ETS provides therapeutic interventions with Trauma-Informed Care and Practice (TICP) in mind. TICP is an approach whereby all aspects of services are organised around the recognition and acknowledgement of trauma and its prevalence, alongside awareness and sensitivity to its dynamics. TICP is a strengths-based framework that is responsive to the impact of trauma, emphasising physical, psychological, and emotional safety for both service providers and survivors, and creates opportunities for survivors to rebuild a sense of control and empowerment. It is grounded in and directed by a thorough understanding of the neurological, biological, psychological and social effects of trauma and interpersonal violence and the prevalence of these experiences in persons who receive mental health services (Kezelman, 2011). The key principles of trauma-informed care include safety, trustworthiness, choice, collaboration and empowerment.

There is evidence to support the benefits of trauma-informed care for programs assisting disadvantaged youth (Becker, Greenwald & Mitchell, 2011; Suarez et al, 2014), women with substance misuse (Covington et al, 2008), youth in residential care (Greenwald et al, 2012), Family Drug Court (Powell et al, 2012) and inpatient mental health settings (Muskett, 2014).

7.0 Collaborative Practice

There is general agreement that collaboration between agencies and disciplines is most effective and most appropriate for vulnerable and at-risk children and families. The reason being that these children, youth and families often have multiple and complex problems that cannot be resolved by a single service provider (Bromfield, Lamont, Parker, & Horsfall, 2010; Foster-Fishman, Salem, Allen, & Fahrbach, 2001).

The Golding collaborative practice model supports that the creation of therapeutic networks is best practice for children/young people in child protection (Golding, 2008). Each child is supported by families, communities and professionals, and then other systems (health, school, leisure, legal and child protection) have an impact on the child and in turn the systems are impacted upon by the child.

A combination of interagency collaboration and direct interventions for carers and children are required for mental health services to meet the multifaceted needs of children in care. The Take Two program in Melbourne, Australia's first designated therapeutic service for child protection clients who have suffered trauma and other adverse consequences as a result of serious abuse and neglect, is the most comparable therapeutic service to ETS (Frederico, Jackson & Black, 2005). Take Two have consistently evaluated their program which has produced positive outcomes, in terms of emotional and behavioural symptoms for their consumers (Frederico, Jackson & Black, 2010).

Stakeholder collaboration is a key component of the ETS model. Stakeholder meetings are an opportunity for all the relevant services or parties in a C/YP's life to come together to enhance communication, share information and concerns, identify and manage areas of risk, and collaboratively develop goals to support the C/YP. Stakeholder meetings allow different services to develop stronger relationships with each other and gain a better understanding of each other's roles and responsibilities. They also provide the ETS clinician with an opportunity to share information about a C/YP's mental health difficulties and enhance the group's understanding of the C/YP's needs. Meetings are held regularly to ensure that goals are being worked towards and stakeholders are working together with a shared vision. Stakeholders include Child Safety Services and/or Disability Services as part of the DCCSDS, DET, Foster Care agencies, Youth Justice, foster and kinship carers, residential workers, birth parents, private professionals, and the C/YP.

See Appendix A for a case study outlining the case complexity, trauma-informed intervention and stakeholder collaboration of a 10 year old girl referred to the Evolve Program and receiving treatment from ETS.

8.0 ETS Outcomes

Due to the tight timeframes for the completion of this performance review report, only a snapshot of findings from 2012 and 2013 were able to be included. Findings from the comprehensive 2012 and 2013 ETS Annual Outcome Reports are summarised in the section below including a demographic profile (Table 1), clinical profile (Table 2), Key Performance Indicator outcomes (Table 3), and an overview of the training provided by ETS (Table 4).

Brief information regarding the content of ETS Annual Outcomes Reports from 2009, 2010 and 2011 has been included in the demographic profile to illustrate changes in relation to the program over time.

8.1 Demographic Profile

The number of C/YP opened to ETS per year has increased significantly since the first ETS Annual Outcome Report for 2009 (n=283) where seven teams were operational, to the ETS Annual Outcome Report for 2013 (n=595), where all ten teams (with an additional position being hosted in Mt Isa) were operational across the State. On admission to ETS, with the exception of 2009, the average age of the C/YP was 9.5 years of age. In 2009 the average age was 11.5 years. Across all years, on average, 60% of those cases open to ETS were male and 40% were female. Of all C/YP cases open to ETS, on average a third have been Aboriginal and/or Torres Strait Islander descent, with the exception of 2009 where it was 25%. The demographic profile for 2012 and 2013 is summarised in Table 1.

Table 1: Demographic Profile of ETS Consumers

	2012 Year	2013 Year
Demographic Profile		
Number of C/YP	521	595
Average Age	9.4 years	9.45 years
Gender	60.8% male	57% male
Aboriginal and Torres Strait Islander status	31.7%	34%
Active cases open per month	319	391.5

8.2 Clinical Profile

The clinical profile of C/YP on admission to ETS is summarised in Table 2. The Children's Global Assessment Scale (CGAS)[1], Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA)[2] and the Strengths and Difficulties Questionnaire (SDQ)[3] are part of the suite of

[1] The Children's Global Assessment Scale (CGAS) is a global measure of the level of functioning of children and adolescents. It is considered a useful measure of overall severity of disturbance; has been found to be reliable between raters and across time; and has demonstrated both discriminant and concurrent validity.

[2] The Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) is a clinician-rated measure designed to assess problem severity and clinical outcomes across five domains – behaviours, impairments, symptoms, social functioning and information.

[3] The Strengths and Difficulties Questionnaire (SDQ) is a brief behavioural screening questionnaire about children aged 4-17 years.

National Outcome and Casemix Collection (NOCC) mental health measures which are mandatory for all Queensland mental health services. These measures have good reliability and validity (Rey et al, 1995; Brann, Coleman and Luk, 2001; Bilenberg, 2003; Goodman, 2001; Whyte & Campbell, 2008).

Process Indicators include service duration and reason for case closure. The service duration average was 17.8 months across both 2012 and 2013 which is consistent with the Evolve Interagency Service manual recommendation of 18 months. In 2012, 76% of C/YP exited ETS due to achievement of Evolve Plan goals and 6% due to disengagement by the C/YP, carer or stakeholder. In 2013, the figures were 58% and 7% respectively.

Half of all C/YP seen in 2013 had a primary diagnosis, at admission, of either Reactive Attachment Disorder, Post Traumatic Stress Disorder, or Behaviour and Emotional Disorder. These diagnoses were defined by the International Classification of Diseases, 10th Edition (ICD-10).

Table 2: Clinical Profile of ETS Consumers

	2012 Year	2013 Year
Clinical Profile		
CGAS (consumers in clinical range)	99.3%	98%
CGAS (consumers with moderate to severe impairment)	72.3%	70.9%
HoNOSCA (consumers in clinical range on six subscales)[4]	72.7% - 92.2%	72% - 93%
SDQ Total Problem Index (carer-rated)	--	Mean rating in the high clinical range

8.3 Key Performance Indicator Outcomes

In addition to the ETS process indicators[5], ETS has seven Key Performance Indicators (KPIs) which collectively capture the inter-connected objectives of the program. They are:

KPI 1. Overall wellbeing of the child or young person
KPI 2. The level of the child's or young person's involvement in their care plan
KPI 3. Carer wellbeing
KPI 4. Placement stability
KPI 5. Engagement in educational/vocational activities
KPI 6. Relationships with carers, peers and the larger community; and
KPI 7. Stakeholder communication and collaboration

The following outcomes are based on 2012 and 2013 data. There were statistically significant improvements from pre to post treatment on measures of overall functioning and wellbeing, engagement in educational activities, and relationships with carers, peers and the larger community. The majority of C/YP where involved in the development of their care plan but under half where actively involved in the stakeholder process. Carer wellbeing measures provided mixed outcomes. There was a reduction in placement changes from pre to post treatment. Measures of stakeholder collaboration and communication were rated highly by carers and clinicians alike. Outcomes are summarised in Table 3 below. In reference to the outcomes in the table, statistical significance, which was set at $p<0.05$ level, suggests that the results obtained are not likely to have occurred randomly or because of sampling error.

[4] These were problems with: emotional and related symptoms; family life and relationships; disruptive, anti-social / aggressive behaviour; peer relationships; over-activity, attention or concentration; and scholastic/language skills.

[5] ETS process indictors include an ETS verbal update at the Evolve Panel one month after being open at Panel, comprehensive assessment report tabled at 4 months after being open at Panel, Evolve Plan tabled at 4 months after being open at Panel, 15 month review tabled at Panel, exit summary tabled at Panel.

Table 3: Key Performance Indicator Outcomes for ETS Consumers

	2012 Year	2013 Year
Key Performance Indicator for Outcomes		
KPI 1. Overall wellbeing of the child or young person		
CGAS	Statistically significant improvement pre to post treatment	Statistically significant improvement pre to post treatment
HoNOSCA	Statistically significant improvement pre to post treatment on all KPI-relevant subscales[6]	Statistically significant improvement pre to post treatment on all KPI-relevant subscales[7], except for scale 4[8]
SDQ	Statistically significant improvement pre to post treatment on carer-rated Total Problem Index	Statistically significant improvement pre to post treatment on carer-rated Total Problem Index
KPI 2. Level of C/YP's involvement in their care plan		
Input into treatment plan	86%	92%
Active participation in stakeholder process[9]	41%	42%
KPI 3. Carer wellbeing[10]		
Ability to cope with C/YP difficulties since commencement at ETS	85% reported an improvement	61% reported an improvement
More hopeful about the C/YP future since commencement at ETS	80% were more hopeful	72% were more hopeful
Level of tiredness and strain	54% reported a decrease	36% reported a decrease
Interruptions to carer's life	56% reported a decrease	50% reported a decrease
KPI 4. Placement Stability		
Reduction in placement changes	Decrease in placements pre to post treatment	Statistically significant decrease in placements pre to post treatment
Placement breakdown possibility[10]	74% of carers reported that there had been a decrease	58% of carers reported that there had been a decrease

[6] These subscales include: disruptive, antisocial or aggressive behaviour; problems with overactivity, attention or concentration; accidental self-injury; problems with non-organic somatic symptoms; problems with emotional and related symptoms; problems with self-care and independence.

[7] These subscales include: disruptive, antisocial or aggressive behaviour; problems with overactivity, attention or concentration; accidental self-injury; physical illness or disability problems; problems associated with hallucination, delusion or abnormal perception; problems with non-organic somatic symptoms; problems with emotional and related symptoms; problems with self-care and independence.

[8] No significant change pre to post on the subscale, 'Problems with alcohol, substance or solvent misuse'. However, only 14% of the sample was rated in the clinical range at pre treatment.

[9] Those consumers that were not actively participating in the stakeholder process were reported by clinicians to be either too young to participate or were unable to manage the setting.

[10] It is important to note the survey data across 2012 and 2013 had different response rates and different collection processes. Therefore, comparisons between the two years are unable to be made.

Table 3: Key Performance Indicator Outcomes for ETS Consumers (Continued)

	2012 Year	2013 Year
Key Performance Indicator for Outcomes		
KPI 5. Engagement in educational/vocational activities		
Problems with scholastic and language skills	Statistically significant improvement pre to post treatment	Statistically significant improvement pre to post treatment
Poor school attendance	Statistically significant improvement pre to post treatment	Statistically significant improvement pre to post treatment
KPI 6. Relationships with carers, peers and the larger community		
Problems with family life and relationships	Statistically significant improvement pre to post treatment	Statistically significant improvement pre to post treatment
Problems with peer relationships	Statistically significant improvement pre to post treatment	Statistically significant improvement pre to post treatment
Pro-social behaviours	Improvement pre to post treatment	Improvement pre to post Treatment
KPI 7. Stakeholder communication and collaboration		
Promoted collaboration amongst stakeholders	94% of clinicians agreed 94% of carers agreed	90% of clinicians agreed 91% of carers agreed
Improved stakeholders understanding of the C/YP needs	92% of clinicians agreed 93% of carers agreed	88% of clinicians agreed 80% of carers agreed
Improved communication amongst stakeholders	87% of clinicians agreed 94% of carers agreed	84% of clinicians agreed 89% of carers agreed
Developed appropriate and achievable goals for the C/YP	90% of clinicians agreed 87% of carers agreed	90% of clinicians agreed 87% of carers agreed
Changed the way stakeholders think about the C/YP in a positive way	83% of clinicians agreed 76% of carers agreed	83% of clinicians agreed 67% of carers agreed

Overall, these findings detail a wide range of converging evidence demonstrating that ETS continues to provide an effective treatment program for C/YP in out-of-home care with severe and complex mental health needs. The evidence of positive changes being achieved in both C/YP's well-being and functioning and other important mediating variables (such as carer well-being, placement stability and stakeholder communication) across the course of treatment provides strong support of the ETS program across all Key Performance Indicators.

There are a variety of factors which influence outcomes such as placement stability and engagement in educational activities, such as the capacity of the service system (e.g. availability of and decisions regarding placement options for all C/YP in out-of-home care; availability of education support staff) and court decisions, not within the direct influence of ETS. The positive outcomes for C/YP across these domains during involvement in the ETS program are due to a combination of improvement in the mental wellbeing of the C/YP, improvements in carers' ability to cope and feelings of hopefulness, and improvements in the C/YP's relationships with carers and peers. Stakeholder understanding of the C/YP's needs, communication and collaboration is also a

strong influencer of positive outcomes which is impacted upon by the involvement of all members of the ETS treating team, i.e. clinicians, team leader, professional development coordinators and indigenous program coordinators/multicultural liaison officer.

8.4 Survey Data 2014

Data from the 2014 ETS Annual Outcomes Report was not available at the time of writing this report. However, a snapshot of findings from a recent stakeholder survey is included. A number of questions were asked in relation to the effectiveness of ETS. Themes based on the raw data of two key questions are included in Table 4. The two questions were:

1. What did you like most about ETS?
2. What changes would most improve ETS?

Of the stakeholder survey respondents, 31% were from DCCSDS (Child Safety Services), 22% were from DET, 19% were from Foster Care Support Agencies, and 28% were representatives from the non-government sector and private sector.

There were a number of consistent themes across the carer and stakeholder responses to the question, "What did you like most about ETS?" These include open communication, stakeholder collaboration, provision of support to the C/YP, stakeholder team, and the professionalism of ETS staff. The key themes from the clinician survey include clear processes, stakeholder collaboration, low caseloads to do intensive work, team support and a professional development focus.

In response to the question, "What changes would most improve ETS?", carers and stakeholders both agreed that more flexibility in venue and time for sessions could be useful. Clinicians and stakeholders attending more to the carer's perspective was another identified theme. A number of themes were identified in the stakeholder survey data. These include more funding, Occupational Therapy (OT) and Speech Therapy assessment, briefer stakeholder meetings, more therapy time between clinician and C/YP, and decreased jargon. Some of the responding clinicians identified a need for an early intervention pathway within ETS.

Table 4: Feedback Survey

	Carer	Stakeholder	Clinician
What did you like most about ETS?	• Open communication • Stakeholder collaboration • Support provided to C/YP • Support provided to carer • Psycho-education • Caring approachable staff	• Open communication • Stakeholder collaboration • Support provided to C/YP • Support provided to care team • Professionalism of staff • Transparency	• Clear processes • Stakeholder collaboration • Low caseloads to do intensive work • Team support • Professional development focus
What changes would most improve ETS?	• More out of office visits • Attend more to carer's perspective	• More flexibility in venue/time for sessions • More funding • OT and Speech Therapy as part of assessment • Briefer stakeholder meetings • C/YP has more time with clinician • Decreased jargon	• Early intervention pathway

Data from the stakeholder and carer survey also highlighted:

- Almost 70% of stakeholders reported that the C/YP ability to maintain their placement had improved since commencing with ETS.
- 55% reported that the C/YP overall wellbeing / mental health and behaviour had improved.
- Consistent with the stakeholder report, 70% of carers reported that the C/YP ability to maintain their placement had improved since commencing with ETS.
- Over 70% of carers rated an improvement in their ability to cope with the C/YP difficulties, their ability to respond to the C/YP needs, and the C/YP overall behaviour since commencing with ETS.

8.5 Training provided by ETS

To assist in intersectoral capacity building, ETS provides professional development and training to a range of stakeholders including DCCSDS, DET, Queensland Health, foster and kinship carers, youth workers and residential care staff. Training topics included:

- effects of trauma, abuse and disrupted attachment (including neurobiological developmental issues)
- needs of C/YP in out-of-home care
- mental health diagnoses and management
- managing self-harm and aggression
- grief and loss within the child protection context
- systemic work including working within stakeholder systems to maximise collaboration, effectiveness and efficiency
- specific issues in the area of therapeutic residential care

Training sessions in 2009 were attended by 5600 people including carers, government and non-government stakeholders, and key partner agency staff. This expanded to over 6000 attendees in both 2010 and 2011. As summarised in Table 5, attendees in 2012 and 2013 have increased to over 8000 people per year. A decrease in attendees in 2013 would be influenced by reduced training capacity with two Professional Development Coordinator (PDC) positions being vacant, and an increase in PDCs providing consultation liaison clinics to Child Safety Service Centres across the State.

Table 5: Training provided by ETS

	2012 Year	2013 Year
Training provided by ETS		
Number of attendees at sessions	8640	8213
Total hours of training	1912	2021
Total requests for training	842	715

These professional development figures reflect the valued and expanding contribution ETS makes toward enhancing the capacity of the broader child protection community, across both its government and non-government sectors, as well as carers, to better respond to the needs of C/YP in out-of-home care.

9.0 Activity Data

For children/young people with a full year ETS treatment service episode between 1st January 2014 and 31st December 2014, the average number of hours of intervention per week was 4.25. This included direct contact with the C/YP, stakeholder meetings and face to face / phone contact with stakeholders or carers. Using the minimum C/YP-to-staff ratio of six (as outlined in the local service agreements) this figure equates to 25.5 hours per week out of a standard 38 hour working week. This figure does not include travel time (for intensive support provided during a large number of home/school visits and stakeholder meetings which can take up to 3 hours for a round trip), session and meeting preparation, documentation (including assessment) writing, staff meetings, case review and professional development.

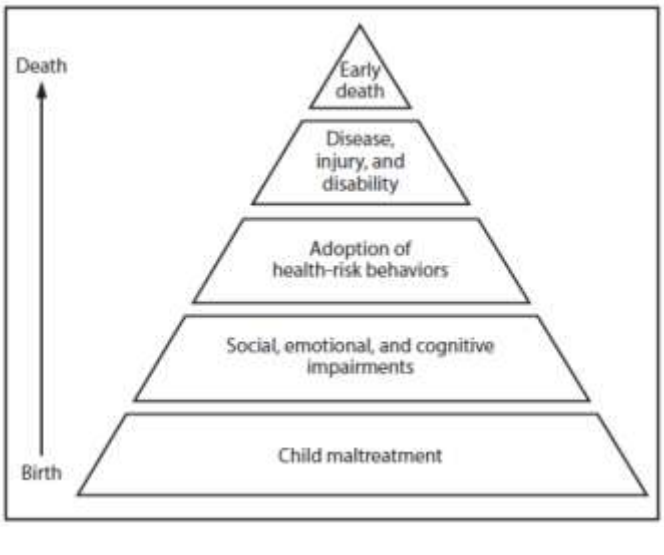
10.0 Economic Return

10.1 Background

Child abuse and neglect cost our society, not only in terms of the trauma caused to the C/YP, but also in economic terms. Economic costs include the funds spent each year on child protection and out-of-home care services (direct costs) as well as the large sums dedicated to addressing the short- and long-term consequences of abuse and neglect (indirect costs).

