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Evidence on programs to address youth homelessness

An Evidence Check rapid review brokered by the Sax Institute for the NSW Department of Communities and Justice—October 2021

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This report was prepared by: John Toumbourou and Jess Heerde.

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Evidence on programs to address youth homelessness

An Evidence Check rapid review brokered by the Sax Institute for the NSW Department of Communities and Justice. October 2021.

This report was prepared by John W Toumbourou (Deakin University) and Jess Heerde (University of Melbourne).

Contents

Summary of key messages

This Evidence Check reviews the 'effectiveness of programs that supported children and young people at risk of homelessness, or who were homeless'. The review was designed to inform a proposed reconfiguration of the NSW Homeless Youth Assistance Program (HYAP), which provides integrated support and accommodation services to children and young people (CYP) aged 12–15 who are homeless or at risk of homelessness. HYAP reconnects CYP with their families and broader support networks or supports them to transition to longer-term supported accommodation.

The methods used for searching and selecting research papers sought to include both peer-refereed and grey literature to identify a) peer-refereed literature reviews and b) evaluations of existing programs with the aim of preventing or reducing homelessness or reducing health and social problems for homeless populations aged 10–17 years. The included literature was organised to firstly identify peer-refereed literature reviews. The program evaluation literature was then identified from the review papers and search strategies to identify named programs and common strategies devised. The evidence for relevant programs that had been identified for inclusion by the Department of Communities and Justice was also examined. The evidence for included programs was rated based on the consistency of evidence from randomised trial evaluation designs for: reconnecting participants with their families (family reunification), reduction of out-of-home placement, homelessness and housing stability/instability, and increased transition to longer-term supported/ secure accommodation.

The present review found no evidence-based programs focused specifically on homelessness prevention or intervention for unaccompanied homeless youth. A total of 20 programs were identified and included in this review (see Table 2). Of these, four programs were rated to have two or more randomised trials showing positive evaluations on the focus outcomes for this review. These four programs were classified as 'evidence-based.' A further seven programs were rated as having one randomised trial showing positive evaluation outcomes. These seven programs were classified as 'promising.' The remaining nine programs were rated as having limited or no evaluation evidence to appraise effectiveness on the focus outcomes for this review. These programs were classified as 'insufficient evidence.' Of the four programs that had two or more randomised trials showing positive evaluations, three involved family therapy and one intensive case management.

Family therapy was evaluated to be effective in achieving housing outcomes and family reunification outcomes. Three RCTs evaluating home-based crisis intervention to improve family functioning (i.e. Intensive Family Preservation Services) found improvements in family reunification and return to the family home (biological family or relatives) among foster care youth. Two other programs, Functional Family Therapy and On the Way Home, found significant effects on housing and family reunification outcomes including less out-of-home care placement and referral for child welfare problems and building safe and supportive relationships with family members or others in community settings.

The evaluation findings for *intensive case management* were generally positive. For example, randomised trials associated Multisystemic Therapy (which included intensive case management as a component) with reduced out of home care placements. Evaluations of Treatment Foster Care

Oregon found significant effects for participants returning to live with relatives and reduced running away from care placements.

An important aspect of the successful program establishment and rollout of the most effective programs was implementation support. The programs identified to have the highest level of evidence for the outcomes that formed the focus of this review tended to also have strong implementation support.

Executive summary

This Evidence Check reviews the 'effectiveness of programs that supported children and young people at risk of homelessness, or who were homeless'. The review was designed to inform a proposed reconfiguration of the NSW Homeless Youth Assistance Program (HYAP), which provides integrated support and accommodation services to children and young people (CYP) aged 12–15 who are homeless or at risk of homelessness. HYAP reconnects CYP with their families and broader support networks or supports them to transition to longer-term supported accommodation.

The methods used for searching and selecting research papers sought to include both peer-refereed and grey literature. Keyword and subject searching identified peer-refereed literature reviews and evaluations of programs with the aim of preventing or reducing homelessness or reducing health and social problems for homeless populations aged 10–17 years. The reference lists of all the included studies were also scrutinised to identify any additional relevant studies. In addition, forward searches were also conducted for articles that cited included studies.

A concurrent search of 'grey literature' was also conducted. Google scholar was formally searched for reports of 'youth homelessness interventions'. National and international evidence-based program repositories were also searched. The included literature was organised to firstly identify peer-referred review papers. The program evaluation literature was then identified from the review papers and search strategies to identify named programs and common strategies.

To be included studies had to be (1) evaluating programs (including services, models, approaches, and strategies) that have been implemented; (2) with children and youth aged 10–17 years old; (3) aimed at preventing or reducing homelessness or achieving beneficial outcomes for homeless populations (e.g. family reunification); (4) from Australia, New Zealand (NZ), United Kingdom (UK), Canada, United States (US) or Western Europe. (5) Review studies were searched for the previous 5-years.

The evidence for included programs was rated using a modified 'thumbs rating' used in previous Evidence Check reports (Clancy et al. 2019, Skvarc et al. 2018, Jorm et al. 2013). The thumb rating was applied to outcomes most directly related to HYAP including: reconnecting CYP with their families and broader support networks, reduction of out-of-home placement and homelessness, and increased transition to longer-term supported/ secure accommodation. 'Evidence-based' programs were defined as achieving at least 2 thumbs up (at least 2 confirmatory randomised controlled trials) in the evaluation criteria. 'Promising' programs were defined as achieving 1 thumb up in the evaluation criteria (1 confirmatory randomised controlled trial). Programs with 'Insufficient evidence' were defined as achieving a 'Question mark' or a 'No evaluation evidence' rating using the thumbs evaluation criteria. Descriptive details were extracted for the programs with the highest evaluation evidence and for specific programs that had been identified for further analysis by the Department of Communities and Justice.

In total, 8 review papers were identified with publication dates between 2018 and 2021. These review papers included evidence summaries of the evaluation of youth homelessness programs and theoretical and good practice principles for implementation. The 8 literature review papers were used to identify programs fitting the inclusion criteria. The evidence-based programs listed in these reviews were added to those identified through the grey literature search of the evidence repositories, and programs identified for inclusion by the Department of Communities and Justice, resulting in a total of 20 programs being included in the current review.

Relevant details of the identified programs were extracted to answer the first question required in this Evidence Check brief *"Q1. What are the key features of the included programs?"* The present review found no evidence-based programs focused specifically on homelessness prevention or intervention for unaccompanied homeless youth. Of the 20 included programs, four programs were rated as 'evidence based' (2 or 3 thumb rating), indicating two or more randomised trials had shown positive evaluations on the focus outcomes for this review. A further seven programs were rated as 'promising' (1 thumb rating), indicating one randomised trial had shown positive evaluation outcomes. The remaining nine programs were rated as 'insufficient evidence' (Question mark or No evaluation evidence ratings), indicating there was limited or no evaluation evidence to appraise effectiveness on the focus outcomes for this review. Of the four programs rated with 2 or 3 thumbs, three involved family therapy and one intensive case management.

Relevant details of identified programs were also extracted to answer the second question required in this Evidence Check brief "*Q2. What are the core and/or common components or elements in the included effective programs and in successful program establishment and rollout?"* The 20 included programs were categorised under the following themes in descending order of evidence: family therapy, intensive case management, service capacity building and early intervention. It is noted that programs were categorised under these four themes in accordance with their primary focus; many of the identified programs have secondary foci that cross over multiple themes.

Family therapy and support

The three programs with the highest level of evidence included in the current review involved areas of family therapy and support. Family therapy was evaluated to be effective in achieving housing outcomes and family reunification outcomes. Three RCTs evaluating home-based crisis intervention to improve family functioning (i.e. Intensive Family Preservation Services) found improvements in family reunification and return to the family home (biological family or relatives) among foster care youth. Other family related outcomes included reduced report of child abuse and neglect, reduced family conflict, and more positive family management strategies (e.g. reduced conflict between family members). Two other programs, Functional Family Therapy and On the Way Home, found significant effects on housing and family reunification outcomes including less out-of-home care placement (young people were more likely to remain in the family home as opposed to being placed in out-of-home care) and referral for child welfare problems (including child maltreatment, neglect, and assault) and building safe and supportive relationships with family members (including parent-adolescent relationships) or others in community settings (such as prosocial peers). Each of these three therapeutic interventions were conducted with youth already receiving support through foster and out-of-home care placements so may not be generalisable to homeless youth not in these care settings.

Intensive case management

The evaluation findings for intensive case management were generally positive. The available evidence suggested that these interventions show positive effects on out-of-home care placements, housing stability, supportive relationships and other psychosocial outcomes. Multisystemic Therapy included intensive case management as one component. Two RCTs examining Multisystemic Therapy and one RCT examining Multisystemic Therapy for Child Abuse and Neglect showed reduced out of home care placements in the intervention compared to comparison groups. An RCT of Treatment Foster Care Oregon found significant effects on family reunification outcomes including participants returning to live with relatives more often. Other outcomes included reduced running away from care placements, improved parent-child interactions, and building relationships with prosocial peers. An RCT of Take Charge/Better Futures reported similar findings in relation to peer social support. Similar findings were evident for the Pathway Program (PPP) and YVLifeSet, which demonstrated improved housing stability (without there being a specific housing intervention) and placements in safe and stable housing, as well as improvements in independent living skills (including paying bills such as rent and utilities). Several studies explored other psychosocial outcomes with findings suggesting that there were some improvements in outcomes such as less contact with the justice system and less engagement in antisocial behaviour, improved educational attainment, reduced mental ill-health and the development of supportive relationships.

Service capacity building

The current review found some limited evidence that service capacity building frameworks have significant effects on homelessness, housing or family reunification outcomes. An RCT evaluation of the Creating Ongoing Relationships Effectively (CORE) program showed positive effects on supportive relationships among youth residing in foster care. Youth receiving CORE were more likely to identify having at least one adult in their life loved them, compared to the comparison group. Another framework, the Sanctuary model, found few differences between the intervention and control groups, and available evaluations did not examine outcomes relevant to housing/homelessness. A quasi-experimental study of the Behaviour Analysis Services Program (BASP) found runaway behaviours in foster care youth were identified and appropriate support provided, resulting in improved housing stability. There was no evidence available to assess the effectiveness of the service capacity building model, Ruby's.

Early intervention

The current review found no sound evidence for the effectiveness of early intervention programs for young people experiencing homelessness. These programs did not have published pilot data, or had not been evaluated, or had been implemented at only one intervention site. The Geelong Project involved Universal Screening for students at risk for homelessness and responded with tailored case management and support for at-risk students. Evaluation findings showed some improvements in educational outcomes (e.g. reduced early school leaving) and non-entry into the specialist homelessness services system. However, in the absence of a control condition and a prospective

comparison group the existing evidence is unclear whether program outcomes were the result of the program or other conditions.

Relevant details of these programs were also extracted to answer the third question required in this Evidence Check brief *"Q3. What are the reported challenges and facilitators across the included programs?"* Examining the evidence from the family therapy interventions that had the highest evidence in the currently included programs, it becomes apparent that one of the most important challenges is failure to implement these programs with fidelity to their original design. An important aspect of the successful program establishment and rollout of effective programs is implementation support. The programs identified to have the highest level of evidence for the outcomes that formed the focus of this review tended to also have strong implementation support. For example, initial state rollouts of Functional Family Therapy failed to replicate the initially observed evaluation outcomes due to poor implementation. This observation underpins a consistently observed challenge in implementing the four youth homelessness programs that show the highest evidence, the requirement for strong organisational support for programs to be implemented with fidelity and skilled staff with required implementation expertise.

Previous literature reviews of facilitators of service implementation and youth engagement in youth homelessness services identify both organisational and staff factors to be key facilitators. Specifically, organisational policies have been identified as important in shaping the quality and quantity of intervention implementation. Staff expertise, behaviours and training were also identified as important for the successful implementation of many interventions.

Background and introduction

This Evidence Check reviews the evidence for the 'effectiveness of programs that supported children and young people at risk of homelessness, or who were homeless'. The review was designed to inform a proposed reconfiguration of the NSW Homeless Youth Assistance Program (HYAP), which provides integrated support and accommodation services to children and young people (CYP) aged 12–15 who are homeless or at risk of homelessness. HYAP reconnects CYP with their families and broader support networks or supports them to transition to longer-term supported accommodation.

In 2017, the NSW Department of Communities and Justice commissioned an evaluation of HYAP to understand if the program was effective in transitioning the target group of children and young people out of homelessness (Page and Robertson 2021). The HYAP evaluation found the program was of some benefit in assisting the housing needs of children who had no prior involvement in the child protection system (44% of clients). However, the program had little or no impact on the children who were known to child protection services (56% of HYAP clients). These vulnerable children with a child protection history continued to experience housing instability and difficulties reconnecting with family and friends after accessing HYAP. Younger children and children with a child protection or out-of-home care history showed no improvement or worsened over time across several domains (Page and Robertson 2021). The current Evidence Check arose in response to the HYAP evaluation findings and, the intention to reconfigure the program to better meet the needs of the target group over the next three years.

As part of the review of HYAP, Albers et al. (2018) completed a rapid review of interventions that enhance family reunification and/or family functioning in a cohort defined as 12–15 years of age who are at risk of homelessness and/or out-of-home care placements. The review identified four programs that had potential to be integrated into the HYAP service model.

A previous literature review completed by the Department of Communities and Justice (DCJ) Family and Community Services Insights, Analysis and Research (FACSIAR) library in 2020 identified 7 systematic literature reviews of the effectiveness of youth homelessness programs (models). Evaluations of Australian and international programs were also sourced from peer-reviewed scholarly journals and grey literature from government agencies, recognised academic research centres and non-government organisations.

A rapid literature review was conducted to identify effective youth homelessness interventions (FACSIAR Evidence Brief 2021, unpublished). This review was based on the search conducted by FACSIAR's library and an additional search of the Campbell Collaboration and Cochrane databases for peer-reviewed meta-analyses, systematic reviews and reviews of reviews. Evidence-based program databases were also searched to examine the evidence ratings of specific programs using the California Evidence-Based Clearinghouse for Child Welfare and The PEW Charitable Trusts: Results First Clearinghouse.

Method

The methods used for searching and selecting research papers in the current review included both a search of peer-refereed and grey literature. To identify peer-refereed literature reviews and program evaluations of programs with the aim of preventing or reducing homelessness or reducing health and social problems for homeless populations aged 10–17 years. Keyword and subject headings were searched in June 2021 with the following: (homeless* OR runaway) AND ((child*) OR (adol*) OR (youth) OR (young)) AND evaluat*). We examined titles, abstracts or full texts, depending on relevance, and excluded articles not relevant to the research question. The following limits were applied: published in Australia, NZ, UK, Canada, US or Western Europe; and, for review papers, published in the last 5 years (from 2016). The reference lists of all the included studies were also scrutinised to identify any additional relevant studies. In addition, forward searches were also conducted for articles that cited included studies.

We used Pubmed with the following search terms: homeless* OR runaway) AND ((child*) OR (adol*) OR (youth) OR (young)) AND evaluat*) AND ("2016/01/01"[Date - Publication] : "3000"[Date - Publication]), yielding 278 records (21 July 2021). We then examined relevant papers and searched 'similar articles' listed by Pubmed.

