
MH – Children and Young People, NSW Ministry of Health

14 October 2016
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# Glossary of terms

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<tr>
<th>Acronym</th>
<th>Description</th>
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<tbody>
<tr>
<td>AASW</td>
<td>Australian Association of Social Workers</td>
</tr>
<tr>
<td>AH&amp;MRC</td>
<td>Aboriginal Health &amp; Medical Research Council</td>
</tr>
<tr>
<td>AHPRA</td>
<td>Australian Health Practitioner Regulation Agency</td>
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<tr>
<td>AMHS</td>
<td>Adult Mental Health Service</td>
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<tr>
<td>APDC</td>
<td>NSW Admitted Patient Data Collection</td>
</tr>
<tr>
<td>ASQ</td>
<td>Age and Stage Questionnaire</td>
</tr>
<tr>
<td>AUWI</td>
<td>Australian Unity Wellbeing Index</td>
</tr>
<tr>
<td>CALD</td>
<td>Culturally and Linguistically Diverse</td>
</tr>
<tr>
<td>CHeReL</td>
<td>Centre for Health Record Linkage</td>
</tr>
<tr>
<td>FACS</td>
<td>New South Wales Department of Family and Community Services</td>
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<tr>
<td>Family focused care</td>
<td>The delivery of health care based on partnerships between clients, families and all those involved in the care of the mother, child and family</td>
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<tr>
<td>HoNOS</td>
<td>Health of the Nation Outcomes Scales. A set of 12 scales, each one measuring a type of problem commonly presented by patients/mothers in mental health care settings.</td>
</tr>
<tr>
<td>Kessler 10</td>
<td>Kessler Psychological Distress Scale. A 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period</td>
</tr>
<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>LHD</td>
<td>Local Health District</td>
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<tr>
<td>MaKM Program</td>
<td>Mums and Kids Matter Program</td>
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<tr>
<td>MaKM staff</td>
<td>Personnel employed by Wesley Mission to deliver and manage the MaKM program</td>
</tr>
<tr>
<td>Mental health assessment</td>
<td>A clinical assessment of a client’s mental health which gathers information in areas such as presenting problems, history of presenting problems, psychiatric history, medications, medical history, family history etc.</td>
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<tr>
<td>MH-AMB</td>
<td>NSW Mental Health Ambulatory Data Collection</td>
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<tr>
<td><strong>MH-CYP project team</strong></td>
<td>Mental Health-Children and Young People (a devolved unit of MHDAO, NSW Ministry of Health) responsible for delivery of the MaKM program evaluation</td>
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<tr>
<td>-------------------------</td>
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<tr>
<td><strong>MHDAO</strong></td>
<td>Mental Health and Drug and Alcohol Office. A branch of the Ministry of Health and funder for the Mums and Kids Matter Program.</td>
</tr>
<tr>
<td><strong>Minimum Data Set</strong></td>
<td>A broad set of data items that are collected in relation to consumers, the services they receive, and the outlets that provide these services.</td>
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<tr>
<td><strong>MoH</strong></td>
<td>New South Wales Ministry of Health</td>
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<tr>
<td><strong>Mothers</strong></td>
<td>Mums who are participants in the MaKM program</td>
</tr>
<tr>
<td><strong>NEAF</strong></td>
<td>National Ethics Application Form</td>
</tr>
<tr>
<td><strong>NCFAS</strong></td>
<td>North Carolina Family Assessment Scale. A scale to determine family functioning.</td>
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<tr>
<td><strong>OOHC</strong></td>
<td>Out-of-Home-Care</td>
</tr>
<tr>
<td><strong>Nous project team</strong></td>
<td>The Nous team responsible for conducting the evaluation of the MaKM program</td>
</tr>
<tr>
<td><strong>Severe and persistent mental illness</strong></td>
<td>Mental illnesses with complex symptoms that require ongoing treatment and management.</td>
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<tr>
<td><strong>SHN</strong></td>
<td>Speciality Health Network</td>
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<tr>
<td><strong>PIR</strong></td>
<td>Partners in Recovery: coordinated support and flexible funding for people with severe and persistent mental illness with complex needs, funded through the Australian Government Department of Health</td>
</tr>
<tr>
<td><strong>PHaMS</strong></td>
<td>The Personal Helpers and Mentors (PHaMs) service: aims to provide increased opportunities for recovery for people whose lives are severely affected by mental illness and assists people aged 16 years and over whose ability to manage their daily activities and to live independently in the community is impacted because of a severe mental illness</td>
</tr>
<tr>
<td><strong>PHSREC</strong></td>
<td>Population and Health Services Research Ethics Committee</td>
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<tr>
<td><strong>ROSH</strong></td>
<td>Risk of Significant Harm</td>
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1 Executive Summary

1.1 Overview

The MaKM Program commenced in March 2014 and is operated by Wesley Mission. The MaKM Program is funded under the National Partnership Agreement (NPA) supporting National Mental Health Reform. The MaKM Program aims to reduce the length of hospitalisation of mothers and avoid unnecessary hospitalisation through providing comprehensive services and intensive support. It also links mothers to a comprehensive range of community based local supports according to each mother’s particular needs and preferences. It further aims to decrease out of home care and homelessness through providing social and parenting support, health support for mothers and their families, supporting mothers to remain living in the community.

The Mental Health Drug and Alcohol Office (MHDAO) engaged Nous Group (Nous) to evaluate the MaKM Program. The evaluation was multi-faceted; containing process, outcome and economic components. The evaluation commenced in November 2015 and was completed in July 2016. Nous used a mixed methods approach for the evaluation. This included drawing on multiple data sources to develop evaluation findings and recommendations, including:

- Quantitative data analysis
- Economic appraisal
- Literature review
- Qualitative data collection and analysis

The evaluation collected and analysed comprehensive quantitative and qualitative data to respond to four key lines of enquiry outlined below. Nous has identified the key findings in response to each line of enquiry:

1. **What has been delivered under the MaKM Program?**
   - The average MaKM participant is from a low SEIFA area, is more likely to be Aboriginal, and more likely to be at risk of homelessness than the general population.
   - Most mothers have multiple diagnoses across numerous disorders, but mood and psychotic disorders are the most prevalent.
   - The sources of referrals vary over time, but South Western Sydney LHD has referred the most patients into the MaKM Program.
   - After a decline in participation in late 2015, participation has recovered as entries into the MaKM Program outnumber exits.
   - Services are evenly distributed across in-home community and residential care packages, a relative proportion that has remained steady over time.
   - The MaKM Program develops care packages tailored to the needs of participants, underpinned by a care planning process and delivered by qualified staff with relevant qualifications.
   - The MaKM Program delivers a variety of services as part of its holistic approach, but data limitations constrain analysis of service activity.
   - Various psychological support sessions are delivered in both formal and informal settings.
• The total hours of services delivered per participant rose throughout 2015 in line with an increase in MaKM Program staff.
• Mothers access specific services at different rates, reflecting the tailored and individual nature of the MaKM Program care packages.

2. **How well does the MaKM deliver services?**
• In the 2014-15 Financial Year, the MaKM Program continued well within budget.
• A rise in FTEs over time is due to an increase in nursing staff and family coaches.
• A governance structure has been established to oversee the implementation and evaluation of the MaKM Program.
• The economic appraisal indicates that the MaKM Program has a large, positive net present value.
• After some initial challenges, feedback indicates that MaKM activities have been implemented effectively.
• All referrer and partner agencies report positive interactions with the MaKM Program staff.
• The majority of participants interviewed had a positive experience in the MaKM Program, however the exit process could be improved to deliver greater care and more lasting benefits.
• Participants value the ability of MaKM staff to listen, tailor support and be flexible.

3. **What impact has the MaKM Program had?**
• Mothers exiting the MaKM Program report they have increased confidence in parenting and managing their mental illness.
• Care planning checklists ensure good health management processes, but there is scope to expand and redefine the factors that they consider.
• Formal assessments indicate substantial improvements in mothers’ mental health status and levels of psychological distress.
• The assessment of outcomes for children and families highlights the limitations of the existing outcomes measurement tools.
• The MaKM Program has ensured that every mother has suitable accommodation arrangements upon exiting the program.
• Since exiting the program, the average mother has had fewer mental health related episodes of care, shorter total inpatient episodes of care, and fewer ambulatory mental health care contacts.
• Mothers’ primary diagnostic categories for inpatient and ambulatory care have changed substantially since exiting the program.
• The impact of ceasing the MaKM Program would be significant.
• The MaKM Program is unique and tailored specifically to mothers with severe and complex mental illness and their children, offers a distinct set of services, and mothers can be referred from any LHD or relevant Specialty Health Network (SHN) in NSW.

The following section outlines the response to the fourth key line of enquiry (the future opportunities and priorities to consider for the MaKM Program).
1.2 Recommendations to further improve the impact of the MaKM Program

<table>
<thead>
<tr>
<th>Current state of the MaKM Program</th>
<th>Recommendations to improve the MaKM Program</th>
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<tbody>
<tr>
<td><strong>Operating model</strong>&lt;br&gt;The current operating model provides effective step-up step-down services to mothers with a severe mental illness and their children. It offers mental health, health, parenting and education services tailored to individual needs and effectively provides services both in the community and within a residential setting.</td>
<td><strong>Operating model</strong>&lt;br&gt;1. The future operating model should provide greater reach in rural areas proportional to birth rate and demand.&lt;br&gt;2. There should be an increased focus on fathers and families in the MaKM Program.</td>
</tr>
<tr>
<td><strong>Funding model</strong>&lt;br&gt;The MaKM Program’s funding is based on a 3 financial year funding cycle with amounts dedicated to the various service components.</td>
<td><strong>Funding model</strong>&lt;br&gt;3. MaKM Program staff should have the capacity to continue to move funding between program elements.</td>
</tr>
<tr>
<td><strong>Capability</strong>&lt;br&gt;The MaKM Program’s personnel increased in late 2015, which resulted in an increase in staff capability and specific skillsets. The Program currently attracts qualified staff to deliver the specialised, holistic care model that the Program is based on.</td>
<td><strong>Capability</strong>&lt;br&gt;4. Future professional development should be evidence based, tailored and available for all MaKM Program staff and a formalised supervision program should be mandatory for all staff.</td>
</tr>
<tr>
<td><strong>External alliances and partnerships</strong>&lt;br&gt;The MaKM Program has established relationships with a number of referrer and partner agencies across NSW, who positively report on the impact of the Program.</td>
<td><strong>External alliances and partnerships</strong>&lt;br&gt;5. A stakeholder engagement plan should be developed to build and sustain relationships with new and current referrers and interacting agencies.&lt;br&gt;6. Awareness of the Program should be increased to support mothers to transition into the Program as smoothly as possible and increase participation from remote and regional areas.</td>
</tr>
<tr>
<td><strong>Business processes</strong>&lt;br&gt;The MaKM Program has begun to establish promising processes to obtain referrals into the MaKM Program and manage transition out of the Program.</td>
<td><strong>Business processes</strong>&lt;br&gt;7. The MaKM Program’s referral process should be reviewed to increase efficiencies.&lt;br&gt;8. The MaKM Program’s transition processes in and out of the Program should be strengthened.</td>
</tr>
<tr>
<td><strong>Systems and reporting</strong>&lt;br&gt;The MaKM Program staff report to the Ministry of Health using a number of objective measurement tools.</td>
<td><strong>Systems and reporting</strong>&lt;br&gt;9. Future development of information systems should ensure they are comprehensive, patient and family centered and overcome current data limitations.&lt;br&gt;10. The program logic framework should be revised to improve the measurement of outcomes, particularly for child and family outcomes.&lt;br&gt;11. Program reporting to MH-CYP should deliver key insights in an easily accessible form and be based on accurate information.</td>
</tr>
<tr>
<td><strong>Technology</strong>&lt;br&gt;The MaKM Program’s use of technology has been limited to date and there is scope to increase this to further support mothers and maintain relationships with referrer and partner agencies.</td>
<td><strong>Technology</strong>&lt;br&gt;12. Technology should be used to engage referrers and provide mental health and other support to participants and their families.&lt;br&gt;13. The MaKM Program website should be updated to enhance program promotion.</td>
</tr>
<tr>
<td><strong>Governance</strong>&lt;br&gt;The MaKM Program consists of a number of governance structures and reporting channels.</td>
<td><strong>Governance</strong>&lt;br&gt;14. A clinical governance structure should guide ongoing program design and improvement.</td>
</tr>
</tbody>
</table>
2 Background and context

2.1 About the evaluation

The Mums and Kids Matter (MaKM) Program provides an important mental health and tertiary parenting service in New South Wales (NSW) for mothers with severe and complex mental health problems and their children (0-5 years). The MaKM Program aims to address the perinatal mental health service system gap for mothers with severe and complex mental health problems by:

- supporting mothers to remain living with their families in the community
- providing step-up/step-down, flexible and tailored community psychosocial support
- minimising the risk of developing chronic disability and social isolation
- delivering prevention and early intervention benefits for children through optimising development and opportunities
- enhancing their access to specialist mother-child mental health care
- delivering appropriate family focused care to address the needs of the mother and the child.

Referrals to the MaKM Program are only accepted from NSW public mental health services, which is the clinical mental health service provider for mothers participating in the MaKM Program.

The Mental Health Drug and Alcohol Office (MHDAO) engaged Nous Group (Nous) to evaluate the MaKM Program. The evaluation was multi-faceted; containing process, outcome and economic components. The aim of the evaluation was to:

- evaluate the program’s effectiveness
- measure achievements against Key Performance Indicators (KPIs)
- determine the extent to which the model has been implemented
- make recommendations on the future delivery and improvement of the program.

The evaluation commenced in November 2015 and was completed in July 2016. This Final Report details all key findings from the evaluation and recommendations to consider for future delivery of the MaKM Program.

2.2 MaKM Program background

The MaKM Program commenced in March 2014 and is operated by Wesley Mission. The MaKM Program was originally funded under the National Partnership Agreement (NPA) supporting National Mental Health Reform. The objective of the NPA was to improve health, social, economic and housing outcomes for people with severe and persistent mental illnesses by addressing service gaps and preventing ongoing cycling through state mental illness services.¹

¹ NSW Implementation Plan: National Partnership Agreement supporting national mental health reform, June 2012.
In Australia, it is estimated that between 21 and 23 percent of children living in Australian households have at least one parent with a mental health issue.\(^2\) Parents with mental health issues are also over-represented among maltreating families: 13 percent of cases referred for child protection concerns include a parent with a mental illness.\(^3\)

The MaKM program is being delivered within the context of mental health reform in NSW. *Living Well: A strategic plan for mental health in NSW 2014 – 2024*, outlines a plan for mental health reform to improve service delivery through the provision of integrated, family focused care for people with mental illness in their local communities wherever possible. It is underpinned by key actions such as ‘getting in earlier’, particularly for young children of parents who have mental illness.

Prevention is a key aspect of the ‘Keeping People Healthy’ direction in the NSW State Health Plan.\(^4\) It aims to deliver a health system that allows the government and the community sector to build healthy communities that provide the right support for those living with chronic illness. Mothers with a mental illness may require access to an array of interconnected services. They are at risk of parenting difficulties, social isolation, hospitalisation and poverty. Clear links also exist between homelessness and mental health issues. In turn, these factors increase the child’s vulnerability in areas such as education, health, risk of placement in out of home care, substance abuse and offending.

The MaKM Program aims to reduce the length of hospitalisation of mothers and avoid unnecessary hospitalisation through providing a consumer driven recovery focus of treatment that includes comprehensive services and intensive support. It also links mothers to a comprehensive range of community based local supports according to each mother’s particular needs and preferences. It further aims to decrease out of home care and homelessness through providing health (for mother and child/ren), welfare and parenting support and training to mothers in the MaKM Program. The MaKM Program does this through offering the following services:

- **Residential services**: a single site for short term (up to three months) non-acute residential care in eight accommodation units. Services provided include psychological therapies, parent education, living skills training and support, playgroup sessions and health clinic sessions.