Within Australia, as of 30 June 2014, 43,009 C/YP were in out-of-home care, 14,991 of which were of Aboriginal and Torres Strait Islander descent. In 2013-14 total recurrent expenditure on child protection and out-of-home care services was approximately $3.3 billion across Australia. This was a real increase of $77.8 million (2.4 per cent) from 2012-13 (Steering Committee for the Review of Government Service Provision, 2015). Within the Queensland context, the total operating expenditure for the DCCSDS was $2.86 billion.

The first comprehensive, national study of the costs of child abuse and neglect in Australia conducted in 2008, found that child abuse and neglect costs Australians ten times more than obesity (Taylor et al, 2008). The report also found that the real cost of child abuse to the Australian community in 2007 was $10.7 billion, and could be as high as $30.1 billion. Figure 1, derived from the seminal US Adverse Childhood Experiences Study, represents the linkages between childhood trauma and impaired life/premature death all of which have significant impact upon government expenditure.



Source:
http://www.cdc.gov/violenceprevention/acestudy/

Figure 1. Linkages between childhood trauma and impaired life

Consequently, there has been increasing awareness of the need to prevent child abuse and maltreatment, while at the same time acknowledging there are limited public funds. As a result, the cost-effectiveness of funded programs has become important in the planning of services.

10.2 Funding

DCCSDS provide grant funding to Queensland Health to deliver the ETS. Table 6 outlines the 2012-2013 and 2013-2014 total grant funding provided along with state-wide actual spent and savings. During the 2014-2015 financial year DCCSDS provide grant funding of $19,387,235 to Queensland Health.

Table 6. Funding

Statewide	2012-2013	2013-2014
Budgeted	$18,811,600	$19,236,306
Actual	$17,202,896	$17,092,391
Labour	$14,084,933	$14,283,227
Savings	$1,608,704	$2,143,915

During 2012, 521 discreet C/YP received a service from ETS. During 2013 this increased to 595 discreet C/YP. It is important to note that the C/YP-to-staff ratio of ETS has been set at a minimum of six, with a maximum of eight, C/YP per full-time-equivalent clinician position. This is to allow:

- intensive work, often including outreach and travel, with the C/YP
- systemic interventions including intervention as needed with any and all other services supporting the C/YP (e.g. foster parents, carers and care agencies, schools, justice systems), and
- facilitation of the collaborative process through stakeholder meetings.

It also recognises the high documentation and administrative processes of Evolve Interagency Services. Case load numbers are further influenced by the acuity and severity of C/YP's presenting issues, experience of the clinician, acceptance of sibling groups and status of the C/YP within the justice system.

10.3 Rough unit cost per child/young person

A cost-benefit analysis of the Evolve Program was commissioned by DCCSDS in 2010 (See Appendix B). The report found that based on an approved benefit-cost analyses modelling:

> *"the Net Present Value (NPV) of Evolve (which represents benefits minus the costs of the program) is estimated at $360,238 per child, with benefits being realised over 12 years between the ages of 13 and 24. The results of sensitivity analysis suggest that the positive NPV is robust even in scenarios of much higher costs or lower benefits. For example, if benefits were only half the estimates figure, the NPV would be $180,119" (p.3).*

Data further indicated that there is a demonstrable positive reduction in the average child related costs once a C/YP is open to the Evolve Program and receives a provision of service. For instance, a reduction in child related costs from an average of $209,000 to an average of $162,000 per annum. This equated to a decrease in costs and a conservative saving of $47,000 per annum per C/YP[11] (Evolve Interagency Services Performance Report 2009 and 2010: Appendix C).

[11] DCCSDS collection of this data ceased after the Evolve Interagency Services Performance Report 2009 and 2010.

Due to a number of constraints, a desk top analysis for 2012 and 2013 (Table 7) was conducted using the following crude formula: actual monies spent each financial year divided by total discreet C/YP numbers in the calendar year.

Table 7. Rough unit cost per child / young person

Calendar year	Financial year - Actual	Number Child/young person seen	**Rough unit cost per child/young person**
2012	$17,202,896	521	$33,019
2013	$17,092,391	595	$28,727

It should be noted that these figures do not represent the true Net Present Value of the ETS program. Given that the above benefit-cost analyses occurred almost five years ago when the Evolve Program was still in its infancy, when not all ETS teams were operational, and ETS staff and stakeholders expertise in child protection and mental health was starting to be silicified, it can be argued that the NPV today would be much higher. Nevertheless, using the NPV range of $180,119 - $360,238, Table 8 outlines the potential NPV for 2012 and 2013 C/YP seen within the ETS program.

Table 8. Potential Net Present Value

Calendar year	Number Child/young person seen	NPV - $180,119.00 x number of C/YP seen	NPV - $360,238.00 x number of C/YP seen
2012	521	$93,841,999	$187,683,998
2013	595	$107,170,805	$214,341,610

Because not all benefits can be translated into dollar values, the rough unit cost and NPV outlined above does not incorporate other potential benefits of the ETS program. The ETS program contributes to positive change through purposeful community development and capacity building. This occurs via stakeholder meetings, consultation liaison, and targeted professional development activities (accessed by foster carers, residential support services, Educational staff, Child Safety etc). Such activities have indirect flow onto other C/YP in out-of-home care, students within the educational system, and siblings. If these indirect costs were measured, one can easily argue that the true NVP of the ETS program would be much higher again.

Karol, Kilburn, & Cannon (2005) note that the features associated with more successful programs tend to be costly. Thus the more money spent on effective programs, such as ETS (as clearly demonstrated by 2012 and 2013 ETS Annual Outcome Report data), the greater benefit for the system. Further Karol et al indicate that the changes brought about by interventions that aim to

improve children's life chances bring about significant economic and social benefits. Because crime and loss of life are very expensive to both the individuals concerned and to society, almost any intervention that makes an impact on these areas will represent a net benefit, especially as prevention services are relatively inexpensive.

11.0 Staffing Profile

ETS was established with a strong focus on direct clinical therapeutic work and capacity building. Although there may be variations, ETS teams across the state comprise of the following positions:

- Team Leader
  - Manage the human and financial resources of the ETS team and promote effective interdepartmental relationships with key government, non-government and private sector providers; provide consultation liaison services to key government, non-government and private sector providers; and, in conjunction with the consultant psychiatrist, provide clinical leadership to the multi-disciplinary ETS teams.
- Consultant Child and Adolescent Psychiatrist
  - Provide clinical leadership to the multidisciplinary ETS team, including the provision of training, education, supervision and research. Provide specialist clinical services in the areas of assessment, intervention, treatment planning and evaluation. In conjunction with the team leader, promote effective interdepartmental relationships and collaboration.
- Mental Health Clinician
  - Qualified and registered Nurse, Psychologist, Occupational Therapist, or Social Worker.
  - Provide specialist clinical services, in the areas of assessment, intervention, treatment planning and evaluation. Provide and contribute to training, education, supervision and research.
- Administration Officer
  - Coordinate and oversee the administrative activities of the ETS team, provide advice to the team leader on matters relating to the administration of the service, and provide an efficient and confidential secretarial and administrative support service to the team.
- Professional Development Coordinator
  - Coordinate, facilitate and implement training and professional development activities for ETS and relevant government, non-government and private sector service providers as prioritised. Contribute to the ongoing development of a state-wide evidence-based model of service delivery.
- Indigenous Program Coordinator
  - Facilitate the delivery and provision of culturally appropriate services to Aboriginal and Torres Strait Islander children, young people and their families and communities. Develop and promote strategic networks across key government, non-government and private sector stakeholders. Develop, implement and coordinate cultural consultancy, cultural assessment, training, peer supervision and the provision of clinical resources.

Table 9 outlines the funded and actual full-time-equivalent (FTE) position per team as of December, 2014. Both the ETS State-wide Program Manager (funded 1.00, filled 1.00) and the Senior Service Evaluation and Research Coordinator (funded 1.00, filled 0.70) are not listed in the table below.

Table 9. Funded and actual full-time-equivalent positions per team

(as at December 2014)

	Team Leader		Psychiatrist/ Registered Medical Officer		Mental Health Clinician		Professional Development Coordinator		Indigenous Program Coordinator/ Multicultural Liaison Officer[12]		Admin Officer	
	Funded	Unfilled	Funded	Unfilled	Funded	Unfilled	Funded	Unfilled	Funded	Unfilled	Funded	Unfilled
Far North Queensland	1.00	-	0.5	0.20	7.00	2.40	1.00	-	1.00	-	1.00	-
North Queensland												
Townsville	1.00	-	1.00		7.00	1.20	1.00	-	1.00	-	1.00	-
Mackay	-	-	-	-	2.00	-	-	-	-	-	-	-
Mount Isa	-	-	-	-	1.00	-	-	-	-	-	-	-
Central Queensland	1.00	-	0.70	-	6.80	1.50	1.00	-	-	-	1.00	-
Sunshine Coast												
S/C/Gympie	1.00	-	1.00	0.20	5.00	0.50	1.00	-	-	-	1.00	-
Sth Burnett	-	-		-	1.00	-	-	-	-	-	-	-
Wide Bay	-	-		-	4.00	0.40	-	-	-	-	-	-
Brisbane North	1.00	-	0.50	-	9.00	1.40	1.00	-	1.00	-	1.00	-
Brisbane South	1.00	-	0.50	-	9.00	0.50	1.00	-	1.00	-	1.00	-
Logan	1.00	-	1.00	-	11.00	2.60	1.00	-	1.00	-	1.00	-
Gold Coast	1.00	-	0.50	-	5.63	1.00	1.00	-	0.50	-	1.00	-
Ipswich	1.00	-	0.50	0.10	9.00	2.00	1.00	-	1.00	1.00	1.00	-
Toowoomba	1.00	-	0.50	-	8.00	1.20	-	1.00	1.00	1.00	1.00	-
Total	**10.00**	**-**	**7.70**	**0.5**	**85.43**	**14.7**	**10.00**	**1.00**	**7.50**	**2.00**	**10.00**	**-**

Overall, ETS is currently funded for 133.63 staff. As of December 2014, there were 114.13 filled FTE. Actual on the ground staffing levels was higher given that an FTE can equate to two actual people working part-time. The vast majority of funded staffing within ETS are frontline workers. Most clinical staff have post graduate (including Masters and PhD) qualifications. A recent estimation of ETS staff years of experience working within the Health system was well over 965 years.

[12] South Brisbane ETS is the only team that is funded for a Multicultural Liaison Officer.

12.0 Governance and Program Integrity

Research clearly indicates that for consistent positive outcomes from a program operating over multiple sites, consistency in the program (e.g., eligibility criteria, processes, services offered) is critical. For ETS this is a real challenge following the introduction of the then 17 Hospital and Health Services in 2012 and the regionalisation of DCCSDS. Despite this, ETS continues to maintain the integrity of the program across the state while being flexible to local/regional needs. This has been achieved due to a number of external and internal factors.

External factors include the Evolve Interagency Service Manual and the current local service agreements between DCCSDS and HHS's. With respect to the Local Service Agreements having been negotiated at the HHS level and local DCCSDS region, the current Local Service agreements across the state are largely consistent.

Internal factors that have helped to maintain the integrity of the program, since moving from a centralised program to HHS's, include:

- State-wide Program Manager that provides state-wide strategic direction and leadership, programmatic and quality improvement support, and coordination of state-wide professional development activities.
- Senior Service Evaluation and Research Coordinator that supports service evaluation, research and quality improvement, including contribution to the ongoing development of a Service Evaluation Framework, and an evidence-based Model of Service Delivery, at the state-wide level.
- the ETS State-wide Model of Service document
- the ETS State-wide Steering Committee
- the ETS State-wide Clinical Reference Group
- the ETS Team Leader Forum
- the Professional Development Meetings
- State-wide Professional Development / Workforce and Capability Development activities
- Coordinated and frequent communication and consultation, outside of the meetings listed above, between the ETS state-wide Program Manager and the Team Leaders, Consultant Psychiatrist and the Professional Development Coordinators.

An overview of the outlined meetings above can be located in Appendix D.

Built into this governance, both at the state-wide and local level, the flexibility of the program is acknowledged and honoured. Within the limits of the service agreement, each ETS team works with stakeholders to explore how best to meet the needs of the child/young person, the funding body and stakeholders. Examples of flexible service delivery include:

- Via a collaborative agreement between Queensland Health and ETS, Queensland Health provides afterhours and crisis care
- Consultation liaison provided to staff within Child Safety Service Centres
- Consultation liaison provided to Evolve Behaviour Support Services and CYMHS
- Circle of Security ^{TM} programs provided to carers who currently look after C/YP that currently do not meet Evolve criteria but could in the future.
- Transition timeframes from ETS, in negotiation with DCCSDS (Child Safety Services) and Stakeholders, and where clinically appropriate, at times these have been extended beyond three months (timeframe as outlined in the Evolve manual).
- Staff travelling to Thursday Island (from outside funded HHS) to provide transition support for sibling groups to link into new school and safe house, and to support handover to new Team Leader and CSO.
- Flexible agreements between a number of Universities, Queensland Health and ETS to provide speech pathology services:

- to children and young people open to ETS. Some associated expenditure is costed against ETS.
- to children and young people that do not meet the current EIS eligibility criteria. This is a service provided within the Brisbane North team only, via mutual agreement, utilising resources that became available from the disestablishment of the Services Evaluation and Research Coordinator.

13.0 Conclusion

The findings in this report illustrate the complexity of the ETS model of service delivery with multiple interventions occurring simultaneously and reinforcing one another to achieve positive outcomes. Individual therapeutic work with the child, psycho-education for the carer, dyadic work involving the child and carer together, and work with the broader system of 'stakeholders' are all important characteristics of the ETS model. All of these components can contribute to successful outcomes.

Overall, the findings detail a wide range of converging evidence demonstrating that ETS continues to provide an effective treatment program for C/YP in out-of-home care with severe and complex mental health needs. The evidence of positive changes being achieved in both C/YP's well-being and functioning and other important mediating variables (such as carer well-being, placement stability and stakeholder communication) across the course of treatment provides strong support of the ETS program across all Key Performance Indicators.

References

Australian Research Alliance for Children and Youth. (2008). *Children's need should top the national agenda*. Australian Research Alliance for Children and Youth. Braddon, ACT.

Becker, J., Greenwald, R., & Mitchell, C. (2011). Trauma-Informed Treatment for Disenfranchised Urban Children and Youth: An Open Trial. *Child* and *Adolescent Social Work Journal*, 28, 257–272.

Bellamy, J., Traube, D., & Gopalan, G. (2010). A national study of the impact of outpatient mental health services for children in long-term foster care. *Clinical Child Psychology and Psychiatry*, 15(4).

Bilenberg, N. (2003). Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA). Results of a Danish field trial. *European Child & Adolescent Psychiatry*, *12*, 298–302.

Brann, P., Coleman, G., & Luk, E. (2001). Routine outcome measurement in a child and adolescent mental health service: an evaluation of HoNOSCA. *Australian and New Zealand Journal of Psychiatry*, *35* (3), 370-376.

Bromfield, L., Lamont, A., Parker, R., & Horsfall, B. (2010). *Issues for the safety and wellbeing of children in families with multiple and complex problems: The co-occurrence of domestic violence, parental substance misuse, and mental health problems* (NCPC Issues Paper No. 33). Melbourne: National Child Protection Clearinghouse, Australian Institute of Family Studies. Retrieved from www.aifs.gov.au/nch/pubs/issues/issues33/index.html

Commonwealth of Australia. (2009). *Fourth National Mental Health Plan - An agenda for collaborative government action in mental health 2009–2014.* Canberra, Australia: Author.

Covington, S.S., Burke, C., Keaton, S.M.A., & Norcott, C. (2008).Evaluation of a trauma-informed and gender-responsive intervention for women in drug treatment**.** *Journal of Psychoactive Drugs*, 40(S5), 387-399.

Crime and Misconduct Commission (CMC) (2004). *Protecting children: An inquiry into abuse of children in foster care.* Brisbane, Australia.

DeJong, M. (2010). Some reflections on the use of psychiatric diagnosis in the looked after or 'in care' child population. *Clinical Child Psychology and Psychiatry*, 15(4).

Foster-Fishman, P. G., Salem, D. A., Allen, N. A., & Fahrbach, K. (2001). Facilitating interorganizational collaboration: The Contributions of interorganizational alliances. *American Journal of Community Psychology,* 29(6), 875–905.

Frederico, M., Jackson, A., & Black, C. (2005). Reflections on Complexity – Take Two First Evaluation Summary Report. La Trobe University. Bundoora, Australia.

Frederico, Jackson, & Black (2010) "More than Words" – Take Two Third Evaluation Report. La Trobe University. Bundoora, Australia.

Golding K. S. (2008). Nurturing Attachments. Supporting Children who are Fostered or Adopted. Jessica Kingsley Publishers. London.

Golding, K. (2010). Multi-agency and specialist working to meet the mental health

needs of children in care and adoption. *Clinical Child Psychology and Psychiatry,* 15, 573-587.

Goodman, R. (2001). Psychometric properties of the Strengths and Difficulties Questionnaire. *Journal of the American Academy of Child and Adolescent Psychiatry, 40* (11), 1337-1345.

Greenwald, R., Siradas, L., Schmitt, T.A., Reslan, S., Fierle, J., & Sande, B. (2012). Implementing Trauma-Informed Treatment for Youth in a Residential Facility: First-Year Outcomes. *Residential Treatment for Children & Youth*, 29, 141–153.

Karol, L.A, Kilburn, R., & Cannon, J.S., (2005). *Early Childhood Interventions: Proven Results, Future Promise*. RAND Corporation. Santa Monica, CA.

Kezelman, C. (2011).*Trauma-informed care – what is it and why is it important?* NSW CAG Annual Forum. Retreived 12 January 2015 at http://www.nswcag.org.au/files//our_work/focus_for_advocacy/dr__cathy_kezelman_-_ticp_-_cag_annual_forum.pdf

Muskett, C. (2014). Trauma-informed care in inpatient mental health settings: A review of the literature. *International Journal of Mental Health Nursing*, 23(1), 51-59.

Powell, C., Stevens, S., Dolce, B.L., Sinclair, K.O., & Swenson-Smith, C. (2012). Outcomes of a Trauma-Informed Arizona Family Drug Court. *Journal of Social Work Practice in the Addictions*, 12, 219–241.

Queensland Child Protection Commission of Inquiry. (2013). *Taking Responsibility: A Roadmap for Queensland Child Protection.* Brisbane, Australia.

Rey, J. M., Starling, J., Wever, C., Dossetor, D. R., & Plapp, J. M. (1995). Inter-rater reliability of global assessment of functioning in a clinical setting. *Journal of Child Psychology and Psychiatry*, *36*, 787-792.

SCRGSP (Steering Committee for the Review of Government Service Provision). (2015). *Report on Government Services 2015*, vol. F, *Community Services*, Productivity Commission. Canberra, Australia.