We also conducted a concurrent search of 'grey literature'. We formally searched google scholar for reports of 'youth homelessness interventions' since 2016 and reviewed the 90 'most relevant' records (21 July 2021). The following national and international evidence-based program repositories were also searched as follows:

- Washington State Institute for Public Policy (WSIPP: http://wsipp.wa.gov/BenefitCost?topicId=3): Identifying child welfare programs with positive economic returns. Keyword search for housing, accommodation & homeless* [yielding 6 programs].
- Institute of Education Sciences, What works Clearinghouse (https://ies.ed.gov/ncee/wwc) Search results were filtered for: Kindergarten to 12th Grade / Staying in school (yielding 12 programs]
- Blueprints for Healthy Youth Development (www.blueprintsprograms.org/program-search) Program specifics - Continuum of Intervention - Selective/ Indicated prevention and keyword searches for housing, accommodation & homeless* [yielding 13 model and 49 promising programs]
- Californian Evidence Based Clearinghouse for Child Welfare (CEBC: www.cebc4cw.org/program) using the 'Advanced search' for ages 10–17 and 'high' Child Welfare System relevance [yielding 135 programs)
- Early Intervention Foundation Guidebook, (https://guidebook.eif.org.uk) searching the terms adolescence and selective or indicated [yielding 23 programs)

The included literature was organised to firstly identify peer-referred review papers. The program evaluation literature was then identified from the review papers and search strategies to identify named programs and common strategies (e.g. family therapy and support, intensive case management).

Evaluation measures were organised to identify outcomes including preventing or reducing homelessness/housing instability and reduction of health and social problems (e.g. mental health problems, substance use problems, school disengagement) for homeless populations (including children in out of home care/foster care) aged 10–17 years.

Inclusion criteria

To be included studies had to be:

(1) Evaluating programs (including services, models, approaches, and strategies) that have been implemented
(2) With children and youth aged 10–17 years old
(3) Aimed at preventing or reducing homelessness/housing instability or achieving beneficial outcomes for homeless or vulnerable child populations
(4) From Australia, NZ, UK, Canada, US or Western Europe
(5) For review papers, published in the last 5 years.

Programs were included if their evaluations assessed programs to CYP aged 10–17 at risk of homelessness, or currently homeless. The review was intended to inform the reconfiguration of the HYAP support and accommodation services to CYP aged 12–15 who are homeless or at risk of homelessness. Specific programs identified for further analysis by the Department of Communities and Justice were also reviewed. Preliminary scoping of the evidence revealed that several evaluations targeted from age 10 and age 16 and above, were applicable to 12- to 15-year-olds and potentially implementable by HYAP.

Programs were excluded if they were:

(1) Government level policies and strategies (e.g. national homelessness strategies)
(2) Focused on adult homelessness (age 18 and older), including those for families (i.e.housing, accommodation, and employment)
(3) Included homeless within programs targeting issues such as health treatments for tuberculosis, sexually transmitted infection. In scoping the review, it was agreed health programs were likely to be implemented by health services rather than HYAP
(4) School-led programs. In scoping the review, it was agreed school-led programs were likely to be implemented by school services rather than HYAP.

Figure 1—Flowchart of the literature review and program inclusion selection process

Evidence ratings for included programs

For this report, the evidence for programs was rated using a modified 'thumbs rating' used in previous Evidence Check reports (Clancy et al. 2019, Skvarc et al. 2018, Jorm et al. 2013) shown in Table 1 below.

Table 1—Evidence **rating for included programs**

Evidence	Rating
Three or more randomised trials, supplemented with high quality quasi-experimental evaluations showing consistent evidence that the approach works.	'Evidence-based' 3 thumbs up
Two randomised trials, supplemented with high quality quasi-experimental evaluations showing consistent evidence that the approach works, but the evidence is not as strong as for the best approaches.	'Evidence-based' 2 thumbs up
There is at least one randomised trial supplemented with a high quality quasi-experimental evaluation showing that the approach works	'Promising' 1 thumb up
There is not enough evaluation evidence to say whether the approach works. These approaches have low quality evaluations or have been implemented at only one intervention site	'Insufficient evidence' Question mark
There are no evaluations of sufficient quality to provide indications of effectiveness.	'Insufficient evidence' No evaluation evidence

The thumb rating was applied to outcomes most directly related to HYAP including: reconnecting CYP with their families and broader support networks, reduction of out-of-home placement and homelessness, and increased transition to longer-term supported/ secure accommodation/housing. All evaluation outcomes were also described for the included programs including improved family functioning, reduced substance use, improved mental wellbeing, and other outcomes.

'Evidence-based' programs were defined as achieving at least 2 thumbs up in the evaluation criteria. 'Promising' programs were defined as achieving at least 1 thumb up in the evaluation criteria. 'Insufficient evidence' programs were defined as achieving a Question mark or No Evaluation rating using the thumbs evaluation criteria.

Program description headings

Details were extracted for the programs with the highest evaluation evidence (see Table 2 and the section listed as 'INCLUDED PROGRAM DETAILS'). Descriptive details extracted for the included programs were:

- Underpinning evidence (summarised thumbs ratings)
- Design – including the evaluation features, client characteristics (e.g. age, reason for assistance, mental health, LGBQTI, first nations) and structural elements (e.g. budget, location, metro/regional/remote, local service systems)
- Intended outcomes (Such as enabling the CYP to live in a safe and stable family home or other secure housing; strengthened family relationships; reduced problematic behaviours)
- Target populations (e.g. specific age range of children and young people at risk of homelessness; CYP who are homeless; CYP from CALD backgrounds; Australian and Torres Strait Islander or indigenous internationally; CYP with behavioural and/or substance abuse issues; CYP who identify as LGBQTI; vulnerable families)
- Delivery methods (face to face, online, group, individual; Frequency of interventions [e.g. weekly CBT or family therapy]; Length of program; Tailoring of program to CYP and how this is managed; where responsibility for this sits; One organisation or across multiple organisations)
- Location of services – rural, metro, urban etc.
- Intervention focus (Such as CBT, family therapy, case management, housing support, combination)
- Assessment process to enter program, including eligibility criteria
- Referral pathways – into the program and onto other services
- Community engagement processes and ownership
- Resourcing, including how the program is funded
- Staff (Numbers; Type; Qualifications; Training – how provided, frequency, type)
- Other resources such as building infrastructure, IT
- Cost to deliver the program
- IP of the program.

Where programs have been identified as 'evidence-based' or 'promising', a detailed description of the following was included:

- Outcomes, including characteristics of client groups and populations where program has been most and least effective
- Data required to assess effectiveness
- Length of time for positive outcomes to be shown, and how long effectiveness was maintained
- Other relevant contributors to program's effectiveness
- Cost effectiveness (where available, including components that contribute to the program's cost effectiveness).

Process evaluation information, where available, included (for example):

- Evaluations of how the program was established
- Length of time to set up the program
- How communities and families were engaged
- Engagement of CYP in program

- Liaison with other services and organisations involved in program delivery
- Coordination with other services and organisations providing related care.

Table 2—Literature review and conceptual papers included from the search strategy

Reference	Details
Curry et al. (2021). Improving program implementation and client engagement in interventions addressing youth homelessness: A meta-synthesis	This systematic review identified 47 studies (3,112 youth and 495 staff participants) that met their inclusion criteria. Successful implementation and youth engagement were identified to require organisational and system policies that ensure the quality and quantity of interventions. Staff behaviours and training were also identified as important to the success of many interventions. Only 3 studies explicitly focused on racial or LGBTQI equity.
Greeson et al. (2020). Interventions for youth aging out of foster care: A state of the science review.	Searched the peer-refereed and grey literature from program repositories to identify the level of evidence for programs for youth aging out of foster care. Included 79 programs. Programs were included from this review that had a high evidence rating (CEBC 3 or higher) and enhanced 'access to safe and affordable housing', or helped 'youth build safe and stable lifelong relationships'.
Heerde et al. (2018). The impact of transitional programs on post-transition outcomes for youth leaving out-of-home care: a meta-analysis.	This meta-analysis appraised internationally published literature evaluating the impact of programs for youth transitioning from out-of-home care settings (for youth with a baseline age of 15–24 years) on post-transition outcomes of housing, education, employment, mental health and substance use. A comprehensive search included 19 studies in the meta-analysis. Living independently and homelessness were the most commonly described housing outcomes. Rates of post-transition employment varied, while rates of post-secondary education were low. Depression and alcohol use were commonly reported among transitioning youth. Moderator analyses showed outcome variation based on study design, sample size and sampling unit, but not for mean age or gender.
Morton et al (2020). Interventions for youth homelessness: A systematic review of effectiveness studies.	This review of experimental and quasi-experimental studies identified 53 unique studies of 54 different interventions, mostly from the US. Of the 53 studies, 22 involved randomised (experimental) evaluation. We included programs with evidence rating A or B (RCT or Quasi-experiment) and outcomes on housing or permanent connections.
Noh (2018). Psychological Interventions for	Systematic review of mental health outcomes for psychological interventions for runaway and homeless youth. Included 11 studies and identified five types of psychological interventions: art therapy, cognitive behavioural therapy (CBT)-based interventions, family therapy,

Table 2—Literature review and conceptual papers included from the search strategy

Reference	Details
Runaway and Homeless Youth	motivational interviewing, and strengths-based interventions. The narrative synthesis found positive effects of family therapy on substance use and positive effects of CBT-based interventions on depression. However, according to the meta-analyses, none of the interventions had any significant effects.
Schwan et al. (2018). Preventing youth homelessness: An international review of evidence	An international review of all available research on youth homelessness prevention, including both scholarly research and grey literature published between 2000 and 2018. International experts and key organisations were also consulted to assess emerging evidence, innovation, and knowledge with respect to youth homelessness prevention.
Vojt et al. (2018). Lack of evidence on mental health and well-being impacts of individual-level interventions for vulnerable adolescents: systematic mapping review	This systematic review examined evaluations of individual-level interventions intended to improve mental health or well-being for adolescents aged 10–24 years who were vulnerable due to issues that included homelessness. Both peer-reviewed and grey literature were searched up until 2016. Thirty systematic reviews and 16 additional trials were identified. There was insufficient high-quality evidence to identify promising individual-level interventions that improve the mental health/well-being of the vulnerable adolescent groups.
Wang et al. (2019). The impact of interventions for youth experiencing homelessness on housing, mental health, substance use, and family cohesion: a systematic review.	Reviewed peer-refereed literature until January 2018. Included 4 systematic reviews and 18 articles on randomised controlled trials. Cognitive behavioural therapy led to improvements in depression and substance use. Three family-based therapies reported decreases in substance use. Housing first, a structural intervention, led to improvements in housing stability. Many interventions showed inconsistent results compared to services as usual or other interventions, but often showed improvements over time in both the intervention and comparison group. Differential outcomes were evident based upon gender and ethnicity.

The literature review papers summarised in Table 2 were examined to identify programs fitting the inclusion criteria and general principles and theoretical underpinnings of effective programs. The evidence-based programs listed in these reviews were added to those identified through the grey literature search of the evidence repositories and the specific programs that had been identified for inclusion by the Department of Communities and Justice, resulting in a total of 20 programs being included in the current review. Relevant details of these 20 programs were then extracted to answer the first question required in this Evidence Check brief as listed below.

Question 1: What are the key features of the included programs?

Table 3 below summarises the 20 included programs and the thumb rating of quality for the evidence for their effectiveness. Further details of these programs are provided below in the section headed, Included Program Details. Overall, the current review found no evidence-based programs targeted towards unaccompanied homeless youth and designed to prevent, or intervene to reduce, homelessness. Of the 20 included programs, 4 programs were rated as 2 or 3 thumbs, indicating two or more randomised trials had shown positive evaluations on the focus outcomes for this review. These programs were classified as being 'evidence-based'. A further 7 programs were rated as 1 thumb, indicating one randomised trial had shown positive evaluation outcomes. These programs were classified as being 'promising'. The remaining 9 programs were rated Question mark or No Evidence, indicating there was limited or no evaluation evidence to appraise effectiveness on the focus outcomes for this review. These programs were classified as 'insufficient evidence'. Of the 4 programs rated with 2 or 3 thumbs, three involved family therapy and one intensive case management.

Table 3—Summary details of included programs, data available and thumb quality rating of effectiveness

Program name	Details	Data available	Thumbs Rating
FAMILY THERAPY & SUPPORT			
Intensive Family Preservation Services HOMEBUILDERS ®	Short-term, home-based crisis intervention to improve family functioning and prevent removal of a child from the biological family home (or to promote return to that home).	3 RCTs 2 Quasi-experiments	Evidence-based (3 Thumbs)
Functional Family Therapy (FFT)	Short-term, family-based therapeutic intervention for youth at risk of being institutionalised or those transitioning between care settings. Designed to improve family functioning, based on the risk profile of each family (including preventing out-of-home care placement). Family therapy.	3 RCTs 1 quasi-experiment	Evidence-based (3 Thumbs)
On the Way Home (OTWH)	Medium term family reunification program for youth in residential care. Family therapy.	2 RCTs	Evidence-based (2 Thumbs)

Table 3—Summary details of included programs, data available and thumb quality rating of effectiveness

Program name	Details	Data available	Thumbs Rating
Youth Hope*	Program providing support for vulnerable and at-risk families who are involved in (or who are at risk of being involved in) statutory child protection services.	No published evaluation	Insufficient evidence (No Evidence)
INTENSIVE CASE MANAGEMENT			
Multisystemic Therapy (MST) and Multisystemic Therapy for Child Abuse and Neglect (MST-CAN)*	Medium-long term intensive family and community based therapeutic intervention to improve the quality of family relationships, prevent placement on out-of-home care, and increase informal/formal support networks. Intensive case management.	3 RCTs	Evidence-based (3 Thumbs)
Treatment Foster Care Oregon adolescent*	Medium-long term intervention for youth in foster care or residential care, designed to increase social, emotional and relational skills and supportive relationships with adults (including parents). Intensive case management.	1 RCT	Promising (1 Thumb)
Take Charge / Better Futures*	Short-medium term, community-based intervention designed to improve educational and employment outcomes for youth in foster care. Intensive case management.	1 RCT	Promising (1 Thumb)
Pathway Program (PPP)	Medium term intensive case management program designed to improve education and employment outcomes. Shows additional improvement in housing stability.	1 RCT	Promising (1 Thumb)
My Life	Foster care independent living program designed to increase education and employment outcomes, and support housing placements.	1 RCT, 1 other study	Promising (1 Thumb)

Table 3—Summary details of included programs, data available and thumb quality rating of effectiveness

Program name	Details	Data available	Thumbs Rating
Transition to Independence Process (TIP)	Short-term, targeted intervention designed to improve life outcomes and provide support during the transition from foster care.	2 studies	Insufficient evidence (Question mark)
YVLifeSet	Short-term targeted program designed to provide support and guidance to young people leaving care settings, in areas including housing, education, employment and life skills. Intensive in-home support and guidance.	1 RCT	Promising (1 Thumb)
North Carolina Independent Living Program	Independent living program for youth leaving foster care designed to support housing stability and the development of life skills. Intensive support and guidance.	1 RCT	Promising (1 Thumb)
SERVICE CAPACITY BUILDING			
Ruby's*	Medium-long term model of service delivery for young people at risk of homelessness. Designed to provide intensive accommodation support and assist with family reunification.	No evidence available	Insufficient evidence (No Evidence)
Behaviour Analysis Services Program (BASP)*	Medium term, data analytic model designed to identify 'runaway behaviours' in foster care youth, with appropriate support provided by services.	1 study	Insufficient evidence (Question mark)
Sanctuary*	Long-term model of service delivery, designed to facilitate recovery from trauma.	1 Study	Insufficient evidence (Question mark)
Creating Ongoing Relationships	Model of trauma-informed service delivery designed to support youth to develop	1 RCT	1 RCT

Table 3—Summary details of included programs, data available and thumb quality rating of effectiveness

Program name	Details	Data available	Thumbs Rating
Effectively (CORE)	healthy relationships. Service capacity building.		
EARLY INTERVENTION			
The Geelong Project (TGP)/Universal Screening*	Short-medium term school and community-based homelessness early intervention program.	1 Study	Insufficient evidence (Question mark)
Youth Foyers*	Short-medium term model of accommodation services for young people who experience, or at risk of, homelessness. Model provides integrated learning and accommodation settings.	1 Study	Insufficient evidence (Question mark)
Premier's Youth Initiative*	Medium term program aiming to prevent homelessness among at-risk young people leaving care and divert them from the homelessness service system.	1 quasi-experimental study	Insufficient evidence (Question mark)
Reconnect*	Federally funded homelessness prevention and early intervention response program.	1 internal evaluation	Insufficient evidence (Question mark)

*This program was identified for inclusion by the Department of Communities and Justice.
RCTs = randomised controlled trial

Discussion

The discussion was organised to answer two further questions required in the Evidence Check brief. The section that follows outlines findings relevant to the core and common components of the included interventions.