- **In-home community care packages**: personalised support packages which are tailored to the needs of each mother and their child/ren. The intensity of support provided is determined through making a comprehensive assessment of the mother’s level of need and developing an appropriate package to meet that need. Each care package varies between high, medium and low levels of intensity.

- **Brokerage for specialist care**: funding is available to support mothers who are clients of the MaKM Program and who require a period of inpatient acute mental health and/or tertiary parenting care. Services are provided through St John of God Burwood, Tresillian in Canterbury, Nepean and Willoughby and Karitane Residential Units in Camden and Carramar.

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3 NSW Department of Community Services, Parents with Mental Health Issues: consequences for children and effectiveness of interventions designed to assist children and their families. November 2008

3 Methodology

3.1 Evaluation plan

A detailed Evaluation Plan, endorsed by the Steering Committee on 4 February 2016, guided the evaluation.

The evaluation comprised three key stages:

- **Stage 1**: design the evaluation (November to December 2015)
- **Stage 2A**: process and economic evaluation (January to April 2016)
- **Stage 2B**: outcome evaluation (May to July 2016)

Between November 2015 and March 2016, the main focus of the evaluation was to establish the project foundations, plan the evaluation, develop an ethics strategy and submit ethics applications. We also commenced the initial consultations and data collection and analysis.

From March to April, the Nous team conducted the majority of qualitative and quantitative data collection activities.

From May to June the Nous team completed interviews with program participants and the analysis of all remaining quantitative data.

Figure 1 illustrates the activities and deliverables completed throughout the course of the evaluation.

![Figure 1: Overview of project activities and deliverables](image-url)
3.2 Mixed methods approach, ethical guidelines and data limitations

Nous used a mixed methods approach for the evaluation. This included drawing multiple data sources to develop evaluation findings and recommendations, including:

- Quantitative data analysis
- Economic appraisal
- Literature review
- Qualitative data collection and analysis

However, there were a number of limitations to the activity data analysed that should be taken into account when considering the findings and recommendations presented in this report. More detail on the approach to data collection and data limitations can be found in Appendix 2 and Appendix 4 respectively.

In order to conduct participant interviews and access linked data from the Department of Family and Community Services (FACS) and the MoH data sets, Nous submitted ethics applications to the following committees between January and February 2016:

- South West Sydney Local Health District (SWSLHD) Ethics Committee - Nous received approval from SWSLHD ethics committee on 5 April 2016.
- Aboriginal Health and Medical Research Council (AH&MRC) - Nous received approval from AH&MRC on 15 February 2016.
- NSW Population and Health Services Research Ethics Committee (PHSREC) - Nous received data custodian approval for the MoH datasets from MHDAO 24 March 2016 and the data custodian approval for the FACS datasets was received on 30 May 2016.

More detail on the ethics approval process can be found in Appendix 3.

3.3 Governance structure

The governance structure for the evaluation was established at project commencement. It consisted of the following stakeholder groups as outlined in Table 1.

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>Representation</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>MaKM Evaluation Project Team</td>
<td>Representatives from: MH-CYP and the MaKM Wesley Mission team</td>
<td>Nous’ key point of contact throughout the evaluation</td>
</tr>
</tbody>
</table>
3.4 Conceptual framework

This evaluation consisted of three components – process, outcome and economic evaluations. Nous developed a clear conceptual framework for the evaluation based on the Results Based Accountability (RBA) framework used in the MaKM Program performance measures. Our conceptual approach is illustrated in Figure 2 below.

The RBA framework outlines the four questions to measure different aspects of performance. It also informed the four key lines of enquiry for the evaluation, as detailed in Key lines of enquiry.

Figure 2: Nous’ adaptation of the RBA performance measurement framework

3.5 Best practice principles underpin the evaluation

A number of best practice principles guided all evaluation activities to ensure the ongoing development of robust findings, adherence to ethical requirements and delivery of an efficient project. Figure 3 outlines our best practice principles. Further details relating to our adherence to ethical requirements are detailed below in Section 3.6.

Figure 3: Nous’ best practice evaluation principles
4 Findings

The following section outlines the evaluation findings relating to the analysis of service activity, outcomes and linked data, as well as a review of programs with comparable elements. The findings presented in this report represent a synthesis of:

- analysis of service activity from the Wesley Mission MDS including the quantity of services delivered up to 31 March 2016
- analysis of outcomes data, including formal assessments and service utilisation provided by linked data
- desktop review of programs with comparable elements
- analysis of online survey results from the survey distributed to referring agencies and program partners, including public mental health services referring into MaKM and other interacting agencies
- focus groups with MaKM Program partners, including public mental health services referring into the MaKM Program, other program partners and interacting agencies
- interviews with MaKM Program participants.
4.1 What has been delivered under the MaKM Program?

Findings

- The average MaKM participant is from a low SEIFA area, is more likely to be Aboriginal, and more likely to be at risk of homelessness than the general population.
- Most mothers have multiple diagnoses across numerous disorders, but mood and psychotic disorders are the most prevalent.
- The sources of referrals vary over time, but South Western Sydney LHD has referred the most patients into the MaKM Program.
- After a decline in participation in late 2015, participation has recovered as entries into the MaKM Program outnumber exits.
- Services are evenly distributed across in-home community and residential care packages, a relative proportion that has remained steady over time.
- The MaKM Program develops care packages tailored to the needs of participants, underpinned by a care planning process and delivered by qualified staff with relevant qualifications.
- The Ma KM Program delivers a variety of services as part of its holistic approach, but data limitations constrain analysis of service activity.
- Various psychological support sessions are delivered in both formal and informal settings.
- The total hours of services delivered per participant rose throughout 2015 in line with an increase in MaKM Program staff.
- Mothers access specific services at different rates, reflecting the tailored and individual nature of the MaKM Program care packages.

The MaKM Program is a unique program that provides a holistic approach to recovery for mothers who are experiencing or ‘living with’ severe and complex mental illness. The mothers who have participated in the MaKM Program have disproportionately high mental health risk factors including homelessness and substance use, and have diagnoses across multiple mental health disorders.

Although mothers predominately live in areas with low Socio-Economic Indexes for Areas (SEIFA), referrals can span across NSW. Given the small size of the participant cohort to date, referrals from specific parts of NSW have been intermittent. Despite some cyclicality in total referrals into the program since June 2014, MaKM Program staff have continued to ramp up the program’s operations over the past two years, with both staffing and the number of services delivered increasing steadily.

Another change to the MaKM Program has been its evolution to include more structured, evidence-based interventions such as psychological therapy and parent education, in addition to psychosocial support and informal social group activities. This has been driven at least in part by the hiring of key staff with specific training and skillsets. Financially, the MaKM Program has historically returned a surplus but, with the addition of more staff with specialist skills, the program has begun to meet budgeted expenditure.
4.1.1 The average MaKM participant is from a low SEIFA area, is more likely to be Aboriginal, and more likely to be at risk of homelessness than the general population

Although MaKM Program participants have diverse backgrounds and come from LHDs across NSW, there are many common characteristics in the participant cohort. These similarities, which are often driven by eligibility criteria, include having at least one infant and having a severe mental illness. Similarly, mothers are overwhelmingly from NSW LGAs with low SEIFA indices. A number of mothers have been referred from rural or regional towns, including Orange, Tuncurry and Dubbo. **An important characteristic of the cohort is that approximately 21 per cent of mothers are Aboriginal and/or Torres Strait Islander, which is seven times the corresponding proportion for the general population.**

Figure 4 below outlines some of the key demographic characteristics of the MaKM Program participants up to and including 31 March 2016. Figure 5 shows a number of mental health risk factors that are prevalent amongst participants in the MaKM Program cohort based on multiple sources of information, such as referral forms and linked data.

Figure 5 shows that **two in five mothers were homeless, at risk of homelessness or in unstable housing at the time of referral.** Based on MaKM staff assessments, 12 per cent (5/42 mothers) were homeless and 28 per cent (12/42 mothers) were at-risk of homelessness. **This figure is disproportionate with 0.3 per cent of females in the general population estimated to be homeless in the general population as at the last census.** Table 2 provides further detail with respect to the mental health risk factors in Figure 5.

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5 It is estimated that approximately 2.9 per cent of women in NSW are Aboriginal and/or Torres Strait Islander. Australian Bureau of Statistics, 2013, 3238.0.55.001 - Estimates of Aboriginal and Torres Strait Islander Australians - June 2011, ABS.

6 The MaKM Team Leader for Community Transitions and Connections also estimated that 11 mothers of the 42 who have exited the program to date (26 per cent) were ‘highly likely’ to require a new referral to Specialist Homelessness Services had they not accessed the MaKM program. This percentage was used as an assumption in the economic appraisal component of this evaluation.

7 Australian Bureau of Statistics, 2015, Cat. 2049.0 Census of Population and Housing: Estimating homelessness, ABS.
Figure 4: Participant characteristics

58 Mothers have participated in MaKM to end of March 2016

27.5 Years is the median age of mothers in the program

>70% Of mothers live in LGAs with a SEIFA 4 or less (bottom 40% most disadvantaged)

21% Of mothers are Aboriginal and/or Torres Strait Islander

68 Children have participated in MaKM to March 2016

1 Year is the median age of children in the program

1.6 Is the average number of children per mother

Proportion of participants and their children by different age groups

Age of mother (n=58)

- 21% 21 and under
- 79% 22 – 45

Age of child (n=93)

- 65% 0-2 (in program)
- 6% 3-5 (in program)
- 20% 0-2 (not in program)
- 9% 3-5 (not in program)

Kids ‘in program’ includes the child that entered into the program with mother, with which most of the therapeutic work occurred.

‘Not in program’ includes kids older than 5 or kids who were not in the care of the mum

Figure 5: Mental health risk factors affecting MaKM participants (n=58)

- 14% Disability (n = 58)
- 28% Substance use (n = 36)
- 40% Homeless or in unstable housing (n = 42)
- 64% History of violence (n = 58)
- 79% FACS involvement (n = 43)

8 ‘In program’ includes the child that entered into the program with the mother and with whom most of the therapeutic work occurred.

9 ‘Not in program’ includes children older than 5 or children who were not in the care of the mother.

10 Nous did not have access to data to split the distribution of mother’s ages into more than two groups.
### Table 2: Referral form questions relating to mental health risk factors of participants

<table>
<thead>
<tr>
<th>Mental health risk factor</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability</td>
<td>Disability is based on whether the mother receives the Disability Support Pension. Referrers are asked to describe the reasons for the Pension.</td>
</tr>
<tr>
<td>Homelessness</td>
<td>This is based on MaKM staff assessments during the care planning process.</td>
</tr>
<tr>
<td>Substance use</td>
<td>This is based on data from the third HoNOS subscale that assesses “problem drinking or drug taking”. A mother is counted in this data if she has scored a 1 or higher, indicating at least some problem drinking or drug taking, on either administration of the HoNOS (entry or exit).</td>
</tr>
<tr>
<td>History of violence</td>
<td>This is based on referral form information at entry to the Program. Referrers are asked whether there is a history of violence perpetrated, received or witnessed by mothers, and are asked to provide further detail.</td>
</tr>
<tr>
<td>FACS involvement</td>
<td>34 out of 43 mothers have been linked to FACS data because their children were the subjects of ROSH reports. This proportion therefore reflects FACS involvement due to a risk of significant harm to the children.</td>
</tr>
</tbody>
</table>

### 4.1.2 Most mothers have multiple diagnoses across numerous disorders, but mood and psychotic disorders are the most prevalent

An analysis of mothers’ diagnoses as recorded on the referral forms indicates that most mothers have multiple diagnoses. Across higher level groupings of mental health disorders (see Grouping of MaKM Mental Health Diagnoses for the categorisation of diagnoses that MaKM uses), some mothers have up to five diagnoses, whilst one mother has six specific diagnoses (two of which are grouped within one type of mental disorder). As demonstrated in Figure 6 below, the most prevalent diagnosis group is mood disorders, with 24 mothers diagnosed with some form of depression. Almost a fifth of mothers have been diagnosed with psychotic disorders such as schizophrenia. Anxiety disorders, including Generalised Anxiety Disorder, and Personality disorders, such as Borderline Personality Disorder, are also very common diagnosis groups amongst the cohort.

Referral form data about diagnoses is limited in that it does not specify the primary diagnosis of the mother. Similarly, it is difficult to ascertain the original source of the diagnosis. Consequently, Figure 6 is based on the total number of diagnoses, and mothers with multiple diagnoses are represented multiple times. Section 4.3.8 discusses primary diagnoses based on the linked datasets used in this evaluation.
Figure 6: Prevalence of each type of mental disorder amongst MaKM participants \((n=58)\)\(^{11}\)

![Pie chart showing prevalence of mental disorders]

Figure 7 below is a heat map showing the relationship between any two sets of mental disorders amongst MaKM Program participants. Given the frequency of mood, psychotic, anxiety and personality disorders amongst mothers, it is not surprising that the most prevalent combinations of diagnosis groups are:

- mood and anxiety disorders
- mood and psychotic disorders
- mood and personality disorders.

As indicated, many mothers have been diagnosed with more than two types of mental disorders. Only two are shown in Figure 7 below.

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\(^{11}\) The MaKM staff are not responsible for the diagnosis of the participants. The diagnosis is made by the referrer and is confirmed by MaKM through a discharge summary, care plan from a GP, treating psychiatrist clinical notes or patient hospital records.
4.1.3 The sources of referrals vary over time, but South Western Sydney LHD has referred the most patients into the MaKM Program

As at the end of March 2016, there had been referrals into the MaKM Program from all LHDs apart from Far West NSW LHD, Northern NSW LHD and Southern NSW LHD. Figure 8 highlights the LHDs with the most referrals into the MaKM Program since inception. With a total of 16 referrals made, South Western Sydney is the only LHD to have referred more than ten mothers into the MaKM Program. In recent months, Illawarra Shoalhaven LHD and Northern Sydney LHD have been the leading referrers of mothers into the Program (see Figure 9).

Figure 8 and Figure 9 are based on referrals of mothers who were accepted into the MaKM Program. It does not include an analysis of the number of enquiries made about the program or the total number of referral applications submitted, which would be a better gauge of demand for MaKM’s services and awareness of the Program. Nous was not able to source this information from the MaKM staff.

Referral numbers into the Program could also be affected by the relationship between referrer agencies and their clients and the rate at which referrer and partner agencies are informed of the mental health issues facing a pregnant woman or mother. One of the recognised barriers to pregnant women and mothers acknowledging mental health problems to referrers and accessing appropriate support is the stigma and fear that their baby will be removed.12

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Figure 8: Heat map of LHD referrals since the MaKM Program's inception ($n=62^{13}$)

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13 $62$ represents the number of mothers referred and accepted into the program. Of these, 4 mothers did not continue in the program so this accounts for the difference between this figure and figures 4 and 5 above.
Figure 10 provides some insight into the relationship between the number of Program referrals and the demand for services (estimated using the female population of child bearing age and birth rate within each LHD). Despite the small number of data points, there appears to be a correlation between the female population of child bearing age and the number of referrals ($\rho = 0.58^{16}$). The seven LHDs with the highest female population of child bearing age make up approximately 85% of referrals. There is a less significant correlation between fertility rates and the number of referrals ($\rho = 0.33$). However there is some discrepancy in the data. For example, South Eastern Sydney has the highest female population of child bearing age but has referred very few mothers into the program. Furthermore, Illawarra Shoalhaven and Nepean Blue Mountains have very similar female populations of child bearing age (85,035 and 83,346 respectively), yet Illawarra Shoalhaven has nine times as many referrals as Nepean Blue Mountains despite having a lower fertility rate. This highlights that key drivers of referrals are likely to be the MaKM Program staff’s relationships with LHDs, and the Program marketing and awareness.