Suarez, E., Jackson, D.S., Slavin, L.A., Michels, M.S., & McGeehan, K.M. (2014). Project Kealahou: Improving Hawaii's System of Care for At-Risk Girls and Young Women through Gender-Responsive, Trauma-Informed Care. *Hawaii Journal of Medicine & Public Health*, 73(12), 387-392.

Tarren-Sweeney, M. (2008a). The mental health of children in out-of-home care. *Current Opinion in Psychiatry,* 21, 345-349.

Tarren-Sweeney, M. (2010). It's time to re-think mental health services for children in care, and those adopted from care. *Clinical Child Psychology and Psychiatry,* 15, 613–626.

Taylor, P., Moore, P., Pezzullo, L., Tucci, J., Goddard, C. and De Bortoli, L. (2008). The Cost of Child Abuse in Australia. Australian Childhood Foundation and Child Abuse Prevention Research Australia. Melbourne, Australia.

Whyte, S., & Campbell, A. (2008). The Strengths and Difficulties Questionnaire: A useful screening tool to identify mental health strengths and needs in looked after children and inform care plans at looked after children reviews? *Child Care in Practice, 14*, 193-206.

APPENDIX A. Case Study

Case Study: Amber[13]

Presenting concerns and context of referral

Amber was a ten year old girl who had been in out-of home care for seven years when referred to Evolve Therapeutic Services (ETS). She had been placed with her current foster carer, Jackie, for three years. Presenting concerns in the home setting included chronic stealing, lying, taking and hoarding food, destruction of others' property, making false allegations against the carers and sabotaging positive situations as if to prevent herself from gaining rewards. The carer reported struggling with Amber's behaviours and had come to view Amber as "deceitful", "controlling", and "manipulative". This had put significant strain on the stability of the placement, with Jackie indicating that she may no longer be able to care for Amber. A range of behaviours were also present within the school setting, including major behavioural escalations which were sometimes in response to seemingly insignificant or difficult-to-identify triggers, difficulties managing her emotional states, leaving the classroom without permission, at risk behaviours such as climbing on the roof of the building, and stealing others' belongings. Amber had poor peer relationships, often playing alone, struggling to initiate play with peers and being overwhelmed by the activity of the playground.

Trauma history

Amber had been taken into care at three years of age. In the preceding two years, there had been multiple child protection notifications relating to inappropriate physical discipline of Amber's older sister, squalid home environment and Amber's parents exposing the children to known perpetrators of sexual abuse. Further notifications of physical abuse and concerns about inappropriate mother-child interactions were also made following the separation of Amber's parents, with Amber's mother Karen admitting she had not been coping and that bruises on the children had been inflicted by her. Karen is herself an adult survivor of childhood sexual abuse and has a diagnosis of Bipolar Disorder, while her father Rodney has a diagnosis of mild Intellectual Impairment. Rodney has had multiple episodes of Major Depression, sometimes with psychotic features. Karen seems to interpret Amber's problems as like her "highs" of Bipolar Disorder, and lacked insight as to the likely impact of past trauma on Amber's emotional development. Once in out-of home care, Amber's challenging behaviours were noted as a major factor contributing to the difficulties keeping her and her older sister and younger brother together in one stable placement. After several placement breakdowns, including a failed reunification with her mother, Amber and her siblings were placed with Jackie who had previously been their family day care provider.

Medical/developmental issues

In the three years prior to Amber's attendance at Evolve, two different medical specialists diagnosed Attention Deficit Hyperactivity Disorder and features of Autistic Spectrum Disorder as medical/developmental explanations for her problems, and prescribed medications, although the treating Child Psychiatrist had observed that such "autistic" behaviours could perhaps be attributable to the impact of deprivation, neglect and emotional harm experienced in the early years prior to coming in to care. On the basis of her diagnosed "high functioning autism", Amber had qualified for an Individual Education Plan (IEP) under Education Queensland guidelines. This had involved Special Education Unit support and considerable attention to behaviour support strategies, including increased structure and routine, and supervised lunch and play activities. Although the frequency and severity of Amber's escalations at school had diminished somewhat with this IEP in place, they were still a recurring concern.

ETS intervention

During the assessment phase, the ETS Clinician met with all stakeholders (including both of Amber's biological parents) to collect information regarding both Amber's current presentation and her history. In consultation with the Child Safety Officer (CSO), and following the information

[13] This case study is de-identified and appeared in the 2010 ETS Outcomes Report. Ethical clearance was approved for the inclusion of case studies in the report.

sharing provisions of the Child Protection Act, a comprehensive review of Child Safety Services (ChSS) files was conducted to collate and integrate the diverse case history material on Amber. This process was important to develop a comprehensive mental health assessment and conceptualisation of Amber's case, to identify interventions that may have had success previously and to avoid previously failed interventions from being repeated. This conceptualisation was then shared with the stakeholders with a particular emphasis on enhancing the stakeholders' understanding of the likely impact of early trauma during critical stages of Amber's social and emotional development, and how this was still being reflected in Amber's current functioning across different settings. An Evolve Plan with an emphasis on consistency of responses across settings was developed. Monthly stakeholder meetings were used to maintain the shared focus on understanding Amber's behaviours within a trauma-attachment framework and monitoring progress towards goals.

Individual therapy sessions with Amber were initiated to develop rapport and trust and provide the therapist with some understanding of how Amber perceived her world. The ETS clinician also met individually with the carer, to develop an understanding of what the carer had already tried, and the challenges the carer had been facing. To strategically increase the frequency and opportunity for moments of emotional connection and reciprocal enjoyment between Amber and Jackie, a variety of playful, interactive activities and daily 'rituals' were developed collaboratively between the therapist and the carer for application in the home environment. These assisted Jackie to attune to Amber and decreased the need for Amber to engage in angry or sabotaging ways. Jackie was also coached to recognise the ways in which Amber's behaviours would trigger her anger or annoyance, so that she could work towards decreasing the emotion and creating opportunities for repair.

Simultaneously, the carer participated in a group psycho-educational program for carers developed internally by ETS aimed specifically to assist carers to understand child problems from an attachment and trauma informed perspective. After this six-week group program, the ETS clinician continued to meet with the carer, sometimes with her agency support worker also in attendance, to develop more individualised ways of responding to Amber from this perspective. The focus of these sessions was to reframe the meaning of Amber's challenging behaviours and to implement a new set of responses less likely to trigger the feelings of shame which were commonly the precursor to these behaviours.

Jackie and Amber then participated in a several months of dyadic therapy sessions (involving child and carer being seen *together* by the therapist). This provided opportunity to work directly with the patterns of interaction between carer and child to improve the attachment relationship and the child's sense of security with the carer. Once the carer was consistently reporting the placement as more settled and stable, the ETS clinician further invited the carer to engage in a few sessions to explore *her own* attachment history, with a view to further enhancing the carer's reflective capacity and her emotional availability to Amber. The carer was an active contributing partner in all of these activities. Amber and her carer also participated together in a social skills group held at ETS.

Outcomes achieved

For the stakeholder team, a shared understanding of Amber's strengths and difficulties was developed that drew more on attachment and trauma concepts, with less emphasis on her medical diagnoses and developmental 'disabilities'. Through the Evolve planning process, consistency in how to respond to Amber in various aspects of her life, while avoiding triggering feelings of shame, was developed. This consistency appeared somewhat settling for Amber. The stakeholder team worked well together, regularly reviewing the Evolve plan and refining their collective approach.

For Amber herself, a range of positive developments occurred coinciding with the period of ETS intervention. Amber ceased engaging in risk-taking behaviour or absconding from her placement or school. Instead she learnt new ways to regulate how she responded to social situations. She developed a range of strategies for staying calm and some ability to reflect on her own impulses and use her 'thinking brain' in various environmental situations that challenge her. She has ceased stealing within the school setting. Whilst at home she still occasionally takes some food or other

peoples' belongings, she has recently shown an increasing range of examples where she has directly asked for food, or eaten food in communal areas (instead of hoarding it in her room).

Jackie identified as particularly helpful the impact ETS intervention had had on her understanding of Amber's behaviour, resulting in an improved ability to respond appropriately to behaviours that she had previously experienced as distressing and sometimes overwhelming. Jackie is now confident in her ability to continue to be Amber's long-term carer into the foreseeable future.

Evaluation data and stakeholder reflections

Following case closure, a survey of stakeholder satisfaction and perceptions of change was conducted. These results indicate a high level of agreement across the participating members of the stakeholder team that significant gains had been made by Amber across each of the key outcomes domains.

Stakeholder feedback regarding the ETS intervention for Amber

Carer

"I loved how Evolve brought all the stakeholders together, so that we all worked together to help Amber. I was offered the opportunity to participate in [a group program developed by ETS for foster carers]. I learned so much from that. It helped me understand Amber's behaviours and how to change my reactions to those behaviours which has had an immensely positive result."

CSO

"The effective communication strategies that were used by the ETS clinician to engage the young person and to work at her own pace."

"Enlisting the carer's ongoing co-operation and working through the issues with her and developing clear strategies to effectively manage the young person."

"The effective and continued engagement by ETS with Education Queensland, and in particular the Special Education Unit staff, for the young person's benefit was one of the most powerful catalysts for the improvement in the young person's behaviour."

Foster Carer Support Worker

"The collaboration and consistency of approach that was developed between ETS the child's carer and the school. The group program for foster carers which my carer attended enabled her to understand the effects of trauma on children and their future behaviour. The ETS worker then worked with my carer individually to educate her on more effective and therapeutic responses to the child's behaviour - I feel that it is this change in the carer's response that has contributed immensely to the change in the child's behaviour. The ETS worker developed a strong relationship with both the child and the carer. Through respectfully challenging the thoughts and responses of the carer, the worker was able to provide practical advice and strategies to be integrated into the household. This has been evidenced through both the decreased escalations of the child and the decreased stress felt by the carer. My carer has communicated to me that working with ETS was an extremely positive experience for her and this is repeatedly evident in many of my ongoing conversations with her about the child's behaviour".

APPENDIX B. Cost-benefit analysis of the Evolve Program

Cost-benefit analysis of the Evolve program

TABLE OF CONTENTS

EXECUTIVE SUMMARY

This report outlines the findings of a study which estimated the costs and benefits of Evolve, an interagency program which provides intensive therapeutic and behaviour support services to children in out-of-home care with severe and complex needs.

The cost-benefit analysis methodology used a combination of Evolve program data and research findings to model the impact of Evolve intervention on children in Evolve, compared to children with similar needs who had no Evolve intervention. This includes benefits realised in care (13-17 years) and in the years immediately after exiting care (18-24 years).

Based on this modelling, the Net Present Value (NPV) of Evolve (which represents the benefits minus the costs of the program) is estimated at **$360,238 per child**, with benefits being realised over 12 years between the ages of 13 and 24. The results of sensitivity analysis suggest that the positive NPV is robust even in scenarios of much higher costs or lower benefits. For example, if benefits were only half the estimated figure, the NPV would be $180,119.

1. PURPOSE

This report aims to inform policy and program development by estimating the costs and benefits of the Evolve program. The analysis is designed to complement the broader evaluation of Evolve by examining the allocative efficiency of the program and providing information on whether the outcomes achieved justify the resources used, relative to alternative uses.

Background to the Evolve program

Evolve is an interagency initiative of Queensland Health (QH), Department of Communities (Child Safety Services) (CSS), Disability Services Queensland (DSQ) and Education Queensland (EQ) which provides intensive therapeutic and behaviour support services to children in out-of-home care with severe and complex needs.

The cohort of children targeted by Evolve (i.e. children with complex and extreme needs) make up approximately 17% of the population of children in out-of-home care in Queensland (Child Safety Services 2004). This group of children have generally experienced the most severe abuse and neglect of all children in care, resulting in significant damage and trauma. Abuse and neglect often result in impaired functioning and challenging behaviour, which in turn can lead to poorer outcomes across a range of domains.[1] It is widely recognised in research literature that if not addressed, the social, emotional and physical impact of abuse and trauma on these children can also have serious negative consequences over their whole life span (Disney and Associates 2006).

The Evolve program uses a collaborative approach, with each of the partner agencies contributing resources and expertise to aspects of assessment, planning and treatment to improve children's emotional wellbeing and daily functioning. Evolve services are delivered through QH Evolve Therapeutic Services teams (ETS) in 7 locations and DSQ Evolve Behaviour Support Teams (EBSS) in 9 locations across Queensland. The program commenced in 2006 and is currently undergoing its first full performance reporting process.[2]

Rationale for conducting cost-benefit analysis

As outlined above, children with severe and complex needs that are not addressed often experience significant ongoing social, emotional and physical costs. This is compounded by the flow-on social costs borne by families, government and the community more broadly. Conversely, children in this cohort who have their needs addressed stand to gain significant short and long-term benefits, which also creates social benefits for the broader community. As an intensive intervention program, Evolve entails significant costs to government and the community. In the context of scarce resources and potentially limitless needs, decisions about what level of investment to make in a program like Evolve will generally involve considering what value the program can generate, relative to other uses. In this context, cost-benefit analysis has a role in comparing costs and benefits and providing information on whether the program constitutes an efficient allocation of resources.[3]

---

[1] For example, a child who has frequent violent outbursts may be unable to attend school, may cause harm to themselves or others and is more likely to experienced multiple out-of-home care placements.
[2] A full description of the historical background of Evolve and its program model, evidence base and governance arrangements are outlined in the Evolve Performance Report 2008 (draft)
[3] It is important to note that by definition, cost-benefit analysis may not capture all the 'intangible' (therapeutic and other) benefits that derive from Evolve and should be viewed as complementary to the broader program evaluation.

2. COST-BENEFIT METHODOLOGY

The study on which this report is based utilised cost-benefit analysis (CBA) methodology, which is applied widely across Australia and internationally to inform public policy decision-making where no market exists to provide information about costs and benefits. By placing a monetary value on costs and benefits, CBA provides a basis for comparing the value of projects and programs. While in the past CBA was primarily applied to infrastructure-related projects, it is increasingly recognised as a valuable tool in the evaluation of social policies and programs.[4]

The study used a combination of Evolve program data and modelling based on research findings to estimate the costs and benefits of Evolve intervention for children with severe and complex needs. This includes benefits realised in care (13 to 17 years) and in the years immediately after exiting care (18 to 24 years).

Cost-benefit analysis process

The following process was used to undertake the study:

1. Review literature on CBA methodology and existing cost-benefit studies on related social policy issues
2. Develop benefits valuation framework to identify what types of benefits could be measured and modelled using program data and research estimates
3. Complete benefits valuation
4. Complete cost valuation
5. Calculate Net Present Value (NPV)
6. Report findings.

Methodological issues

A key challenge in any CBA is how to place a monetary value on benefits. This can be particularly difficult when there is no clear way of observing 'willingness to pay' and benefits are expected to be realised over the long term. This study utilises *remedial cost* and *preventative expenditure* techniques, which value benefits by observing what people (i.e. taxpayers) are willing to pay to prevent or repair damage to people or property.

Key concepts in cost-benefit analysis

opportunity cost: resources are priced at their value against their best alternative use, which may be above or below the actual cost of production.

willingness to pay: outputs are valued at what consumers [in this case, tax payers] are willing to pay for them.

the cost-benefit rule: a project or policy is acceptable where net social benefit (total benefit – total cost) is positive, subject to budget constraints and equity considerations.

(adapted from Department of Finance and Administration: 2006)

A second challenge in CBA is the tendency to overestimate benefits. This is mitigated by using *sensitivity analysis*, to estimate how the outcome of the CBA would be different if benefits were valued at a lower level.

A third methodological issue is the need to account for the fact that people prefer to receive benefits as early as possible and pay costs as late as possible. This is done in the study by *discounting* future costs and benefits to present values by 5%.

[4] Plotnick and Deppman 1999; Karoly 2008; NSW Department of Community Services (DoCS) 2004.

Benefits valuation framework

The benefits valuation framework (outlined in the table below) draws together the established Evolve Performance Framework with research findings to establish a series of quantifiable benefits and methods for valuing them.

Evolve outcomes/client benefits

1. Children with severe and complex behaviours are able to access effective Evolve services to meet their needs
2. Children experience safety and stability whilst in receipt of Evolve services
3. Evolve services contribute to the child's wellbeing
4. The child's support network has the capacity to effectively respond to their needs
5. Children's behaviour is conducive to optimal functioning across a range of settings
6. Stability and quality of children and young people's living arrangements
7. Children engaged in school / vocational / education / training / employment
8. Children experience healthy relationships (e.g. peer, community, school home)

Source: Evolve Performance Framework 2009

BENEFITS VALUATION FRAMEWORK

	Benefit	Method / technique	Source
Benefits realised in care (13 to 17 yrs)	**Reduced placement package costs**	Change in Transitional Placement Package funding during Evolve intervention *(remedial cost technique)*	Transitional Placements database; Evolve program data
	Reduced care costs	Change in care costs (non-placement package) *(remedial cost technique)*	SAP, Evolve program data
	Increased placement stability	Case manager time spent finding a new placement Cost of startup allowance *(remedial cost technique)*	Evolve program data; modelling based on workload analysis, O'Neill 1997
Benefits realised after care (18-24 yrs)	**Increased income due to increased educational attainment**	Returns on each additional year of schooling *(productivity technique)*	Leigh and Ryan 2003; ABS 2004; Cashmore & Paxman 2007
	Increased income tax and GST revenue	Income tax and GST revenue gained from increased income *(productivity technique)*	Morgan Disney Associates 2006 / FACSIA
	Reduced cost of support services a. Housing support b. Mental health c. Justice d. Drug & Alcohol e. Family services f. Income support g. Employment support	Average annual savings in support service costs (18-24 yrs) from a decrease in support needs (level 4 to level 3) as a result of Evolve intervention. *(remedial cost, preventative expenditure techniques)*	Morgan Disney Associates 2006 / FACSIA

Assumptions and profiles used in modelling

Several assumptions were used to estimate costs and benefits and these are made explicit throughout the report. For the purposes of estimating the Net Present Value

(NPV), a profile of a 'typical' client of Evolve was developed to analyse the impact of Evolve intervention over time[5]. The 'profile client':

- was born on 1 January 1996 and turned 13 on 1 January 2008
- commenced Evolve intervention on 1 January 2008, continuing for 2 years
- remained in out-of-home care until they turned 18 years of age
- was placed in an Transitional Placement of 'average' cost from 13-17 years of age
- derived an 'average' level of benefit from Evolve intervention
- sustained the benefits gained in Evolve.

[5] It is recognised that children in the child protection system have highly differentiated needs and take various pathways through the system

3. SUMMARY OF FINDINGS

In cost-benefit analysis, the Net Present Value (NPV) is the basis for decision making. It represents the value of benefits minus costs, taking into account the discount rate applied to future costs and benefits[5]. The estimated NPV of the Evolve program is based on the 'profile client' outlined above. This includes benefits realised in care (13 to 17 years of age) and after care (18 to 24 years of age).