Question 2: What are the core and/or common components or elements in the included effective programs and in successful program establishment and rollout?

Core and/or common components or elements were identified by examining the key components of the evidence-based programs. In the current review, the 20 included programs can be categorised under the following themes in descending order of evidence: family therapy, intensive case management, service capacity building and early intervention. The programs identified as evidence-based were family therapy and intensive case management. The evaluations of these programs and their key components are discussed in more detail in the sections that follow.

Family therapy and support (evidence-based).

The present review identified three programs with the highest level of evidence involved areas of family therapy. Family therapy was evaluated to be effective in achieving housing outcomes (Blythe and Jayaratne 2002, Fraser et al.1996, Morton et al. 2020, Walton 1998) and family reunification outcomes (Fraser et al 1996, Gottfredson et al. 2018, Morton et al. 2020, Pecora et al. 1992, Trout et al. 2013, Turner et al. 2017). Three RCTs evaluating home-based crisis intervention to improve family functioning (i.e. Intensive Family Preservation Services) found improvements in family reunification and return to the family home (biological family or relatives) among foster care youth. Two other programs, Functional Family Therapy and On the Way Home, found significant effects on housing and family reunification outcomes including less out-of-home care placement and referral for child welfare problems (Turner et al. 2017) and building safe and supportive relationships with family members or others in community settings (Trout et al. 2012). Each of these three therapeutic interventions were conducted with youth already receiving support through foster and out-of-home care placements so may not be generalisable to homeless youth not in these care settings.

Intensive case management (mostly promising)

The evaluation findings for intensive case management were generally positive. The available evidence suggested that these interventions show positive effects on out-of-home care placements, housing stability, supportive relationships and other psychosocial outcomes. Multisystemic Therapy

included intensive case management as one component. Two RCTs examining Multisystemic Therapy showed reduced out of home care placements in the intervention compared to comparison groups (Ogden et al. 2004, Ogden & Hagen 2006). One RCT examining Multisystemic Therapy for Child Abuse and Neglect (MST-CAN) showed young people receiving MST-CAN were less likely to experience an out-of-home placement and had fewer out-of-home care placement changes compared to the comparison group (Swenson et al. 2010). Similar findings were evident for the Pathway Program (PPP; Theodos et al. 2016) and YVLifeSet (Greeson et al. 2020, Jacobs et al. 2015). Several studies explored other psychosocial outcomes with findings suggesting that there were some improvements in outcomes such as less contact with the justice system and less engagement in antisocial behaviour (Chamberlain & Reid 1998), improved educational attainment (Geenen et al. 2013, Powers et al. 2012), reduced mental ill-health (Geenen et al. 2013) and the development of supportive relationships (e.g. Haber et al. 2008).

Service capacity building. (Insufficient evidence)

The current review found some limited evidence that service capacity building frameworks have significant effects on homelessness, housing access/stability or family reunification outcomes. An RCT by Nesmith and Christophersen (2014) evaluated the outcomes of the Creating Ongoing Relationships Effectively (CORE) program. Results showed positive effects on supportive relationships, with youth receiving CORE more likely to identify having at least one adult in their life loved them, compared to the comparison group. Another framework, the Sanctuary model, found few differences between the intervention and control groups, and available evaluations did not examine outcomes relevant to housing/homelessness. In their review, Morton et al. (2020) reported improved housing outcomes through implementation of the Behaviour Analysis Services Program (BASP). In a quasi-experimental study of the BASP, runaway behaviours in foster care youth were identified and appropriate support provided, resulting in improved housing stability (Clark et al. 2008). There was no evidence available to assess the effectiveness of the service capacity building model, Ruby's.

Early intervention. (Insufficient evidence)

Although previous reviews that included practitioner perspectives found early intervention to be promising (Schwan et al. 2018), the current review found limited evidence for the effectiveness of early intervention programs for young people experiencing homelessness. One program, The Geelong Project (TGP), involved universal screening for students at risk for homelessness. This program provided tailored case management and support for these students. Evaluation findings showed some improvements in educational outcomes (e.g. reduced early school leaving) and non-entry into the specialist homelessness services system. However, in the absence of a control condition and a prospective comparison group the existing evidence is unclear whether program outcomes were the result of the TGP or other conditions (Morton et al. 2020).

An important aspect of the successful program establishment and rollout of effective programs is implementation support. The programs identified to have the highest level of evidence for the outcomes that formed the focus of this review tended to also have strong implementation support (see the section headed Included Program Details below).

Question 3: What are the reported challenges and facilitators across the included programs?

Examining the evidence from the family therapy interventions that had the highest evidence in the currently included programs, it is apparent that one of the most important challenges is failure to implement these programs with fidelity to their original design. A good example is functional family therapy, where initial rollouts in Washington State failed to replicate the initially observed evaluation outcomes due to poor implementation (Sexton & Turner 2010). This underpins a consistently observed challenge in implementing the four youth homelessness programs identified in this review that showed the highest evidence - the requirement for strong organisational support for programs to be implemented with fidelity and skilled staff with required implementation expertise (Curry et al. 2021). In their review of facilitators of service implementation and youth engagement in youth homelessness services, Curry et al. (2021) identify both organisational and staff factors to be key facilitators. Specifically, organisational policies were identified as important in shaping the quality and quantity of intervention implementation. Staff expertise, behaviours and training were also identified as important for the successful implementation of many interventions.

In their review Albers et al. (2018) identified common practice elements that may have facilitated the positive outcomes achieved in the four evidence-based programs they identified as having potential to be integrated into the HYAP service model. These common elements were:

(1) The intensity with which services are delivered
(2) The individualisation of treatment plans
(3) The intensity and accuracy with which practitioners follow up on services delivered to young people and outcomes achieved for them
(4) The role of young people in skill building
(5) The integration of multiple systems in service delivery (family, peers, school / education, community actors etc.) – and the level of support provided to them
(6) Efforts to build positive peer networks for young people
(7) The level of supervision and support provided to practitioners.

The current review identifies support for these practice elements, to the extent that they form components in the most effective of the programs included in the current review. Missing from the Albers et al. (2018) practice elements is the centrality of family therapy as a method of improving housing and accommodation and restorative family outcomes for homeless CYP.

An internal rapid review by the Department of Communities and Justice (FACSIAR Evidence, 2021 unpublished) noted the evidence is lacking on how interventions vary for sub-populations who are disproportionately affected by homelessness (Morton et al. 2020). More research is needed for specific sub-populations, including Aboriginal young people, young people from culturally diverse backgrounds, LGBTQI young people, young people with a disability and young people who are pregnant or have children, particularly ‘rigorous evaluative evidence’ (Morton et al. 2020, p11).

The present review found no evidence-based programs focused specifically on homelessness prevention or intervention for unaccompanied homeless youth. Of the identified evidence-based programs, all targeted young people who can be considered as being at-risk for homelessness, in particular young people transitioning from foster care or other high-risk settings (e.g. justice involved youth). Many of these programs targeted reducing longitudinal risk factors for later homelessness

identified in population-based samples (e.g. academic underachievement, antisocial behaviours, antisocial peer engagement; Heerde et al. 2020, 2021a, 2021b).

The current review focused on published evaluations using randomised trials and for this reason shows some divergence from reviews that also incorporate practitioner perspectives. Schwan et al. (2018) reviewed both published evidence and expert practitioner perspectives in the implementation of youth homelessness services. They found evidence supporting 'systems prevention' in points of transition across systems. This concept included: youth-led discharge planning; family mediation and reunification prior, during, and after exits from public systems; financial and housing supports following exits from care or prison; trauma-informed case management; prison diversion program; and improved access to mental health and addiction services.

In their review Schwan et al. (2018) noted the structural prevention of homelessness remains critical to ensuring other forms of prevention are effective. This included tackling poverty and affordable housing. One of the challenges using randomised trials to evaluate youth homelessness outcomes is the difficulty of applying this evaluation design in broader service settings. For example, previous reviews (Morton et al. 2020) note the lack of rigorous evaluation of transitional, supportive and subsidised housing programs. Housing programs that have been evaluated using less rigorous methods show positive results on housing stability (Morton et al. 2020 p.8). Despite the lack of rigorous trials, Schwan et al (2018) found support for housing interventions including immediate-term efficacy of both financial assistance (e.g. rent subsidies) and legal advice, supports, and representation in preventing evictions. Youth-focused housing models were also reported to show promise. Strengthening young people's wellbeing, family and community connections was also identified as contributing to homelessness prevention.

Analysis of the applicability for NSW HYAP

The current review was focused on identifying programs that were relevant to the NSW HYAP target group of homeless young people 12–15 years of age. The review identified a growing evidence base evaluating outcomes through the delivery of services to homeless youth, within the target demographic and age range of the HYAP service. The reviewers identified evidence that several of the included programs with the most rigorous supporting evaluations have been implemented and evaluated in NSW services.

Intensive Family Preservation (FACSIAR Evidence Brief 2020), Functional Family Therapy – Child Welfare (FFT-CW®) and Multisystemic Therapy for Child Abuse and Neglect (MST-CAN®) each received high thumbs evaluations and have previously been implemented in NSW (FACSIAR Evidence Brief 2020, Shakeshaft et al. 2020). The NSW evaluations comprise process, outcome and economic data which described varied fidelity (Shakeshaft et al. 2020). Efforts in NSW to improve program implementation are currently supported by a range of internal and external key stakeholders and service providers (Shakeshaft et al. 2020).

The current report was designed to comprehensively identify programs with robust evidence for improving family reconnection, reducing out-of-home placement and homelessness, and increasing transition to longer-term supported/ secure accommodation for vulnerable youth. An important finding of the current review is the considerable activity implementing programs to address youth

homelessness in NSW. Programs that are being implemented in NSW with two or three thumb ratings were the Family Therapy and Support Programs: Intensive Family Preservation Services, Functional Family Therapy (FFT) and Multisystemic therapy for child abuse and neglect [MST-CAN]. Programs that are being implemented with 'insufficient evidence' evaluation ratings were the Family Therapy and Support Program, Youth Hope, and the Early Intervention programs: Universal Screening, Premier's Youth Initiative, and Reconnect.

Implications

The main implication of the present report is to emphasise that the current review found no evidence-based programs focused specifically on homelessness prevention or intervention for the unaccompanied homeless youth population that forms an important focus of HYAP. Given there are significant gaps in the evidence base for this client group, some service innovation will be warranted incorporating evidence-based practices and rigorous planned evaluation.

The evidence-based programs identified in the current review highlight the importance of family therapy as a component that can be included within programs for young people considered as being at-risk for homelessness (e.g. those transitioning from foster care), and within the services offered through HYAP. These programs were identified based on robust evaluation evidence for their potential to improve family reconnection, reduce out-of-home placement and homelessness (including longitudinal adolescent risk factors for later homelessness), and increase transition to longer-term supported/ secure accommodation for the vulnerable HYAP target group. These programs have been implemented in NSW in recent years and current efforts are focused on improving their fidelity and impact (Shakeshaft et al. 2020). The implication is that efforts to reconfigure the HYAP service models should develop referral and service linkage pathways to ensure that relevant HYAP clients can access the family therapy programs that are identified in the current review to have rigorous evaluation evidence (Table 2) and are already operating in NSW. These evidence-based programs emphasise close adherence to their practice models.

The current review has further implications in extending the understanding of common practice elements that may facilitate positive outcomes within the HYAP service model (Albers et al. 2018). In their review Albers et al. (2018) identified seven common elements as:

(1) The intensity with which services are delivered (frequent contact and high staff accessibility)
(2) The individualisation of treatment plans
(3) The intensity and accuracy with which practitioners follow up on services delivered to the youth and outcomes achieved for young people
(4) The role of youth skill building
(5) The integration of multiple systems in service delivery (family, peers, school / education, community actors etc.) – and the level of support provided to them
(6) Efforts to build positive peer networks for young people
(7) The level of supervision and support provided to practitioners.

The current review identifies support for these practice elements, to the extent that they form components in the most effective of the programs included in the current review. However, the current review has the implication of highlighting the central importance of the practice element of family

therapy as a method of securing accommodation and restorative family outcomes for vulnerable homeless youth.

The current review has the further implication of emphasising fidelity to effective program models and practices as an important implementation challenge affecting service outcomes in NSW in recent years (Shakeshaft et al. 2020). This emphasis is in some respects divergent from the common elements approach, as it suggests that improvements in outcomes for the most vulnerable youth in NSW will require *disciplined attention* to the implementation of the core program strategies embedded within the programs that have demonstrated outcomes within rigorous evaluation designs.

An important implication emerging from the current review is the consistently observed requirement for strong organisational support for evidence-based programs to be implemented with fidelity to their intended design and skilled staff with required implementation expertise (Curry et al. 2021). Specifically, organisational policies have been identified as important in shaping the quality and quantity of intervention implementation. Staff expertise, behaviours and training have also been identified as important for the successful implementation of many interventions. Given that variability in outcomes has been experienced in previous efforts to initially rollout evidence-based programs (Sexton & Turner 2010), an implication of the current review is that Australian implementations of adapted, revised and novel youth homelessness programs should be accompanied with rigorous (preferably randomised) evaluation designs.

Given the current report identifies four programs that have two or three thumbs evaluation evidence for beneficial outcomes for homeless youth, a final implication of the current report is to set a clear rationale for future youth homelessness program investment in program development and evaluation. Future youth homelessness program investment should be justified as exceeding the benefit of existing evidence-based programs or by achieving similar benefit at reduced cost. In this context it is important to accompany program investment with relevant evaluation funding for the programs being implemented with Question mark or No evaluation ratings in NSW including the Family Therapy and Support Program, Youth Hope, and the Early Intervention programs: Universal Screening, Premier's Youth Initiative, and Reconnect.

The current report identifies a range of programs that have been evaluated across the world using random assignment designs to assess outcomes that are directly relevant to youth homelessness services. In order to build a NSW evidence base it is feasible to evaluate service innovation using random assignment designs. Randomisation may be achieved by considering organisations, localities and or clients as the unit of assignment. A first foundation for improved evaluation is to ensure all services are accompanied with valid and standardised longitudinal monitoring of outcomes for each client. Program changes assigned to specific programs can then be evaluated by comparison to clients that continue to receive services based on business as usual.

Conclusion

This Evidence Check reviews the ‘effectiveness of programs that supported children and young people at risk of homelessness, or who were homeless’. The review was designed to inform a proposed reconfiguration of the NSW Homeless Youth Assistance Program (HYAP), which provides integrated support and accommodation services to children and young people (CYP) aged 12–15 who are homeless or at risk of homelessness. This report searched both peer-refereed and grey literature to identify peer-refereed literature reviews and evaluations of programs with the aim of preventing or reducing homelessness or reducing health and social problems for homeless populations aged 10–17 years.