14 All figures in the table are for 3 months periods (quarters), except for the single month of June 2014.
15 The total number of mothers in this table (62) represents the number of mothers referred and accepted into the program. Of these, 4 mothers did not continue in the program so this accounts for the difference between this figure and figures 4 and 5 above
16 A correlation coefficient (Pearson’s $\rho$) of 0.58 indicates a moderate positive relationship between the two variables.
4.1.4 After a decline in late 2015, participation has recovered as entries into the MaKM Program outnumber exits

The number of mothers participating in any given month peaked at 20 in May 2015, which was then followed by a decline in the number of participants to a total of 11 in October 2015. In the past six months, participation has increased once again, with 16 mothers participating in the MaKM Program in March 2016. Figure 11 breaks down this trend into entries, exits and net changes in the number of participants.

In particular, as the black diamonds show in Figure 11, the number of entries has mostly remained steady at around three per month. However, high numbers of mothers exiting the program in June 2015 and in January 2016 were not offset by a rise in the number of new entrants, which led to a net decline in total participation. Conversely, fewer exits in recent months have resulted in a net rise in participation.

The result of these changes in gross flows of participants since June 2015 is that there has been a substantially greater turnover of MaKM Program participants in that period than in the early months of the program. For example, in the nine months from July 2015 to March 2016, there were 50 entries and exits (26 entries and 24 exits). In the corresponding nine months from October 2014 to June 2015, there were a total of 37 entries and exits (19 entries and 18 exits), despite higher average total participation (15.1 compared with 13.7 in the nine months to March 2016). In other words, participants have been moving in and out of the program at a faster rate in recent months.

17 Female population and birth rate data for each LHD was obtained through HealthStats NSW, available at: http://www.healthstats.nsw.gov.au/Indicator/mab_fert/mab_fert_lhn_trend; St Vincent’s Health Network and Justice & Forensic Mental Health Network has not been included as the population and fertility rate data for these networks are captured by LHD data.
Consequently, the higher turnover of MaKM Program participation has led to a corresponding decline in the average duration of participation (see Figure 12); the cumulative (moving) average duration of participation of all the MaKM Program mothers declined from 25.6 weeks by the end of March 2015 to 18.4 weeks by the end of March 2016.\textsuperscript{18} The cumulative (moving) average duration of residential packages by the end of March 2016 was 10.7 weeks. An outline of the referral pathway for program participants is provided in Figure 26 later in this report.

\textbf{Figure 11: Total and change in the number of MaKM Program mothers by month (n=58)}\textsuperscript{19}

\textsuperscript{18} Although a cumulative moving average is weighed down by the longer participation periods in the early months of the MaKM Program, it provides smooth average that is not as susceptible to volatility caused by the small sample of participants in each month.

\textsuperscript{19} The analysis in this report uses different datasets to produce the different graphs, therefore the ‘exit figures’ and total number of mothers in each graph will not necessarily align.
4.1.5 Services are evenly distributed across in-home community and residential care packages, a relative proportion that has remained steady over time

Consistent with a patient centred model, new mothers entering the MaKM Program work with the staff to determine a tailored program of services that is appropriate for their needs and the needs of their family. The vast majority of these services have been delivered as either in-home/community packages or at the residential facility in Sadleir.

Interestingly, despite the individualised nature of the care packages, the relative proportion of residential to in-home/community packages has remained steady (50/50 split) since inception, with only small variations. This can be seen in Figure 13, which also shows that in each quarter, except for the December quarter 2015, there have been a small number of mothers who have been admitted into the inpatient mother-baby unit at St John of God Health Services, Burwood.

Mothers often switch between packages during their participation in the program. Therefore, the average duration of overall program participation is not a weighted average of the average durations of each of the packages, and will necessarily be higher.
4.1.6 The MaKM Program develops packages tailored to the needs of participants, underpinned by a care planning process and delivered by qualified staff with relevant qualifications

The mix and frequency of MaKM Program services delivered to each participant are tailored to the needs of the mother and her children. This fundamental feature of the MaKM Program is underpinned by a care planning process. According to MaKM Program staff, care planning consists of the following steps:

1. Each mother’s care plan is based on a goal setting exercise (see Goal Setting Tool, Appendix 9) and includes an analysis of other relevant documentation and a discussion with members of the multi-disciplinary team.
2. All care plans are reviewed by the Mental Health Nurse Team Leader, the Team Leader - Psychological Therapies and the Operations & Clinical Manager. The Team Leader, Community Transitions & Connections also reviews the care plans, with a focus on interventions that address psychosocial determinants of health, mental health and well-being.
3. External key stakeholders such as mental health case workers and other key stakeholders (e.g. FACS workers) are routinely invited to participate in care planning, care review and transition planning meetings.21
4. Strategies/interventions are developed based on a needs analysis. For example, a dialectical behaviour therapy (DBT) program may be a key strategy for a mother diagnosed with Personality Disorder.
5. The mother’s progress is discussed and noted at regular care review meetings. Interventions may subsequently be adapted to better meet the needs of the mother.

21 Each mother is invited to participate in these meetings. MaKM staff have told Nous that most mothers prefer to speak to a smaller group of team members immediately following the meeting.
While the MaKM Program initially faced hurdles hiring qualified professionals, the Program now attracts relevant qualified staff to deliver the holistic care model that the Program advocates. Of the 22 non-administrative MaKM staff:

- 21/22 have Bachelors degrees
- 10/22 have Masters degrees
- 11/22 have other qualifications (e.g. Diploma of Child Protection)

The relevant qualifications of MaKM staff are detailed below:

- BA - Adult Education (Community)
- BA - Psychology (Hons)
- BA - Social Science
- BA - Counselling
- BA - Nursing
- BA - Psychology / Health
- BA - Social Work
- Cert IV - frontline management
- Cert IV - Skills for career pathway
- Cert IV - Training and Assessment
- Cert IV - Welfare work
- Diploma - Child protection
- Diploma - Community Service
- Diploma - Community Welfare
- Diploma - Counselling
- RN - Obstetrics Paediatrics
- Diploma - Social Work
- Diploma MH Nursing
- Grad Cert - Critical Care
- Graduate Diploma - Counselling
- Graduate Diploma - Expressive therapies
- MA - Analytical Psychology
- MA - Applied Ethics
- MA - Art Psychotherapy
- MA - Clinical Psychology
- MA - Gestalt Psychotherapy
- MA - Psychology
- Marte Meo therapist
- Master of Social Work

Overall, 12 of the 22 MaKM Program staff are registered with the Australian Health Practitioner Regulation Agency (AHPRA) and three are registered with the Australian Association of Social Workers (AASW).

4.1.7 MaKM delivers a variety of services as part of its holistic approach, but data limitations constrain analysis of service activity

Activities delivered by the MaKM Program can be grouped into 16 services and evidence based interventions, each with a focus on health check-ups for the mother and child, maternal mental health interventions, parenting and other skills development, assisting community integration, or other social supports. These services are outlined in Table 3 below and further detail about these services and activities involved can be found in Overview of MaKM programs (Appendix 7). Although Table 2 groups activities under one of five possible categories, it is important to note that many services have multiple components, some of which could be grouped within another category. For example, social group sessions have aspects of parenting and skills development.
As the MaKM Program has grown and staffing has increased, MaKM Program services have become more formalised with a stronger focus on evidence based interventions. Since 2015, MaKM Program staff have initiated a change management process to ensure that there was a strong multi-disciplinary approach to care planning.

Key evidence based activities include focussed psychological strategies, which includes cognitive behavioural interventions and psychological therapy sessions. The psychological therapy sessions are informed by Dialectical Behavioural Therapy (DBT). Cognitive behavioural interventions are primarily delivered by allied health professionals called ‘family coaches’, while psychological therapy sessions are delivered by the MaKM Program’s registered psychologists. The program also involves mental state examination (daily for mothers in the residential program) and medication monitoring.

### Table 3: Services delivered by MaKM Program

<table>
<thead>
<tr>
<th>Health support</th>
<th>Mental health interventions</th>
<th>Parenting and skills development</th>
<th>Community engagement</th>
<th>Other support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood check-ups for children</td>
<td>Psycho-education</td>
<td>Supported playgroup sessions</td>
<td>Child care in local community</td>
<td>Peer consultation</td>
</tr>
<tr>
<td>Additional specialist services</td>
<td>Focussed Psychological strategies</td>
<td>Home visits</td>
<td>External playgroup at exit</td>
<td>Social group sessions</td>
</tr>
<tr>
<td>Physical health assessment for mothers</td>
<td>Psychological therapy sessions</td>
<td>Parent support sessions</td>
<td>Facilitating community integration</td>
<td>Activities of daily living support</td>
</tr>
<tr>
<td>Parent education sessions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Data limitations have created challenges in analysing changes in specific activities delivered by the MaKM Program over time. This is evident in Figure 14, which shows data for all activities only in the December quarter 2015 and March quarter 2016, and excludes information prior to the June quarter 2015 due to very limited data on service activity levels.

In particular, prior to April 2015, MaKM Program staff did not record instances of parent support sessions, early childhood check-ups for the children, home visits to the mother and family in their community, community integration facilitations, and psychoeducation sessions. Similarly, prior to the December quarter 2015, MaKM Program staff did not record instances of focussed psychological strategy sessions, nor did staff record activities of daily living support. This is a fundamental service.

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22 Health Clinic services, which initially formed part of the MaKM program scoping and was captured in the program logic, was never implemented on site. MaKM staff have noted that the requirement for ‘physical health assessments’ would be met by ensuring mothers in the program are linked to a local GP in their community, have a full health screening and/or attend a women’s sexual health service and that their children attend an Early Childhood Centre.
encompassing help with daily tasks that occupies much of the staff time outside of organised sessions. Finally, some key activities (e.g. childcare in the local community) are only measured in terms of the number of mothers accessing the services, as opposed to the number of sessions delivered, which limits insights into the total number of activities delivered.

Although this could suggest that the services were not delivered, MaKM Program staff advised Nous that there is evidence in clinical notes that most of these services have been offered to mothers since 1 June 2014. Other services, such as Supported Playgroup sessions, which launched in October 2014, were introduced shortly thereafter.

It appears from the data that Parent Support sessions led to a rise in total activities delivered per mother in the December quarter 2015. It is unclear what the key drivers of this were, but MaKM staff have noted that it can partly be attributed to a single mother who was identified as needing a substantial number of these Parent Support sessions.

Figure 14: Total number of services delivered by quarter per mother (n=58)

4.1.8 Various psychological support sessions are delivered, in both formal and informal settings

The MaKM Program has moved toward formal therapy and services grounded in evidence-based practice, which has been enabled by hiring of more experienced staff. Concurrently, the MaKM Program administrators began reducing the number of sessions of informal activities, such as playgroups and other social group gatherings. In addition all permanent MaKM Program staff now attend mandatory supervision with an accredited social worker or clinical psychologist supervisor. This does not yet extend to casual staff, however it is planned that this will be implemented for all staff.

Figure 15 and Figure 16 show this evolution. In the first quarter of 2015, a mother on average had two individual psychological therapy sessions in that quarter. In comparison, in the first quarter of 2016, a mother on average had 3.5 individual psychological sessions. This demonstrates an increase of 1.5 sessions per mother per quarter. Similarly, formal parent education sessions became a key activity, with each mother on average receiving three individual and group sessions in the March quarter 2016, compared to 0.2 in the first quarter of 2015. Over the same period, the average number of playgroups and other social group sessions declined from 3.1 per quarter to 1.1.

It is important to note that while this may seem like a small number of activities overall, some activities do not form key package components for some mothers (see section 4.1.10).
Figure 15: Total number of sessions delivered by quarter per mother (n=58)

Figure 16: Total number of sessions delivered by quarter per mother (n=58)
4.1.9 The total hours of services delivered per participant rose throughout 2015, in line with an increase in MaKM Program staff

As the MaKM Program increased its staff resources in late 2015, the number of hours dedicated to delivering services to each participant rose. Figure 17 shows this increase in both ‘direct’ and ‘non-direct’ hours up to the end of 2015, followed by a fall in the number of direct hours per mother in the first quarter of 2016. Note that ‘direct hours’ refers to any time spent face-to-face with mother or child, whilst non-direct hours refers to any time spent writing clinical notes, making phone calls, arranging appointments and attending clinical meetings.

The increase in MaKM Program staff has allowed certain activities that were previously limited to be increased. In particular, Figure 18 shows the rise in the number of home visits per mother. However, the number of community integration facilitations, in which the MaKM Program links mothers and their families to various local resources and services, fell in the first quarter of 2016. Similarly, there has been a decline in the number of early childhood check-ups for the children (not shown in Figure 18).

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23 Travel time was previously captured in non-direct hours and so has been added to this chart to ensure a like-for-like comparison over time.

24 ‘Home visits’ is calculated as a proportion of all in-home/community packages, not the total number of mothers participating at that point in time.
4.1.10 Mothers access specific services at different rates, reflecting the tailored and individual nature of the MaKM Program care packages

For the majority of service delivery data analysed, the number of activities delivered per mother has been calculated by dividing the total number of sessions by the total number of mothers in the MaKM Program in that period. This data can be misleading as the sessions may be unevenly distributed across the cohort, given the tailored and individual nature of MaKM Program packages.

In contrast, evaluating the utilisation statistics, such as the number and percentage of mothers using each service in any given month, provides a view of how widespread each component activity of the MaKM Program is. Figure 19 shows that the majority, but not all mothers access either individual or group psychological therapy sessions. Generally, most of the variation in the proportion of mothers who access particular services can be attributed to the tailored nature of the packages and the care planning process (see section 4.1.6 for more detail). However, as outlined in Figure 19, the fact that not all mothers receive psychological therapy sessions each month can also partly be attributed to the fact that some mothers use in-home/community packages and are already connected to a psychologist. Another reason is that mothers who enter the MaKM Program midway through a cycle of group psychological therapy cannot immediately participate. This presents an important challenge for MaKM to provide an appropriate alternative until the next cycle commences.

A variety of parenting interventions are offered. Figure 20 shows an inconsistency in parent education participation. This can be attributed to a lack of willingness on the part of some mothers to be videotaped in the Marte Meo activities, which is a requirement of this activity. Also, some mothers have completed a ‘Circle of Security’ program prior to entering the MaKM Program so opt out of this activity.25

Figure 21 shows that, historically, approximately half of all mothers have child care arranged upon exiting the program. A similar proportion has external playgroups arranged. However, mothers that have exited the program in recent months appear not to have accessed these services. This could represent a risk to the child’s development. The reasons why mothers have not accessed the services may be attributed to a range of factors including the fact that the MaKM Program is guided by the mother in consultation with a Family Coach, and therefore each mother will make decisions based on her preferences, and whether she would like to be involved in an external playgroup or have childcare arranged.

In contrast, Figure 22 shows that Parent support sessions, which consist of any informal parenting strategies specific to the parents (e.g. settling, feeding, wrapping baby), are an integral part of the MaKM Program model, with almost all mothers participating in these sessions each month. Peer consultation, on the other hand, is driven at least partly by the availability of the peer worker, who went on leave at the end of 2015.

Unfortunately, data limitations have hindered the analysis of the usage of additional specialist services and other ‘activities of daily living.’ Activities of daily living including personal hygiene care, shopping, budgeting and cooking form a key component of the MaKM Program that support the intervention for the mother on a day-to-day basis.