Net Present Value of Evolve program, per child ($ thousands)

Year	Costs	Benefits						Net benefits	Discount factors (r=.05)	Discounted net benefit
	Evolve	Placement	Stability	Care costs	Income	Tax	Services			
1	-60,000	61,992	10,086	16,305				28,383	0.952380952	27,031
2	-60,000	61,992	10,086	16,305				28,383	0.907029478	25,744
3		61,992	10,086	16,305				88,383	0.863837599	76,349
4		61,992	10,086	16,305				88,383	0.822702475	72,713
5		61,992	10,086	16,305				88,383	0.783526166	69,250
6					2,921	2,000	20,705	25,626	0.746215397	19,123
7					2,921	2,000	20,705	25,626	0.71068133	18,212
8					2,921	2,000	20,705	25,626	0.676839362	17,345
9					2,921	2,000	20,705	25,626	0.644608916	16,519
10					2,921	2,000	20,705	25,626	0.613913254	15,732
11					2,921	2,000	20,705	25,626	0.584679289	14,983
12					2,921	2,000	20,705	25,626	0.556837418	14,270
									NET PRESENT VALUE	$ 360,238.60

To determine the robustness of the estimated NPV, a sensitivity analysis was undertaken as shown in the table below. Despite reducing estimated benefits and increasing costs by a very significant margin, the NPV remained positive.

Sensitivity test	Adjusted NPV result
1. No benefits after leaving care	$ 271,087
2. Benefits reduced by 50%	$ 180,119
3. Costs increased by 100%	$ 305,816
4. No placement package savings	$ 150,685

[5] 5% is a widely accepted discount rate for public projects (Productivity Commission: 2007)

BENEFITS REALISED IN CARE

Reduced placement package costs

The benefit from 12 months Evolve intervention for children on Transitional Placement (TP) packages is estimated at **$61,992 per child, per annum in TP and Child Related Cost savings.**

Background

The cost of providing placements for children in out-of-home care depends to a large extent on their level of need: children with higher levels of need generally require more intensive and costly placement and support services. Child Safety Services assesses children's needs on a scale of moderate, high, complex and extreme to assist in matching them to an appropriate placement, including foster and kinship care, specialist foster care or residential care. Funding is also provided through Transitional Placement (TP) packages to provide placements for children with complex and extreme needs. The average cost of TP placements is significantly higher than for other placements and a significant proportion of Evolve clients have a TP-funded placement.

Evidence from performance reporting to date suggests that Evolve intervention has resulted in children's behaviour stabilising over time, in many cases. The purpose of this valuation was to test the extent to which children's care costs decrease over time while in the Evolve program, compared to children who were in a TP placement but did not receive Evolve intervention.

Valuation process

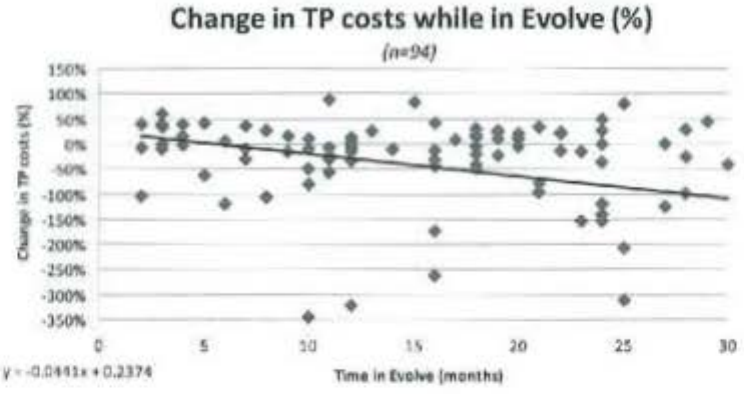
In order to assess the actual impact of the program in this area, the Transitional Placements (TP) database, together with Evolve program data was examined to identify children who had:

- received Evolve services for at least 2 months between 2006 and 2008
- resided in a TP-funded placement in the 2007-08 and 2008-09 financial years (and/or TP cost data was available for 'before and after' Evolve intervention)
- a TP placement where costs decreased, remained the same or increased by < CPI (3.5%).

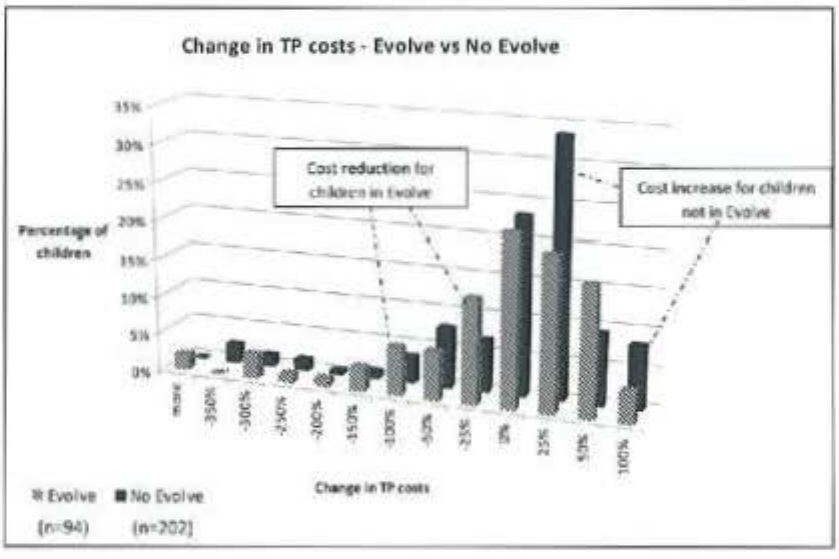
Based on these criteria a sample of 94 children was identified, along with a sample of 202 children who had a TP placement but no Evolve intervention. Statistical analysis (linear regression) was used to examine the relationship between number of months in the Evolve program and change in TP costs. The results of the regression are displayed in the graph and accompanying equation below entitled 'Change in TP costs while in Evolve'.

The black line represents the line of 'best fit'. The line indicates a negative relationship between time in Evolve and TP costs so that **TP costs decrease by a greater rate the longer the time spent in Evolve**.

Using the equation derived from the regression, the impact of 12 months Evolve intervention was modelled using the mean TP costs for Evolve clients in TP. This gave a result of $76,363. The deduction of the cost saving observed in the 'no Evolve' control sample ($14,371) gave the final figure of **$61,992**.



The table below shows the distribution of cost savings, by percentage of cost change and percentage of children in the 'Evolve' and 'No Evolve' samples. It shows that a higher percentage of the Evolve sample (shaded columns) experienced cost reductions of 25-100% while a higher percentage of the No Evolve sample (black columns) experienced cost increases of 1-100%.



Assumptions / Caveats

- Evolve intervention is likely to one of the primary contributors of reductions in TP costs observed for the sample of children.
- the regression revealed that while the relationship between time in Evolve and TP costs is negative, the values are highly dispersed with a relatively high standard deviation from the mean and therefore the results should be interpreted with care.

Increased placement stability

The monetary benefit of increased placement stability for children in Evolve is estimated at **$10,086 per child, per annum**.

Background

Placement stability has been found to be a key factor in the psychosocial wellbeing of children in out-of-home care (Barber and Delfabbro 2003). In addition to the emotional cost on children and other people involved, placement instability places a significant cost on the out-of-home care system, particularly due to the time and resources used to find and establish new placements.

Valuation process

In order to estimate the benefit of increased placement stability as a result of Evolve intervention, program data was examined to identify changes in number of placements (other than respite placements) for children in Evolve before and after Evolve intervention. Based on a sample of 176 children for whom data was available, the mean change in number of placements during Evolve intervention was **-1.01**.

Quantifiable costs associated with placement breakdowns include caseworker/support worker time in finding a new placement and Start-Up Allowance paid to the new carer. Estimation of the cost of finding a new placement was guided by data from the Workload Analysis Project phase 1 report, which estimated that 17% of Child Safety Officer time is spent on placement and support-related tasks[7]. O'Neill (1997) estimated the cost of breakdown of a permanent placement at $25,234 (approximately $30,000 in 2008 dollars).

The cost of placement breakdown for the cohort of children in Evolve can be expected to be high due to their level of need and the difficulty in finding an appropriate placement. Assuming a very conservative figure of 1/3 the O'Neill estimate, the cost of each placement breakdown, (including Start-up Allowance of $86, which would also be foregone for each placement breakdown avoided), is estimated at **$10,086**.

This is a conservative estimate that does not account for situations were a placement breakdown leads to a child being placed in a more resource-intensive placement.

Assumptions / Caveats

- children who experience placement breakdown are placed in foster care, rather than a more resource-intensive placement type.
- cost of a placement breakdown for a temporary placement is less than for a permanent placement, therefore 1/3 of the O'Neill estimate is used.

[7] Workload Analysis Project phase 1 full report. 2009 (p 14)

Reduced care costs

The benefit arising from reduced (non-placement package) Child Related Costs for children receiving Evolve services is estimated at **$16,305 per child, per annum.**

Background

Child Related Costs (CRC) are a form of financial supported provided by the Child Safety Services to meet the needs of children in care and their foster and kinship carers. CRC expenditure covers areas such as:

- health needs, such as physical and mental health services
- educational needs, including out-of-school support
- carer support, including fortnightly caring allowance, high support needs allowance
- client support, including outfitting, recreational
- Transitional Placement funding (excluded for the purposes of this analysis).

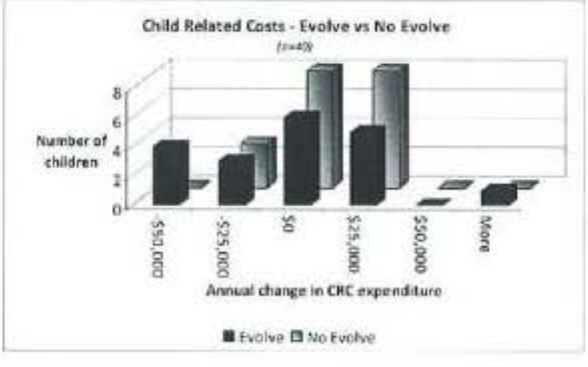
CRC expenditure can be expected to vary according to the level of need of each child. Reductions in CRC expenditure provide one indication that a child's needs are being addressed.

Valuation process

A random sample of 40 children was generated from Evolve program data and Transitional Placements database (using Excel random sampling function), including 20 children who had received Evolve intervention and 20 children who had no Evolve intervention. Child Related Costs (CRC) data was extracted from the departmental financial system (SAP) for this sample. CRC costs were then compared:

- for the 'Evolve' sample, total CRC expenditure for the 12 months prior to Evolve intervention was compared to CRC expenditure for the 12 months
- for the 'No Evolve' sample, total CRC expenditure for the 2007-08 financial years was compared to 2008-09 financial year.

The comparison showed an average annual reduction in CRC expenditure of $23,711 for the 'Evolve' sample and $7,406 for the 'No Evolve' sample, giving an average difference of **$16,305 per child per annum**.



Assumptions / Caveats

- It is recognised that increases in CRC expenditure may in some instances indicate increased positive outcomes for children (e.g. increased recreational activities).

BENEFITS REALISED AFTER LEAVING CARE

Increased income due to increased educational attainment

The benefit from Evolve intervention over 2 years on educational attainment is estimated as 1 additional year of schooling between the ages of 13 and 17, which is estimated to increase income after leaving care by **$2,921 per annum**.

It is widely recognised that the participation in education of children with severe and complex needs is often lower than other children due to behavioural issues and the impact of abuse on neglect on ability to learn (Downey 2007). Along with the impact on children's social and educational development, disengagement from school is found to reduce earning capacity as adults (Leigh and Ryan 2003).

Qualitative evidence gathered by the Evolve program suggests that Evolve intervention can result in increased educational participation for approximately 70% of children.[8] Evolve case studies point to dramatic increases in educational attainment for certain children, while for others the effect is smaller. For the purposes of this modelling it is assumed that children on average experience a 20% increase in educational participation over 4 years (i.e. between 13 and 17 years) as a result of the 2 years of Evolve intervention, enabling them to complete 1 additional year of schooling.

Leigh and Ryan estimate the benefit from each additional year of schooling, in additional income earned, to be 10% (Leigh and Ryan 2003). The total return on an additional year of schooling is estimated at $116,842 over 40 years, or **$2,921 per year**.

Assumptions / Caveats

- the child is not engaged in any education and increases their educational participation by 20% of a fulltime school load, completing 1 additional year of schooling over the 4 years between 14 and 17 years of age.

Increased income tax and Goods and Service Tax (GST) revenue

A modest improvement in earning capacity as a result of Evolve intervention would have positive flow-on effects in increased income tax and GST revenue. This benefit is valued at **$2,000 per child per annum.**

Increased earning capacity would have positive flow-on effects for government revenues in the form of increased income tax and GST revenues. Research commissioned by the Department of Families, Community Services and Indigenous Affairs (FaCSIA) in 2006 found that the tax foregone for individuals who have left the child protection system is up to $4,000 per annum (Disney and Associates 2006). For the purposes of this modelling, a figure of half this amount (**$2,000 per annum**) is assumed, in recognition of the higher needs of the Evolve cohort.

---

[8] Evolve Performance Report 2008 (draft)

Reduced cost of support services

A shift in service usage pathways from more to less service usage, partly attributed to Evolve intervention, would result in an estimated benefit of **$20,705 per child, per annum.**

Background

Evolve intervention is intended to address the therapeutic and behaviour support needs of children who have experienced trauma, abuse and neglect. If not addressed, these needs can be expected to increase the future usage of government-funded support services across a range of areas. As Evolve case studies have highlighted, addressing these issues and improving the day-to-day functioning of children can be expected to decrease support service needs in the long-term.

Valuation process

Disney and Associates (2006, in research commissioned by FaCSIA) mapped the alternative pathways taken by young people leaving the formal care system in Australia and the comparative costs to governments of these pathways over time. Service usage pathways were ranked from 1 (service usage similar to broader population) to 5 (very high usage) across a range of service systems including: Drug and Alcohol; Justice; Family services; Income support; Housing support; Health (general); Mental Health; Employment.

Given the inter-related nature of individual needs, Evolve intervention can be expected to directly or indirectly assist in reducing future need for these services (excluding general Health). For the purposes of modelling, the 'average' child leaving care without having Evolve intervention is assumed to take service usage Level 4, while a child with Evolve intervention is assumed to take Level 3. The characteristics of these pathways and associated costs are illustrated below:

Level 4 service usage
(NO EVOLVE)

- increased use of high cost government-provided mental health and drug and alcohol services
- significant use of family services (especially child protection)
- regular and long-term income support
- early use of employment services

Annual cost (16-24 yrs) = **$69,210**

Level 3 service usage
(EVOLVE)

- use of community based mental health and drug and alcohol services
- increased income support
- minor use of juvenile/adult justice services
- more intensive use of employment support
- most likely to increase or decrease depending on whether there is positive intervention or support

Annual cost (16-24 yrs) = **$27,800**

The cost saving associated with a reduction in service usage from level 4 to level 3 is $41,410. If 50% is attributed to Evolve intervention, the benefit is valued at **$20,705 per child per annum**.

Assumptions / Caveats

- 50% of reduction in support service usage is attributed to 2 years intensive therapeutic intervention, while 50% is attributed in individual client factors and factors such as the level of transition from care support.

4. DISCUSSION OF FINDINGS

The findings of the cost-benefit analysis highlight the significant value that a program such as Evolve can generate over time through making a relatively modest contribution to improved functioning for this cohort of children. This is highlighted by the sensitivity analysis showing that *even without any after care benefits*, the Net Present Value generated by Evolve for children between 13 and 17 years of age is estimated at over $271,087.

A striking feature of the analysis of existing program data is the highly differentiated pathways that children take during their time in the Evolve program. This suggests that while on average the benefit for children is significant, Evolve works particularly well for some children and not as well for others, though the reasons are unclear.

Methodologically, there are some limitations to the study arising from a lack of longitudinal data to add robustness to the modelling of expected future benefits. However at each stage the study used very conservative estimates of future benefits, often halving the estimated benefits cited in the research literature. Part of the uncertainty of estimating future benefits has also been avoided by only estimating benefits to 24 years of age. Had the study estimated benefits over a full working life (to 60 years), the overall Net Present Value would have been significantly higher.[9]

The findings suggest that Evolve can be seen as an 'early intervention' program in the sense that it intervenes before damaged children become adults, when the personal and social costs of their trauma and attachment issues are more difficult to address. It is assumed that intervening earlier before children become adults is both more effective (due to the nature of trauma and attachment issues) and less costly because of the lower opportunity costs (i.e. the lower cost of children's time).

The study also provides a basis for conceptualising Evolve as a program that can benefit children and the community in broader ways. For example, increases in educational attainment give children greater capabilities to live lives they value, while also contributing to the economic and cultural life of the community.

---

[9] This assumption is consistent with Karoly's (2008) found in a survey of multiple cost-benefit analyses in the US, the actual benefits of social programs are likely to be significantly under-estimated.

5. RECOMMENDATIONS FOR FUTURE WORK

Longitudinal study

Building on the methodology developed for this study, a longitudinal study could be conducted for a group of children receiving Evolve intervention and a control group. This could combine quantitative data (e.g. Transitional Placements and Child Related Costs expenditure) with qualitative data on improvements in functioning gathered from Evolve teams and track developments over time. This type of study could help identify why Evolve works for some children more than others.

Opportunities for economic evaluation

This study indicates the potential for economic evaluation to be used, in tandem with other approaches, to assess and improve the effectiveness and efficiency of Child Safety Services policies and programs. The use of techniques such as cost-benefit analysis in the context of child protection (and other social services) is very limited in Queensland and Australia, though the need has been recognised. In a research brief on models of out-of-home care, Osborn and Bromfield concluded that:
"Rigorous evaluation, including cost–benefit analysis, is needed to determine the effective components of intensive support services and care models and to examine what types of children and young people are more likely to benefit from certain types of services" (Osborn and Bromfield 2007: 7).

A list of opportunities for utilising economic evaluation is included in **Appendix 2**.

References

Barber, J and Delfabbro, P. 2003. 'Placement Stability and the Psychosocial Well-Being of Children in Foster Care', *Research on Social Work Practice*, 13, 415-431.

Commonwealth of Australia (Department of Finance and Administration). 2006. 'Handbook of cost-benefit analysis', Available: www.finance.gov.au/publications/finance-circulars/2006/docs/Handbook_of_CB_analysis.pdf.

Department of Communities (Child Safety Services). 2009. 'Evolve Performance Report 2008' (draft)

Department of Communities (Child Safety Services). 2009. '

Department of Community Services (NSW) 2004. 'Economic Evaluation Guidelines', Available: www.community.nsw.gov.au.

Department of Community Services (NSW) 2004. 'Benefits Assessments in Child Welfare', Available: www.community.nsw.gov.au.

Department of Community Services (NSW). 2006.

Downey, L. 2007. Calmer Classrooms: A guide to working with traumatised children', Child Safety Commissioner, Victoria. Available: www.ccsc.vic.gov.au/dowloads/calmer_classrooms.pdf

Karoly, L. 2008. 'Valuing Benefits in Benefit-Cost Studies of Social Programs', RAND Labor and Population Technical Report. Available: www.rand.org/pubs/technical_reports/2008/RAND_TR643.pdf

Leigh, A. and Ryan, C. 2003. 'Estimating the Returns to Education Using Different Natural Experiment Techniques', *Economics of Education Review*, 29, p.149-160.

Morgan Disney and Associates. 2006. 'Transition from care: Avoidable costs to governments', Research commissioned by FaCSIA. Available: www.fahcsia.gov.au/sa/communities/pubs/transitionfromcare/Documents/vol1_transition_care.pdf

O'Neill, C. 1997. 'Policy and practice implications of permanent placement disruption', *Australian Social Work*, 50 (2), p.41-47.