A total of 20 programs were included in this review. Notably, none of the identified programs focused specifically on homelessness prevention or intervention for the unaccompanied homeless youth who form an important focus of HYAP. Of the reviewed programs, four were rated as evidence-based, having two or more randomised trials showing positive evaluations on the focus outcomes for this review. A further 7 programs were rated as promising, having one randomised trial showing positive evaluation outcomes. The remaining 9 programs were rated as insufficient evidence, having limited (7) or no evaluation (2) evidence to appraise effectiveness on the focus outcomes for this review. Of the four programs that had two or more randomised trials showing positive evaluations, three involved family therapy and one intensive case management.

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Appendix 1

Family Therapy Programs

Intensive Family Preservation Services (HOMEBUILDERS®)

Underpinning evidence – Evidence based (3 thumbs)

(3 RCTs + 2 Quasi-experiments)

(WSIPP 2019, Program/78) 2 included studies for intervention at age 10 preventing out-of-home placement=Cox effect size at age 11 = -0.553 (SE 0.148) and at age 17= -0.553 (SE 0.148). WSIPP (2019, Program/78) cite three RCTs (Blythe and Jayaratne 2002, Fraser et al. 1996, Walton 1998) and these cite a quasi-experiment (Pecora et al. 1992). Blythe and Jayaratne (2002) in a non-peer refereed report state at their 12-month follow-up the rates of children living at home were 93% amongst the 66 families randomised to an Intensive Family Preservation Service (IFPS), compared to 43% in the foster care control group. Fraser et al. (1996) report random assignment of children (aged 0–17) in Utah foster care services. The intervention received an IFPS (n = 57) and the comparison routine reunification services (n = 53). Of the 57 children in the intervention, 55 (96.5%) were reunited with their families within the 90-day service period – the remaining two children (3.5%) never returned during the 455-day observation period. Children returned to the homes of relatives, as in private or state-sponsored kinship care, were not counted as successes. Of the 53 children in the control condition 28 (52.9%) were reunited with their families, 17 (32.1%) during the 90-day service period and 11 (20.8%) during the post-treatment, 12-month follow-up period. Walton (1998) reported a trial where 62 children were randomised to IFPS and 58 to usual state welfare services. After 90 days 75% of the IFPS children were reunified with their families, compared with 49% of the controls. Positive effects were maintained to a six year follow-up. Pecora et al. (1992) report a 12-month quasi-experimental follow-up with 581 children where 93% of at-risk children remained with their families or relatives after receiving Intensive Family Preservation Services.

California Clearinghouse (2021 program/homebuilders): 3 included studies, 2 RCTs, for intervention at ages 1–17 years for family reunification; length of postvention follow-up 1–5 years. Wood et al. (1988) report a quasi-experimental trial with child protective service clients where 59 children referred to an IFPS. These were compared to 49 children receiving usual county services. At 1-yr follow-up there was lower out-of-home placement and placement costs in the IFPS intervention. A NSW implementation trial has been reported (FACSIAR Evidence Brief 2020).

Design

Pecora et al. (1992) describe HOMEBUILDERS as one of the original home-based Intensive Family Preservation Services (IFPS). These programs involve intensive delivery of services in the home setting over a short duration (four to six weeks) (Pecora et al. 1992). "*These programs are intended to*

prevent removal of a child from his or her biological home (or to promote his or her return to that home) by improving family functioning." (WSIPP 2021, Program/78).

Target populations:

Parents assessed to be at risk of or experiencing out-of-home placement of their child or adolescent 0–17 years.

Delivery methods:

"Service duration of four to six weeks, and provision of intensive, concrete services and counselling." (WSIPP 2021, Program/78). Program runs for "*an average of four to six weeks. Two after-care 'booster sessions' totalling up to five hours are available in the six months following referral." (California Clearinghouse 2021). "Therapists use a variety of clinical methods, including parenting training, active listening, contracting, values clarification, cognitive-behavioural strategies, and problem-management techniques. They provide or arrange for a variety of concrete services to help families obtain food, clothing, housing, and transportation. Other community resources that provide families with food stamps, medical care, day care, and employment training may be coordinated by the worker as well.*" (Pecora et al.1992, p179).

Location of services:

NSW implementation trial has been reported (FACSIAR Evidence Brief 2020). Staff deliver services to households, care setting.

Assessment process to enter program:

Families assessed by services to be at risk of or experiencing out-of-home placement of child.

Referral pathways:

Families are referred based on assessment that they are at risk of or experiencing out-of-home placement of child.

Resourcing:

Skilled staff work with caseloads limited to two to four families at one time over a period of four to six weeks, with staff available 24 hours a day if required during this period (Pecora et al. 1992). "*Staff work intensively and are accessible round the clock with small caseload sizes.*" (WSIPP 2021, Program/78). The staff team consists of "*3–5 therapists, 1 supervisor (carries a partial caseload), and 1 secretary/support staff". Resources include "a small amount of staff work/office space, supplies, telephone, copier, etc. pagers and /or cell phones. Clinical staff use their own vehicles for home visits, mileage is paid for all client and program related travel."* Resourcing requires *"access to a computer and Internet for client records and data collection.*" (California Clearinghouse 2021).

Outcomes:

Prevention of placement in out of home care and/or facilitation of successful reunification (Blythe & Jayaratne 2002, Fraser et al. 1996, Pecora et al. 1992). Additional outcomes: reduced child abuse and neglect, reduced family conflict, reduced child behaviour problems, and improve family management skills.

Data required to assess effectiveness:

Evaluations based on cost of placement services, whether or not children remained at home, and success of family reunification.

Length of time for positive outcomes to be shown:

Two months after referral, no cases remained open. The average length of the intervention was 28 days. Length of postvention follow-up at least 1 year. (Blythe and Jayaratne 2002).

How long effectiveness was maintained:

6 years (Walton 1998).

Other relevant contributors to program's effectiveness:

Fraser et al. (1996) report analyses of program factors that contributed to effectiveness. These included therapist and family factors.

Cost-effectiveness:

Benefits minus cost: "*US$13,824 per participant = Costs US$3,674, Benefits US$17,498.*" (WSIPP 2021, Program/78).

Minority populations:

Families are typically socioeconomically disadvantaged, and in minority cultural groups. We found no reports of delivery for ATSI or LGBTI families.

Process evaluation information – evaluations of how the program was established:

Fraser et al. (1996) provide a brief report of the history and establishment in Utah where family service coalitions led the implementation. The California Clearinghouse (2021, program/homebuilders) report there is "*a manual that describes how to deliver this program*" and "*training available*" through Shelley Leavitt, PhD, Associate Director, Institute for Family Development.

Length of time to set up program:

Walton (1998) report staff were trained over a three-month period. Additional time would be required for staff recruitment and office establishment.

How communities and families were engaged:

Based on Fraser et al. (1996) family service coalitions led the implementation in Utah. Families were then engaged through these services.

Engagement of CYP in program:

CYP at risk of being removed from their families and or placed into out-of-home care are engaged through their families, who are assisted to achieve this by service staff.

Liaison with other services and organisations involved in program delivery

No information available.

Coordination with other services and organisations providing related care:

Based on Pecora et al. (1992 p179) staff will require liaison and coordination links to expertise in mental health, psychology, parent education, social services and welfare services.

Functional Family Therapy (FFT)

Underpinning evidence – *Evidence based (3 Thumbs)*

(1 large Quasi experiment, 1 RCT (reducing out-of-home placement) and 2 RCTs improving family connection and reducing youth behaviour problems).
https://www.blueprintsprograms.org/programs/28999999/functional-family-therapy-fft/
https://guidebook.eif.org.uk/programme/functional-family-therapy

WSIPP (2019 Program/761): 1 study for intervention at age 10 preventing out-of-home placement = Cox effect size = 0.188 (SE 0.179, n = 1,625). Turner et al. (2017) report a quasi-experimental trial where families referred to New York services for child welfare concerns received either Functional Family Therapy for Child welfare (FFT-CW®: n = 1,625) or usual care (n 2,250). After 16-months the FFT children had less out-of-home placement and referral for child welfare problems.

WSIPP (2019 Program/32) 1 study for intervention with court involved youth at age 16 preventing out-of-home placement = Cox effect size = -0.075 (SE 0.078, n = 280). Gottfredson et al. (2018) reported a trial where 129 court involved youth were randomised to FFT. By 18 months this group demonstrated lower recidivism and court detention (Gottfredson et al. 2018). NSW implementation evaluations comprising process, outcome and economic data are in process (Shakeshaft et al. 2020).

Design:

Family-based therapeutic intervention. "*Functional Family Therapy (FFT) is a short-term (approximately 30 hours), family-based therapeutic intervention for delinquent youth at risk for institutionalisation and their families. FFT is designed to improve within-family attributions, family communication, and supportiveness while decreasing intense negativity and dysfunctional patterns of behaviour. Based on the specific risk and protective factor profile of each family, the program targets parenting skills, youth compliance, and a wide range of behaviours involving cognitive, emotional, and behavioural domains*." (Blueprints 2021, Program/fft). "*The five major components of [this family therapy model] include engagement, motivation, relational assessment, behaviour change, and generalisation* (WSIPP 2019/32). "*PTT intervention consist of direct contact with family members. During the first phrase of therapy (Engagement) the therapist is matched to family values/culture and is required to respond to initial barriers of attending therapy as a family unit (e.g. transportation, reluctance). The second phase (Motivation) focuses on trust and alliance-building with all family members. The fourth phase (Behaviour change) includes parent training (contracting, rewards and consequence techniques)".* (EPISCenter)

Target populations:

Early adolescents (12–14 years) and late adolescents (15–18 years).

Deliery methods:

Family therapy (indicated/selective prevention); FFT should be implemented with a team of 3–8 master's level therapists, with caseloads of 10–12 families, with oversight by a licensed clinical therapist (Blueprints 2021, Program/fft). "*The program typically involves 12–15 face-to-face sessions of approximately 1 h during which trained therapists work with the targeted youth as well as his or her caregivers, usually in a home setting. The entire program is usually delivered over a three-month*

period." (Gottfredson et al. 2018 p.941). When delivered with court involved youth typically involves 12–14 therapist visits over a three- to five-month period (WSIPP 2019/32).

Location of services:

NSW implementation evaluations are in process (Shakeshaft et al. 2020). Usually implemented in a home setting (Gottfredson et al. 2018 p.941), but also in school, community centre, outpatient health settings; social service settings (Blueprints 2021, Program/fft). This program has been implemented in Australia, Belgium, Canada, Chile, Denmark, New Zealand, Norway, Singapore, Sweden, United Kingdom, and the United States (Blueprints 2021 Program/fft).

Assessment process to enter program:

Assessed by family services to be children at risk of out-of-home placement due to referral for child welfare concerns (Turner et al. 2017). Youth assessed at risk of institutionalisation due to crime or recidivism while transitioning from corrections settings (Blueprints 2021, Program/fft).

Referral pathways:

Families referred for child welfare concerns (Turner et al. 2017) or from corrections settings (Blueprints 2021, Program/fft).

Resourcing:

"FFT should be implemented with a team of 3–8 master's level therapists, with caseloads of 10–12 families, with oversight by a licensed clinical therapist." (Blueprints 2021, Program/fft).

Outcomes:

Reduced antisocial and externalising behaviours; reduced delinquency; reduced criminal behaviour; reduced cannabis and illicit substance use (Blueprints 2021, Program/fft).

Data required to assess effectiveness:

Child welfare agency reports of out-of-home placements and referrals for child welfare concerns (Turner et al. 2017).

Length of time for positive outcomes to be shown:

16 months for out-of-home placements (Turner et al. 2017); 6–18 months for other outcomes (Alexander & Parsons 1973).

How long effectiveness was maintained:

16 months for out-of-home placements (Turner et al. 2017).

Other relevant contributors to program's effectiveness:

To be effective, this program must be implemented with fidelity (Sexton & Turner 2010).

Cost-effectiveness:

Benefits minus costs $US7,197 per participant, costs US$4,084 and benefits US$11,282 per participant (WSIPP 2019, Program/32). 72% chance this program will produce benefits that outweigh costs (WSIPP 2019, Program/32).

Minority populations:

Families are typically socioeconomically disadvantaged, and in minority cultural groups. We found no reports of delivery for ATSI or LGBTI families.

Process evaluation information – evaluations of how the program was established:

This program is established through training and the use of a manual supplied by the developer (see citation to Alexander et al. 2000 in Sexton & Turner 2010).

Length of time to set up program:

We estimate selection of skilled staff, office resources and training would require 6 months to establish this program in Australia.

How communities and families were engaged:

Services are established by welfare or correction services and communities and families are then engaged according to the protocols typically utilised by these services within a specific state system.

Engagement of CYP in program:

The CYP is engaged by the therapist as part of an in-home service delivery for welfare involved families or in a correction setting for court involved youth.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

US Medicaid funding was used by the state services to support FFT in Philadelphia (Gottfredson 2019). Liaison and coordination with other services occurs according to the typical protocols for services to welfare involved families or in a correction setting for court involved youth. The population in the Gottfredson et al. (2018) study were involved in Philadelphia's social service system which provided: crisis intervention, drug/alcohol treatment, mental health outpatient, and medication management.

On the Way Home (OTWH)

Underpinning evidence – *Evidence based (2 Thumbs**)***

(2 RCTs)
https://www.cebc4cw.org/program/on-the-way-home-otwh/
(CEBC 2021: Level 2 evidence rating – defined as research study outcomes that have been published in a peer-reviewed journal).

Included from Morton et al. (2020, Supplementary Tables) literature review. RCT with 12 months follow-up showed outcomes improving permanent connections and education for 13–17 age group.

Included in Greeson et al. (2020) literature review as helping "*youth build safe and stable lifelong relationships*". Boys Town, Nebraska was rated '3' (Promising Research Evidence).

OTWH explores the viability of reunification with biological parents. The 12-month program includes a family engagement component to promote stability for reunified youth exiting residential care. One RCT showed that 91% of youth receiving OTWH (n = 24) remained in home and community settings with family members, while only 65% of the control group (n = 20) receiving traditional transition services remained in home and community settings (Trout, Tyler, Stewart, & Epstein 2012). A second RCT of the same program also found significant results. Youth in the control group (n = 41) were five times more likely to exit their homes compared to youth receiving OTWH services (n = 47; Trout et al. 2013). A third trial Trout et al. (2020, n = 187) showed positive effects on youth and family well-being.

Design:

"*OTWH is a 12–14 month reunification program developed to address the transition needs of middle and high school youths with, or at-risk of, emotional and behavioural disorders who are reintegrating into the home and community school settings following a stay in residential care*." (CEBC 2021).

Target populations:

Children/adolescents 12–18 yrs, parents and caregivers of children/adolescents 12–18 yrs.

Delivery methods:

Targeted program. "*The program modifies and integrates three interventions: Check & Connect, Common Sense Parenting, and homework support to address the educational and family-based transition challenges most common for school-aged youth. Services are provided by a trained OTWH Consultant in the family home, school, and community, and primary objectives are to promote youth home stability and prevent school dropout. On average, families engage in 2 hours of direct service hours per week and consultants carry caseloads of up to 15 families. Training is manualised, service decisions are guided by weekly data analysis, and consultants are supervised in weekly individual and group consultation. Weekly contact with the family and school. On average, OTWH Consultants provide two direct service hours in the home and school environments and an additional hour of indirect services (e.g. completion of paperwork, travel, preparation, scheduling) related to the youth, family, and school reunification needs*." (CEBC 2021).

Location of services:

NSW implementations not yet reported. Implemented in home, Care setting, school setting

Assessment process to enter program:

No published information available.

Referral pathway:

No published information available.