Further insights into the utilisation of various services could be gained from understanding the rate at which mothers participated in activities which formed part of their recovery strategy. Unfortunately, MaKM staff have indicated that this data is only captured in clinical notes so Nous has not analysed this data. The tailored approach of the Program leads mothers to participate in different activities which may

25 Data does not indicate what level of the ‘Circle of Security’ program was provided to MaKM participants prior to and during the Program.
or may not reflect the goals outlined in their care plan. There is currently no data that tracks the extent to which mothers complete activities that are in their care plans. This would be useful information for staff to understand how frequently mothers attend required activities and which activities have a high participation rate.

Figure 19: Number and percentage of mothers participating in psychological therapy sessions each month (n=58)

![Figure 19: Number and percentage of mothers participating in psychological therapy sessions each month (n=58)](image1)

Figure 20: Number and percentage of mothers participating in parent education sessions each month (n=58)

![Figure 20: Number and percentage of mothers participating in parent education sessions each month (n=58)](image2)
Figure 21: Number and percentage of mothers with arranged external playgroups and childcare upon exit (n=42)

Figure 22: Number and percentage of mothers receiving parenting support and peer consultation in each month (n=58)

The analysis in this report uses different datasets to produce the different graphs, therefore the ‘exit figures’ and total number of mothers in each graph will not necessarily align.
4.2 How well does the MaKM deliver services?

Findings
- In the 2014-15 Financial Year, the MaKM Program continued well within budget.
- A rise in FTEs over time is due to an increase in nursing staff and family coaches.
- A governance structure has been established to oversee the implementation and evaluation of the MaKM Program.
- A conservative estimate of the net present value of operating MaKM for one year is $1.9m, but is likely to be substantially higher when taking into consideration broader effects not included in the analysis.
- After some initial challenges, feedback indicates that MaKM activities have been implemented effectively.
- All referrer and partner agencies report positive interactions with the MaKM Program staff.
- The majority of participants interviewed had a positive experience in the MaKM Program, however the exit process could be improved to deliver greater care and more lasting benefits.
- Participants value the ability of MaKM staff to listen, tailor support and be flexible.

4.2.1 In the 2014-15 Financial Year, the MaKM Program continued well within budget

The MaKM Program has annual funding of $4 million. The MaKM Program ended Financial Year 2014-15 with a surplus of over $2.3 million. This is largely attributable to a lengthy procurement process leading to a delay in program commencement and activity within the first financial year.

In FY15, the MaKM Program continued its underspend despite actual staff costs exceeding budget by $350,000. This was attributable to large contract labour costs to fill nursing and family coaching positions in the interim. The continued underspend, on the other hand, was driven by lower travel costs, administration expenses, and a mostly unutilised expense reimbursement budget. The expense reimbursement budget refers to funding provided for brokerage for specialist care, which was accessed at a lower rate than was budgeted.

Figure 23 breaks down the financial results for FY15. Staff costs accounted for almost 75 percent of the expenditure in FY15, which is consistent with other programs and health services. Figure 24 breaks down the year-to-date financial results for the first nine months of FY16. While the composition of expenses appears to be the same, it is evident that the MaKM program is expending its full annual funding amount, but has been unable to run down the surplus that has been carried over from previous years.
Figure 23: Breakdown of financial results from financial year 2014-15 ($,000)

Staff costs accounted for almost two thirds of all expenditure in FY15

Figure 24: Breakdown of YTD financial results for the first three quarters of FY16 ($,000)

Staff costs accounted for two thirds of all expenditure in the nine months ending 31 March 2016.
4.2.2 A rise in FTEs over time is due to an increase in nursing staff and family coaches

As the MaKM Program has ramped up to full operation, the number of Full Time Equivalents (FTEs) has expanded, especially in roles such as nursing staff and Family Coaches (see Figure 25).

Despite high staff costs in FY15 due to the contracting of agency staff, overall FTE was still low in July 2014. Over the course of the financial year, the total FTE doubled from ten in July 2014 to 20 in June 2015. In the six months from October 2015 to the end of March 2016, the level of staffing has stabilised and has fluctuated between 20.5 and 23.5 FTE.

As mentioned earlier in this report, this rise in staffing has enabled the delivery of key services and has consequently coincided with a rise in the number of activities provided per participant.

Figure 25: Breakdown of MaKM Program FTE by role

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27 Family Coaches and Nurses include the FTE from contract agency staff and casual staff.
28 Management and operations consists of: Operations & Clinical Manager, Team leader, Site administrator, and Quality Risk Compliance Specialist.
29 Psychologists and Nurses must have appropriate qualifications and be registered with the Australian Health Professionals Regulatory Authority (AHPRA). Family coaches must be qualified psychologists or social workers and be registered with Australian Association of Social Workers (AASW) (this requirement has been included in Position Descriptions (PDs) to be used in recruitment of staff going forward).
4.2.3 A governance structure has been established to oversee the implementation and evaluation of the MaKM Program

The MaKM Program governance structure was established at the commencement of the MaKM Program to oversee the implementation and evaluation of the program. Figure 26 outlines the pathways through care and provides an overview of the governance structure for the MaKM Program. Wesley Mission is responsible for the delivery of services with support provided through linkages with government agencies and other program partners. MH-CYP is responsible for managing reporting and evaluation and provides governance for escalation of referral and access issues.

The current MaKM Program team organisational structure is shown in Figure 27 overleaf.
Figure 27: MaKM Program team organisational structure
4.2.4 A conservative estimate of the net present value of operating MaKM for one year is $1.9m, but is likely to be substantially higher when taking into consideration broader effects not included in the analysis.

The evaluation includes a limited economic appraisal of the MaKM program to answer the evaluation meta-question:

“To what extent has service delivery been cost-effective?”

Nous conducted a limited cost-benefit analysis to quantify the net present value (NPV)\(^{30}\) of the MaKM Program in terms of government savings from reduced utilisation of certain services. Nous’ approach is similar to an interrupted time series study. The economic benefit of MaKM was determined by comparing the outcomes for participating mothers with mothers who did not participate in the program. The evaluation compared the expected lifetime trajectory and implications for government service provision for two pathways:

1. mothers who have completed the MaKM Program (the intervention group)
2. mothers with severe mental illness who do not participate the MaKM Program (the counterfactual group).

The intervention group consists of the mothers who participated in the MaKM Program and their children. The counterfactual cohort consists of the same mothers and children, but is based on information prior to the mothers’ admissions into the MaKM Program. These trajectories, or ‘pathways’, determine the expected need for services for mothers and their children in each of the two scenarios above.\(^{31}\) Examples of the services include mental health acute inpatient care, mental health ambulatory care and Out-of-Home-Care (OOHC) for children, amongst others. The full list of services along with all other model assumptions can be found in Appendix 4, while the detailed methodology can be found in Appendix 2. In summary, the economic appraisal:

1. estimated the lifetime trajectories of total service use for the typical mother and typical child for the MaKM cohort
2. estimated the lifetime trajectories of total service use for the typical mother and typical child for a ‘counterfactual’ cohort equivalent
3. calculated the differences between the treatment group and the counterfactual, and discounted these to present value dollars
4. multiplied the difference by the average number of mothers and children in the program in any given year to arrive at a total annual program NPV.

The result of steps 1 to 3 is summarised in Figure 28 below, which shows the cumulative cost trajectories for the typical mother. Importantly, the net savings in terms of service utilisation for the mother amount to almost $130,000 throughout her lifetime. In contrast, the cost of the MaKM Program outweighs the benefits the child is expected to receive by the age of 24, which is the maximum age for the child assumed for this analysis, by almost $27,000. If the model were to consider additional benefits out of scope and extend the child’s pathway out to a full lifetime to accommodate them, it is very probable that the net savings would be very large instead of negative. There are several limitations in producing

\(^{30}\)Net Present Value (NPV) is the difference between the present value of cash inflows and the present value of cash outflows. ‘Present value’ is a concept that reflects the time value of money; specifically, money can be invested to earn a compound rate of interest over time so future costs and benefits need to be discounted to today’s value.

\(^{31}\)Nous consulted with maternal and child health and specialist perinatal mental health advisors to confirm the most likely scenarios for these two pathways.
the child trajectory due to the availability of data for this evaluation and the original program logic that was agreed as part of the evaluation plan. This includes the absence of data for all children, not just those in the program (e.g. OOCH length of stay) as well as those limitations outlined under tier 2 exclusions below. Further detail is also provided in Appendix 3: assumptions used to develop the child pathway.

Figure 28: Lifetime trajectory for the typical mother cumulative cost of service utilisation (present value $)

Multiplying the net benefits by the average number of mothers and children results in a total NPV of about $1.93 million, and a benefit-cost ratio of 1.48. This is the value of one year of operating the MaKM Program. A three-year funding cycle for the program would have a NPV of $5.8 million. However, this value depends on the assumed discount rate, as it does on the various other assumptions and drivers of the model. Table 4 shows that the NPV of operating the MaKM Program for one year varies significantly depending on the discount rate used.

Table 4: NPV discount rate sensitivity

<table>
<thead>
<tr>
<th>Nominal discount rate</th>
<th>2.52%</th>
<th>5.61%</th>
<th>8.66%</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPV</td>
<td>$5,468,786</td>
<td>$1,933,392</td>
<td>$261,062</td>
</tr>
<tr>
<td>Benefit-cost ratio</td>
<td>2.37</td>
<td>1.48</td>
<td>1.07</td>
</tr>
</tbody>
</table>

The economic appraisal is a limited cost-benefit analysis in that it does not model many other benefits that could arise from participation in the MaKM Program. These exclusions can be thought about in two tiers, which are listed below but do not form an exhaustive list:

32 The average number of mothers in a program year is 23 and the average number of children is 37.

33 The three discount rate assumptions are 5.61% (real discount rate of 4% inflated by CPI), 2.52% (NSW Govt. 10 year bond rate), 8.66% (real discount rate of 7% inflated by CPI). CPI inflation, calculated as 1.56%, was measured as the average of the trimmed and weighted means of the year-on-year change in the Consumer Price Index from the March quarter 2015 to the March quarter 2016.
Tier 1 – directly measurable services not included

Expert advisor Professor Elisabeth Murphy made two observations for the service utilisation pathways of mothers and children, which were not included in the model:

1. **Emergency department presentations.** Mothers who are homeless are more likely to have emergency department contacts, which is a large cost burden on the system. To the extent the MaKM Program reduces likelihood of homelessness and increases mothers’ ability to care for themselves, there will be benefits of participation in the program.

2. **Acute inpatient care for children of mothers with severe mental illness.** Mothers who are homeless are more likely to have their children admitted to inpatient care for reasons ranging from respiratory infections to injuries. To the extent the MaKM Program reduces likelihood of homelessness and increases mothers’ ability to care for their children, there will be benefits of participation in the program.

Tier 2 – broader and longer term effects that are out of scope for the analysis

3. **Likelihood of the child developing a mental illness.** The child of a mother who is not able to manage her severe mental illness may be more likely to develop a severe mental illness. This will have its own associated costs in terms of service utilisation.34

4. **Employment outcomes of children.** Children who have been in OOHC and/or experienced developmental delay may have higher unemployment rates as adults and earn less during their lifetime.35 They may also receive financial benefits through Centrelink, for example, Youth Allowance.

5. **Quality-adjusted-life-year (QALY) effects.** Mothers with severe mental illness who are better able to manage their illness may have a higher quality of life with higher utility.36

Expanding the economic appraisal to include some or all of the points above would result in a substantially larger NPV and a higher benefit-cost ratio, depending on the scale of the assumptions and how they are incorporated.

4.2.5 After some initial challenges, feedback indicates that MaKM activities have been implemented effectively

Nous received 16 full or partial responses to an online survey distributed to 54 programreferrer and partner agencies, including public mental health units, services, and other interacting agencies. Following the online survey, 17 referral and partner agency representatives participated in focus groups to test the findings in the survey and provide additional insights on the MaKM Program, the effectiveness of its implementation and opportunities for improvement.
In the focus groups and surveys, referrer and partner agencies indicated that the MaKM Program has been implemented effectively. Other key stakeholders stated that the procurement process was more lengthy than anticipated. This resulted in a delay in the MaKM Program commencement and activity within the first financial year. Stakeholder consultations highlighted that the main initial barriers to implementation were staff recruitment and awareness of the MaKM Program, however both of these factors are improving.

**Recruiting staff with the appropriate level of skills and expertise was an initial challenge.**

In the focus groups, referrer and partner agencies indicated that there were a number of staff changes in the early months of the MaKM Program. The changes in staff made it difficult to establish strong relationships with referrers. However, feedback suggests that this has substantially improved in the last 4-6 months (see Section 4.2.6). This is likely in response to the greater stability in staff with the appointment of the Team Leader of Mental Health Nursing and other key staff.

**Participant intake into the MaKM Program was initially slow, but is now improving.**

As expected for any new program, intake for the MaKM Program was initially slow. However the rate of intake improved through an increase in awareness of the MaKM Program and its ability to provide in-home care packages across all LHDs in NSW. In the focus groups, referrer and partner agencies stated that the geographical spread of the Program (particularly the community care packages) enables the MaKM Program to attract mothers with a variety of needs from various communities. MaKM Program staff have also improved the referral process in response to feedback from mental health services across LHDs. This new process is still in the process of being streamlined across NSW.

Referrer and partner agencies now strongly endorse the MaKM Program’s framework and approach and agree that that the MaKM Program’s activities have now been implemented effectively.

**Figure 29: To what extent do you agree that the MaKM Program been implemented effectively? (n=15)**

In particular, survey respondents and focus group participants value the Program’s focus on mental health and parenting support for mothers. Figure 30 demonstrates that referring and partner agencies...
consider parenting support and education and psychological therapies as the most effective activities. In the figure below, psychological therapies includes both individual and group therapies.

Figure 30: To what extent do you agree that the MaKM Program activities been implemented effectively? (n=15, 16)

4.2.6 All referrer and partner agencies report positive interactions with the MaKM Program staff

All referrer and partner agencies who participated in the survey and focus groups reported positive interactions with the MaKM Program staff. The key words participants used in the survey and focus groups to describe the MaKM Program staff include:

“Collaborative”  “Available”  “Responsive”  “Comprehensive approach”
“Flexible in meeting the needs of participants”  “Can do’ attitude”  “Understanding of mothers’ stresses”  “Genuinely care for mothers”

Figure 31 shows the majority of survey respondents have positive interactions with the MaKM Program.
The majority of referrer and partner agencies who participated in focus groups agreed that the MaKM Program is vital as it fills a gap in services that is otherwise financially inaccessible. 100% of respondents to the survey stated they would refer clients to MaKM Program (n=15), as the MaKM Program is person-centred and holistic and provides a unique array of services for mothers and their children.

4.2.7 The majority of participants interviewed had a positive experience in the MaKM Program, however the transition process could be improved to deliver greater care and more lasting benefits.

The Nous Project Team conducted six face to face interviews with MaKM Program participants to understand the mother’s experience of the MaKM program and the outcomes achieved. Interviewees represented a mix of women from metropolitan and regional communities who each received different program services. Figure 32 below illustrates where participants resided at the time of the interview.
The majority of participants interviewed had a very positive experience in the MaKM Program. They each expressed a different aspect of the Program that worked for them, clearly illustrating the way in which MaKM services are built around the needs of the individual. The Program’s ability to work with clients and their mental health from the perspective of being a mother has been an important factor. Interviewees reported that MaKM provided them with access to information on mental health, breastfeeding, safe sleeping, discipline and child health as well as strategies they can use to look after their own wellbeing and settle their babies. One interviewee mentioned she received useful and practical advice when MaKM staff visited her family as part of the community care package. The same interviewee reported that other programs had not been as ‘hands-on’ or practical because they visited when her children were asleep. Participants interviewed noted the night time support of the residential service and they appreciated the respite when MaKM staff looked after her baby. One interviewee reported she formed relationships with other mothers during her time in the Program and that these connections have continued since she left the Program. The majority of participants interviewed felt supported and reassured by staff.