Osborn, A. and Bromfield, L. 2007. 'Residential and Specialised models of care'. *Research Brief no. 9*. National Child Protection Clearinghouse. Available: www.aifs.gov.au/nch/pubs/brief/rb9/rb9.pdf.

Plotnick, R and Deppman, L. 1999. 'Using Benefit-Cost Analysis to Assess Child Abuse Prevention and Intervention Programs', *Child Welfare*, vol LXXVIII (3). p.381-407.

APPENDIX 1: Calculations

Reduced placement package costs – Regression output for TP costs

SUMMARY OUTPUT

Regression Statistics	
Multiple R	0.27389336
R Square	0.07501758
Adjusted R Square	0.06507153
Standard Error	1.22949041
Observations	95

ANOVA

	df	SS	MS	F	Significance F
Regression	1	11.4015207	11.4015207	7.542451	0.007235488
Residual	93	140.58314	1.511846669		
Total	94	151.984661			

Linear Equation (y = -0.0441x + 0.2374)

RESIDUAL OUTPUT

Observation	Predicted Y	Residuals	Observation	Predicted Y	Residuals	Observation	Predicted Y	Residuals
1	-0.5570065	0.06220643	36	-0.4687406	-2.1420375	61	-0.2922089	0.29945024
2	-0.203943	-0.5925832	37	-0.0715442	-0.2305702	62	-0.248076	-0.0750865
3	-0.6894053	-0.0903986	38	-0.0715442	-0.2305702	63	-0.8218041	1.08148368
4	0.10498755	0.2187724	39	-0.2922089	0.14198075	64	-0.1156771	-0.9392309
5	-0.4687406	0.16232509	40	-0.0715442	-0.0321831	65	-0.5570065	0.74441572
6	-0.8659371	-2.2397037	41	0.01672167	-0.6345706	66	-0.8659371	-1.2219549
7	-0.5128736	0.59501211	42	-0.3804748	0.28488597	67	-0.203943	0.10183522
8	0.14912049	-0.2390508	43	-0.248076	-0.3261748	68	-0.9983359	0.72956131
9	-0.0274113	0.06846565	44	-0.203943	-0.2836292	69	-0.7335383	0.9536218
10	-0.5570065	0.69029354	45	-0.203943	-0.2854197	70	-0.7335383	0.94034455
11	-0.2922089	-2.9334854	46	0.10498755	-0.2003669	71	-0.6894053	1.01961083
12	-0.5570065	0.3547863	47	0.06085461	0.32737614	72	-0.8659371	1.67022739
13	-0.248076	1.13296579	48	0.10498755	0.47576443	73	-1.0424688	1.49070901
14	-0.0715442	0.42304473	49	-0.9983359	-6.9599974	74	-0.1598101	-0.0065824
15	-0.6452724	0.58737918	50	-0.5570065	0.86287754	75	-0.4687406	-1.2760686
16	-0.0274113	-1.1681918	36	-0.4687406	-2.1420375	76	-0.4246077	1.25104861
17	-0.248076	0.00155485	37	-0.0715442	-0.2305702	77	-0.2922089	0.20790968
18	-0.6894053	-0.2631129	38	-0.0715442	-0.2305702	78	-0.8218041	-0.7181036
19	-0.9983359	1.27058357	39	-0.2922089	0.14198075	79	-0.7335383	0.93326401
20	-0.203943	-3.2496153	40	-0.0715442	-0.0321831	80	-0.9983359	0.00286067
21	0.14912049	-1.198253	41	0.01672167	-0.6345706	81	-0.2922089	-0.0512913
22	0.06085461	-0.0833518	42	-0.3804748	0.28488597	82	-0.8218041	0.8152066
23	-0.6011395	0.35917472	43	-0.248076	-0.3261748	83	-0.0274113	0.06518374
24	-0.4687406	0.02615521	44	-0.203943	-0.2836292	84	-1.0866016	0.67704155
25	-0.6011395	0.83899187	45	-0.203943	-0.2854197	85	-0.7776712	-0.7513746
26	-0.2922089	0.35596875	51	-0.6452724	0.85728638	86	0.01672167	0.39962307
27	-0.248076	0.1788478	52	0.10498755	-0.1136569	87	-0.6011395	0.85188218
28	-0.2922089	0.35708504	53	-0.8218041	-0.5677386	88	-0.8218041	1.30547191
29	-0.1156771	0.3807553	54	-0.203943	0.29780114	89	-0.8218041	0.46128368
30	-0.954203	0.9442672	55	-0.6452724	0.75647696	90	0.06085461	0.10115301
31	0.14912049	0.23903825	56	-0.8218041	-0.3626132	91	-0.7776712	0.62736358
32	0.10498755	0.28317119	57	-0.2922089	0.40762379	92	-1.0424688	-4.9627071
33	-0.1598101	0.31347121	58	-0.7335383	0.60964117	93	-0.954203	-0.2918299
34	-0.4687406	0.87648719	59	-0.5570065	0.5009612	94	-0.3383418	0.60356164
35	-0.5570065	0.13107897	60	-0.4687406	0.32743179	95	-0.6011395	0.69361848

APPENDIX 2: Utilising economic analysis in Child Safety Services (CSS)

Rationale

Having a quantifiable evidence base to support policies and programs is increasingly important in the context of tighter budgets, Machinery of Government changes and the Government's focus on delivering efficient and effective public services.

Opportunities – linked to current Service Delivery Plan

Cost-benefit analysis (CBA)
Assesses whether investment in a policy or program represents an efficient use of resources, compared to other uses.

- Evolve program (draft completed)
- Therapeutic Residential Services (TRS) – 6 or 12 month review
- support Future Directions proposals – e.g. model the effect of further 'inverting the pyramid' in Queensland
- One Chance at Childhood
- Referral for Active Intervention (RAI)
- integrate CBA into project planning and appraisal process.

Cost-effectiveness analysis (CEA)
Assesses the most efficient way of delivering a program or service

- Transitional Placements
- Professional Foster Care (specific response)

Institutional/principal-agent analysis
Analyses how the formal and informal 'rules of the game' shape the behaviour of different actors within the system.

- Review contracting, monitoring and accountability arrangements for the non-government sector
- Assess the processes used to purchase Transitional Placements across different zones.

Risks/limitations

- poor quality / non existent data in some areas
- scepticism of / resistance to economic approach
- sensitivity of findings (particularly if unfavourable)
- existing Australian research base is limited in some areas.

Resourcing

Each of the opportunities outlined above would require varying levels of resources according to the scope and approach chosen, however guiding principles could be:

- use an 'operations research' approach focused on practical applications, linked to current priorities
- draw on existing expertise and knowledge across workgroups (PMB, Finance, PrMB)
- build internal policy capacity 'on the job', supplemented with focused training

APPENDIX C. Evolve Interagency Services Performance Report 2009 and 2010

evolve

INTERAGENCY SERVICES

Evolve Interagency Services Performance Report 2009 and 2010

Queensland Government

Table of Contents

Executive Summary

This report focuses on the outcomes of children and young people receiving a service through the Evolve Interagency Services (Evolve) program during 2009 and 2010. The report is in four sections:

1. Purpose, methodology, the program and governance
2. Client demographics and intervention processes
3. Outcomes
4. Key findings and recommendations

This 2009–2010 report on the Evolve program follows the initial *Evolve Performance Report 2008* which was the first comprehensive review of Evolve program data and outcomes. Reporting on two years, 2009 and 2010, allows for an extended assessment of outcomes for children and young people and comparisons across the three years of reporting on the program.

The report has two attachments that provide detailed data and information –
The Evolve Therapeutic Services Outcomes Report 2009 (**Attachment 1)** and
The Evolve Therapeutic Services Outcomes Report 2010 (**Attachment 2**).

The Evolve program provides intensive therapeutic and behaviour support services to children and young people in the care of the Department of Communities (Child Safety Services) with severe and complex psychological and behavioural support needs. The target population has been identified as approximately 17% of children in care. The program caters to children referred by Child Safety Services who are aged from birth to 18 years with severe and complex psychological and/or behavioural problems. The program provides assessment and intervention over approximately 18 months and is established in each region across the state.
The Evolve program is a partnership between the
Department of Communities (Child Safety Services)
Department of Communities (Disability and Community Care Services)
Queensland Health (QH) and
Department of Education and Training (DET).

In 2008–09 financial year, Child Safety Services provided total grant funding of $15.838M to Queensland Health and Disability Services to deliver Evolve therapeutic and behaviour support services to children in care. This funding increased to $20.779M in 2009–10 and to $22.138M in 2010–11 financial years.

Specialist therapeutic interventions are provided by Queensland Health through Evolve Therapeutic Services and specialist disability assessments and specialist positive behaviour support interventions are provided by the Department of Communities (Disability and Community Care Services) through Evolve Behaviour Support Services.

Child protection, placement and case management support is provided through the Department of Communities (Child Safety Services), with the Department of Education and Training providing educational support.

The Evolve model of service is based on two fundamental principles of operating under a child centred focus within an interagency collaborative framework.
Overall the report highlights enhanced access to quality therapeutic and behaviour support services for children and young people in out-of-home care.

Data and information for 2009 and 2010 from across the partner agencies confirms:

- reductions in clinical symptoms across a range of behavioural and emotional indicators of function and overall well being: reflecting improvements in aggressive, noncompliant, and anti-social behaviours, self-injuring behaviour, destruction of property, unusual or repetitive

behaviours, problems with attention and concentration, non-organic somatic complaints, self-care and independence, and emotional difficulties

- increases in the child or young person's involvement in other activities
- improvements in the child or young person's family relationships
- improvements in carers knowledge and their understanding of the child or young person's difficulties and relationships with carers
- improvements in problems with scholastic and language skills
- increased placement stability
- a more functional engagement in peer relationships and with their wider environment
- improvement in attendance at and participation in educational/vocational activities.

A cost-benefit analysis indicated short and medium term savings in costs of care for 181 children and young people receiving Evolve services in 2009 who were identified as being on Transitional Placement Packages. This is evidenced across this group in the average cost per child or young person reducing by $48,000.

From January to December 2009, 406 children and young people accessed an Evolve service. A review of data from the *Evolve Performance Report 2008* shows an overall increase of clients accessing Evolve services of 19.4 percent from December 2008 to December 2009.

From January to December 2010, 585 children and young people accessed an Evolve service.

Overall the proportion of Indigenous children and young people supported by Evolve closely reflects the proportionate representation of Aboriginal and/or Torres Strait Islander children and young people in care and reflects variations in demographics and need across service delivery locations.

Evolve staff provided training across government, non-government and private sectors to support professional development within the sector, develop knowledge and skill across children and young people's support networks, and provide direct support to carers to enhance outcomes for children and young people. Evolve Therapeutic Services records showed that across 2009 and 2010, training was provided for 11,852 attendees.

When identifying appropriate outcomes and performance measures the small size and specific nature of the target population was considered. Outcomes sought are linked to client benefits. This report demonstrates the achievement of positive outcomes for children and young people with severe and complex psychological and behavioural problems, including the identified benefits for stakeholders providing support to these children and young people and the system of care.

Section 1

Purpose

This report focuses on the outcomes for children and young people receiving a service through the Evolve Interagency Services (Evolve) program during 2009 and 2010.

In order to enhance the ability to map trends across a three year period this report is consistent with the initial Evolve Performance Report 2008[14]. The report has been generated for internal government use only and is to be distributed to the following parties:

- Queensland Treasury
- Department of the Premier and Cabinet
- Department of Communities, Child Safety Services
- Department of Communities, Disability and Community Care Services
- Queensland Health and
- Department of Education and Training.

This report captures available performance data detailing service deliverables highlighting and measuring outcomes for children and young people engaging with Evolve services.

Methodology

Evolve data and information captured in this report have been sourced from Queensland Health Evolve Therapeutic Services, Disability Services Evolve Behaviour Support Services, Child Safety Services, Department of Education and Training; and interagency local panels and steering committees reports.

Data and reporting systems were enhanced during 2009 and 2010. This included the development of the Disability Services Evolve Behaviour Support Services data system (refer **Attachment 3**) and consistent reporting processes by local panels and steering committees. This resulted in enhanced performance monitoring, contributed to the evaluation of the program and informs continuous improvement processes.

Limitations

As stated in the preliminary 2008 performance report, there are data gaps and limitations in reporting on Evolve services. Some of these gaps continue in the 2009–10 report due to retrospective data collection, some manual data extraction, and the use of multiple data sources from across the partner agencies. This limited the capacity to roll-up data across the program and as a result data is reflected individually for each agency for some data sets and data matching has occurred where possible.

In addition, due to individual agency priorities and collection processes; the impact of natural disasters; and ongoing community recovery prioritisation; full year data sets were not available for 2010.

When reviewing this document it should be noted that difficulties lie in adequately capturing and measuring the outcomes achieved for children and young people, accessing Evolve services, due to the programs timeframe of intervention. Although some indicators are captured through clinical outcome measures highlighting changes in behaviour and functioning. In addition, when identifying appropriate outcomes and performance measures the small size and specific nature of the target population was considered. It is recognised that data linked to broad population trends is not appropriate.

[14] The *Evolve Performance Report 2008* was the first comprehensive review of the Evolve Interagency Services data and achievements of the program. It responded to the Evolve Performance Framework developed collaboratively across the Evolve partner agencies in 2008.

Evolve – Program and Governance

Governance processes and structure
Evolve is provided through a partnership between the Department of Communities, Queensland Health and the Department of Education and Training.

Queensland Health provides therapeutic services and Department of Communities (Disability and Community Care Services) provides positive behaviour support services and specialist disability assessments.

The Department of Communities (Child Safety Services) is the lead agency, referring children and young people to Evolve and providing case planning coordination.

The Department of Education and Training provides educational support through participation in local panels in most areas, participation in stakeholder meetings and contribution to collaborative individual planning and support for children and young people who are clients of Evolve.

In 2009-10 the governance structure consisted of three levels, each with specific responsibilities and reporting requirements. Each governance level required the participation of each of the key partners to constitute a quorum. The structure consisted of:

- local panels responsible for management of referrals, reviews and exit, and coordination of service delivery to individual clients
- local steering committees responsible for ensuring engagement of appropriate agencies and strategic management of the local service system including monitoring of service delivery trends and issues resolution and
- a state-wide Steering Committee responsible for the policy and program coordination across the state and the strategic management of the program.

Evolve partners work collaboratively in each location to develop effective service responses to meet the needs and issues of children and young people who have been referred.

The Evolve panel is the interagency mechanism to ensure the therapeutic and behaviour support needs of children and young people are addressed with the resources available. The Panel has the following key functions:

- intake and prioritisation
- therapeutic and behaviour support services care planning
- monitoring and review and
- case closure.

In 2009 Evolve introduced improved panel and steering committee reports under a consistent framework. These reports included data in relation to performance against process indicators, achievement of client goals and data on participation of children and young people on Transitional Placement Packages (TPP) or in residential services and on case closures.

Evolve Steering Committees support local implementation of the Evolve program in line with the state-wide principles and procedures as identified in the Evolve Interagency Services Manual. In particular these committees oversee the panel operations and address local strategic and systems issues.
During the latter half of 2010 the role of the state-wide steering committee was revised with the Child Safety Directors Network assuming this role in 2011 and the Program Coordinators reporting to the Child Safety Directors Network.

Evolve Program

The Evolve program provides therapeutic and behaviour support services to children and young people in the custody or guardianship of the Department of Communities (Child Safety Services) and who have severe and complex psychological and/or behavioural problems. In 2011, the eligibility for services was extended to children under interim child protection orders.
The Evolve model of service is based on two fundamental principles of operating under a child centred focus within an interagency collaborative framework. It aims to provide intervention to children and young people with complex or severe psychological and behavioural support needs who are involved in the Queensland child protection system.

Evolve Therapeutic Services

The therapeutic approaches employed by the Evolve Therapeutic Services teams are based on current research and evidence-informed practice. These teams utilise trauma, attachment and systemic theories, and work towards generating therapeutic environments for children and young people by focusing on underlying problems associated with severe child abuse and neglect.

A key part of the Evolve model is the requirement of clinicians to have a strong awareness of Evolve Therapeutic Services being part of a larger service system and of the importance of working both with and within this broader system.

Evolve Therapeutic Service teams

Evolve Therapeutic Service (ETS) teams are situated within Queensland Health Child and Youth Mental Health Services (CYMHS) and are managed within Health Service District structures, policies and procedures. There are ten teams located throughout Queensland.

ETS teams may comprise the following positions/roles:

- Team Leader
- Consultant Child and Adolescent Psychiatrist
- Clinician (Psychologists, Occupational Therapists, Social Workers and Nurses)
- Indigenous Program Coordinator
- Professional Development Coordinator
- Service Evaluation and Research Coordinator and
- Administration Officer.

The 2009–2010 funding allocation included provision for:

- ongoing program management within Queensland Health to support the development of policy and procedures; service rollout; and reporting and governance compliance.
- Service expansions commenced operation in the 2010/2011 financial year comprising of: Brisbane South (October 2010), Ipswich (March 2011) and Toowoomba (May 2011).

The 2010 Evolve Therapeutic Services Outcomes Report (Attachment 2) includes three case studies which provide examples of Evolve Therapeutic Services intervention.

Evolve Behaviour Support Services

Evolve Behaviour Support Services provide medium to long term positive behaviour support services, commencing with an Initial Assessment. Following the Initial Assessment Evolve Behaviour Support Services undertake a Functional Assessment and develop a Positive Behaviour Support Plan. A Functional Assessment aims to identify the possible functions or causes of the behaviour/s of concern.

Positive behaviour support plans are comprehensive, multi-component plans and address a range of needs, including:

- immediate needs of the child or young person

- immediate and short term strategies for families, carers and staff if required and
- strategies to respond to the long-term needs of the child or young person.

Behaviour support plans will have as their primary aim to enhance the quality of life of the child or young person. This is achieved by reducing the frequency, intensity or duration of the behaviour/s of concern, and enhancing the skills, emotional, personal and social experiences of the child or young person. Furthermore, these plans will contain a range of strategies and approaches based on the principle of the least restrictive alternative for working with children and young people who present with challenging behaviour.

Evolve Behaviour Support Services clinical staff (psychologists, speech and language pathologists, occupational therapists and social workers) play an important role in helping to form and lead the stakeholder team. This is integral to the collaborative development and implementation of the positive behaviour support plan. Evolve Behaviour Support Services, in conjunction with the stakeholder team, is responsible for monitoring and evaluating the positive behaviour support plans.

Evolve Behaviour Support Services also provide Specialist Disability Assessments (SDAs) and a Transition and Post-Care Support Program. SDAs present a comprehensive profile of the disability specific support needs of a child or young person. The SDA aims to inform the stakeholders about necessary supports, services and placement options that will be required to best meet the child/young person's, and in some cases their family's needs.

The target group for SDAs are children and young people (birth to 18 years of age) with a disability who are:

- at risk of entering statutory care
- entering statutory care
- in care, or
- returning home from statutory care.

Transition and Post-Care Support Program

From late 2007 until June 2009, Transition Officers worked with young people with a disability with very high and complex needs aged 15-18 to assist them to plan their transition from statutory care. During this period the program was developed and delivered within the funding provided for Evolve Behaviour Support Services.