Resourcing:

Program delivered by qualified clinical team (team leader, foster carers, consultants, coaches, therapists, administrator, program manager). Practitioners have 3–4 days of program training depending on their role. Booster training of practitioners is recommended.

Outcomes:

Internalising and externalising disorders, disruptive behaviour, maladaptive school and home behaviours, and poor school engagement.

Data required to assess effectiveness:

The above citations demonstrate how effectiveness was assessed.

Length of time for positive outcomes to be shown:

12–14 months.

How long effectiveness was maintained:

Up to 14 months.

Other relevant contributors to proram's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

In the studies cited above led by Trout most families were Caucasian with around one third reporting a minority racial or cultural background.

Process evaluation information – evaluations of how the program was established:

There is training and a manual available for this program. The training contact is Susan Lamke (susan.lamke@boystown.org) (CEBC 2021).

Length of time to set up program:

The standard training requires five days (40 hours) of OTWH consultant training and two days (16 hours) of supervisor training (CEBC 2021).

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

Young people are engaged through the program training implemented together with their family.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other servies and other organisations providing related care:

Liaison and coordination has occurred in the US studies using the networks used by the Boys Town services, which offer placement and services for youth with social and behavioural problems.

Youth Hope

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – Insufficient evidence (No Evidence)

No public evaluation evidence available; evaluation proceeding:
https://aifs.gov.au/cfca/pacra/youth-hope-evaluation

Program providing support for vulnerable and at-risk families who are involved in (or who are at risk of being involved in) statutory child protection services.Outcomes on homelessness and family connection are unclear. Intervention shows implementation problems and no outcomes (Australian Institute of Criminology 2016).

Design:

Early intervention service targeting children and young people at risk of significant harm.

Target populations:

Children and young people 9–15 years of age (and their family)

Delivery methods:

Wraparound informed service delivery model. Family-based service delivery.

Location of services:

NSW – Central coast, Hunter-New England, Western NSW, Tamworth, Western Sydney and South Western Sydney

Assessment process to enter program:

Children and young people referred through child protective services.

Referral pathways:

Children and young people referred through child protective services.

Resourcing:

Process evaluation is ongoing. Program participation expected for at least 12-months (can include family re-referral for an additional 12-months).

Outcomes:

Process evaluation is ongoing. Outcomes on homelessness and family connection are unclear.

Data required to assess effectiveness:

No published information available. Process evaluation is ongoing.

Length of time for positive outcomes to be shown:

No published information available. Process evaluation is ongoing.

How long effectiveness was maintained:

No published information available. Process evaluation is ongoing.

Other relevant contributors to program's effectiveness:

No published information available. Process evaluation is ongoing.

Cost-effectiveness:

No published information available. Process evaluation is ongoing.

Minority populations:

No published information available. Process evaluation is ongoing.

Process evaluation information – evaluations of how the program was established:

No published information available. Process evaluation is ongoing.

Length of time to set up program:

No published information available. Process evaluation is ongoing.

How communities and families were engaged:

No published information available. Process evaluation is ongoing.

Engagement of CYP in program:

No published information available. Process evaluation is ongoing.

Liaison with other services and organisations involved in program delivery:

No published information available. Process evaluation is ongoing.

Coordination with other services and organisations providing related care:

No published information available. Process evaluation is ongoing.

Intensive Case Management

Treatment Foster Care Oregon adolescent

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Promising (1 Thumb)*

(1 RCT)
(Astrom et al. 2020 cited in FACSIAR Evidence Brief, 2021)
https://guidebook.eif.org.uk/programme/treatment-foster-care-oregon-adolescent
(EIF, 2021: Level 3+ evidence rating; short-term positive impact on child outcomes from at least one rigorous evaluation (results not yet replicated in a second rigorous study)

**Previously known as Multidimensional Treatment Foster Care (MTFC).*" (EIF 2021)1 RCT. Chamberlain et al. (1998) report a US randomised trial where 79 male adolescents with histories of chronic and serious juvenile delinquency were randomised to MTFC or usual corrections services. MTFC participants had significantly fewer criminal referrals and returned to live with relatives more often. MTFC was associated with fewer days in juvenile lockup, reduced criminal referral rates and less engagement in antisocial behaviour.

Design:

"*Treatment Foster Care Oregon – Adolescent (TFCO-A)* is for young people between the ages of 12 and 18, and their families. These young people are in foster placements or residential placements and are displaying delinquent behaviour. Young people are placed with a 'treatment foster family' trained in the TFCO-A model, for a period that typically lasts 9–12 months.*" (EIF 2021).

Target populations:

Children and adolescents (12–18 years, including parents or caregivers of these children and adolescents)

Delivery methods:

Targeted, indicated program. "*TFCO aims to increase a young person's social, emotional and relational skills and therefore reduce the need for more challenging and antisocial behaviours. The main way this is achieved is via: Providing close supervision, offering multiple opportunities for feedback and reinforcement, providing a responsive, warm and predictable environment, providing daily structure with fair and consistent limits for inappropriate behaviour, young people having a supportive relationship with at least one mentoring adult, and young people having less exposure to peers with similar problems."* (EIF 2021). The program has four main components:

- "*Component 1: TFCO Foster Carers deliver the TFCO model directly to the young people in their everyday interactions, under the guidance of the TFCO Team Leader. They have two days of TFCO training prior to the first placement. While they have a young person in their care, they attend weekly foster carer meetings, and complete a daily Parent Daily Report that monitors young people's behaviours and carer stress. The Foster Carers have access to 24/7 support and are provided with regular respite.*

- *Component 2: All young people follow an age appropriate behavioural incentive programme within the foster placement, developed and overseen by the Team Leader. All young people receive weekly Skills Coaching sessions for 1–1.5 hours and weekly hourly sessions with their Individual Worker/Therapist for the duration of their placement, and for up to 3 months post-TFCO.*
- *Component 3: The Birth Family Coach works weekly with the birth family and/or extended family to help them learn and implement the TFCO parenting program. This helps to shape up their own strengths and skills as carers/parents and aims to improve the quality of contact that they have with their child, increasing the chances of young people being returned home. This work can continue once the programme is completed or will be offered to the follow-on placement.*
- *Component 4: The TFCO team work closely with schools/colleges or work placements to develop interventions for identified adults to deliver*." (EIF 2021)

Location of services:

NSW implementations not yet reported. Implemented in home, secondary schools, college, community centres, out-patient clinics and day treatment programs (implemented in Denmark, NZ, Norway, UK, US).

Assessment process to enter program:

Chamberlain & Reid (1998) report assessments were made using the protocols used by their state youth justice system.

Referral pathways:

Chamberlain & Reid (1998), all participants referred for community placements by the youth justice system.

Resourcing:

Program delivered by qualified clinical team (team leader, foster carers, consultants, coaches, therapists, administrator, program manager). Practitioners have 3–4 days of program training depending on their role. Booster training of practitioners is recommended. Program training manual, DVD training, and face to face training required (licence required to run the program).

Outcomes:

Preventing crime, violence, and antisocial behaviour (reduced running away from placements, rates of criminal referral, delinquent behaviour, and fewer days spent in detention facilities – if arrested); improve peer relationships; improve parent-child interaction; improve coping skills.

Data required to assess effectiveness:

The citations above provide information on how effectiveness was evaluated (e.g. Chamberlain & Reid 1998).

Length of time for positive outcomes to be shown:

6–9 months. Chamberlain & Reid (1998), 12-month follow-up.

How long effectiveness was maintained:

12-months (Chamberlain & Reid 1998)

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

Little information available. Cost rating 5 "*indicates that a programme has a high cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of more than £2,000".* (EIF 2021).

Minority populations:

This program is delivered to US minority and disadvantaged populations.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

No published information available.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

No published information available.

Multisystemic Therapy (MST) including Multisystemic therapy for child abuse and neglect [MST-CAN]

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Evidence based (~~2~~3 Thumbs)*
(~~2~~3 RCTs)
https://guidebook.eif.org.uk/programme/multisystemic-therapy
(EIF, 2021: Level 4+ evidence rating; evidence of long-term positive impact, 3 included studies)
"*Multisystemic Therapy® (MST®) is an intensive family- and community-based treatment that addresses the multiple causes of serious antisocial behaviour across key settings, or systems within which youth are embedded (family, peers, school, and neighbourhood). Because MST emphasizes promoting behaviour change in the youth's natural environment, the program aims to empower parents with the skills and resources needed to independently address the inevitable difficulties that arise in raising teenagers, and to empower youth to cope with the family, peer, school, and neighbourhood problems they encounter*."
2 RCTs showing reduced out of home care placement: Ogden et al. (2004) reported a trial in Norway with youth of mean age 14.95 years (age range adolescents to 18 years) referred to the study for mental health and behavioural problems. The evaluation randomised youth to MST (62 families) or receipt of usual child welfare services (38 families). MST youth were more likely to remain in the home setting (i.e. reduced out of home care placement) 6-months after the intervention. Ogden & Hagen (2006) reported a further 2-year follow-up of the participants from the 2004 Norway trial. MST participants were less likely to be placed in out of home care at follow-up ($p < .07$).

Multi-systemic Therapy for Child Abuse and Neglect - MST-CAN
https://guidebook.eif.org.uk/programme/multisystemic-therapy-for-child-abuse-and-neglect
(EIF, 2021: Level 3 evidence rating; 'short-term positive impact' on child outcomes from 1 RCT)
"*Multi-systemic Therapy for Child Abuse and Neglect (MST-CAN) is an intensive treatment for families who have recently been reported to Child Protection Services for physically abusing and/or neglecting a child between the ages of 6 and 17*." (EIF 2021).
Swenson et al. (2010) report a randomised trial targeting physically abused youth and their families in US (Charleston County). The youth were aged 10–17 years (mean 13.88 years) with 55.8% female and 68.6% black. Families (n = 86) involved with child protective services were randomised to MST or usual services. At the 16-month follow-up young people receiving MST were less likely to experience an out-of-home placement and had fewer out-of-home care placement changes (*p* .05). NSW implementation evaluations comprising process, outcome and economic data are in process (Shakeshaft et al. 2020).

Design:

"*The MST model views the parents as the primary agents of change. Each family's treatment plan therefore includes a variety of strategies to improve the parents' effectiveness and the quality of their relationship with their child*." (EIF 2021). Key aims: 1. identify strategies that work for young people and their family (as well as young people's informal and formal support network; and 2. Provide intervention to increase family cohesion and positive family management strategies.

Target populations:

Children, pre-adolescents and adolescents (delivered to the individual). Includes early adolescents (12–14 years) and late adolescents (15–18 years).

Delivery methods:

Targeted, indicated prevention program. "*MST is delivered by a therapist to young people and families on an individual basis in their homes or other community settings. Therapists are available to the family 24/7 and carry a caseload of four to six families at a time. Therapy sessions typically last between 50 minutes and two hours. The frequency of the sessions may vary depending on the needs of the family and the stage of the treatment, typically ranging from three days a week to daily*." (EIF 2021). Ogden et al. (2006), report that during the RCT, MST therapists had caseload of 3–6 families, available to families 24/7 throughout study. "*MST-CAN therapists provide the family with tailored individual and family support and therapy over a six- to nine-month period with the aim of helping parents learn how to parent their child in a way that is not abusive or neglectful. MST-CAN has initial evidence of reducing parents' maltreating behaviour and out-of-home placements*." (EIF 2021). "*MST-CAN is delivered by a therapist individually to families in their homes. Therapists are available 24/7 to the family and carry a caseload of three to four families at a time. Therapy sessions typically last between 50 minutes and two hours. The frequency of the sessions varies depending on the needs of the family and the stage of the treatment, typically ranging from three days a week to daily. Therapists work with individual families for an average of six to nine months*." (EIF 2021)

Location of services:

NSW implementation evaluations are in process (Shakeshaft et al. 2020). Implemented in home, social services, correctional-facilities, schools, mental health and treatment centres (widely implemented in Australia, Belgium, Canada, Chile, Denmark, Germany, Iceland, Ireland, Netherlands, NZ, Norway, Sweden, Switzerland, UK, US). MST-CAN - implemented in Australia, Netherlands, Norway, UK, US.

Assessment process to enter program:

Ogden et al. (2004) report participants were referred for range of behavioural and mental health problems (including criminal offences).

Referral pathways:

Families are referred based on assessment that they are at risk of or experiencing out-of-home placement of child.

Resourcing:

Program delivered by qualified MST therapist (5-day MST orientation + booster training). Program training manual, DVD and face to face training required. Licence required to implement the program.

Outcomes:

Reduced out of home care placements. Other reported outcomes include: improved mental health and wellbeing (reduced emotional problems, improved wellbeing); Preventing child maltreatment (improvement parent-adolescent relationships; reduced neglect, psychological aggression, minor &

severe assault, non-violence discipline, **increased out-home care placement stability**), preventing crime, violence and antisocial behaviour (reduced offending, aggression, delinquency, psychopathology, reoffending, antisocial behaviour, internalising behaviour, conduct problems, improved social competence and prosocial behaviour), preventing substance abuse (variety and volume of substance misuse); Improved engagement with prosocial peers.

Data required to assess effectiveness:

The above citations describe a range of data that has been collected to assess effectiveness.

Length of time for positive outcomes to be shown:

6–24 months (Ogden 2004, 2006).

How long effectiveness was maintained:

24 months (Ogden 2006).

Other relevant contributors to program's effectiveness:

Reviews of the implementation of this program suggest that organisational support for program implementation fidelity and staff expertise are important contributors to effectiveness ().

Cost-effectiveness:

MST & MST-CAN Cost rating 5 "*indicates that a programme has a high cost to set up and deliver, compared with other interventions reviewed by EIF. This is equivalent to an estimated unit cost of more than £2,000*". (EIF 2021).

Benefits minus costs $US2,174. Costs US$12,576 per participant, benefits US$14,751 per participant. (WSIPP 2019, Program/22).

Minority populations:

MST has been delivered to males/female, all race/ethnicities (white, Hispanic or Latino, and African American). The program has been implemented in Australia, but we found no published report, leaving the target populations unclear.

Process evaluation information – evaluations of how the program was established:

This program is established through training and the use of a manual supplied by the developer. In the Norway implementation (Ogden et al. 2004), "*consultants from MST Services (from LLC in Charleston, South Carolina, a university-affiliated training organisation) were responsible for the introductory training of the Norway teams, and provided the teams with weekly telephone consultations and quarterly booster sessions. MST Services also participated in the site assessment before MST teams were established in order to ensure that goals and guidelines were consistent with the demand specifications in the MST Organisational Manual (Strother, Swenson, & Schoenwald 1998). Clinical supervision was offered on a weekly basis by the local MST supervisors.*" (Ogden et al. 2004 p. 80).

Length of time to set up program:

We estimate selection of skilled staff, office resources and training would require 6 months to establish this program in Australia.

How communities and families were engaged:

Services are established by welfare or correction services and communities and families are then engaged according to the protocols typically utilised by these services within a specific state system. Ogden (2004, 2006) report in Norway, that participants with mental health and behavioural problems were referred for study participation.

Engagement of CYP in program:

The CYP is engaged by the therapist as part of a service delivery for targeted families, which often includes court involved youth.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care

In the Norway trial (Ogden et al. 2004) referrals to the study were made by the municipal child welfare services, with liaison and coordination with other services occurring according to the typical protocols for services to welfare involved families.

Take Charge/ Better Futures

This program has been identified for inclusion by the Department of Communities and Justice

Underpinning evidence – *Promising (1 thumb)*

(1 RCT, but no accommodation or reunification outcome) https://www.cebc4cw.org/program/better-futures/
(CEBC 2021: Level 2 (high) evidence rating – defined as research study outcomes that have been published in a peer-reviewed journal).