However interviewees also stated a few areas of program delivery that could be improved. One felt the Program ended very suddenly that there was no transition process when services were no longer available. The impact of this is that she now finds it difficult to trust other health services or support. Participants interviewed also raised family engagement as another area for program improvement. One interviewee found it very hard to be away from her partner and other children while in the residential...
facility. Interviewees also suggested wireless internet in order for mothers to connect with their families more regularly during the residential component of the program.

Despite these suggested improvements, the majority of participants interviewed reported they would recommend the Program to other mothers. The quotes below demonstrate the interviewees’ high level of satisfaction in the Program.

4.2.8 Participants value the ability of MaKM staff to listen, tailor support and be flexible

The majority of participants interviewed reported the MaKM Program staff to be supportive and flexible. Interviewees noted that there was always a range of staff available to work with them in a holistic way. For example, a mental health nurse, a family coach, a psychologist (for mothers and children) and additional specialists such as an art therapist or financial advisor. Interviewees also appreciated the flexibility of staff who worked on weekends which demonstrated that MaKM are there for them and can be relied upon. The majority of participants interviewed reported that staff listened to them and were not judgemental.

Some of the participants interviewed suggested a few areas of improvement for staff. This included to limit the number of staff changes and to ensure that staff have the appropriate experience. One interviewee explained how her family coach had to change during the program and that the new family coach was perceived less experienced and not as genuine. Another stated that the financial advice could have been better targeted. One of the participants interviewed, who was an early participant in the MaKM Program, reported that when she was in the residential program, there were lots of arguments between staff and that this had a negative impact on participants who were “given three different stories about everything.”
4.3 What impact has the MaKM Program had?

Emerging findings

- Mothers exiting the MaKM Program report they have increased confidence in parenting and managing their mental illness.
- Care planning checklists ensure good health management processes, but there is scope to expand and redefine the factors that they consider.
- Formal assessments indicate substantial improvements in mothers’ mental health status and levels of psychological distress.
- Children are less likely to be subject to Risk of Significant Harm reports and are less likely to be placed in Out-of-Home-Care.
- The assessment of outcomes for children and families highlights the limitations of the existing outcomes measurement tools.
- The MaKM Program has ensured that every mother has suitable accommodation arrangements upon exiting the program.
- Since exiting the program, the average mother has had fewer mental health related episodes of care, shorter total inpatient episodes of care, and fewer ambulatory mental health care contacts.
- Mothers’ primary diagnostic categories for inpatient and ambulatory care have changed substantially since exiting the program.
- The impact of ceasing the MaKM Program would be significant.
- The MaKM Program is unique:
  - The Program is tailored specifically to mothers with severe and complex mental illness and their children.
  - The Program offers a distinct set of services, as it focuses on the treatment of both the mother’s mental illness, along with developing their parenting skills.
  - Mothers can be referred from any LHD or relevant Specialty Health Network (SHN) in NSW.

4.3.1 Mothers exiting the MaKM Program report they have increased confidence in parenting and managing their mental illness

Upon exiting the MaKM Program, mothers are asked to complete exit feedback forms. These provide insights into the mother’s satisfaction with the MaKM Program, and whether they believe they have:

- improved confidence in parenting
- improved confidence in managing their mental illness
- improved knowledge of how to lead a healthy lifestyle
- improved confidence in their independent living skills.

Figure 33 presents the results from 31 mothers who completed feedback forms upon exiting the MaKM Program out of a total of 41 mothers who exited the program through to the end of February 2016. Ten
mothers did not complete the exit form as they either refused to complete the feedback form, were unable to be contacted to complete the form, or had exited the MaKM Program suddenly and consequently did not provide feedback. It is important to note that the feedback form is not anonymous. This can compromise the level of honesty provided in the responses. The fact that ten mothers did not complete the exit form could perhaps indicate that these mothers were not satisfied with the Program.

Over 90 per cent of mothers who responded to the feedback forms report their overall satisfaction with the services that the MaKM Program provided to them and almost all mothers felt that they had improved confidence in parenting. Similarly, more than four in every five mothers felt more confident in managing their mental illness.

Although the majority of respondents reported that they had improved knowledge of leading healthy lifestyles and had improved confidence in their ability to lead independent lives, those questions were only posed to the most recent 12 participants to exit. This is because these questions were only added to the feedback forms in 2015.

Figure 33: Exit feedback form responses from participants (n=31)\textsuperscript{37}

The exit feedback forms are self-reported surveys that present a snapshot of each mother’s opinion at one point in time. There is no follow-up questionnaire that asks the mothers similar questions after a certain period of time has passed.

The impact of the Program on participants’ confidence in parenting and managing their mental health was also evident through interviews with Program participants. The majority of participants interviewed reported that they feel more confident to manage their mental illness and that they also feel more confident in their parenting abilities. For many of them, a large part of this was the recognition that it is “ok to have a mental illness” and it is “ok to ask for help when you need it.” One interviewee reported that she has a new way of dealing with her anxiety. Another stated that she has improved confidence in managing her medication. Figure 34 below outlines the anecdotal evidence from the participants interviewed of how the MaKM Program has made an impact on their mental health and their life in general.

\textsuperscript{37} N/A refers to mothers who were not asked the relevant questions in their exit feedback form.
With regard to their current state of mind, the majority of participants interviewed stated that they “feel like life is on the way up.” One interviewee reported that she feels she is a better parent now than before the Program and that she “now knows it is ok to discipline her children”. Prior to the Program she was frightened by this. Overall, the participants interviewed reported that they now enjoy spending time with their children.

During the interviews, participants reflected on their confidence to live independently and live a healthy lifestyle. Again, this meant different things for different participants. One interviewee reported that for her this has meant she is able to manage her relationship with her partner and recognise the circumstances where he is abusive. Another reported that MaKM referred her to a financial adviser which has helped her gain independence to manage her finances. Some of the participants interviewed noted that they are now more assertive at home. In regards to special interests and hobbies, one interviewee reported that since she transitioned out of the Program she has started studying and is working towards finding employment.

Feedback from interviewees demonstrates how the Program’s holistic approach can result in multiple outcomes for the mother and her family. The vignettes below in Figure 35 and Figure 36 provide a sense of what the journey is like for program participants and the wide ranging and deep impact the MaKM Program can have.
The names and photographs used in the vignettes are fictional and although the stories do represent the experiences of the mothers in the program, they are not representative of any particular program participant.
4.3.2 Care planning checklists ensure good health management processes, but there is scope to expand and redefine the factors that they consider

A key component of the program logic for the MaKM Program is a checklist that is completed by the Family Coach. This ensures that mothers have completed certain activities with respect to the maintenance of their physical and mental health and engagement in the community. The form, previously the “family coach feedback form” and now the “care planning checklist”, takes into account information at entry into the MaKM program, throughout the program and then at exit. However, MaKM staff have noted that historically the form has been completed at exit. A copy of the care planning checklist can be found at Appendix 11.

Figure 37 shows two things in particular:

1. The proportion of mothers who, from the perspective of the family coach, have complied with their medication plan, the MaKM care plan and the safety plan (or have generally sought assistance when unwell).
2. The proportion of mothers who, during the program, undertook a full health screen, had a GP appointment, and visited the dentist.39

The low percentage of mothers who visited the dentist is concerning when considering the importance of oral health care to overall health and wellbeing. One of the reasons why mothers have not visited the dentist could be due to mothers’ availability and their access to dental services. It could also potentially be an area that mothers may not prioritise, which suggests that more attention could be given to educating mothers on the importance of dental care for themselves and their families.

With the exception of dental check-ups, the majority of mothers have achieved the goals in point 1 and 2 above. This is an indicator of successful management and care planning by MaKM staff and the program as a whole.

Figure 37: Family Coach Feedback Form assessment (n=32 to n=33)

Of the participants interviewed, a number reported that they saw a psychiatrist or psychologist during the Program and most stated that they have continued to access this support since they exited the Program. Interviewees also reported that they are now more likely to seek support from other health

39 Visits to the dentist in the prior 12 months are also taken into account.
professionals such as their GP or the mental health team at their local hospital. Participants interviewed expressed that the MaKM Program helped them access a mothers group which has been a source of additional support, even after exiting the program. One interviewee reported that she has good relationships with some of her neighbours and is making plans to invite them to her son’s birthday party.

Figure 38 shows whether, upon exiting the Program and shortly thereafter, mothers gained new community connections. That is, as the mother transitions out of the program, the MaKM staff help to establish connections and support in her local community. MaKM staff have noted that some of these community connections can overlap or appear arbitrary. They have additionally noted that the checklist does not consider other important factors like housing, financial and legal needs and that these should be considered in the measurement framework going forward.

The chart indicates that in most instances, although the mother has made some new community connections, she is not likely to have engaged in the specific types of connections listed on the form (i.e. organised sports, library and recreational activities). These specific types of connections do appear to be a small subset of the ways in which a mother can engage with her community. Additionally, the follow-up period is likely to be very small and mothers are not likely to have been given long periods of time to re-engage with their community following their exit from the MaKM Program.

Figure 38: Family Coach Feedback Form assessment (n=32 to n=33)

4.3.3 Formal assessments indicate substantial improvements in mothers’ mental health status and levels of psychological distress

The MaKM Program uses two assessment tools to measure the mental health outcomes of mothers; the Kessler 10 Psychological Distress Scale (K10), and the Health of the Nation Outcome Scale (HoNOS). The K10 is a self-reported scale measuring non-specific psychological distress, which is based on questions about negative emotional states experienced by respondents and their frequency (i.e. “none of the time” to “all of the time”). HoNOS is also a clinician-rated set of scales that measure the health and

social functioning of people with severe mental illness. HoNOS covers 12 items that measure behaviour, impairment, symptoms and social functioning. As with K10, the lower the score the smaller the observed problem is on each scale.

The MaKM Program participants are assessed on these two different measures at entry (pre-MaKM) and at exit (post-MaKM) from the program. Figure 39 and Figure 40 show the average total results for MaKM participants. The average total K10 score, which can range from 10 to 50, has fallen by a statistically significant amount from 25.6 to 21.4. The NSW Ministry of Health has grouped scores to indicate the severity of psychological distress, which include:

- 10-19: The score indicate that the client or patient may currently not be experiencing significant feelings of distress
- 20-24: The client or patient experience mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder
- 25-29: The client or patient experience moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder
- 30-50: The client or patient experience severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.

It is evident that the average MaKM participant’s psychological distress levels have fallen substantially, placing her in a lower category of severity from the start to the end of the program. However, the range of total K10 scores remains large indicating there are still some mothers whose scores indicate they have very high levels of psychological distress upon exiting the program.

Figure 39: Kessler 10 total scores before and after MaKM participation (possible range: 10 to 50) (n=36)

Figure 40: HoNOS total scores before and after MaKM participation (possible range: 0 to 40) (n=39)

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41 http://www.rcpsych.ac.uk/traininpsychiatry/conferencestraining/resources/honos/whatishonos.aspx
42 Paired t-tests were used to measure statistical significance. The significance level was set at 0.05 (α = 0.05).
44 HoNOS total score sums the first ten scales and excludes the last two.
The HoNOS results similarly show a reduction in the average total scores, albeit not statistically significant. This indicates that, as a whole, the average MaKM participant has improved mental health and social functioning after participating in the program.

More insight into the various elements of the HoNOS result can be seen in Figure 41, which breaks down the changes in scores for each of the 12 items on the HoNOS questionnaire. While changes in three scales were statistically significant, nine had improvements overall. The three scales for which the result deteriorated (i.e. the average score increased) were “overactive behaviour”, “problem drinking / drug taking” and “hallucinations / delusions”. Given problem drinking and drug taking is often underreported until trust is established between the client and health care worker, it is not surprising that these results are increasing over time. However, these changes were not statistically significant.

Figure 42 looks at a specific sub-group of the HoNOS scales, the “social support scale”, which is composed of items nine to 12. This result also shows a statistically significant improvement for the average mother, which may indicate improved relationships, living skills and arrangements.

Figure 41: Scores for 12 HoNOS scales before and after MaKM participation (scale: 0 to 4) (n=36 to n=40)
4.3.4 Children are less likely to be reported at Risk of Significant Harm reports and are less likely to be placed in Out-of-Home-Care

Linked data obtained from NSW FACS provided insight into the outcomes for children with respect to the likelihood of statutory intervention. In particular, Risk of Significant Harm (ROSH) reports and OOHC placements were analysed to help determine the impact the MaKM program has had on child outcomes in this area.

This data was aggregated for Nous for the 12 month period prior to each mother’s entry into MaKM as well as for period following program exit. Notably, as many mothers have been out of the MaKM Program for less than 12 months, the average post-MaKM period for the mothers of the children with linked data is approximately 9.4 months, which is less than the 12 month pre-MaKM period. The ROSH and OOHC rates are therefore scaled up to enable before/after comparisons.

Figure 43 below shows the fall in the number of ROSH reports per child from the 12 months prior to the mother’s entry into MaKM (pre-MaKM) to the 12 months after exiting (post-MaKM). This result is primarily driven by fewer children being subject to ROSH reports, as opposed to fewer ROSH reports being made for the same number of children. In fact, the ROSH report rate for children who have had at least one ROSH report made has increased from 2.41 pre-MaKM to 2.98 post-MaKM.
Figure 43 shows the decline in the OOHC placement rate, indicating a fall in the likelihood of children to be placed in OOHC after the mother’s participation in the MaKM program.46

Further insight into the flow of OOHC placements before, during and after the mothers’ participation in MaKM can be gleaned from Figure 45 below. The chart represents the movement of children into and out of OOHC at different points in the mothers’ journeys. In particular, the linked data analysed as part of this evaluation was structured to allow a comparison of the 12 month period pre-MaKM with the 12 month period post-MaKM. Consequently, these two points in time, along with the date into the program and the date out, help structure the timeline in Figure 45.

Although it is evident that the 12 months pre-MaKM period had more OOHC placements than the 12 months post-MaKM period, the rate of children exiting OOHC is consistently lower at each stage of the mother’s path. This results in more children in OOHC overall in the 12 month period post-MaKM than in the 12 months pre-MaKM period. This is strongly related to the larger pool of children overall in the post-MaKM period, as many mothers had children in the 12 months prior to entering the MaKM program. The waterfall graph below (Figure 45) shows the OOHC placements and exits in the 12 months pre-MaKM period and 12 months post-MaKM period. Nine children (of mothers who went on to participate in the MaKM Program) were already in OOHC placements at the point in time 12 months before the mothers’ entry into the Program. In the 12 month period leading up to the mothers’ admission to the MaKM Program, another nine children were placed in OOHC, while two exited in the

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45 Eligible children refers to all children under the age of 18 who had been born prior to, or during, the reference period (pre-MaKM vs. post-MaKM); it is irrespective of the number of children who have been linked in the FACS data (i.e. n = 55 in Figure 43 and n = 35 in Figure 44). For the purpose of calculating OOHC placement rates, it excludes children already in OOHC.
- After adjustments, there were 60 children pre-MaKM and 71 children post-MaKM, which are the denominators used in the ROSH report rates presented in Figure 43.
- After adjustments, there were 51 eligible children in both the pre-MaKM and post-MaKM periods, which is the denominator in the OOHC placement rates presented in Figure 44.

46 The average length of stay in OOHC is 302 days.
same period of time. This pattern continues and, at the point in time 12 months after mothers exited the MaKM Program, 22.9 children (scaled up from 2247) were in OOHC.