From July 2009, funding was secured from the Council of Australian Governments (COAG) National Partnership Agreement on Homelessness for a four year Transition and Post Care Support (Disability) program. The aim of this program is to support young people with a disability who are in, or have recently left statutory care (aged 15 to 21) to achieve long term, cost effective and stable placements to reduce the risk of homelessness.

This program has been implemented and is fully operational, with the development of a service model, approved operational manual, and twelve government Transition Officers trained and supporting this cohort of young people across the state. In addition, the program funds three Transition Officers in the funded non- government service provider sector in the south-east corner of the state.

According to monthly 2009 statistics, the number of young people supported ranged between 42 and 81, with an average of 64 clients supported each month.

Evolve Behaviour Support Service teams

Each Evolve Behaviour Support Services team managed by Disability and Community Care Services consists of a:

- Team Leader;
- Psychologists;

- Speech and Language Pathologist, Social Workers or Occupational Therapist; and
- Administration Officer.

Evolve Behaviour Support Services Team Leaders carry a case load and provide direct services. The Cairns Evolve Behaviour Support Services was provided through non-recurrent funding until mid 2009 when recurrent funding was made available. In late 2009, additional Evolve Behaviour Support Services teams were recurrently funded in Logan, Toowoomba and Brisbane South. The Toowoomba Evolve Behaviour Support Services team commenced in 2010; with the Team Leader starting in May 2010.

In addition to the 11 regionally based Evolve Behaviour Support Services Disability and Community Care Services also have a central program development team consisting of an Evolve Behaviour Support Services senior manager, two senior service development officers and an administration officer. This team is responsible for:

- establishment of new Evolve Behaviour Support Services
- state-wide recruitment to all clinical positions
- development and delivery of induction and professional development activities for clinical staff
- Disability Services Evolve program development – includes the development of policy, procedures and practice manuals and coordination of the expansion and roll-out of additional services
- research to inform and develop current research based practice
- reporting responsibilities – program outcomes and financial – internal and to Child Safety
- participation in Evolve Program Management and governance functions
- program support to Evolve clinicians state-wide and
- state-wide and cross-agency coordination activities.

Department of Communities, Child Safety Services

During 2009 Child Safety Services contributed to Evolve through the provision of program management staff, from internal resources, to undertake state-wide and cross agency coordination activities, management of program governance and reporting.

Specific service delivery staff, for example Child Safety Officers and/ or Team Leaders, who support each child or young person, participate in stakeholder meetings as part of the ongoing planning and implementation of coordinated responses. Contributions in individual services for children and young people focus on the provision and coordination of ongoing work on case management, placement and family relationships.

In addition Department of Communities, Child Safety Services, provided administrative support to the interagency components of the program within each region, providing secretariat support to the steering committees and panels and data collection and reporting. Administrative positions have been funded through Evolve savings and became recurrently funded in 2010/11.

It should be noted that due to other priorities, including disaster management, data usually collected and collated early in the year, for the prior months of July through to December, were not able to be provided by the regions. Therefore, Child Safety Services 2010 data are based on the January to June period only.

Department of Education and Training

Department of Education and Training play a part in Evolve by contributing to program management and governance of the interagency program. Participation by local operational staff in steering committees and panels varies across the state according to local priorities and resources. For example, education representatives are core members of some Evolve panels whereas

education representatives will attend other panels only to discuss certain items. Specific staff who support each child or young person, such as teachers, guidance officers and principals, also participate in stakeholder meetings as part of the ongoing planning and implementation of coordinated responses for children and young people.

Department of Education and Training contributions are focused on delivering improved participation, learning and achievement for all children and young people.

Access to Services

Service locations and capacity

Evolve is targeted towards children and young people in care who are categorised as having complex or severe needs (estimated to be approximately 17 percent of children in care). Based on this estimation there were 1,206 children and young people eligible for Evolve services as at 30 June 2009 and 1,250 children and young people as at 30 June 2010.

In areas where Evolve Therapeutic Services and/or Evolve Behaviour Support Services were not fully operational, combined outreach was developed so both therapeutic and behavioural support services were available. The size and distribution of teams has been reviewed as the rollout of Evolve services progressed across the state.

In late 2008 a Local Steering Committee was established in Ipswich and Evolve Behaviour Support Services, commenced providing limited services to this region. While an EBBS service was in place, this team provided services across both Ipswich and Logan areas. High demand in Logan impacted on capacity for Ipswich clients.

Two key areas of the state without full Evolve services in 2009 were Ipswich and western areas and southern Brisbane and Redlands. In mid 2009, additional funding was allocated to Evolve (across both Disability and Community Care Services and Queensland Health) and the rollout of services to these areas commenced later that same year.

Historically, both Evolve Therapeutic Services and Evolve Behaviour Support Services have faced challenges recruiting appropriately skilled and qualified staff in some locations. This pattern continued during 2009 and 2010 impacting on service capacity throughout the year. This is consistent with difficulties in recruiting allied health staff nationally due to skills shortages. Efforts to enhance workforce capacity are underway including rolling recruitment and provision of information to University students.

Table 1 below provides a snapshot of Evolve locations and staff allocations as at November 2009 as well as unfilled positions as at November 2009.

Table 1: Evolve teams (locations and staffing) as at November 2009.

	Full teams	**Staffing FTE**	
Evolve Therapeutic Services	Far North Qld	11.25	(inc.2.4 unfilled)
	North Qld (Townsville and Mackay)	11	(inc.2.3 unfilled)
	Central Qld (Rockhampton and Gladstone	10	
	Sunshine Coast/Burnett (includes Gympie, Fraser Coast and Bundaberg)	14	(inc.2.5 unfilled)
	North Brisbane	13	(inc.1.6 unfilled)
	Logan	17	(inc. 3.2 unfilled)
	Gold Coast	10	(inc. 2.2 unfilled)
Evolve Behaviour Support Services	Cairns*	3	
	North Qld Townsville/Mackay	5	(inc. 1 unfilled)
	Rockhampton/Gladstone	3	(inc. 1 unfilled)
	Maryborough/Bundaberg	3	(inc. 1 unfilled)
	Sunshine Coast	4.5	
	Brisbane North	6	

Brisbane South	established - Dec '09
Ipswich	5 (inc. 1 unfilled)
Logan	established - Dec '09
Gold Coast	5 (inc. 2 unfilled)
Toowoomba	established - Dec '09
Central Office	4

***** Staffing for Cairns EBBS was non-recurrent until mid 2009 when recurrent funding was allocated.

Monthly recruitment data collected throughout 2010 (Table 2) showed staffing levels remained fairly consistent with positions filled ranging between 66 and 79 percent across the teams; and positions unfilled varying between 21 and 34 percent.

Table 2: Evolve teams (locations and staffing) as at December 2010.

	Full teams	**Staffing FTE**
Evolve Therapeutic Services	Brisbane North	13.5 (3.0 unfilled)
	Logan	17 (6.0 unfilled)
	Gold Coast	10.4 (1.6 unfilled)
	Brisbane South	13.5 (3.7 unfilled)
	Toowoomba	11.5 (10.5 unfilled)
	Ipswich	11.5 (10.5 unfilled)
	Far North Qld	11.25 (1.6 unfilled)
	Nth Qld (Townsville and Mackay)	13
	Central Queensland (Rockhampton, Gladstone and Emerald)	10.25 (0.5 unfilled)
	Sunshine Coast/Burnett (including Gympie, Fraser Coast and Bundaberg)	15.25 (1.6 unfilled)
Evolve Behaviour Support Services	Cairns	4 (2.2 unfilled)
	Townsville/Mackay	6 (0.2 unfilled)
	Rockhampton/Gladstone	4 (1.4 unfilled)
	Maryborough/Bundaberg	4 (1 unfilled)
	Sunshine Coast	7 (1 unfilled)
	Brisbane North	8
	Brisbane South	6 (1 unfilled)
	Ipswich	7 (0.2 unfilled)
	Logan	6
	Gold Coast	6
	Toowoomba	4 (2 unfilled)
	Central Office	3

* Further staff increases have occurred across the Evolve services since Dec 2010.

Section 2

Client Demographics

Demographic information, such as age, culture and gender is collected as combined data across both Evolve Therapeutic Services and Evolve Behaviour Support Services. These data were provided monthly to Department of Communities (Child Safety Services) as part of the ongoing reporting. Data relating to the complexity of the client group are collected separately by Evolve Therapeutic Services and Evolve Behaviour Support Services given the specific nature of the presenting issues for each child and young person supported by these services.

Complexity of client group

Referral and initial assessment data indicate children and young people supported by Evolve have severe and complex psychological and behaviour support needs. Some children and young people have co-existing mental health issues and a range of disabilities. The issues faced by these children and young people impact on their ability to function in daily life across a range of situations and settings such as home life, relationships with others, social situations and school attendance and performance. Their behaviours can frequently pose a risk to themselves and others through self harming, risk taking and aggression.

Age

During 2009 and 2010 Evolve provided services to children and young people within the eligible age ranges of birth to 17 years of age. In addition, Evolve services supported a small number of young people (18 years of age and older) after leaving care to ensure an appropriate transition to adult services.

Whilst children and young people from birth to 17 years are able to access Evolve services, in 2009, the majority of children and young people were aged between six and 17 years, with the largest age bracket falling within the 13 to 17 year age range.

Whilst the majority of clients were adolescents, the referral data highlighted children in the four to five year old age range increased by 60 percent and children in the six to 12 year old age range increased by 38 percent. This shift reflects the aim to provide intervention at an earlier age to achieve more effective outcomes for children and young people. It also reflects an increase in understanding of appropriate referrals by the referring staff.

Available regional data for 2009 indicated that the age distribution varied between Evolve Therapeutic Services and Evolve Behaviour Support Services reflecting differences in the needs of children and carers where issues of mental health or disability are identified and the different services provided across these two elements of Evolve services. Further it corresponds with ages where complex behaviours become more challenging, for example during adolescence.

Overall, during 2010 the majority of referrals for children and young people to Evolve Therapeutic Services were in the six to 12 year age group (59 percent), whereas the majority of Evolve Behaviour Support Services referrals were adolescents with 65 percent aged between 13 to 17 years.

Aboriginal and Torres Strait Islander Clients

All Evolve teams across the state provided services to Aboriginal and Torres Strait Islander children and young people. The annual average percentage for 2009 was 25 percent, varying between 23 to 26 percent. The average increased by 2 percent in 2010 to 27 percent, with monthly variation between 23 and 30 percent.

Overall the proportion of Aboriginal and Torres Strait Islander children and young people supported by Evolve closely reflects the proportionate representation in care and reflects variations in demographics and need across locations.

Gender

Table 3 below shows the gender breakdown of children and young people receiving Evolve services across 2009 and 2010. The higher percentage of males receiving Evolve services reflects the externalising behaviours of males which cause concern for child safety staff and carers.

Table 3: Gender

	2009		2010	
	Male	Female	Male	Female
Evolve Therapeutic Services	63%	37%	63%	37%
Evolve Behaviour Support Services	73%	27%	72%	28%

Referral, Review and Exiting Evolve services

Increasing level of service 2009-10

From January to December 2009, 406 children and young people accessed an Evolve service. Throughout 2009 there was growth in client numbers across the program from 272 children and young people (179 ETS and 93 EBSS, inclusive of the 15 joint ETS/EBSS clients) accessing the service in January to 365 (244 ETS and 121 EBSS, inclusive of the 17 joint ETS/EBSS clients) in December. A comparison with data from the *Evolve Performance Report 2008* shows an overall increase of 19.4 percent from December 2008 to December 2009.

It should be noted that Child Safety Services ceased Evolve funding for the Transition from Care project officers in June 2009.

From January to December 2010, 585 children and young people accessed an Evolve service. In January 2010, 349 children and young people accessed the service (115 ETS & 234 EBSS, with 17 joint ETS/EBSS clients) which increased to 355 by December 2010 (222 ETS & 144 EBSS, with 17 joint ETS/EBSS clients).

Marginal deviations in referrals in 2010 for *Evolve Therapeutic Services* were noted ranging between 222 (in both September and December) to 244 (in February). Fluctuations occurred throughout the year for Evolve Behaviour Support Services referrals ranging between 106 (in both February and March) and 153 (in April); with slight variations for Evolve Therapeutic Services/Evolve Behaviour Support Services joint referrals ranging between 11 (in November and December) and 21 (in March).

Referrals are managed by an Evolve panel in the regional service area. The panel tracks the number of active clients and case closures monthly. The development of reporting systems for improved tracking of referrals commenced in 2009. This system is managed by the panel supported by regional Evolve administration officers. The data system was not finalised and implemented until 2010 and was therefore not available to support the collection of data for this report.

Responsive service access

The number of children and young people accessing Evolve services was directly impacted by each region's service capacity at different points in time (i.e. staffing levels and caseloads of

clinician's limits the ability to accept new referrals). There has been an increase in 2009 and 2010 of the number of referrals allocated to an ETS or EBSS staff member within one month.

Based on available 2009 regional data of the 312 referrals of new clients received in 2009, 228 (73 percent) were accepted. The majority of 2009 referrals accepted were considered and allocated within three months of referral (181 of the total 228 referrals for 2009 or 79 percent), with 66 percent of referrals (150) being allocated within one month.

These figures highlight a reduction in time between referral and allocation from the *Evolve Performance Report 2008*, where the majority of referrals (61 percent) were considered and allocated within three months of referral, with 45 percent having been allocated within one month.

Evolve Therapeutic Services data – new client profile

Children and young people accepted into Evolve Therapeutic Services presented with a range of concerns consistent with the mandatory entry criteria and prioritisation criteria for the Evolve program. As part of a comprehensive assessment process, children and young people are rated using the Health of the Nation Outcomes Scales for Children and Adolescents (HoNOSCA)[15]. Over 70% of children and young people scored in the clinical range on six of the 13 HoNOSCA items.
The areas of concern with the highest percentages of children scoring in the clinical range were similar for 2009 and 2010 and are consistent with the target population of Evolve Therapeutic Services. These areas were:

1. problems with family life and relationships (90.7%)3
2. problems with emotional and related symptoms (89.2%)
3. problems with peer relationships (84.8%)
4. disruptive, antisocial and aggressive behaviour problems (84.7%)
5. problems of overactivity, attention and concentration (79.6%)
6. scholastic or language skills problems (72.5%).

A frequency analysis using available data in 2009 revealed that 90.6% of children and young people had four or more HoNOSCA items rated at the clinically significant level. Furthermore, over 97% of children scored in the clinical range on a measure of global adjustment and functioning (Children's Global Assessment Scale). The majority of children (69.1% in 2009 and 70% in 2010) had scores of 50 or less on the CGAS indicating moderate to severe levels of impairment in functioning. Taken together, these results highlight the severity and complexity of cases accepted by the Evolve Therapeutic Services.

Evolve Behaviour Support Services data - new client profile

For children and young people accessing Evolve Behaviour Support Services in 2009, the primary disability was intellectual disability (56 percent), with a significant proportion of children and young people having autistic spectrum disorder/autism (23 percent). These figures indicate a consistency across years as supported by the *Evolve Performance Report 2008*. Also consistent with 2008 data, a majority of children and young people were assessed as having more than one disability.

[15] Health of the Nation Outcomes Scales for Children and Adolescents (HoNOSCA). The HoNOSCA is a 15 item clinician-rated measure designed specifically for use in the assessment of child and adolescent client outcomes in mental health services. The measure assesses behaviours, impairments, symptoms, and the social functioning of children and adolescents with mental health problems (Gowers, et al., 1998). The HoNOSCA is rated on a 5-point scale reflecting the client's functioning over the preceding two weeks (0 = no problem, 1 = minor problem, 2 = mild problem but definitely present, 3 = moderately severe problem, 4 = severe to very severe problem). Ratings of 2 or greater are considered to be clinically significant in severity, such that they require clinical attention.

The secondary disabilities identified in 2009 included: intellectual, speech, hearing, neurological, vision, psychiatric, attention deficit hyperactivity disorder, developmental delay, oppositional defiant disorder, conduct disorder, attachment and post-traumatic stress disorder. This range of disabilities emphasises some of the complexities within this cohort and underscores the need to continue delivering quality professional development programs that reflect the range of complexities for children and young people in care with a disability.

Data as at 31 July 2010 show the highest primary disabilities identified (for children and young people accessing Evolve Behaviour Support Services at the initial assessment stage) were:

- intellectual disability (109 clients)
- autistic spectrum disorder/ autism (23 clients) and
- neurological (14 clients).

Further, the prominent secondary disabilities captured with this cohort at initial assessment consisted largely of:

- attention deficit disorder/ attention deficit hyperactivity disorder (28 clients)
- speech (24 clients)
- intellectual (23 clients)
- physical (17 clients)
- autistic spectrum disorder/ autism (16 clients)
- psychiatric (12 clients),
- neurological (10 clients); and
- others such as, developmental delays, vision and hearing.

Referrals not accepted

Regional reporting commenced during 2009 and captured the reasons referrals for Evolve services were not accepted. For the 90 referrals where data were available in 2009 (full year not available for all regions) the primary reasons referrals were not accepted were there were *other services more suitable* able to be accessed by the client (33 percent) or the Evolve service was *at capacity* (21 percent).

It is recognised that in some areas there were significant restrictions on capacity due to an inability to fill staff vacancies for extended periods. Evolve panels monitor throughput, to assist in achieving timely responses, and also their support provided for referral to alternative services where referrals did not match Evolve criteria or were not accepted.

Data for the months of January through to June 2010 indicated that the primary reasons referrals were not accepted included *eligibility criteria not met* (34 percent) and the secondary reason, *other service more suitable* (26 percent). Additionally, *at capacity* amounted to 25 percent of referrals not being accepted.

In congruence with 2009 data above, in 2010, across some regions, Evolve Therapeutic Services and Evolve Behaviour Support Services continued to experience critical staff shortages which impacted on their capacity to accept referrals and service delivery.

Evolve Therapeutic Services and Evolve Behaviour Support Services continue to put in place recruitment strategies to improve and maximise their client intake capacity.

Referrals of children on Transitional Placement Packages or in Therapeutic Residential Care Services

Children and young people who are on, or referred to, a Transitional Placement Package or Therapeutic Residential Care placement are prioritised for Evolve services. This prioritisation process recognises the severe and complex psychological and behaviour support needs common to children and young people in these placements. The Evolve program provides medium to long

term (approximately 18 months) intensive intervention, requiring small caseloads of six clients per clinician. The nature of the behaviours and complex histories of trauma for this group of children and young people requires an intensive level of support from an experienced clinician to make some significant changes in their lives.

Available regional panel report data[16] indicates that throughout 2009 there were 82 children and young people on Transitional Placement Packages referred to Evolve; of these 51 were accepted. This equated to 22 percent of the total referrals accepted by Evolve being some of the most complex work undertaken.

A second priority group for referrals are young people referred to, or accessing, therapeutic residential services. Available regional data indicates that during 2009, 27 referrals of young people also referred to, or accessing therapeutic residential care services, were received by Evolve; 17 of whom were accepted.

When reviewing both 2009 and 2010 data for these priority groups the total percentage of referrals accepted by Evolve has remained static.

Progress through intervention stages

For each child or young person accessing Evolve services, a plan is developed that identifies specific goals. Plans are reviewed by the Evolve panel on a quarterly basis to facilitate monitoring of the progress towards achievement of goals. This also facilitates coordination of referrals to additional support services as required.