"*The purpose of Better Futures is to support young people in exploring their postsecondary interests and opportunities, and in preparing them to participate in postsecondary education, including college and vocational training programs. Grounded in self-determination promotion, and developed as a postsecondary-focused adaptation of the My Life program, Better Futures engages youth in a four-day postsecondary immersion experience along with the following supports that are provided for 9 months after that experience."* (CEBC 2021)

ONE RCT: Geenen et al. (2015) report a randomised trial in Oregon (US) where 67 youth (average age 16.76 years, 23.9% Native American, 19.4% African American) from the child welfare system were randomised to the Take Charge program or usual welfare services. The results showed the intervention resulted in positive trends for educational attainment, mental health recovery, and quality of life at 6-month follow-up.

Design:

"Youth and young adults in foster care, including youth with disabilities and/or mental health conditions, who are: 1) in their final year of high school or GED completion, 2) not opposed to the idea of participating in postsecondary education, and 3) permitted to go into the community with their Better Futures coach." (CEBC 2021).

Target populations:

Children/adolescents 16–19 years. Primary target group is young people in foster care/out of home care, who have significant mental health challenges (to assist with improving their educational attainment).

Delivery methods:

Targeted program. No training manual, however, program requires face to face onsite certification training (it is unclear whether a licence is required to run the program). Two 60–90-minute contacts per month on average; distribution of time may vary with activity focus. It is common for youth and their coaches to meet more intensively when the youth is actively exploring postsecondary programs, preparing applications, or dealing with barriers that arise. Likewise, there may be less active periods when youth and their coaches may meet monthly (e.g. applications have been submitted and youth is busy with high school)." (CEBC 2021).

Location of services:

NSW implementations not yet reported. Implemented in community living settings, care settings, outpatient clinic, school setting, treatment programs.

Assessment process to enter program:

Participants include those under state care (i.e. in the foster care system) and have a significant mental health condition.

Referral pathways:

Children recruited from welfare services.

Resourcing:

Program delivered by qualified clinician.

Outcomes:

Educational engagement, life skills, emotional coping and self-management skills, mental health, substance use, interpersonal skills, social support.

Data required to assess effectiveness:

Geenen et al. (2015), 6-month follow-up.

Length of time for positive outcomes to be shown:

Geenen et al. (2015), 6-month follow-up.

How long effectiveness was maintained:

Geenen et al. (2015), 6-month follow-up.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

Geenen et al. (2015) report a mainly minority population.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

Participants are engaged by coaches trained through the program.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occurs through the protocols for the welfare system within the implementing community.

Pathway Program (PPP)

Underpinning evidence – Promising (1 thumb)

(1 RCT)

Included from Morton et al. (2020, Supplementary Tables) literature review. RCT with 18-month follow-up showed improved outcomes related to housing, permanent connections and educational participation for 16–24 age group (n = 476). Theodos et al. (2016) (US).

Design:

Intensive case management, mentorship, and advocacy.

Target populations:

Adolescents 16–24 years

Delivery methods:

Young people are “matched with a 'promotor', who provides intensive case management, mentorship, and advocacy, and aims to improve education and employment outcomes, boost life skills, prevent delinquency, and reduce unhealthy behaviours for at-risk youth transitioning to adulthood.”(Theodos et al. 2016)

Location of services:

NSW implementations not yet reported. Implemented in the US.

Assessment process to enter program:

No published information available.

Referral pathways:

No published information available.

Resourcing:

Average caseload of approximately 11 young people.

Outcomes:

Increased housing stability (without any specific housing intervention). Other outcomes include improved educational attainment, employment, reduced births, reduced risk taking behaviour and improved help-seeking (where services needed).

Data required to assess effectiveness:

No published information available.

Length of time for positive outcomes to be shown:

18 months

How long effectiveness was maintained:

No published information available.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

No published information available.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

Participants are engaged by promotors trained through the program.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occurs through the protocols for the welfare system within the implementing community.

My Life

Underpinning evidence – *Promising (1 Thumb)*

(1 RCT, 1 Other Study)

Identified from Greeson et al. (2020) literature review as having evidence for enhancing "access to safe and affordable housing". Rated '3' (Promising Research Evidence).

Powers et al. (2012) reported an RCT where 69 youth aged 16.5–17.5 were randomly assigned to TAKE CHARGE or to the foster care independent living program. Assessments were completed at baseline, post-intervention and at one year follow-up. A statistically significant difference was found at post-intervention ($t(1\ 1\ 6) = 8.21$, $p < .05$; $d = 0.92$) and follow up ($t(1\ 1\ 6) = 7.58$, $p < .05$, $d = 0.58$) between the treatment group ($n = 33$) and control group ($n = 36$) in involvement in independent living activities (e.g. paying rent and utilities). Statistically significant differences were also reported between the treatment group and control group's utilisation of community transition services such as Chaffee-funded housing at post-test ($p < .05$; $d = 0.60$) and at follow up ($p < .05$; $d = 0.65$). At post-intervention and one year follow-up improvements were also found for self-determination and quality of life. Youth in the intervention group also completed high school and were employed at notably higher rates than the comparison group. Self-determination was confirmed as a partial mediator of enhanced quality of life.

MY LIFE also had a statistically significant impact on key school achievement and performance variables for the treatment group compared to the control group, including credits toward graduation at follow-up ($t(1\ 0\ 8) = 1.88$, $p < .05$; $d = 0.42$) and time spent on homework at post-test ($t(2\ 0\ 4) = 2.39$, $p < .05$; $d = 0.45$; Geenen et al. 2013).

Design:

Youth were targeted in foster care or special education. The intervention included coaching for youth in the application of self-determination skills to achieve youth-identified goals, and youth participation in mentoring workshops with near peer foster care alumni.

Target populations:

Youth under the guardianship of Oregon Department of Human Services in foster care or special education. Powers et al. (2012) report a sample of youth aged 16.5–17.5 years (in state care foster system). Geenen et al. (2013) report a sample of youth aged 14–17.8 years (mean 15.5 years).

Delivery methods:

Up to 12-months of coaching (to identify, reach and support attainment of goals) included two elements: (a) individual, weekly coaching sessions for youth in the application of self-determination skills to achieve self-identified goals and to carry out a youth-led transition planning meeting; and (b) quarterly workshops for youth with young adult mentors who were formerly in foster care. The intervention was designed as a universally accessible approach for supporting the transition to adulthood of all youth while being accessible to young people with disabilities.

Weekly coaching was typically conducted during unscheduled school class periods, immediately before or after school, or in the evenings or on weekends, whichever was most feasible for the

student. Each youth learned to apply skills in achievement (e.g. set goals, problem-solving), partnership development (e.g. schmoozing, negotiation), and self-regulation (focus on your accomplishments, ARM yourself against stress) to identify and work toward personally valued transition goals, and to develop an individualised transition plan that s/he shared with those adults considered by the youth to be important in his or her life (e.g. teachers, foster care case worker, attorney, foster parent, biological family, athletic coaches, etc.). These skills and the transition planning process were presented in a self-help guide that leads youth through the process of short-term goal identification and achievement, with each strategy presented as a small number of systematic steps (Powers 2006).

For example, the steps youth learn for SET GOALS are: 1) Look at what you are doing now; 2) Choose activities that: are important to you, a good place to start, and others will support; and 3) Decide exactly what you will do (break your goal down to bite-sized pieces). Coaches assist, encourage, and challenge youth to apply the skills to achieve their personal goals. They assist youth to review their self-help materials, to cheer their progress, to occasionally challenge them to take action, and to help them rehearse their use of strategies (i.e. role-play negotiating a goal with a foster parent) or to perform particular activities necessary for goal achievement (i.e. call an agency to obtain information).

Over time, as the youth demonstrates increasing skill and motivation to accomplish chosen activity goals, the coach fades his/her direct involvement in activity completion and encourages the youth to select more complex goals and apply the meta-cognitive skills to achieve them

Location of services:

NSW implementations not yet reported. Implemented in Oregon, US.

Assessment process to enter program:

Powers et al. (2012) – (a) receiving special education services, (b) 16.5–17.5 years of age, (c) under the guardianship of Oregon DHS (with at least 90 days in foster care) and (d) attending a large school district in the study target area.

Referral pathways:

No published information available.

Resourcing:

Powers et al. (2012) – intervention included a) individual, weekly coaching sessions; b) quarterly workshops between youth and mentors (i.e. up to 4 mentoring workshops)

Outcomes:

Education. Employment. Housing. Reduced barrier to postsecondary education; increased career options (for youth in out of home care); connection to employment; support placements into safe and stable housing.

Data required to assess effectiveness:

No published information available.

Length of time for positive outcomes to be shown:

Powers et al. (2012), 12-month intervention. Geenen et al. (2013), baseline, 9 month (T2) and 18-month follow-up (T3).

How long effectiveness was maintained:

Geenen et al. (2013) 18-months.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

Youth of colour, youth with disabilities.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

Participants are engaged by coaches trained through the program.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occur through the protocols for the welfare system within the implementing community.

Transition to Independence Process (TIP) Model

Underpinning evidence – *Insufficient evidence (Question Mark)*

(2 Studies)
https://www.cebc4cw.org/program/transition-to-independence-tip-model-2/
(CEBC 2021: Level 3 (medium) evidence rating – defined as research study outcomes that have been published in a peer-reviewed journal). **Also known as Steps-to-Success Program (CEBC 2021).

Dresser et al. (2015) report a post-intervention survey following the participation in the program of youth of age range 14–27 years (Mean = 17.7 years, 45% African American, 3% Hispanic, 7% Native American, and 10% Multiracial) with a severe mental health condition. Most participants had multiple-system involvement (e.g. juvenile justice, mental health, out-of-home placement, special education), many with co-occurring substance use. Results showed positive transitions on most outcomes (e.g. stable accommodation with family or in independent living setting), no corrections involvement and education and employment progress.

Karpur et al. (2005) report a quasi-experimental trial where youth (average age 18) with emotional and behavioural disorders completing the program showed improved postsecondary outcomes, relative to a matched comparison group with similar disorders. Haber et al. (2008) reported a multi-site pre-post comparison targeting youth (aged 14–21 Mean = 17.2 years) with serious mental health conditions transitioning out of the child welfare system. At 1-year follow-up results showed positive transitions to adulthood on most measures, including stable accommodation.

Design:

"*Transition to Independence Process (TIP) Model was developed for working with youth and young adults (14–29 years old) with emotional and behavioural difficulties to: a) engage them in their own future planning process; b) provide them with developmentally appropriate, non-stigmatising, culturally competent, trauma-informed, and appealing services and supports; and c) involve the young people, their families (of origin or foster), and other informal key players, as relevant, in a process that prepares and facilitates their movement toward greater self-sufficiency and successful achievement of their goals. Youth and young adults are guided in setting and achieving their own short-term and long-term goals across relevant Transition Domains, such as: employment/career, educational opportunities, living situation, personal effectiveness/well-being, and community-life functioning*." (CEBC 2021).

Target populations:

Children/adolescents 14–25 years

Delivery methods:

Targeted program, highly individualised. "*The TIP Model is operationalized through seven Guidelines and their associated Core Practices that drive the work with young people to improve their outcomes and provide a transition system that is responsive to them and also to their families. This program involves the family or other support systems in the individual's treatment: A parent/caregiver is involved in the process as relevant to the progress of the individual youth or young adult. In most states, for a youth under 18, a parent or other legal guardian has legal authority. Therefore, the*

Transition Facilitator does, at times, have to mediate between differing youth and parent/guardian perspectives in order to achieve youth engagement and progress. The Transition Facilitator and young person involve family members, other natural supports, and professionals in individualized planning and services as relevant to the young person's current goal or issue." (CEBC 2021).

Location of services:

NSW implementations not yet reported. Implemented in the US in community living settings, care settings, out patient clinic, school setting, treatment programs.

Assessment process to enter program:

Youth with mental and behavioural disorders.

Referral pathways:

Youth are referred from multiple service systems including juvenile justice, mental health, out-of-home placement, special education.

Resourcing:

Program delivered by qualified clinician.

Outcomes:

Engagement, life skills, emotional coping and self-management skills, mental health, substance use, interpersonal skills, social support.

Data required to assess effectiveness:

No published information available.

Length of time for positive outcomes to be shown:

18 months.

How long effectiveness was maintained:

No published information available.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

No published information available.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

No published information available.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

No published information available.

YVLifeSet

Underpinning evidence – Promising (1 Thumb)

(1 RCT, 1 additional RCT with positive results in older populations)
Included at request of SAX
https://www.cebc4cw.org/program/yvlifeset/detailed
(CEBC 2021: Level 3 (high) evidence rating – defined as research study outcomes that have been published in a peer-reviewed journal).

Listed in Greeson et al. (2020) review: An evaluation found a statistically significant difference in housing instability (e.g. homelessness, couch-surfing) for the treatment group (n = 659) compared to the control group (n = 455) at one-year follow up. Twenty-one percent of the treatment group and 27.2% of the control group had experienced homelessness in the previous year; 35.7% of the treatment group and 44.1% of the control group reported couch-surfing during the same time period (Jacobs, Skemer, & Courtney 2015).

Courtney et al. (2019) report an additional randomised trial in Tennessee (USA), with older youth. Participants (n = 1,322) aged 18–24 years (5.8% Hispanic, 37.1% Black, and 6.0% Other) were youth in the custody of the state children's services agency for at least one year between age 14 and 17. They were randomly assigned to either the YVLifeSet or the control group. After 14 months results showed positive impacts of the YVLifeSet program on housing instability (homelessness, effect size [ES] −0.14, p = 0.017; couch surfing ES –0.17, p = 0.005); unable to pay rent, ES −0.09, p = 0.146). Positive effects were also found for employment and earnings, economic hardship, and health and safety. However, the YVLifeSet program had no impact on measures of education, social support, criminal behaviour and justice system involvement.

Design:

"*LifeSet provides intensive in-home support and guidance to young adults leaving the foster care, juvenile justice, and/or mental health systems, as well as to others who find themselves at this stage in life without the necessary skills and supports to make a successful transition to adulthood. Program success is defined as a young adult's maintenance of stable and suitable housing, avoidance of negative legal involvement, participation in an educational/vocational program, and development of life skills necessary to become a successful, productive citizen. The program not only assists with young adults who are "aging out' of state custody, but also works with the young person's family and support systems to ensure a more successful transition."* (CEBC 2021).

Target populations:

Children/adolescents 17–22 years (aging out of child welfare system)

Delivery methods:

Manualised program. Case management. Targeted program - This program involves the family or other support systems in the individual's treatment: LifeSet specialists work not only with the individual young person, but in all areas (systems) that may affect the young adult (community, peers, family, school, and work). Based on each young person's individual needs, circumstances, and goals, specialists help young adults create a sustainable support network among family, friends, and service

providers. Specialists collaborate with staff at other programs/agencies to ensure the young adults are able to establish the supports necessary to achieve their goals. (CEBC 2021).

Location of services:

NSW implementations not yet reported. Implemented in the USA in home, community setting, care setting, school setting, treatment setting.

Assessment process to enter program:

No published information available.

Referral pathways:

No published information available.

Resourcing:

"*The most important resource necessary to successfully deliver this program is high quality and well-trained staff. With a low caseload of 8 to 10 young people per specialist, as well as a high level of supervision and clinical consultation (4 to 5 specialists per clinical supervisor; 7 to 8 teams per clinical consultant), personnel are the key to achieving positive outcomes for young people. Since LifeSet is a community-based program, needs for office/meeting space are minimal and can be met in a variety of ways. Specialists at Youth Villages document their work with young people in an electronic medical record system that captures most of the data necessary to monitor program performance and model fidelity; although systems may vary, a core set of data elements, as well as strong processes to monitor program implementation is a key resource requirement for the program*."(CEBC, 2021)

Outcomes:

Stable/suitable housing, avoidance of legal involvement, educational participation, parent-adolescent relationship, life skills.