4.3.5 The assessment of outcomes for children and families highlights the limitations of the existing outcomes measurement tools

The main assessment tool used by the MaKM Program to evaluate outcomes for children in the program is the self-reported Parents’ Evaluation of Developmental Status (PEDS). PEDS is a questionnaire that asks mothers to assess the developmental and behavioural problems her child may be having. It is applied to children aged from birth to seven years and 11 months.49

PEDS scoring results in a ‘pathway’ that helps determine whether the mother’s causes for concern are indicative of the child’s developmental delay, other problems, or none at all. In particular, PEDS paths A and B are predictive for developmental delay in the child.

- Path A indicates the mother has multiple concerns that suggest developmental problems in the child requiring referral
- Path B indicates one such concern
- Path C refers to non-predictive concerns
- Path D refers to communication difficulties with the child

Given the average period of time since exiting the MaKM Program is 9.4 months for the mothers represented in the OOHC linked dataset, the figures in the post-MaKM period were scaled up to represent a full 12 month post-MaKM period. This enabled a like-for-like comparison.

Figure 45 represents a flow of children in and out of OOHC, and figures in the post-MaKM period have been scaled up to represent a full 12 month period. Consequently the figures will not sum to total sample size of 35.

http://www.rch.org.au/ccch/resources_and_publications/Monitoring Child Development/
Path E indicates no concerns.

Additionally, more than one pathway can be identified per PEDS administration when some areas may predict an area for concern, while other areas may predict no concern.

Figure 46 shows the results of the initial PEDS assessments. Notably, almost one third of the 59 children who were assessed at entry to the Program were identified as being at risk of developmental delay. Figure 47, which compared PEDS results pre-MaKM with post-MaKM, has a sample size of only 12 children. The chart shows that the number of children at risk of developmental delay rose substantially from three to eight at the end of the program.

However, there are two important considerations for this result. First, the small sample size impacts on the ability to infer that children are at a higher risk of developmental delay if their mother has participated in the MaKM Program. Second, and more importantly, the PEDS tool is self-reported by the mother. This means that the result could be interpreted as mothers being more perceptive and knowledgeable about their children after participating in MaKM, which leads them to be more aware of their child’s needs. Furthermore, as the report seeks to measure “parent concern”, a mother’s responses would be impacted by her mental health and wellbeing. As such it is recommended that a second independent screen and assessment be used to validate the results, such as the Ages and Stages Questionnaire (ASQ).

The primary assessment tool used to evaluate family functioning of MaKM participants is the North Carolina Family Assessment Scales (NCFAS). This form consists of 13 scales that cover items ranging from parenting skills to physical health and family relationships. As with the HoNOS and K10 tools, lower scores indicate an improvement; i.e. the lower the total score the better the family functioning. Unlike the PEDS, which is self-reported, the NCFAS is scored from the perspective of the worker most involved with the family – the family coach.

However, the NCFAS also has limitations. Given the NCFAS is completed by a Family Coach who knows the mother, there is potential for bias in the results that would not necessarily exist if it were an

---

50 The MaKM Program only recently began administering the PEDS tool at program exit. Consequently, as at the end of March 2016 only 12 children have data points for both pre-MaKM and post-MaKM.
independent assessment. Furthermore, the paper-based NCFAS form that the MaKM Program uses has been superseded by an online version. MaKM staff have noted that the online NCFAS tool is more detailed, and that paper based versions are not sensitive enough on some scales. For example, it is not sufficiently detailed to capture changes in parenting skills and child characteristics.

Figure 48 shows the average total score at entry to the MaKM Program and at exit. The statistically significant reduction in the average total score points to improved family functioning as measured by the NCFAS overall. Figure 49 and Figure 50 show improvements in both the child characteristics and parenting skills subscales, although there has only been a statistically significant improvement in the average parenting skills subscale score. This result is noteworthy, despite the limitations to these two specific subscales discussed above. In particular, the parenting skills subscale scores four options from “good parenting skills” (score: -3) to “destructive parenting patterns” (score: 5). The average total score post-MaKM of -1.4 suggests that the average mother scores somewhere between “good parenting skills” and “moderate difficulties in parenting skills”. However, the range suggests that a number of mothers still have “moderate difficulties in parenting skills” upon exiting the program.

The range of scores on the child characteristics subscale suggests that with the exception of one child who has “minor problems”, all children were scored as “age-appropriate, no problem” upon exiting the program.

Figure 48: NCFAS total scores before and after MaKM participation
(possible range: -17 to +43) (n=39)
4.3.6 The MaKM Program has ensured that every mother has suitable accommodation arrangements upon exiting the program

The MaKM Program assists all mothers to find suitable accommodation arrangements when they exit the program. As discussed in Section 4.1.1, MaKM staff have indicated that 17 out of 42 mothers (40 per cent) who have exited the program to the end of March 2016 were homeless or at risk of homelessness at entry. This can be seen in Figure 51, which also shows breakdown of the types of accommodation arrangements. Almost half of all participants moved into public housing or supported / transitional accommodation. One third had private residential arrangements, while the majority of the remaining group had family living arrangements. Of the six participants interviewed, all reported that they are now living in stable housing.
4.3.7 Since exiting the program, the average mother has had fewer mental health related episodes of care, shorter total inpatient episodes of care, and fewer ambulatory mental health care contacts

To evaluate the impact that the MaKM Program has had on service utilisation, Nous utilised linked data, which provided insights into participants’ utilisation of inpatient care services as well as the use of mental health ambulatory care. Specifically, two datasets were linked to the medical records of participants; the NSW Admitted Patient Data Collection (APDC) and the NSW Mental Health Ambulatory Data Collection (MH-AMB). These data were aggregated for Nous for the 12 month period prior to each mother’s entry into MaKM as well as for period following program exit. Notably, as many mothers have been out of the MaKM Program for less than 12 months, the average post-MaKM period is approximately 8.5 months, which is less than the 12 month pre-MaKM period.

The other important consideration in interpreting the linked data is that this relies on mothers presenting to the services. That is, if a mother has not been admitted to a hospital in a period, she will not be presented in the aggregated data for that period. Consequently, the statistics around service utilisation have been adjusted to take account of the mothers whose data have not been linked, given that not being admitted to inpatient care is an important outcome in itself.

Figure 52 and Figure 53 show the change in the number of inpatient episodes of care and the number of ambulatory care contacts, respectively. The average number of annual inpatient episodes of care for both same-day separations and overnight stays has fallen, from 0.99 in total to 0.76. This has been driven primarily by less frequent same-day episodes of care. It is important to note that this chart only

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51 The 2% OOHC Placement represents a MaKM program participant who was in OOHC prior to entry into MaKM.
represents episodes of care where the primary diagnosis was related to mental diseases and disorders. The composition of total episodes of care is discussed in the following section.

A similar decline can be seen in mental health ambulatory care contacts, which fell more than 60 per cent per year to fewer than 20 contacts per year. This result is at least partially attributable to the large number of mothers who did not have linked data in the post-MaKM period, indicating that they did not use these types of services at all since exiting the program.

Figure 52: Average number of mental health inpatient episodes of care (annualised, adjusted n = 42)  
Figure 53: Average number of mental health ambulatory care contacts (annualised, adjusted n = 42)

Another significant finding is that the average length of stay for inpatient care has fallen from 8.3 days to 6.1 days in the post-MaKM period. However, due to data limitations, the average lengths of stay have not been adjusted to reflect only mental health related admissions. Rather, they also include other reasons for admission, such as pregnancy and childbirth related diagnoses, which form a significant proportion of admissions in the pre-MaKM period (see Section 4.3.8 below). Despite this limitation, the reduction in the average length of stay is all the more significant given that inpatient admissions for pregnancy and childbirth related diagnoses are typically much shorter than for mental health related diagnoses. Consequently, even though admissions in the post-MaKM period are predominantly related to mental health issues that have longer typical lengths of stay, the average length of stay has still declined substantially as shown in Figure 54.
4.3.8 Mothers’ primary diagnostic categories for inpatient and ambulatory care have changed substantially since exiting the program

The linked data also provided insights into the primary diagnoses recorded against the inpatient care and ambulatory care events. Figure 55 shows the primary, major diagnostic categories recorded for 113 inpatient episodes of care in the pre-MaKM period and 34 episodes of care in the post-MaKM period. Notably, almost half of all primary diagnoses in the pre-MaKM period were related to pregnancy, childbirth or the postnatal period while a quarter of all diagnoses are related to mental diseases and disorders. Given that MaKM eligibility criteria require participants to have young children (under the age of five), it is not surprising that pregnancy and childbirth related issues are common reasons for inpatient episodes of care in the 12 month period prior to entry into the MaKM Program. In the post-MaKM period, mental health diagnoses account for almost 60 per cent of all inpatient care primary diagnoses, while pregnancy, childbirth and the puerperium become insignificant.

52 Diagnoses and Major Diagnostic Categories in the linked datasets follow ICD-10 categorisation. The mental health diagnosis groups are therefore different to the diagnoses discussed in Section 4.1.2 (which are based on referral data (the referral diagnosis is made by the referrer and is confirmed by MaKM through a discharge summary, care plan from a GP, treating psychiatrist clinical notes or patient hospital records)).

53 The pre-MaKM period has linked data for 36 mothers, while the post-MaKM sample contains data for ten mothers. The total number of episodes per mother has fallen, when accounting for the mothers who have not been admitted in this period (and therefore there is no linked data).
Figure 55: Major diagnostic category – inpatient episodes of care 
(n = 36 (pre-MaKM) and n=10 (post-MaKM))

Figure 56 shows the primary diagnoses that make up the Mental Diseases and Disorders major diagnostic category. There has been a significant change, in the time since exiting the MaKM Program, in the number and composition of primary diagnoses for inpatient care episodes, while a smaller change in the composition is also evident for ambulatory care contacts.

With respect to inpatient care, 80 per cent of all care episodes were attributable to three primary diagnoses in the pre-MaKM period. In the post-MaKM period, the schizophrenia, schizotypal and delusional disorders category alone accounted for 80 per cent of diagnoses. Given the substantial fall in the total number of inpatient care episodes post-MaKM, this should not be interpreted as a rise in problems associated with schizophrenia in mothers. Rather, it indicates that the fall in the number of episodes of care is attributable to a reduction in the severity of mood disorders and neurotic, stress-related and somatoform disorders, while the severity of schizophrenia, schizotypal and delusional disorders amongst mothers remains a cause for concern.

The composition of primary diagnoses for mental health ambulatory care contacts has also changed for mothers since exiting the MaKM Program. However, this compositional change is less dramatic and the fall in the use of ambulatory care services has been substantial across all diagnosis categories.\(^{54}\)

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\(^{54}\) Figure 56 references activities as opposed to contacts. Diagnoses were provided for each ambulatory care activity and there could be multiple activities per contact. In the pre-MaKM period, the average number activities per contact was 1.8, while in the post-MaKM period it was 2.08.
Figure 56: Primary diagnoses of mental diseases and disorders in inpatient care episodes and ambulatory care contacts

<table>
<thead>
<tr>
<th>Primary diagnosis</th>
<th>Mental health inpatient care episodes</th>
<th>Mental health ambulatory care contacts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-MaKM (n=36)</td>
<td>Post-MaKM (n=10)</td>
</tr>
<tr>
<td>Organic, including symptomatic mental disorders (F00–F09)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Mental and behavioural disorders due to psychoactive substance use (F10–F19)</td>
<td>8%</td>
<td>13%</td>
</tr>
<tr>
<td>Schizophrenia, schizotypal and delusional disorders (F20–F29)</td>
<td>31%</td>
<td>80%</td>
</tr>
<tr>
<td>Mood (F30–F39)</td>
<td>28%</td>
<td>0%</td>
</tr>
<tr>
<td>Neurotic, stress-related and somatoform disorders (F40–F48)</td>
<td>22%</td>
<td>0%</td>
</tr>
<tr>
<td>Behavioural syndromes associated with physiological disturbances and physical factors (F50–F59)</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Disorders of adult personality and behaviour (F60–F69)</td>
<td>8%</td>
<td>0%</td>
</tr>
<tr>
<td>Mental retardation (F70–F79)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Disorders of psychological development (F80–F89)</td>
<td>0%</td>
<td>7%</td>
</tr>
<tr>
<td>Behavioural and emotional disorders with onset usually occurring in childhood and adolescence (F90–F98)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Unspecified mental disorder (F99)</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

4.3.9 The impact of ceasing the MaKM Program would be significant

Through surveys and focus groups, program referrer and partner agencies felt strongly that the MaKM Program is an important program that demonstrates benefits to those involved. They also believe that ceasing the program would have a significant impact on mothers, service delivery and the health system, as outlined in Figure 57 below.

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55 For pre-MaKM information, primary diagnoses for ambulatory care contacts are based on the most recent contact prior to entry into the MaKM Program.
Figure 57: What would be the impact of ceasing the current MaKM program? (n=13)

Figure 58 outlines anecdotal evidence from referrer and partner agencies of key areas where the MaKM Program has made an impact on mothers, children and the system.

Figure 58: Comments from referrer and partner agencies in surveys

The MaKM program is so specific and targeted to an area of great need, particularly for Aboriginal women with whom I work. Ceasing would leave a big gap.

MaKM has given me options as a practitioner to keep families together and manage risk until outcomes are more predictable.

MaKM provided a mother consistent, respectful and effective mental health care.

Referring this client has allowed FACS to keep a child out of care who almost certainly would have ended up in the care system.

Referrer and partner agencies who participated in the survey and focus groups were eager to see the MaKM Program continue to improve and lead to even greater outcomes for mothers, their families and the health system more generally.
As discussed in section 4.2.7, the majority of participants interviewed reported that they had a positive experience in the Program and that they would recommend the Program to other mothers. However, some of the interviewees reported that they experienced difficulty around the time of Program exit. Vignette 3 below highlights the significant impact of the Program and why it is important for mothers facing complex issues. It also highlights the impact of exiting a program that provides such an intense level of support over a substantial amount of time (greater than 12 weeks for some mothers).

Figure 59: Vignette 3 - Michelle

Michelle has had a hard time. Post-natal depression hit like an express train, totally out of nowhere. The Mums and Kids Matter program made an extremely difficult time easier. They made time to talk with her. To help her get through long scary nights by just sitting and talking with her. Then they helped her plan how to get through her days while her husband was away, helped her practice going out with the kids without panicking. It’s very hard to leave a program like that. Hard to realise that you have to go back to coping without them. Michelle is so upset by leaving the program and feeling abandoned that she doesn’t want to be involved in any programs again. At the moment she isn’t getting help from anyone. Mums and Kids Matter has a hard job. They work with vulnerable women, and they aim to leave the women feeling stronger and more able to cope. Able to enjoy their babies and look forward to life. They deal with very complex issues and it doesn’t always work out.

4.3.10 The MaKM Program is unique

The Program is tailored specifically to mothers with severe and complex mental illness and their children

Nous conducted a review of nine programs with comparable elements to the MaKM Program that are delivered both in Australia and overseas. Nous examined the services provided, delivery method, geographic reach, eligibility requirements and referral pathways. The high level overview of the comparable analysis is provided in Figure 61. For more detailed information on each program, see Appendix 8. Nous could not find any other program that offered the combination of care components offered by the MaKM Program.

The target cohort of many other programs with comparable elements is mothers who have problematic use of drugs and/or alcohol. While some of these mothers are also living with a mental health problem or illness, the programs are not specifically for those with a severe complex mental illness. Indeed, people with a severe mental illness are excluded from some of the programs.56

The MaKM Program delivers its services through a consumer driven operating model. Services are provided based on the needs of clients through a residential program based in Sadleir, along with

56 Phoenix House in the USA
community care packages which are provided across the whole of NSW.

Staff based in Sadleir travel throughout NSW to coordinate and provide the community care packages. For those clients who require acute services, MaKM Program staff also provide brokerage and coordination services for voluntary inpatient mother-baby mental health and residential tertiary parenting care.