In addition stakeholder meetings are held on a regular basis to facilitate engagement of all those involved in supporting the child or young person and to ensure coordinated planning and intervention. Stakeholder meetings include the child or young person, carer and/or family members (wherever possible and appropriate), Child Safety Officer, Evolve clinician, Department of Education and Training representatives and relevant professionals and stakeholders. Local panels monitored client progress, tracking service efficiency against key process indicators. Panel reports identified the proportion of children and young people accessing Evolve, detail relevant referral information and track the attainment of key process indicators. These data are provided in Figures 1 and 2 over the page.

Overall, the 2009 data regarding process indicators for goal achievements and outcomes was limited. This improved through the year with the transition to revised Evolve plans which identify and monitor short and long term goal attainment. Based on available regional data, during 2009, 48 percent of children and young people (n=157) had achieved the planned goals identified for the review period. Although appearing a low percentage, this 48 percent indicates all goals achieved rather than some goals achieved and is therefore a positive indicator of significant progress.

Figure 1: Evolve Process Indicators for 2009 achieved within specified time frames

[16] Data was not available for the full year in some regions.

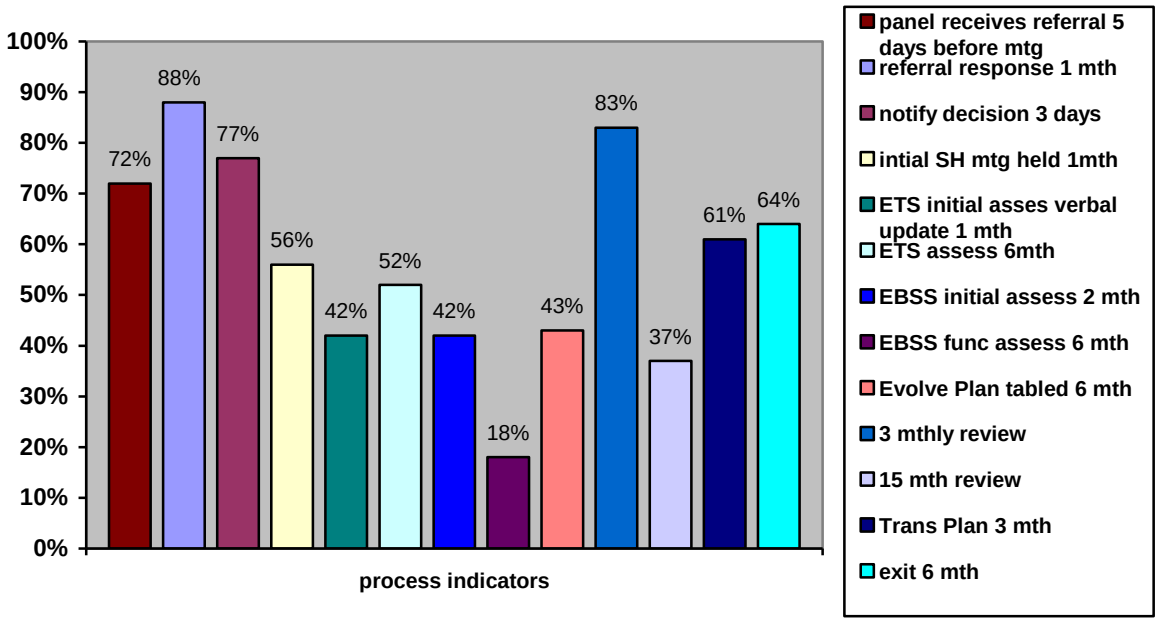
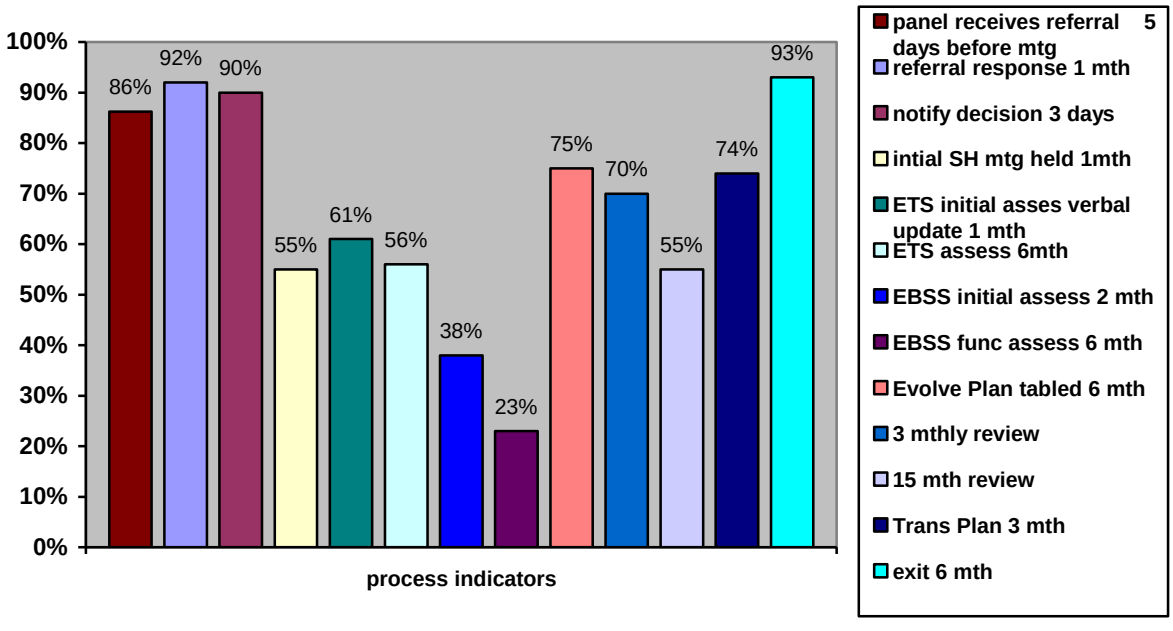


Figure 2 over the page captures the 2010 proportion of children and young people accessing Evolve where key process indicators were met; and reflects an overall improvement in services meeting process indicators during 2010.

Figure 2: Evolve Process Indicators for 2010 achieved within specified time frames (January – June)



Based on the available 2010 regional data as of June 2010, 58 percent of children and young people (n=347) had achieved the planned goals identified for the review period.

Exiting Evolve services

Monthly data provided by Queensland Health and Disability and Community Care Services indicate that during 2009, 165 children and young people exited Evolve, consisting of 56 from Evolve Behaviour Support Services and 109 from Evolve Therapeutic Services. Exits occur for various reasons including completion of intervention, relocation, child or young person exiting care and disengagement of the child or young person from the service.
Data on reasons for case closure in 2009 were available on 84 cases. For these cases, whilst *other* (used to reflect a range of reasons) was the most commonly used category of 'reason for case closure', the most consistent reason cited for the closing of a case was *goals met* (26 percent). For 23 percent of cases the reason for case closure was cited as *not eligible* and seven percent had *moved from the service area*.

The category of not eligible may indicate:

- the child or young person was found not to have the extreme to complex psychological and/or behaviour support needs;
- the child or young person was referred to more appropriate support services;
- the child or young person was no longer under a child protection order;
- the child or young person was assessed as not having a disability (Evolve Behaviour Support Services cases); or
- the child or young person ceased to be in out-of-home care.

During 2010, the Local Steering Committee Reports captured case closures for each region for the months of January through to June only with a total of 82 cases consisting of: 30 being closed within a 12 month period; 18 cases in less than 18 months; 16 under 24 months; and 18 of the cases closed had been involved with Evolve services for over 30 months.

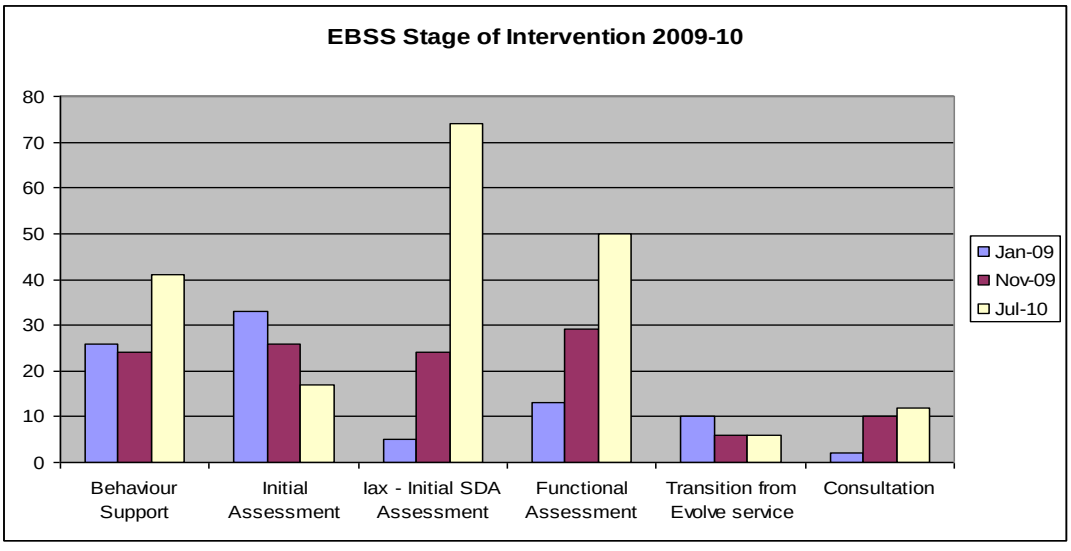
These statistics show that majority of case closures are occurring within a 12 month period. This is due to a range of reasons from attainment of goals through to disengagement or leaving the service provision area. Further, there were 18 cases closed that had been open for 30 months or more compared to the previous six months which showed only nine. Of these, the majority of case closures listed the reason as *other* or either the child or young person and/ or carer as *not engaging*. More work and assessment is required to better understand the time required to appropriately provide therapeutic or behaviour support services to the clients in Evolve.

Note: from the data available in 2010 it was difficult to differentiate the exact reasons and therefore make comparisons with regard to the listed reasons for case closures, due to *other* being listed as a reason and, that across various regions, there were some inconsistencies in the recording and interpreting of closure reasons.

Evolve Behaviour Support Services intervention information

Below is a comparison of the core services provided by Evolve Behaviour Support Services at three points in time across the reporting period.

Figure 3 : EBSS Clients by Stage of Intervention – Comparison for January 2009; November 2009; and July 2010



Note: there was the expansion of EBSS teams and introduction of additional staff (to undertake Specialist Disability Assessments) increased service capacity.

Evolve Behaviour Support Services supported 142 children and young people in January 2009 across the stages of intervention including: 33 initial assessments, 13 at functional assessment, 26 positive behaviour support, and ten transitioned from Evolve services. In addition in January there were five children and young people in receipt of a Specialist Disability Assessment (SDA)[17] and 55 receiving support through the Transition and Post Care Support program.

In November 2009, 188 children and young people were being supported by Evolve Behaviour Support Services accessing services across the stages of intervention including: 26 initial assessments, 29 functional assessment, 24 positive behaviour support, and six transitioned from Evolve services. The 2009 data shows the number of children and young people receiving a consultative service increased throughout the year from two to ten in November. In addition, 67 children and young people received transition support in the month of November 2009.

Increases in service provision throughout 2009 were also reflected in an increase in the provision of specialist disability assessments (initial and comprehensive) with a total of five in January 2009 and 26 in November 2009.

In July 2010, Evolve Behaviour Support Services were supporting 226 children and young people across the stages of intervention including: 22 specialist disability assessments, 17 functional assessments, 37 positive behaviour support and 28 initial assessments, with five children and young people transitioning from an Evolve service and six receiving a consultation service. In addition the transition and post care support program were supporting 111 young people in July.

The number of children and young people receiving a consultative service continued to increase to 12 by July 2010. Increases in service provision throughout 2010 were also evident in the provision

[17] Specialist Disability Assessments (SDA) provide a comprehensive profile of the disability specific needs of a child or young person and a referral may be made by either CSS or DCCS. The target group for an SDA is children and young people (0-18 years) with a disability who are: at risk of entering statutory care; entering statutory care; in care; or returning home from statutory care. The SDA aims to inform stakeholders about necessary supports, services and placement options that will be required to meet the child/young person's, and in some cases their family's needs. The timeframe for an SDA report is 6-8 weeks with support provided concurrently to the Child Safety Officer or Case Manager to implement the recommendations during the assessment and for up to three months post-assessment.

of specialist disability assessments (initial and comprehensive) by 50 from November 2009 to 74 in July 2010. Similarly there was a noticeable increase in the comparison points for functional assessments with totals almost doubling from November 2009 to 50 in July 2010.

The notable spike in July 2010 Specialist Disability Assessment numbers occurred as a result of the expansion of Evolve Behaviour Support Services teams and the introduction of additional staff positions for the SDA service. As a result, this has been identified as a direct contributing factor with regard to the decrease in initial assessments completed by July 2010, with a reduction of nine initial assessments completed (when comparing figures from November 2009 to July 2010). A co-occurring change is reflected in an increase in functional assessments in July 2011.

Overall the above 2009 and 2010 Evolve Behaviour Support Services data highlights the majority of active intervention were either an assessment or behaviour support response. Both the initial assessment and functional assessment phase include significant intervention as part of the process.

The Evolve Behaviour Support Services Data System is detailed in **Attachment 3.**

Section 3 - Outcomes

Outcomes for children and young people engaged in Evolve Therapeutic Services are detailed in the two attached reports –

The Evolve Therapeutic Services Outcomes Report 2009 (Attachment 1) and

The Evolve Therapeutic Services Outcomes Report 2010 (Attachment 2).

Similar reports are not available from Evolve Behaviour Support Services (provided by Department of Communities, Disability Services) as this service is not resourced to a similar level nor specifically for data reporting as is Evolve Therapeutic Services.

Reporting on outcomes for children and young people accessing Evolve Behaviour Support Services, as well as outcomes recorded by Department of Communities, Child Safety Services, are integrated in this, and the previous, section of the report.

Child or Young Person's Wellbeing

Child wellbeing is measured using a range of variables that reflect the impact of intervention on the child's or young person's behaviour, functioning in a range of settings and establishment of healthy relationships.

It is also measured through information obtained from stakeholders who provide services and supports to the child or young person. These stakeholders include carers, teachers, other professionals and the child or young person's family.

Stability and Safety

Placement stability is a significant issue for children and young people with severe and complex needs as their behaviours, disability and/or mental health issues frequently impact on carers' capacity to maintain the placement. In addition, continued placement breakdowns may exacerbate any existing behaviour and emotional difficulties for children and young people and negatively impact their long-term prognosis. As identified in Section 2 of this report, and further detailed in attachments 1 and 2, over two thirds of the Evolve Therapeutic Services client group have problems with family life and relationships rated as moderate to severe.

Data on placement stability have been collected by both Child Safety Services and Evolve Behaviour Support Services. In recognition of the general likelihood of increased placement changes over time, where possible, placement stability pre-and-post Evolve has been captured for comparative periods.

Data relating to Total Placement Changes prior to and during 2009 EBSS Involvement indicate that there was a 34 percent reduction in the total number of placement changes for all current Evolve Behaviour Support Services clients - placement changes reduced from 189 in the 12 months prior to Evolve Behaviour Support Services involvement, to 125 during Evolve Behaviour Support Services involvement in 2009. Further, the number of children or young people who experienced *no placement changes* during their 2009 Evolve Behaviour Support Services involvement increased from 81 to 95. Data collated by Child Safety Services for children and young people accessing Evolve services identified a similar trend.
A decrease in problems with family life and relationships following referral to Evolve Therapeutic Services is also evident (see Attachments 1 and 2 for details).

Transitional Placement Package arrangements

Given the short-term nature and high costs of Transitional Placement Package placements, these individuals are a priority referral group for Evolve services.

Costs of care
Data from 2009 were considered for children and young people who had been with Evolve for 12 months or more, to allow for an effective intervention period with a potential to influence stability of placement. It is noted from these data that the majority of children and young people in Evolve placed on Transitional Placement Packages had a reduction in their Transitional Placement Package costs.

Of those children and young people accessing Evolve during 2009, 94 were subject to Evolve intervention for 12 months or more and were on a Transitional Placement Package at commencement with Evolve. Of the 94, 48 experienced a decrease in package costs with 26 of these ceasing to be on a package, 25 had no change in package costs, 17 had increased costs and six commenced a package during their period of intervention with Evolve.

The average package cost reduction, where children and young people stopped receiving a Transitional Placement Package or had reduced package costs was $164, 280 per child per annum. Across these 94 children and young people, their Transitional Placement Package costs reduced from an average of $209,000 to an average of $162,000 per annum, an average decrease in costs of $47,000 per annum per child.

Child Protection Notifications

Data in relation to Child Protection Notifications were available on 149 children and young people who had been with Evolve for 12 months or more and with Evolve for the full year in 2009. Data for this period shows an increase in the number of children and young people without a child protection notification during the period and a decrease in those with one or more notifications during 2009 as compared to the year before commencing with Evolve. Additionally, the proportion of children and young people with no reported concerns increased where children and young people received 12 months or more of Evolve intervention.

Matters of Concern

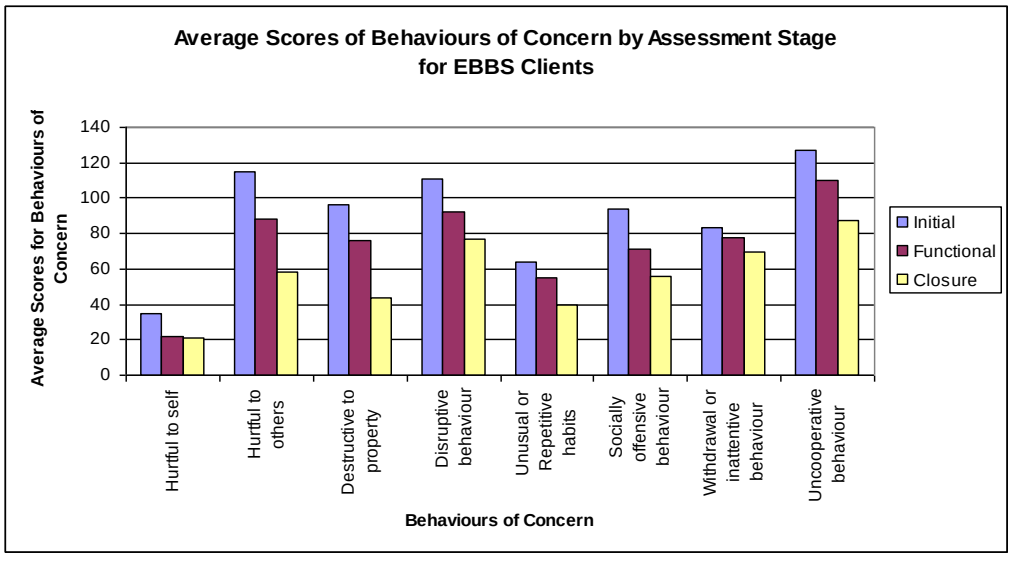
Matter of Concern Reports relate to issues with standards of care provided by the child or young person's carers, including residential care services. Data were available for 155 children and young people. These data indicate improvements, with a reduction in the numbers of children and young people having multiple Matters of Concern recorded, particularly when this is matched across a comparable 12 month period both pre-and-post commencement with Evolve.