Data required to assess effectiveness:

The above citations provide information on the assessment of effectiveness.

Length of time for positive outcomes to be shown:

12 months.

How long effectiveness was maintained:

12 months.

Other relevant contributors to program's effectiveness:

Case managers receive weekly supervision.

Cost-effectiveness:

No published information available.

Minority populations:

Based on the evaluations most participants are highly disadvantaged, with around one third from minority backgrounds.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

Families and communities are engaged through intensive in-home support.

Engagement of CYP in program:

Youth participants are engaged through the foster care, juvenile justice, and/or mental health systems.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occur with foster care, juvenile justice, and/or mental health systems.

North Carolina Independent Living Program (ILP)

Underpinning evidence – *Promising (1 Thumb)*

(1 RCT)
Program included from Greeson et al. (2020) literature review which rated this program as '3' (Promising Research Evidence) for enhancing 'access to safe and affordable housing'.

A study of eight North Carolina counties found that youth receiving ILP services (n = 44) were more likely to be paying their housing expenses or living independently compared to a randomly selected group of comparison youth receiving no services (n = 32). Sixty-eight percent of youth in the treatment group and 41% of those in the comparison group were living independently. Thirty percent of youth in the treatment group and 19% of those in the comparison group were paying all their housing expenses (Lindsey & Ahmed 1999).

Design:

This program targets youth leaving foster care assisting with first month's rent and/or security deposit and housing-related start-up costs.

Target populations:

Youth leaving (transitioning from) foster care involved in independent living program.

Delivery methods:

No published information available.

Location of services:

NSW implementations not yet reported. Services delivered in North Carolina care settings.

Assessment process to enter program:

Foster youth involved in independent living skills program.

Referral pathways:

Foster youth are referred based on approaching the age of transitioning from care.

Resourcing:

No published information available.

Outcomes:

The focus of the ILP is to facilitate access to safe and stable housing and provide assistance with housing-related start-up costs. Lindsay & Ahmed (1999) reported on outcomes assessed 1–3 years after leaving care. Participants success at living independently (t 2.40, $p < 0.05$), paying all housing expenses while living with others (t 3.79, p

< 0.05) and increased educational attainment (e.g. high school completion, college attendance) were reported.

Data required to assess effectiveness:

No published information available.

Length of time for positive outcomes to be shown:

1 to 3 years (Lindsay & Ahmed 1999)

How long effectiveness was maintained:

3 years (Lindsay & Ahmed 1999)

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populsations:

Over 60% of participants identified as Caucasian (30% African American). Female participants comprised 57% of the sample (Lindsay & Ahmed 1999). We found no reports of delivery for ATSI or LGBTI families.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

Based on Lindsay & Ahmed (1999) participants were engaged through their being in foster care.

Engagement of CYP in program:

CYP in the foster care system and nearing the end of their system engagement, who are assisted to achieve to transition from care.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occur with foster care and associated services.

Service capacity building

Ruby's

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Insufficient evidence (No Evidence)*

No published evaluation evidence available.
https://www.unitingcommunities.org/service/rubys-reunification-program

"*Ruby's supports 12–17-year-olds who are homeless or at risk of homelessness. Including young people: living at home but at risk of leaving or being kicked out because of conflict or a relationship break down with their family; staying in and out of home (e.g. spending some nights at home and some nights with friends, extended family or elsewhere); out of home and haven't stayed there for a while. They would like to return home and aren't receiving an independent income from Centrelink."(*Rubys 2021).

Design:

Accommodation service and reunification program. Intensive support service, targeted program designed to prevent entry into the homelessness system. Includes a range of therapeutic services.

Target populations:

Young people at risk of homelessness, or experiencing family conflict, or in out-of-home care. Age 12–17 years

Delivery methods:

Accommodation service and family reunification (between the client and their family). Accommodation provision often a used to provide respite for young people away from the family home. Provision of 24-hour support while in Ruby's accommodation.

Location of services:

NSW implementations not yet reported. Implemented in intensive accommodation support in South Australia (3 home settings across Adelaide, 1 in Mt Gambier).

Assessment process to enter program:

No published information available.

Referral pathways:

No published information available.

Resourcing:

No published information available.

Outcomes:

Resolve family conflict and improve relationships.

Data required to assess effectiveness:

No published information available.

Length of time for positive outcomes to be shown:

No published information available.

How long effectiveness was maintained:

No published information available.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

No published information available.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

No published information available.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

No published information available.

Behavior Analysis Services Program (BASP)

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Insufficient evidence(Question Mark)*

(1 small study)
Included from Morton et al. (2020, Supplementary Tables) literature review. Quasi-experiment with 12-month follow-up showed improved outcomes related to housing for 12–17 age group (small sample n = 39) (Clark et al. 2008) .

Design:

A functional analytic approach to runaway prevention for youth in foster care.

Target populations:

Adolescents 12–17 years.

Delivery methods:

Data analytic method.

Location of services:

NSW implementations not yet reported. Implemented in the US using data driven analysis.

Assessment process to enter program:

Participants with a history of running away.

Referral pathways:

No published information available.

Resourcing:

On-site performance training (Tools for Positive behaviour Change curriculum); individual participant assessments leading to child/family intervention; consultant and onsite support (e.g. in shelters, treatment facilities).

Outcomes:

No published information available.

Data required to assess effectiveness:

No published information available.

Length of time for positive outcomes to be shown:

12 months.

How long effectiveness was maintained:

No published information available.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

No published information available.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

No published information available.

Engagement of CYP in program:

No published information available.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

No published information available.

Sanctuary model

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Insufficient evidence (Question Mark)*

(1 Study)
https://www.mackillop.org.au/institute/the-sanctuary-model
https://www.cebc4cw.org/program/sanctuary-model/detailed

"*Sanctuary is a theory-based, trauma-informed, evidence-supported, whole-culture approach that has a clear and structured methodology for creating or changing an organisational culture*." (Sanctuary 2021).

Rivard et al. (2005) report a quasi-experimental evaluation where accommodation or family outcomes were not assessed. The evaluation examined Youth (n = 158) aged 12-20 years (Mean=15 years, 63% male, 33% Hispanic, 47% Black, 13% White, 1% Asian or Pacific Islander, and 6% Bi-racial or Other) in residential treatment centres in the Northeastern US. Four residential treatment units self-selected to implement the *Sanctuary Model* and an additional four units were assessed in usual care. No significant differences were found between groups at baseline or at 3 months. At six months, there were a few differences showing a positive effect for the Sanctuary Model. Youth in the Sanctuary Model units scored lower on a measure of coping strategies that tend to increase interpersonal conflict or minimise or exaggerate interpersonal issues. They also exhibited a greater sense of personal control. Finally, they reduced use of verbal aggression, while control participants scored higher on verbal aggression over time.

Design:

Organisational change (therapeutic community) model, based on trauma informed practice. Based around 4 pillars: Shared Knowledge - Trauma Theory, scientifically-grounded knowledge about trauma, adversity, and attachment; Shared Values - Sanctuary Commitments – a trauma-informed way of making decisions, problem-solving and planning. Values include 1) Nonviolence, 2) emotional intelligence; 3) social learning; 4) democracy; 5) open communication; 6) social responsibility; and 7) growth and change; Shared Language – S.E.L.F. (Safety, Emotions, Loss, Future) Framework: a set of values that lead individuals and organisations away from trauma-reactive behaviours; Shared Practice - Sanctuary Toolkit: a set of practical and simple interventions that reinforce the model's language and philosophy. Tools include: community meetings, red flag reviews, safety plans, Sanctuary psychoeducation, S.E.L.F care planning, and Sanctuary core team.

Target populations:

"*This program is not a client-specific intervention, but a full-system approach that targets the entire organization with the intention of improving client care and outcomes. The focus is to create a trauma-informed and trauma-sensitive environment in which specific trauma-focused interventions can be effectively implemented*."(CEBC 2021)

Delivery methods:

Organisational trauma-informed model of service delivery. Manualised program and training required. "*The Sanctuary Model® is a blueprint for clinical and organisational change which, at its core,*

promotes safety and recovery from adversity through the active creation of a trauma-informed community. A recognition that trauma is pervasive in the experience of human beings forms the basis for the Sanctuary Model's focus not only on the people who seek services, but equally on the people and systems who provide those services. Sanctuary has been used in organizations that provide residential treatment for youth, juvenile justice programs, homeless and domestic violence shelters as well as a range of community-based, school-based and mental health programs."(CEBC 2021)

Location of services:

NSW implementations not yet reported. Implementations are reported in South Australia (www.mackillopinstitute.org.au/programs/sanctuary). Has been applied in the US in the following settings: residential treatment settings; youth justice settings; homelessness shelters; family and domestic violence shelters, community-, school- and mental health settings.

Assessment process to enter program:

No published information available.

Referral pathways:

No published information available.

Resourcing:

Resources vary (must include employee training and core team meetings). Includes on-site assessment (of the agency) to identify organisational strengths and areas for intervention. Staff attend 5-day training session, community of shared practice.

Outcomes:

Sanctuary model addresses the following outcomes: exposure to trauma; PTSD; chronic stress and adversity; providing physical, social, and psychological safety; emotion recognition and management; complex grief powerlessness and sense of future.

Data required to assess effectiveness:

The above citations provide details of the assessments.

Length of time for positive outcomes to be shown:

6 months (Rivard et al. 2005). Sanctuary model adopted throughout an individuals' engagement in a specified program.

How long effectiveness was maintained:

6 months (Rivard et al. 2005).

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

Spanish translation.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

3 years. All staff must undergo at least 15 hours of training per year.

How communities and families were engaged:

Youth are engaged in residential settings where a decision has been made to implement this program.

Engagement of CYP in programs:

Youth are engaged in residential settings where a decision has been made to implement this program.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occur with services associated with youth residential services.

Creating Ongoing Relationships Effectively (CORE)

Underpinning evidence – *Promising (1 Thumb)*

(1 RCT)

Program included from Greeson et al. (2020) literature review which rated this program as '3' (Promising Research Evidence) for helping 'youth build safe and stable lifelong relationships'. Nesmith and Christophersen (2014) examined CORE as implemented by Family Alternatives in Minneapolis, Minnesota in a three-year evaluation of 88 foster youth. At post-test, youth receiving CORE (n = 58) were more likely than a comparison group (n = 30) at another foster care agency to say that at least one adult in their life loved them. Scores for relationship competency among youth receiving CORE remained stable over the intervention period while the comparison group's scores declined. CORE youth (n = 58) improved on three of four subscale items while the comparison group (n = 30) declined or remained the same (Nesmith & Christophersen 2014).

Design:

This program targets youth transitioning from foster care. CORE is a trauma-informed practice to help youth develop and cultivate relationships with non-parental caring adults and natural mentors. Nesmith and Christophersen (2014) described CORE as "*a foster care program model designed to address the socio-emotional needs of older youth in foster care who are nearing transition to adulthood … The mission of CORE is to ensure that youth have the supportive ongoing relationships necessary to help them through their transition out of foster care and into living on their own as young adults. The model employs a holistic approach by educating youth, foster parents, and social workers, and by transforming the agency culture to one that empowers youth long before they embark on their transition*." (p.2).

Target populations:

Youth in foster care who are nearing adulthood (and ageing out of the foster care system). Nesmith and Christophersen's (2014) three-year study examined changes over time for youth who experienced the CORE model and youth served by a comparison foster care agency. They recruited adolescents aged 14–19 years involved in CORE and at a comparison site. "*The youth in both sites were, on average, 15 years old at admission to their current placement, and 16 or nearly 17 at the first interview. The ethnic breakdown of the two groups was also similar. The samples of both agencies were comprised of about two-thirds boys and one-third girls*." (p. 4) The mean age of participants at baseline was 16.4 years (mean age at post-test interview 17.3 years); 43% of CORE participants identified as African American or Black (20% White, 27% other/biracial).

Delivery methods:

Nesmith and Christophersen (2014) described "*agency social workers and psychologists with extensive training on relationship development skills created 12–15 week sessions that met weekly to help youth build their relationship skills. On a weekly basis, foster parents and youth ate a meal together while they were presented information on relationship skills such as emotion regulation, distress tolerance, interpersonal effectiveness, mindfulness, and anger management.*" Foster parents and youth subsequently discuss learnings in a facilitated environment. Staff are also trained to become trainers of other staff.

Location of services:

NSW implementations not yet reported. Services delivered in US care settings.

Assessment process to enter program:

Youth in foster care who are nearing the age of transitioning from this care setting.

Referral pathways:

Youth are referred based on assessment that they are approaching the age of transitioning from out-of-home placement.

Resourcing:

All CORE staff and foster parents participate in training and programming arrangements.

Outcomes:

The focus of CORE is on development of independent living skills, socio-emotional needs and building healthy relationships. "*The CORE model focuses on three areas: building supportive relationships, youth empowerment, and trauma-informed practice*." (Nesmith & Christophersen, 2014, p. 2).

Data required to assess effectiveness:

Nesmith and Christophersen (2014) sought to evaluate, "1) To what extent did youth's relationship competency change over time?; 2) Was there a difference in relationship competency over time between the two groups?; 3) After exposure to CORE programming, who did the youth count on for support and what was the quality of those relationships?" (p. 2).

Length of time for positive outcomes to be shown:

Each young person was interviewed twice, approximately 9 to 11 months apart (Nesmith and Christophersen, 2014).

How long effectiveness was maintained:

3 years (Nesmith and Christophersen 2014).

Other relevant contributors to program's effectiveness:

Nesmith and Christophersen (2014) report therapist and foster family contributions to program effectiveness.

Cost-effectiveness

No published information available.

Minority populations:

Almost 50% of participants identified as African American or Black. There were small numbers of participant from other cultural groups. We found no implementation with LGBTI families or in Australia with ATSI families.

Process evaluation information – evaluations of how the program was established:

No published information available

Length of time to set up program::

No published information available

How communities and families were engaged:

Based on Nesmith and Chrisophersen (2014) youth and foster families were engaged through their involvement with existing services.

Engagement of CYP in program:

CYP in the foster care system and nearing the end of their system engagement, who are assisted to achieve to transition from care.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other services and organisations providing related care:

Liaison and coordination occur with services associated with the foster care system.

Early intervention

The Geelong Project (TGP)/ Universal Screening

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Insufficient evidence (Question Mark)*
(1 Study)

"*A longitudinal time series evaluation reported reductions in the number of students entering the local homelessness system based on administrative data. However, due to the absence of a control condition, further evaluations including a prospective comparison group are needed to confirm that the observed effects on student homelessness were not the result of other conditions or changes*." (Morton et al. 2020, p.116). A version of Universal Screening has been trialled in two sites in NSW, but evaluation outcomes are not yet available.

Design:

Morton et al. (2020) describes this as "*a coordinated homelessness prevention model among schools and community organisations involving universal screening for students at risk for homelessness and tailored case management and support*". An Australian program based on the community of schools service model, delivered in schools and community organisations.

Target populations:

Youth at risk of homelessness and early school leaving.

Delivery methods:

Community collaborative (joint referral by schools and intervention workers); Population screening for risk; Practice framework (active monitoring, short-term support and wrap-around support for complex cases).

Location of services:

NSW implementations trialled in two sites, but evaluation outcomes are not yet available.
Implemented in school and community settings.

Assessment process to enter program:

Students in school complete screening assessment (risk for homelessness and early school leaving).