The Program offers a distinct set of services, as it focuses on the treatment of the mother’s mental illness, along with developing their parenting skills

The primary focus of many of the programs with comparable elements is to develop the mothers’ parenting skills so they can maintain or regain custody of their child. The MaKM Program is distinct because it focuses on the improvement of the mothers’ mental health, while concurrently developing their relationship with and capability to look after their child. It even assists in the provision of long term housing stability. These are all key social determinants of health for this priority population and no other program addresses all of these primary factors.

The MaKM Program provides the following mental health and parenting services:

- group psychological therapy sessions (approximately once a fortnight)
- individual psychological therapy sessions (while noting individual sessions are tailored to each mother’s needs, the Program provides two individual sessions per month on average to each mother)
- group parent education (approximately three sessions a month)
- individual parent education sessions (while noting individual sessions are tailored to each mother’s needs, the Program provides one individual session every two months on average to each mother)
- psychoeducation sessions
- supported playgroup sessions.

The MaKM Program provides a unique holistic service which incorporates provision of in-home psychological therapies and parenting support and education, as well as coordination of parental and child health care needs. Mothers have the choice of the services being provided in her own home, or during a residential stay in Sadleir. If specialist mental health care or parenting education needs arise, there is access to inpatient mental health care in a mother and baby unit and/or residential tertiary parenting education with mental health support. This ability to step-up or step-down the level of care required by each individual is an important and unique aspect of the MaKM Program. Mothers leaving the residential unit also have access to support in their home through community care packages. These services are also provided by specialist mental health service partners.

Comparatively, other programs’ mental health services generally involve linking participants to mental health services in the community. Figure 60 shows that many programs with comparable elements do not offer comprehensive mental health services for mothers with a severe and persistent mental illness.
Mothers can be referred from any LHD or relevant Specialty Health Network (SHN) in NSW

Most of the programs with comparable elements available in NSW require the mothers to live in a specific LHD. The MaKM Program is unique because mothers can be referred from any LHD or SHN in NSW. The Women and Children’s Program run by Richmond PRA also accepts mothers from across NSW, but it is required to prioritise those living in Western Sydney. In this way, the MaKM Program is a vital program as it offers an important service to mothers who are not eligible to participate in many other programs with comparable elements. Figure 60 shows the programs that accept referrals from all over NSW.

Figure 60: Comparison of services and referral pathways

<table>
<thead>
<tr>
<th>Program</th>
<th>People with a severe mental illness are eligible</th>
<th>Comprehensive mental health services provided</th>
<th>Referrals accepted NSW state-wide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mums and Kids Matter</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Doorways</td>
<td>✓</td>
<td>Participants must be connected to AMHS</td>
<td>X</td>
</tr>
<tr>
<td>Richmond PRA</td>
<td>✓</td>
<td>Psychologist visits fortnightly</td>
<td>✓*</td>
</tr>
<tr>
<td>Newpin</td>
<td>✓</td>
<td>X</td>
<td>Not specified</td>
</tr>
<tr>
<td>Jade House</td>
<td>X</td>
<td>Focus on perinatal anxiety &amp; depression</td>
<td>X</td>
</tr>
<tr>
<td>Tresillian</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>MH Positive Parenting</td>
<td>✓</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Portage, Canada</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Phoenix House, USA</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Forty Carrots, USA</td>
<td>X</td>
<td>Maternal depression/ infant mental health</td>
<td>N/A</td>
</tr>
<tr>
<td>Holding Tight, Finland</td>
<td>X</td>
<td>X</td>
<td>N/A</td>
</tr>
</tbody>
</table>

AMHS – Adult Mental Health Service  * Western Sydney LHD prioritised
Figure 61: High level overview of programs with comparable elements

<table>
<thead>
<tr>
<th>What services are provided?</th>
<th>How are services provided?</th>
<th>Where are services provided?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting skills development</td>
<td>Residential</td>
<td>NSW: One location</td>
</tr>
<tr>
<td>Drug and alcohol services</td>
<td>Home visits</td>
<td>NSW: Various locations</td>
</tr>
<tr>
<td>Comprehensive mental health services</td>
<td>Day programs</td>
<td>NSW State wide</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Residential</th>
<th>Home visits</th>
<th>Day programs</th>
<th>NSW: One location</th>
<th>NSW: Various locations</th>
<th>NSW State wide</th>
<th>Other states</th>
<th>Overseas</th>
</tr>
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<tbody>
<tr>
<td>Mums and Kids Matter</td>
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<td>Doorways</td>
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<tr>
<td>Women and Children's Program, Richmond PRA</td>
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<td>Mental Health Positive Parenting</td>
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<td>Portage, Canada</td>
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<td>Phoenix House, USA</td>
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<td>Forty Carrots, USA</td>
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<tr>
<td>Holding Tight, Finland</td>
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4.4 What are the future opportunities and priorities?

Based on the analysis of quantitative data and consultations with MaKM Program staff, partners and participants, Nous developed a set of recommendations to build on current program success and ensure that the MaKM Program can continue to have a positive impact on participants, their children and families, and the health system.

This section contains a description of the recommendations, each of which are based on the findings detailed in section 4.1, 4.2 and 4.3. The recommendations are structured around the following key elements of organisational design and program delivery:

![Operating model](image)

### 4.4.1 Operating model

**Recommendation 1: The future operating model should provide greater reach in rural areas, proportional to demand.**

While there is demand for MaKM Program services in regional and rural areas, the majority of MaKM Program participants are from metropolitan Sydney. The MaKM Program staff should focus on broadening the reach of the Program's services in regional and rural areas. Referrer and partner agencies expressed an appreciation that MaKM Program staff travel long distances to provide services to mothers in regional and remote areas. They also recognised that a centralised location is positive for quality standards and ease of program coordination. However there needs to be increased program engagement in rural and regional areas. One MaKM Program participant based in a regional area stated she could not continue on the MaKM Program. This was because staff had difficulty linking her into a regional network and reported not having sufficient resources to travel to her regularly (this was soon after the program commenced). A stronger reach in rural areas will also reduce a participant’s distress in being located far away from their family.

It is important to understand the greatest barriers relating to program intake in regional and rural areas. The barriers expressed by referrers relate to lack of awareness of the MaKM Program, lack of trust in the
MaKM Program services or barriers relating to logistics and travel distances. Once the barriers are understood, the most cost-effective strategies to deliver services in these regions should be explored. Some examples of how the services could be provided include:

<table>
<thead>
<tr>
<th>Service model for regional areas</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Consortium of services</strong></td>
<td>- will establish important relationships with the broader mental health community&lt;br&gt;- will be able to leverage the established referral pathways and awareness of the other programs&lt;br&gt;- is cost effective.</td>
<td>- will have limited ability to monitor the quality of services provided.</td>
</tr>
<tr>
<td><strong>Regional hubs</strong></td>
<td>- ability to monitor and ensure the quality of services provided to mothers and their children.</td>
<td>- expensive compared to a consortium.&lt;br&gt;- lack of awareness and trust of the MaKM Program in regional areas may limit initial uptake and interest in the Program.</td>
</tr>
</tbody>
</table>

A stronger presence in regional and rural areas would allow for more timely and efficient care of mothers and have additional benefits in addition to the MaKM Program aims. This includes an increase in regional employment, enhancement of community collaboration and increase of skills in regional areas. MH-CYP should consider these aspects of the operating model when evaluating the future funding for the MaKM program.

**Recommendation 2: There should be an increased focus on fathers and families in the MaKM Program.**

**There is an opportunity to increase engagement with fathers.**

There is a need to build upon the MaKM Program’s family focused approach and work better with families to improve family functioning. Referrer and partner agencies stated that limiting the MaKM Program to only mothers and their children has created barriers to some mothers entering the Program. This is particularly relevant for Culturally and Linguistically Diverse (CALD) and Aboriginal communities. Referrer and partner agencies reported that more mothers would be able to participate in the MaKM Program if there was greater family involvement, particularly for the father. It may not be appropriate for fathers to participate in the residential component of the MaKM Program, as 64% of mothers have experienced violence in the past57 and some participants may be uncomfortable with male adults participating in the residential program.

There are other opportunities to engage fathers in the MaKM Program. These may include:

57 See Figure 5. Note that the father of the mother’s child may not be the perpetrator of the violence against the Program participant.
- day programs
- telehealth services
- regular skype sessions with fathers and other family members including children.

Increasing the fathers’ and families’ engagement in the treatment and recovery of the mothers is consistent with focus of the MaKM Program providing holistic services.

**There is an opportunity to further the MaKM Program’s holistic care model through linking children in the MaKM Program to relevant services in the community.**

It is important to recognise that the focus of the MaKM Program is to support the mental health of the mother participating in the MaKM Program. However, through an analysis of programs with comparable elements, Nous identified that the MaKM Program’s holistic care model could be strengthened by providing additional support to the children of the mothers in the MaKM Program through linking them to required services in the community. In line with the MaKM Program’s focus on holistic care, the MaKM Program could conduct further child assessments to determine the needs of each child. For example, a child’s needs may relate to social skills, gross motor skills, development needs or infant mental health. Cohort specific, age appropriate developmental principles could be further emphasised.

The MaKM Program could link children to services in the community through pre-established referral pathways. The Program could further support mothers to strengthen relationships with family members and remain connected to their children and their community. This is particularly relevant for mothers participating in the residential program, as this will also facilitate improved transition back to the community. Table 5 below outlines how programs with comparable elements have provided support to children.

<table>
<thead>
<tr>
<th>Opportunity to increase focus on the child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Newpin</strong> teaches toddlers social and gross motor skills.</td>
</tr>
<tr>
<td><strong>Newpin</strong> provides school preparation class for four year olds.</td>
</tr>
<tr>
<td><strong>Forty Carrots</strong> provides child mental health services.</td>
</tr>
</tbody>
</table>

It is important to note the limitations of comparing the MaKM Program to other programs. First, the purpose and funding focus of many of these comparable programs is to support and develop the child, unlike the MaKM Program which focuses on the mother. Consequently it is expected that these programs have a stronger child focus. Second, the limited number and the age of children engaged in the residential program and their varying ages may not warrant the MaKM Program holding their own school preparation classes, for example.

**The MaKM Program should maintain its core values and continue its person centred service delivery model.**

The MaKM Program’s core operating model is the provision of person centred care that is tailored to the needs of each mother. The referrer and partner agencies expressed strong regard for this operating model and stated that the MaKM Program should continue to ensure that this model continues. An outline of how the MaKM Program upholds a holistic person centred operating model is outlined in 4.3.10.
4.4.2 Funding model

**Recommendation 3: MaKM Program staff should continue to have the capacity to move funding between program elements.**

Ensuring the continued flexibility of service delivery in the MaKM Program will encourage innovations and improvements, and allow efficient distribution of funding to core activities. In particular, the funding model should support flexibility in two ways:

**Mix of activities:** the ability to adapt the person-centred care model over time appears to have improved the performance and outcomes of the MaKM Program. It is important that, as the program continues to evolve and the staff learn from experience, they continue to have the flexibility to adjust the mix of activities and their relative efforts without barriers or large administrative burdens that could obstruct changes for the better. See section 4.1.8 for an example of program evolution to date.

**Redistribution of funding components:** As discussed in section 4.1.5, funding to inpatient mother-baby units has not been used extensively since the program’s inception. In addition, there is mixed feedback from both program participants and referrers about how effective and appropriate some of these services are for mothers with a severe and complex mental illness (as reported through consultations). The MaKM Program should consider redirecting that funding component on a pro-rata basis throughout the financial year up to a fixed maximum amount (e.g. 50%) of the total funding dedicated to acute inpatient care. The remaining amount that has not been redistributed throughout the year and has not been used for the purpose of funding the inpatient brokerage service, could be rolled over and used at the distributive discretion of the MaKM Program in the following financial year. This will maximise the flexibility and responsiveness of the MaKM Program to the needs of its clients, whilst also maintaining a reserve amount in case the acute services of St John of God or Karitane are suddenly required later in the year.

4.4.3 Capability

**Recommendation 4: Future professional development should be evidence-based, tailored and available for all MaKM Program staff and a formalised staff supervision program should be mandatory for all staff.**

Professional training and development programs should be conducted for MaKM Program staff to better support mothers participating in the MaKM Program who require specialist support. Staff delivering the MaKM Program should be well trained in the selection and delivery of evidence informed therapeutic interventions that meet the needs of individual mothers and their children. Through the focus groups and surveys, referrer and partner agencies highlighted two specific areas of training that would benefit MaKM Program participants:
Regular supervision by appropriately experienced and qualified supervisors is essential to support delivery of a quality service to MaKM participants. It is also important that sufficient time and funding is allocated to allow staff to receive ongoing training.

Referrer and partner agencies suggested that if the MaKM Program staff cannot address particularly complex or unique cases through their own services, they should refer mothers and children to other service providers in the region. This will also ensure that the MaKM Program continues to play a key role in integrating and coordinating care.

4.4.4 External alliances and relationships

**Recommendation 5:** A stakeholder engagement plan should be developed to build and sustain relationships with new and current referrers and interacting agencies.

A stakeholder engagement will support Program staff to have a more proactive and coordinated approach to communicating with key stakeholders.

As indicated in Section 4.2.6, referrer and partner agencies report positive interactions with the MaKM Program. However, consultations with referrers highlighted the importance of sharing information more frequently to improve mothers’ transition in and out of the Program. A stakeholder engagement plan could be implemented to support this. The plan could be a working document for MaKM Program staff and include details of referrers and interacting agencies, as well as the current case managers of participants and indicate:

- key issues to communicate (e.g. program features, an update on the mother’s care plan, wellbeing and transition progress)
- purpose of communication (e.g. to increase program promotion, to plan for the mother’s transition back home from the residential)
- method of communication (e.g. meeting, phone, email)
- frequency of communication (e.g. weekly communication with referrers and interacting agencies during a participant’s engagement with the MaKM program, follow up conversation with referrer and partner agency a month after the participant has transitioned out of the Program)
- who will carry out the communication (e.g. family coach, mental health nurse, operations manager).

**Infant attachment:** provide training for staff to support mothers to develop infant attachment, particularly for those with personality disorders.

**Child and family health:** Increase the MaKM Program’s focus on identification of child and family health needs and referral for follow-up.
It is important that referrers have an understanding of when mothers are transitioning in and out of the Program so that appropriate support can be provided by community mental health teams in the local community. MaKM Program staff should hold the primary responsibility for engaging with referrers and agencies in the lead up to, during and after a participant transitions out of the Program. However MaKM staff and referrer and partner agencies may decide to establish their own agreement around who is responsible for initiating and following up on communication at each stage of the participant’s engagement in the Program.

Targeted communication with referrers and interacting agencies will ensure that referrers and agencies are well-informed at all stages of engagement and in the long run this will result in greater care for clients. The stages of engagement are represented in Figure 62 below. Engagement starts at program promotion and continues through to the referral process, while mothers and their children transition into and are engaged in the MaKM Program, and when mothers transition out of the MaKM Program.

Ongoing communication between MaKM Program staff and program referrers will ensure that participating mothers receive better integrated health care

MaKM program staff are aware of the importance of ongoing communication. They have acknowledged that while they have started to put time and effort towards stakeholder engagement, it is an element of program design they believe needs to be developed further.