The majority of children and young people experienced no Matter of Concern Reports either pre-or-post commencement of intervention. When the change in numbers of Matters of Concern for each child or young person is considered, it can be seen that the majority had no changes in the number of Matters of Concern and the shift in numbers was smaller and more likely to have fewer children and young people with multiple Matters of Concern when compared with a similar 12 month period pre-and-post intervention.

Indicators of Wellbeing for Children accessing Evolve Behaviour Support Services

Children and young people accessing Evolve Behaviour Support Services are also assessed against behaviour of concern and their progress tracked through monitoring reductions in behaviours of concern at key intervention points. Figure 4 below depicts mean scores in all behaviours of concern of closed Evolve Behaviour Support Services clients at the three stages of data assessment – initial assessment, functional assessment and case closure.

Figure 4 : Behaviours of Concern by Assessment Stage



Significant improvements were reported across all behaviours at Functional Assessment stage; that is, after only three to six months of service. This may be a product of the increased understanding, and subsequent support by stakeholders, of the complexity of the child's or young person's disability, communication styles and their trauma and attachment issues. Average reductions in behaviours of concern across the whole intervention period (initial assessment to case closure) ranged between 54 percent (destruction of property) and 16 percent (withdrawal or inattentive behaviour).

Of the twenty-five closed cases, 22 (88 percent) were reported to have significant decreases in behaviours of concern. The remaining clients who are currently receiving services were reported to have experienced behaviour improvements in 85 percent of cases. Understandably, the reported mean decrease in behaviours of concern for the closed cases (up to 80 percent decrease, mean score of 41 percent decrease) is greater than for current clients (mean score of 14 percent decrease) whose service is not yet complete.

Behaviours of concern were reported to increase for three clients (12 percent) whose behaviour support service case was closed. This complexity may be due to a number of causes such as difficulty or inability to implement behaviour support strategies (e.g., multiple residential placements, multiple diagnoses, inappropriate self placement, non-compliance with medication, youth justice involvement and detention centre residency). Other influences include changes to the protection order, and extreme, changing and competing complexities across many domains of the young person's life.

Engagement in school

Children and young people referred to Evolve are frequently those who have high levels of school absence. When a student in out-of-home care displays a pattern of non-attendance, state school principals communicate their concerns to the student's carer and to their Child Safety Officer, endeavouring to work co-operatively with the student, their carer and their Child Safety Officer to develop behavioural support plans with a goal of increasing attendance. These students often benefit immensely from engagement with an Evolve service and these plans are included as part of the student's Education Support Plan which is developed by the school.

Engagement in education was tracked by the Evolve Therapeutic Services and Evolve Behaviour Support Services staff as part of monitoring children and young people's progress against the goals through clinical assessment and stakeholder advice.

As indicated by the findings across both Evolve Therapeutic Services and Evolve Behaviour

Support Services, children and young people accessing Evolve services show improvements in school attendance.

Improvements in school attendance were demonstrated by Evolve Therapeutic Services with statistically significant changes over time on the HoNOSCA item 'Poor school attendance' in both 2009 and 2010.

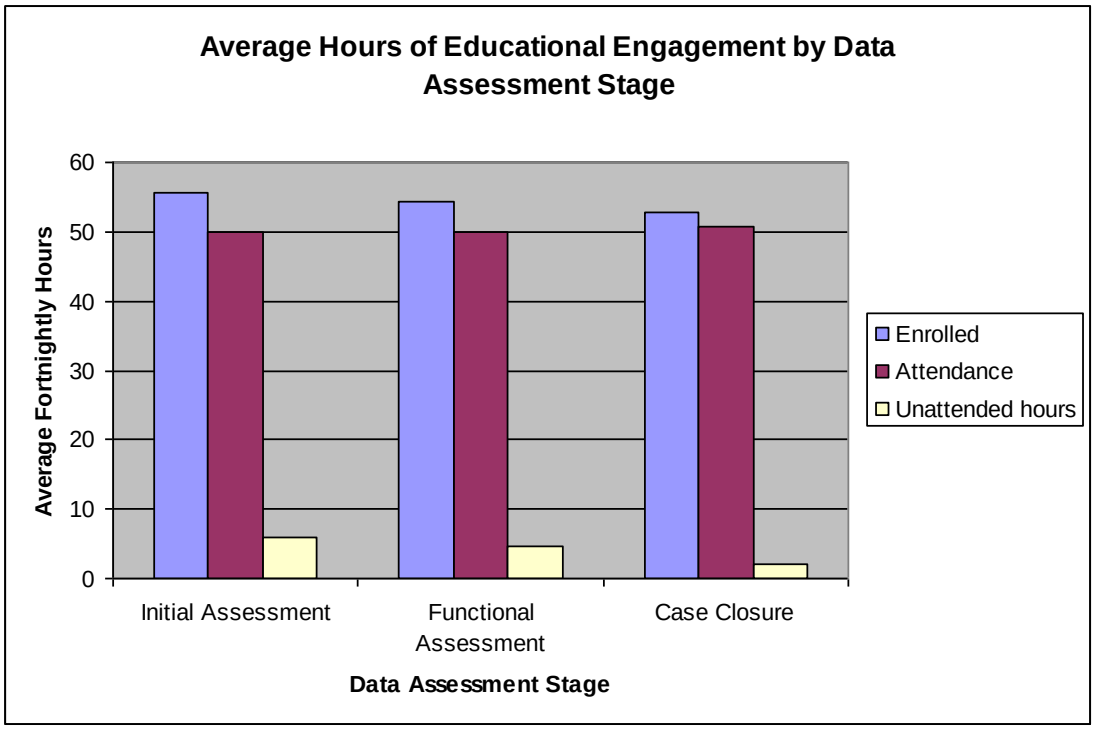
School attendance of Children and Young People accessing Evolve Behaviour Support Services

Enrolled hours are the Department of Education and Training program requirements developed for each child or young person. A full Department of Education and Training program would be 10 days per fortnight, six hours per day. The majority of Evolve Behaviour Support Services clients within Department of Education and Training are not attending for a full program but rather their individualised program may be four days per fortnight and two hours per day, or a variation of days and hours. The measure here reflects the child or young people's actual attendance against their individualised Department of Education and Training program.

The data shows a slight decrease in average enrolled hours across the service provision from 55.75 hours to 52.75 hours (see Figure 5). It is appropriate for the stakeholder group to negotiate enrolment hours and Department of Education and Training programs that children and young people with a disability are able to manage with an aim of increasing this over time.

Figure 5, over the page, shows the average hours of educational engagement of Evolve Behaviour Support Services clients.

Figure 5 : Average hours of educational engagement by assessment stage of EBSS intervention.



Evolve Therapeutic Services

As stated at the start of this section, outcomes for children and young people engaged in Evolve Therapeutic Services are detailed in the two attached reports –

The Evolve Therapeutic Services Outcomes Report 2009 (Attachment 1) and

The Evolve Therapeutic Services Outcomes Report 2010 (Attachment 2).

Analyses of Evolve Therapeutic Services outcomes data, as measured by the Children's Global Assessment Scale and the Health of the Nation Outcomes Scales for Children and Adolescents, showed statistically significant improvements on a range of indicators of functioning. While the data in 2009 was limited by small case numbers and a restricted time range for data collection and only shows limited statistically significant changes in addition to some positive trends, the data from 2010 was more robust and able to demonstrate statistically significant improvements from pre to post treatment on a range of measures.

In 2010, children and young people were shown to improve on measures of global functioning (CGAS), as well as the more specific HoNOSCA measures of disruptive, antisocial or aggressive behaviour; problems with overactivity, attention or concentration; non-accidental self-injury; problems with scholastic or language skills; problems with non-organic somatic symptoms; problems with emotional and related symptoms; problems with peer relationships; problems with self-care and independence; problems with family life and relationships; and poor school attendance.

Case studies included in the Evolve Therapeutic Services Outcomes Report 2010 also provide examples on an individual basis on the complexity and severity of the difficulties experienced by ETS consumers and their carers, the multifaceted nature of the services provided, and the improvements that can be achieved for these children and young people.

Section 4

Conclusions

This report focuses on the outcomes of children and young people receiving a service through the Evolve program during 2009 and 2010. It covers data collected in 2009 and 2010 as well as some data that was collected retrospectively.

When identifying appropriate outcomes and performance measures the small size and specific nature of the target population has been considered. It is recognised that data linked to broad population trends is not appropriate.

Outcomes sought are therefore linked to client benefits. This report aims to demonstrate the achievement of positive outcomes for children and young people with complex and severe psychological and behavioural support needs, including the identified benefits for stakeholders providing support to these children and young people and the system of care.

Achievements in relation to the desired outcomes:

- *Children and young people experience stability and safety whilst in receipt of Evolve services and Evolve supports stability and quality of care in children and young people's living arrangements:*
  - data from across the partner agencies confirmed the majority of children and young people subject to Evolve intervention showed consistent or improved placement stability across 2009 and 2010
  - the majority of clients referred to Evolve Behaviour Support Services have successfully remained with the carers providing placement at time of referral to Evolve
  - carers and clinicians reported improved placement stability
  - carers and professionals working with children received support and training to enhance their work with children and young people and assist in responding appropriately to the child or young person's needs.

- Evolve services contribute to the child or young person's wellbeing:
  - data across a range of areas indicated improved wellbeing through reduced aggression, reduced self harm, and improved relationships
  - Evolve Therapeutic Services data in 2010 demonstrated statistically significant improvement across the duration of treatment on measures of global functioning, disruptive, antisocial or aggressive behaviour problems, problems with overactivity, attention and concentration, self-injuring behaviour, non-organic somatic complaints, emotional and related symptoms, and problems relating to self care and independence
  - the child or young person's support network has the capacity to effectively respond to their needs
  - carers and clinicians indicated improved coping for carers and children
  - anecdotal feedback such as the case studies reported in Evolve Therapeutic Services Outcomes Report 2010 consistently reported improved capacity and positive feedback from carers and stakeholders.

- Children and young people with severe and complex support needs are able to access effective Evolve services to meet their needs:
  - the service was responding to the identified group with a mix of ages, gender, and Indigenous representation reflecting the client group.
  - Evolve Therapeutic Services data highlights the high level of clinical severity and complexity in the client population with statistically significant improvements in a range of key areas following treatment.

- Children and young people's behaviour is conducive to optimal functioning across a range of settings:
  - Evolve Therapeutic Services data indicates improvements in children and young people's wellbeing through improved global functioning, peer and family relationships and engagement in school.

- Children and young people are actively engaged in school/vocational education, training or employment:
  - children and young people have increased participation in school as reported through clinical assessment, carer and clinician reports.

- Children and young people experience healthy relationships:
  - children or young people's relationships with peers, carers and family relationships are reported to have improved.

- Participation in the Evolve program is associated with reduced costs of care:
  - a cost-benefit analysis indicated short and medium term savings in costs of care for 181 children and young people receiving Evolve services in 2009 who were on Transitional Placement Packages. This is evidenced across this group in the average cost per child or young person reducing by $48,000
  - the average Transitional Placement Package cost reduction, where children and young people stopped receiving a Transitional Placement Package or had reduced package costs was $164, 280 per child per annum.

Systemic Issues

The capacity of the program and the ability to provide quality and effective services are influenced by a range of service delivery and staffing issues. Measures of input, output and process have also been considered in the performance framework. Key findings in relation to the delivery of Evolve services included:

Collaborative Processes

Collaborative processes supported the delivery of services and engagement of children and young people and key stakeholders in planning and intervention. Panel and Local Steering Committee reports reflected the continuation of positive stakeholder and partner agency relationships with subsequent benefits for children and young people.

Feedback regarding stakeholder and partner relationships included:

- collaborative work with Child Safety Services, other departments and agencies is continuing to be effective in assisting children and young people across environments
- there has been a focus on collaborative practice, flexibility and commitment from all partners in an effort to improve outcomes for vulnerable children and young people
- Evolve panel members have provided a solid working relationship with strong communication and conflict resolution processes. This has also broadened access to services via each member's knowledge of particular service areas.

Recruitment and retention

The recruitment of suitably qualified and experienced staff continues to be an ongoing issue for the program. During 2009 and 2010 Evolve recruitment processes were conducted on an ongoing basis to enable increased service delivery.

Recruitment for Evolve Behaviour Support Services staff has been consistent with professional

clinician attraction and retention achieving between 75 percent and 85 percent of the full-time establishment target throughout 2009.

The Evolve Behaviour Support Services central office team have a continuous recruitment strategy with five employee recruitment advertising campaigns during 2009 and further campaigns in 2010, and often support or lead selection processes for a number of temporary positions throughout the state.

Monthly recruitment data collected throughout 2010 (refer to Table 2 page 12) showed staffing levels remained fairly consistent with positions filled ranging between 66 and 79 percent across teams; and positions unfilled varying between 21 and 34 percent.

Evolve Therapeutic Services continues to invest in the development of an appropriately skilled workforce, for both Evolve specifically, and the area of child protection generally, by providing training and resources to relevant University courses, as well as for various professionals working within the area of child abuse, trauma and neglect.

Professional development and training provided

Training is central to the Evolve model, supporting the development of increased capacity in the child or young person's support network and enhancing carers and professionals understanding of trauma and attachment issues. This is achieved through the inclusion of Professional Development Coordinators employed through Evolve Therapeutic Services.

Staff within the Evolve program developed expertise in treatment and management of children and young people with extreme and complex behaviours and in the fields of trauma, attachment and positive behaviour support. Evolve staff have provided training across government, non-government and private sectors to support professional development within the sector, develop knowledge and skill across children and young people's support networks, and provide direct support to carers to enhance outcomes for children and young people. Key stakeholders include: Department of Communities (Child Safety Services); Department of Communities (Disability and Community Care Services); Department of Education and Training; Queensland Health; foster carers; youth workers and residential care staff. In addition, information and training is supplied to the broader community, including psychiatrists, medical students, social workers, Queensland Police and court staff.

Training was provided to carers and professionals increasing the capacity and skill to support children and young people with complex and extreme needs. In addition, staff across Evolve Therapeutic Services and Evolve Behaviour Support Services provided training and coaching of carers, teachers, family and other key stakeholders in strategies to manage the specific needs of children and young people in their care. Training was also provided to Therapeutic Residential Care Services as part of the establishment of these services.

The primary focus areas for training conducted were: trauma and attachment; mental health diagnoses; mental illness and clinical presentations; issues around sexualised behaviour; managing self-harm and aggression). Evolve Therapeutic Services records showed that across 2009 and 2010, training was provided for 11,852 attendees. An evaluation of the training provided is conducted for the majority of sessions delivered and overall the training sessions were warmly received.

Limitations

This report provides further evidence of improvements in all areas considered. These results taken together are very encouraging. It is recognised that other factors may impact on results across the range of individual indicators used. The use of multiple indicators across the Evolve partner

agencies assists to confirm the validity of positive outcomes for children and young people accessing Evolve.

As there is no common data system there is currently limited ability to combine data across the program and compare across sites, services and data captured during 2009 and 2010. In addition each agency utilised a range of data sources that were not able to be combined and compared. This is being addressed to some extent by the introduction of consistent reporting by Evolve panels and steering committees and the continued inclusion of data from each agency on key topics which, while the collection tools may differ, provide a rich data set and similar indications of progress against key measures. A reduction in manual data collection has occurred since the 2008 Performance Report and is expected to further improve with the introduction of improved data systems.

APPENDIX D. Internal Queensland Health ETS meetings

ETS State-wide Steering Committee

- Frequency: Bi-monthly for two hours duration
- Membership:
    - Program:
        - Chair: Divisional Director, CYMHS, Children's Health Queensland HHS
        - Secretariat: Evolve Therapeutic Services State-wide Program Manager
        - Senior Service Evaluation and Research Coordinator
    - Strategic Governance:
        - 10 x representatives Hospital and Health Services that host an ETS hub
    - Clinical:
        - 2 x Psychiatrists
    - Operational:
        - 2 x Team Leaders
- Purpose: Support the implementation and ongoing development of the ETS Program through strategic planning, monitoring of operational issues and performance review within the context of Evolve as outlined in the Evolve Manual, the endorsed ETS Model of Service document and the endorsed Local Service Agreements entered into by each HHS with DCCSDS.

ETS State-wide Clinical Reference Group

- Frequency: Quarterly (3 months) for 6 hours duration
- Membership: ETS State-wide Program Manager (Chair), all ETS Team Leaders (or delegate) and all ETS Psychiatrists (or delegate).
- Purpose:
    - Support the implementation and ongoing development of the Evolve Therapeutic Services Program.
    - Feed expert on the ground clinical and operational experience and management information up to the ETS State-wide Steering Committee in order to assist in making broader strategic decisions regarding the ETS program and
    - Guide consistent implementation of practise and process direction from the ETS State-wide Steering Committee across the clinical services
    - Guide the direction of and support a quality, consistent and standardised ETS state-wide.
    - To share common experiences and learning to enhance effective and efficient provision of services.

ETS Team Leader Forum

- Frequency: Bi-monthly for 6 hours duration
- Membership: ETS State-wide Program Manager (Chair) and all ETS Team Leaders (or delegate).
- Purpose:
    - To provide a forum for Operational/Team Leaders to discuss and share knowledge, skills and resources related to the development and provision of a quality consistent and standardised ETS state-wide service and reporting processes.
    - Focussed discussion and resolution of common issues/trends that arise in the delivery of mental health services.
    - To provide an avenue for working groups to seek and receive operational guidance and support.
    - Formal forum for communication between ETS Operational/Team Leaders and state-wide Evolve Program Management.
    - Provide peer supervision and support.

Professional Development Meetings

- Frequency:
    - Video Conferencing:
      Frequency: monthly
        - Length: 1.5 hours
    - Face to face:
        - Frequency: 2 times per calendar year.
        - Length: 2 consecutive days
    - Sub-Groups:
        - Frequency, length and location: By agreement with Sub-Group members, and/or State-wide Program Manager and/or Team Leader Forum as necessary.
- Membership: State-wide ETS Program Manager, all ETS Professional Development Coordinators and CYMHS Child Safety Coordinator (ETS, Mt Isa)
- Purpose:
    - Plan, develop, coordinate, implement and progress professional development and training initiatives, projects and tasks for ETS in accordance with the ETS Professional Development Plan, local service agreements, and as identified by the State-wide ETS Steering Committee, the ETS Program Manager, ETS state-wide Clinical Reference Group, and ETS state-wide Operational Leaders Meeting.
    - Coordinate state-wide tasks across the PDC working group to ensure tasks are shared equitably, undertaken, progressed and completed in a reasonable time frame.
    - Ensure ETS Team Leaders are kept informed regarding the current state-wide workload for the PDC working group (e.g. maintain a list of state-wide PDC Tasks and Projects and regular liaison with ETS Program Manager, etc.).
    - Supporting the development of local and state-wide training activities by ETS PDCs through the sharing of information, strategies and resources; co-development of training programs as well as knowledge and skill building, peer support and supervision for PDCs.
    - Sub-Groups of the PDC working group may be established to enable completion of specific plans or tasks. Members of PDC working group and other persons may be invited to participate in PDC Working Sub-Groups. Each PDC working group will have a Lead PDC who is responsible for chairing, co-ordinating, and reporting back to the PDC working group until the working sub-group is disbanded.