Referral pathways:

Students scoring high on risk for homelessness receive support in school and in the community.

Resourcing:

Training and development programs including 1) Online COSS toolkit for online learning; 2) Inter-professional training – school staff with community sector workers; 3) Communities of practice; and 4) COSS conferences – building a sense of collective impact (Morton et al. 2020).

Outcomes:

The program is intended to improve school engagement, reduce early school leaving and homelessness

Data required to assess effectiveness:

Morton et al. (2020) evaluated non-entry into the specialist homelessness service and/or remaining in education.

Length of time for positive outcomes to be shown:

No published information available

How long effectiveness was maintained:

No published information available.

Other relevant contributors to program's effectiveness:

No published information available.

Cost-effectiveness:

No published information available.

Minority populations:

No published information available.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engage:

No publishded information available.

Engagement of CYP in program:

No published information available.

Liaison with other services and organisations involved in program delivery:

School and community based early intervention.

Coordination with other services and organisations providing related care:

School and community-based support systems.

Youth Foyers

This program has been identified for inclusion by the Department of Communities and Justice.

UNDERPINNING EVIDENCE – Insufficient evidence (Question Mark)

(1 Review Study)

Outcomes on homelessness or family connection are unclear. A literature review (Levin et al. 2015) assessed "*the quality of 15 primary studies that examined the effectiveness of youth foyer or foyer-like programs on the lives of young homeless people … The research reviewed was mostly unable to report key program mechanisms, pointing to a lack of program documentation.*" Existing evaluation studies are unable to establish a link between foyer model mechanisms and outcomes.

DESIGN.

"*The youth foyer model provides an integrated approach to tackling youth homelessness, connecting affordable accommodation to training and employment*." (Levin et al 2015).

TARGET POPULATIONS:

Young people at risk of, or experiencing, homelessness (16–24 years)

DELIVERY METHODS:

"*In Australia and internationally, homeless young people stay in foyer programs for up to 24 months with the aim of supporting them while they undertake further education, training or enter employment, and subsequently move onto independent living or move back with family members*." (Levin et al 2015, p. 2).

LOCATION OF SERVICES:

NSW implementations not yet reported. In Victoria, Education First Youth (EFY) Foyers are located on TAFE campuses at Holmesglen, Kangan Institute and Goulburn Ovens. Internationally they are provided in France, UK, Ireland, Romania, the Netherlands, Germany and Australia (Levin et al. 2015).

ASSESSMENT PROCESS TO ENTER PROGRAM:

No published information available.

REFERRAL PATHWAYS:

No published information available.

RESOURCING:

No published information available.

OUTCOMES:

These programs seek improvements in education, employment, housing and accommodation, health and wellbeing (Levin et al. 2015).

DATA REQUIRED TO ASSESS EFFECTIVENESS:

Outcome effectiveness would require assessment of education, employment, housing and accommodation, health and wellbeing outcomes (Levin et al. 2015).

LENGTH OF TIME FOR POSITIVE OUTCOMES TO BE SHOWN:

Varied outcomes. Some reports of improvements being sustained in the short-term (e.g. 28 weeks) and longer-term. Many studies have not reported on longer term outcomes (Levin et al. 2015). “There is a need to evaluate outcomes in the long-term, after residents leave the foyers, to see whether positive outcomes have been sustained” (Levin et al. 2015, p.10).

HOW LONG EFFECTIVENESS WAS MAINTAINED:

Unclear due to lack of post-intervention follow-up data.

OTHER RELEVANT CONTRIBUTORS TO PROGRAM’S EFFECTIVENESS:

No information available.

COST-EFFECTIVENESS:

No information available due to lack of post-intervention follow-up data.

MINORITY POPULATIONS:

No information available.

PROCESS EVALUATION INFORMATION – EVALUATIONS OF HOW THE PROGRAM WAS ESTABLISHED:

No information available.

LENGTH OF TIME TO SET UP PROGRAM:

No information available.

HOW COMMUNITIES AND FAMILIES WERE ENGAGED:

No information available.

ENGAGEMENT OF CYP IN PROGRAM:

Young people reside in foyer accommodation and participating in education, training, or employment programs for up to 24 months.

LIAISON WITH OTHER SERVICES AND ORGANISATIONS INVOLVED IN PROGRAM DELIVERY:

No published information available.

COORDINATION WITH OTHER SERVICES AND ORGANISATIONS PROVIDING RELATED CARE:

No published information available.

Premier's Youth Initiative

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence – *Insufficient evidence (Question Mark)*

(1 quasi-experimental study)

Outcomes on homelessness or family connection are unclear. Taylor et al. 2020 summarised trend evidence for homelessness from one quasi-experimental evaluation. A non-significant 22% decrease in homelessness was evident after 18 months for those using the Premier's Youth Initiative compared to those who did not. (Taylor et al. 2020, p 82).

Design:

The service model provides a combination of: a) personal advice, b) education and employment mentoring, c) transitional accommodation support, and d) long-term accommodation. "*The PYI aims to prevent homelessness among at-risk young people leaving care and divert them from the homelessness service system*." (Taylor et al. 2020).

Target populations:

Young people in target locations (of NSW), aged 16–17 years. Young people will be at least one of: leaving residential care, leaving care with placement instability, leaving permanent care, or leaving care (and having been in case for at least 12 months) (Taylor et al. 2020)

Delivery methods:

The PYI intervention includes seven service components, encompassing 4 core components. Service components include:

- Personal advisor (accessible by all clients and is the contact for core components 1 & 2)
- Education and employment mentoring (accessible by all clients, contact for core component 3)
- Accommodation (accessible by some clients, subsidised accommodation)
- Transitional support (accessible by some clients, access to transitional support required to move into independent living)
- Brokerage (for items considered essential for supporting clients to achieve outcomes and transition to independent living)
- Engagement (continuous assessment and monitoring of clients' engagement)
- Evidence-informed practice integration (e.g. trauma informed care/practice)/

Four (4) core components:

(1) Leaving care plan implementation (eg. needs assessment, goals, barriers, required support)
(2) Strengthening prosocial support (e.g. connection to prosocial supports)
(3) Education and employment mentoring (e.g. goals, plan progress, barriers, connect to services needed)
(4) Transitional support (e.g. accommodation needs, community housing, advocacy, movement to independent living) (Taylor et al. 2020)

Location of services:

NSW

Assessment process to enter program:

Youth preparing to transition from out-of-home care settings.

Referral pathways:

Transition from out-of-home care settings.

Resourcing:

Resourcing likely to include: salary expenses, fringe benefits, supplies and materials, equipment, contracted services, rent, brokerage, donated supplied and physical space (Taylor et al. 2020).

Outcomes:

Modest improvements in housing and accommodation (not maintained in the long-term). Minimal change in social connections, physical health. No overall improvements in education or employment outcomes. No significant improvements to mental and emotional wellbeing, health and safety risk behaviours, or living skills.

Data required to assess effectiveness:

Outcome and output data, post-intervention data. Taylor et al. assessed regularly collected administrative data, qualitative focus groups, and cost data.

Length of time for positive outcomes to be shown:

Taylor et al. (2020) reported outcomes 18-months post-intervention.

How long effectiveness was maintained:

Taylor et al. (2020) reported outcomes 18-months post-intervention.

Other relevant contributors to program's effectiveness:

The likelihood of post-program homelessness was higher for those that had previously used homelessness services and used Indigenous care services (Taylor et al. 2020, p 81).

Cost-effectiveness:

"*An estimate of the unit cost across all providers is $15,145, however it varies between providers — from a low of $10,606 to a high of $22,732. This was largely driven by salaries*." (Taylor et al. 2020).

Minority populations:

No published information available.

Process evaluation information – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

Young people transitioning from out-of-home care settings.

Engagement of CYP in program:

Young people reside in Foyer accommodation and participated in education, training or employment programs for up to 24 months.

Liaison with other services and organisations involved in program delivery:

No published information available.

Coordination with other service and organisations providing related care:

No published information available.

Reconnect

This program has been identified for inclusion by the Department of Communities and Justice.

Underpinning evidence ***–*** *Insufficient evidence (Question Mark)*

(1 internal evaluation, with no control group or long-term follow-up)

Federally funded homelessness prevention and early intervention response program. An internal government evaluation report (Australian Government 2013) overviewed the program and achievement of service delivery targets. The evaluation design did not include a control group or causal analysis, hence was not sufficiently rigorous to enable outcomes to be attributed to the program activities. It was unclear what outcomes would have been achieved in the absence of this program.

Reconnect is an Australian Government service funding program to enable services to implement flexible community based early intervention programs for young people aged 12–18 years who are experiencing, or at risk of, homelessness and their families. Outcomes on homelessness or family connection are unclear.

Design:

An Australian Government service funding program whereby agencies assess young people and then set and implement service plans. "*The program promotes family reconciliation through managing conflict and improving family communication. Reconnect can: stabilise young people's living situations; improve the ability of young people and parents to better manage conflict and communication; improve young people's engagement with and attitude towards school; and increase engagement with training and employment*." (Australian Government 2013, p.9).

Target populations:

Young people 12–18 years at risk of, or experiencing, homelessness. In 2013 (Australian Government 2013) it was recommended the program age target be expanded to include young people 12–21 years.

Delivery methods:

Program delivery in both standard and specialised services (metropolitan, regional, and rural) involves counselling to assess young people and then set and implement service delivery plans.

Location of services:

Includes NSW. 101 current services in metropolitan, regional, rural and remote locations across Australia (Australian Government 2013).

Assessment process to enter program:

Young people deemed by services to be at risk of, or experiencing homelessness.

Referral pathways:

Referral of young people at risk of, or experiencing homelessness, to Reconnect providers. Referral also made from Reconnect to other relevant specialised services (e.g. education and employment settings/providers, family services, legal services, medical and mental health services)

Resourcing:

Different services are provided across the 101 participating agencies with payment ranging from $4,120 per client in Highly Accessible areas to a maximum of $6,180 for services in Remote and Very Remote areas (Australian Government 2013, p.11).

Outcomes:

At least 70 per cent of young people have improved accommodation at the end of support (Australian Government 2013, p.12). At least 70 percent of cases with these goals received services to improve family functioning and engagement. It is unclear whether services led to improvements beyond the service period.

Data required to assess effectiveness:

Australian Government 2013, analysed routinely collected program data reported by contracted services through the Reconnect Online Database System for the financial years 2010–11 and 2011–12.

Length of time for positive outcomes to be shown:

Australian Government 2013, analysed routinely collected program data (for the financial years 2010–11 and 2011–12) at the end of service delivery, which was less than 3 months in 52% of cases (Australian Government 2013, p 19).

How long effectiveness was maintained:

No published post-intervention information available.

Other relevant contributors to program's effectiveness:

34% of services did not achieve their agreed service delivery goals to reduce homelessness (Australian Government 2013, p 21).

Cost-effectiveness:

Data available only on the cost of services, benefits uncosted. "*Average cost per case is based on a calculation of the amount of funding each service received for the financial year divided by the number of clients per financial year. Services are assessed in accordance with proximity to the prescribed figures below. $4,120 for services in Highly Accessible areas; $4,635 for services in Accessible and Moderately Accessible areas; and $6,180 for services in Remote and Very Remote areas."* (Based on ARIA categories; Australian Government 2013).

Minority populations:

Reconnect works with "*a diverse range of vulnerable client groups such as Indigenous young people, newly arrived youth, young people with mental health issues, Gay Lesbian Bisexual Transgender and Intersex youth, young incarcerated women or young people with mothers who are incarcerated, young South East Asian people, youth with substance abuse issues, and youth leaving detention*." (Australian Government, 2013, p.10)

Process evaluation informationro – evaluations of how the program was established:

No published information available.

Length of time to set up program:

No published information available.

How communities and families were engaged:

Young people experiencing, or at risk of, homelessness.

Engagement of CYP in program:

Young people are connected with Reconnect providers and other appropriate specialised services, as required.

Liaison with other services and oganisations involved in program delivery:

Referral to other services include: Centrelink, child protection, crisis services, justice settings and police services, medical and mental health services, other relevant government services, educational settings.

Coordination with other services and ordanisations providing related care:

As above.

Appendix 2

WSIPP Programs in Initial Search Excluded

- Parent-Child Interaction Therapy (PCIT) for families in the child welfare system. REASON – treatment age too young (8 years).
- SafeCare. REASON – primary focus is on child abuse prevention, treatment age too young (5 years).
- Alternative Response. REASON – primary focus is child abuse prevention, treatment age too young (8 years)
- Flexible funding (Title IV-E Waivers). REASON - focus on federal funding.
- Subsidised guardianship (Title IV E waivers). REASON - excluded as a government economic policy

BLUEPRINTS in Initial Search (13 Model & Model Plus programs) Excluded as they do not include family reunification or housing/accommodation outcomes and for reasons below:

- Accelerated study in associate programs (ASAP). REASON – post-secondary (adult/early adults), focus is on academic attainment/performance.
- Blues program. REASON – primary focus is mental health/illicit drug use, late adolescents (15–18 years).
- Body project. REASON – primary focus is mental health/eating disorders, late adolescence through to early adulthood.
- BASICS. REASON – primary focus is alcohol use, early adulthood.
- Maryland Ignition interlock license restriction. REASON – adult crime focus
- Multisystemic Therapy – Problem Sexual Behavior (MST-PSB). REASON – primary focus on sexual violence/risk behaviour, early & late adolescents.
- Nurse-Family Partnership. REASON – primary focus on infants of first time mothers.
- New Beginnings (for children of divorce). REASON –focus is on divorced families. No homeless or family outcomes.
- Project Towards No Drug Abuse. REASON – late adolescence, substance use/violence focus.
- Other Programs within the 49 ‘promising’ list – REASON not focused on family reunification or housing/accommodation outcomes.

Early Intervention Foundation Included in Initial Search (adolescence, selective/indicated programs) and Excluded

REASON - The following programs excluded as their evaluations were not focused on family reunification or housing/accommodation outcomes.

- Becoming a man
- Friends for Youth
- New beginnings programme for divorced and separating families
- Parents forever
- Parents plus parenting when separated
- Pyramid Club Secondary
- Trauma-focused cognitive behavioural therapy
- Triple P family transitions
- Level 4 Standard Teen Triple P – not relevant (focus is on children <12 years and parents concerned about child behaviour)
- Parents plus adolescent program – not relevant (focus is on parents, and very low evidence rating such that it is unclear whether the program caused change/improvement)

Californian Evidence Based Clearinghouse for Child Welfare Programs Included in Initial Search and Excluded

PROGRAMS REVIEWED UNDER THE CATEGORIES: Core child welfare services (including placement & reunification) & Support Services for youth in the child welfare system. All programs not able to be rated were excluded

- Keep (Keeping Foster and Kin Parents Supported and Trained). REASON - focused on carers rather than adolescents, no family reunification or housing/accommodation outcomes.
- Kinship supports intervention. REASON - focused on caregivers, no family reunification or housing/accommodation outcomes.
- Support Groups for Grandparent Caregivers. REASON - focused on caregivers, no family reunification or housing/accommodation outcomes.
- Fostering Healthy Futures. REASON - age range too young
- Family assessment response. REASON - requires official child maltreatment report, no family reunification or housing/accommodation outcomes.
- Family group decision making. REASON - unclear focus, no family reunification or housing/accommodation outcomes.
- Structured decision making. REASON - requires official referral from child protection, no family reunification or housing/accommodation outcomes.
- Keep safe. REASON – focused on caregivers rather than young people, no family reunification or housing/accommodation outcomes.
- Together facing the challenge. REASON - focus foster parents and agency staff, no family reunification or housing/accommodation outcomes.