Focus group participants reported that while MaKM staff are very responsive to requests for information about MaKM Program participants when asked, communication with Program staff is mostly ad hoc. Focus group participants stated it would be beneficial if communication was comprehensive and consistent for the duration of the MaKM Program. Referrers suggested a letter on commencement outlining the central point of contact and key information as well as regular updates regarding their client’s experience of the program. This is to ensure that specialist mental health service provision continues throughout and after the MaKM Program and that all care is integrated. Focus group participants also stated they would benefit from receiving a detailed discharge summary when a mother transitions out of the MaKM Program. The summary will ensure continuity of care and outline clear levels of responsibility and required follow up. These steps are further outlined in Figure 62 below.
Figure 62: Stages of engagement

Recommendation 6: Awareness of the Program should be increased to support mothers to transition in and out of the Program as smoothly as possible and increase participation from remote and regional areas.

There is a growing demand for programs such as MaKM in regional and rural areas, yet awareness of the Program in these areas is relatively low.

In survey responses and focus groups, stakeholders recognised that MaKM is not as well known in the community as it should be. One referrer said that at the moment the Program is viewed by clinicians in rural and remote areas as “too hard.” However referrers reported that within regional areas there is quite a strong demand and that there would be more uptake of the Program if it was more effectively implemented for regional and rural areas. Although some respondents highlighted a growing need for programs like MaKM in regional and rural areas, referral data indicates that the LHDs in more isolated areas are in fact not accessing the service.

In Broken Hill services are so ridiculously stretched. Had a girl who they knew she was high risk of post-natal depression…We didn’t have the services to keep mother supported. When situation is urgent we’ve pretty much got emergency department.

- Focus group, program referrer

There is not enough awareness of the program across LHDs and there are benefits to mothers and referrers having a taste of the program before they sign up.

- Focus group, program referrer
Referrers and mothers are more likely to engage with the MaKM Program if they have greater access to information

Overall, stakeholders agreed that it would be beneficial for both the referrers and the mothers to have access to more information on the MaKM Program. This information would be useful to:

- Build awareness and trust of the Program and its staff across Health NSW.
- Provide referrers with the background information they need to promote the Program to possible future participants. Background information should include how the MaKM program fits into the broader health system and the types of services and support the Program offers mothers.
- Provide mothers with a greater sense of the residential component of the MaKM Program, which will help to reduce anxiety often associated with moving to Sadleir.
- Help referrers to better prepare mothers for the MaKM Program.
- Allow referrers to outline the specific details of the MaKM Program to stakeholders such as FACS (as there are often requirements which need to be met for FACS to agree to the mothers participation in the program).58
- Provide referrers with the advice they may need to support mothers to transition back to their community after the program, or to support mothers that are on the waiting list to receive the MaKM Program. Referrers suggested that a face-to-face “tour” or information online would be very beneficial.

Referrer and partner agencies proposed specific types of information that would benefit both partner agencies and the mothers. These are outlined in Figure 63 below. Program referrers suggested that more detailed and updated information on the Program’s website would help their clients make an informed decision about whether they would like to attend the Program as well as assist referrers decide which package would be best for the mothers. Ultimately, it will help mothers and referrers get a ‘taste’ of the program and what the experience will be like for them. It was suggested that information be split between two web pages, one targeted to mothers and families and one targeted to referrer and partner agencies. In addition, Nous would suggest developing a ‘videoscribe’ which is an engaging way to provide both clients and referrers with a tangible sense of what the program is like from a participant’s perspective.

58 As explained by one focus group attendee, FACS stated that the mother would be able to remain with her child in the MaKM Program only if 24 hour support was available. The focus group attendee stated that it was difficult to confirm that such support was provided to mothers.
4.4.5 Business processes

**Recommendation 7: The MaKM Program’s referral process should be reviewed to increase efficiencies.**

There are a number of ways the referral process into the MaKM Program could be improved. These include:

1. Increase the transparency of the expected wait time to enter the MaKM Program.
2. Create shorter pathways to enter the MaKM Program for mothers who require more urgent care.
3. Review the staff referral form so that it is a standard mental health format and is not cumbersome.

Focus group and survey participants noted it would be useful to receive more regular updates on the progress of applications into the MaKM Program. Referrers stated the application form is not aligned with the standard NSW mental health format and therefore can be more time consuming to complete than other forms. Focus group and survey participants also commented that some mothers require immediate assistance, particularly for entry in the residential program. If the MaKM Program staff cannot attend to them immediately, the mental health team has to resolve the issue locally or the mother moves onto another option. A shorter pathway for mothers requiring emergency assistance would mean mothers can benefit from the MaKM Program when it is most required.

**Recommendation 8: The MaKM Program’s transition process in and out of the Program should be strengthened.**

Strengthening the transition process will reinforce continuity of care between the MaKM Program staff and the mothers’ mental health team. Many referrer and partner agencies provided feedback that the status of mothers exiting the MaKM Program is not clearly communicated when a participant leaves the Program. For example, one MaKM Program participant ceased her community care package and the participant informed the specialist mental health team, not the MaKM staff. Some MaKM Program participants also highlighted issues with the transition process back into their community through
interviews. One participant stated that the MaKM Program finished so suddenly that she has lost trust in the system overall. She no longer likes to rely on support services that may abruptly disappear.

The MaKM Program staff should improve the transition process through more effectively transitioning between the residential and community care packages. The MaKM Program staff should also focus on linking the participants to independent services in the community when participants transition out of the community care packages. Table 6 below outlines how programs with comparable elements have supported participants to transition back to their communities. However, it should be noted that the Doorways program assists in obtaining employment, which may not be suitable for MaKM Program participants due to their more severe level of mental health issues. For more information on opportunities to increase communication during the transition process, see 4.4.4.

Table 6: Analysis of programs with comparable elements – transition processes

<table>
<thead>
<tr>
<th>Opportunity to improve the transition process</th>
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</thead>
<tbody>
<tr>
<td><strong>Doorways</strong> assists participants to obtain employment, so their independence is sustainable.</td>
</tr>
<tr>
<td><strong>Newpin</strong> and <strong>Forty Carrots</strong> have referral processes into community day programs, so participants’ development continues.</td>
</tr>
<tr>
<td><strong>Portage</strong> has a residential to community care follow up program.</td>
</tr>
</tbody>
</table>

4.4.6 Systems and reporting

Recommendation 9: Future development of information systems should ensure they are comprehensive, patient and family centered and overcome current data limitations.

MH-CYP should encourage MaKM Program staff to invest in an electronic information system that is comprehensive, patient-centred and links all relevant data to participants. Currently, a lot of important service delivery information is captured in clinical notes and cannot be easily accessed for reporting and analysis. To ensure the information obtained is as comprehensive as possible, referral and participant forms should include an option to indicate whether the participant is Aboriginal and/or Torres Strait Islander.

A system that allows staff to record service activity, patient and child progress (including formal assessments), and other clinical notes for each participant will enable the concentration of all information into a ‘single source of truth’. It will also allow for various analyses to be undertaken to track progress of participants with different characteristics and with different care planning packages, thereby enabling a better learning environment for service optimisation.
MH-CYP should ensure that the MaKM outcomes measurement framework is comprehensive and accurately captures program goals. Particular focus should be placed on measuring outcomes for the children in the program, as well as family outcomes in the community. This is appropriate timing to introduce this as the program has now been running for two years.

With respect to child outcomes, the following items should be considered:

1. **Improved parent-child relationship**: the current measurement tool being utilised is the Pianta Parent-Child Relationship Scale. MaKM staff have noted a lack of clarity about the interpretation of the result. Additionally, the Pianta is self-reported and only takes the parent’s perspective into consideration. Other evidence-based alternatives should be investigated, such as the Parenting Stress Index.\(^{59}\)

2. **Children are safe enough not to require statutory intervention**: The NCFAS tool is currently the primary tool being used to measure this outcome. The MaKM staff should ensure they are using the most recent, online version of the survey. It should also consider including additional measures, such as the Child Abuse Potential Inventory, to ensure a more comprehensive assessment of risk.\(^{60}\)

3. **Children who have developmental needs receive developmental intervention**: the PEDS assessment tool is currently administered to measure this outcome. The limitations of this tool are noted in section 4.3.5. The MaKM Program should work with a paediatric specialist to identify additional methods that would improve the measurement of this outcome. The ASQ is more appropriately tailored to the specific age group of the children involved in the MaKM Program so should be considered as a replacement for PEDS. If the PEDS assessment tool is retained as a supporting measure, it should be administered both at entry and exit from the program.

With respect to family outcomes, the following items should be considered:

1. **Mothers knowledge about and use community services, activities and resources to meet family needs**: family coaches have noted that the arbitrary nature of the care planning checklist when it is used for the purpose of measuring community engagement. The checklist measure should be receptive to broader definitions of community engagement, including types of activities not currently noted in the checklist. These activities should also be scored by depth of community engagement (e.g. “frequent and time intensive activity” vs. “occasional, light involvement”).

2. **Families have improved family functioning**: The NCFAS tool is currently the primary tool being used to measure this outcome. MH-CYP should consider engaging an independent assessor to measure this outcome in addition to a MaKM Program staff member. MH-CYP should also ensure the MaKM staff are using the most recent, online version of the survey.

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Recommendation 11: Program reporting to MH-CYP should deliver key insights in an easily accessible form and be based on accurate information.

MH-CYP should work with MaKM Management to identify the important data points that should be reported on. These data points should align with the updated measurement framework discussed in Recommendation 10, be reported on a quarterly basis once the report template is established, and cover at least:

- the mix of packages and count of participants and children
- a summary of program enquiries, total referrals made and referral applications accepted
- service activity and utilisation (as a proportion of all participants prescribed the service in their care planning package)
- an analysis of formal assessment results for mothers and children who left the program in the quarter
- key issues relating to the participants and/or the Program that have emerged in the quarter and how MaKM staff have responded or intend to respond.

The report template should be succinct and a short summary and analysis of the results should guide the reader through the key insights.

4.4.7 Technology

Recommendation 12: Technology should be used to engage referrers and provide mental health and other support to participants and their families.

As mentioned in section 4.2.6, interviews with referrer and partner agencies highlighted the benefits of the MaKM Program staff and referrers interacting on a more regular basis. There are opportunities to increase this interaction through the use of technology, such as video conferencing for transition preparation, case planning and review meetings. Video conferencing would help MaKM to build more of a rapport with referrer and partner agencies and over time this could lead to a greater awareness of the Program and increase in referrals in more Districts across NSW.

In addition to this, for those sessions that do not rely on face to face interaction, Program staff could explore telehealth\(^{61}\) options to deliver aspects of the Program online particularly for those families who are located in very remote areas and where MaKM does not have the networks and connections to deliver community care. To further support Recommendation 2, this could also be extended to fathers and other family members, such as pre-recorded webinars or live video conferencing sessions on parenting, mental health and accessing support in their local community.

Interviews with stakeholders highlighted that the MaKM Program residential site does not currently have Wi-Fi facilities. It is recommended that Wi-Fi be available to all participants. This is an essential measure to ensure that mothers can stay connected to their family and community, particularly in remote and regional areas, while participating in the residential program.

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61 Telehealth services use information and communications technologies to deliver healthcare, services or related activities.
Recommendation 13: The MaKM Program website should be updated to enhance program promotion.

Referrer and partner agencies report that more detailed information on the MaKM Program’s website would enable them to better understand the Program and consider how their clients could be involved. Focus group participants suggested that one area of the website could be targeted to referrer and partner agencies and another could be targeted to mothers and their families. Both areas should include a virtual tour or images of the facilities as well as personal accounts from mothers and referrers on the impact of the Program so that those who visit the website can better understand what it would be like to participate in the Program and what they can hope to expect. The targeted area for referrer and partner agencies should also include information on the types of services available and guidelines on the referral process.

It is recommended that MaKM staff build and test the design of a new website with referrer and partner agencies – and participating mothers if appropriate – to ensure the design is fit for purpose. It is also recommended that staff have the means to track the number of people visiting the website so that they can evaluate its activity and usefulness over time.

4.4.8 Governance

Recommendation 14: A clinical governance structure should guide ongoing program design and improvement.

One of the benefits of the MaKM Program is its ability to respond to the needs of the participants and tailor its services to provide targeted, high level care to each participant. Consequently, MaKM Program staff work in a culture of continuous improvement and constantly think about how the Program can reflect evidence-based research, better meet the needs of participating mothers and their children, and remain aligned to the Program’s objectives.

In interviews, Program staff and stakeholders noted that it would be beneficial to have a more formalised clinical governance arrangement to ensure that any decision made around program improvement is aligned to the Program’s KPIs and outcomes. Currently, MaKM staff raise suggested program changes with MH-CYP, who provide advice in line with the Service Level Agreement.

In August 2015 Wesley Community Services (Wesley) and South Western Sydney Local Health District (SWSLHD) entered into a Collaboration Agreement to support the delivery of the MaKM Program. The agreement sets out a framework to support collaboration between Wesley and SWSLHD, increase the range of mental health services available to mothers participating in the Program and increase mothers’ access to services provided by SWSLHD mental health service that are not able to be provided by Wesley or the Program. It is recommended that the MaKM Program maintain the Agreement with SWSLHD including the ongoing annual reviews to ensure the Agreement continues to support Wesley and SWSLHD to collaborate effectively to improve outcomes for jointly managed clients.

## Appendix 1  Key lines of enquiry

<table>
<thead>
<tr>
<th>Line of enquiry</th>
<th>Evaluation meta-question</th>
</tr>
</thead>
<tbody>
<tr>
<td>What has been delivered under the MaKM Program?</td>
<td>How many people use the MaKM service?</td>
</tr>
<tr>
<td></td>
<td>How many services have been delivered over the life of the program (by type)? (Totals)</td>
</tr>
<tr>
<td></td>
<td>How are services delivered?</td>
</tr>
<tr>
<td></td>
<td>Where are services delivered?</td>
</tr>
<tr>
<td></td>
<td>What is the current service usage (by type)?</td>
</tr>
<tr>
<td>How well does the MaKM deliver services?</td>
<td>What is the ongoing investment to deliver MaKM services?</td>
</tr>
<tr>
<td></td>
<td>How well have the MaKM services been implemented?</td>
</tr>
<tr>
<td></td>
<td>Has service delivery been cost-effective?</td>
</tr>
<tr>
<td></td>
<td>Are clients satisfied with service delivery?</td>
</tr>
<tr>
<td></td>
<td>Does MaKM effectively sustain engagement with participants?</td>
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<tr>
<td></td>
<td>Are referrer/partner agencies satisfied with service delivery?</td>
</tr>
<tr>
<td>What impact has the MaKM had? (i.e. what number and proportion are better off?)</td>
<td>What has been the impact for mothers? (skill, knowledge, behaviour, circumstances)</td>
</tr>
<tr>
<td></td>
<td>What has been the impact for children?</td>
</tr>
<tr>
<td></td>
<td>What has been the impact for families?</td>
</tr>
<tr>
<td></td>
<td>What has been the impact for the system? (health status, service use and quality)</td>
</tr>
<tr>
<td></td>
<td>How does the impact of MaKM compare with other similar programs?</td>
</tr>
<tr>
<td>What are the future opportunities and priorities?</td>
<td>Where are the opportunities for further improvements in outcomes?</td>
</tr>
<tr>
<td></td>
<td>What are the opportunities to improve delivery of the current model?</td>
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<tr>
<td></td>
<td>What should be the priorities for the MaKM over the next 3-5 years?</td>
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</tbody>
</table>
Appendix 2  Methodology

Nous used a mixed methods approach which draws on multiple data sources to develop evaluation findings and recommendations. The following section describes the process taken to complete data collection and analysis.

Quantitative data analysis

Between February 2016 and April 2016 Nous analysed MaKM Program documents and the Wesley Mission Minimum Data Set (MDS), including key demographic information, activity data and referral information. The activity data analysis was restricted by a number of key data limitations. Nous worked in consultation with MaKM Program staff to resolve this as best as possible. Section 3.2 and Appendix 4 provide detailed information about the data limitations to consider when reviewing the findings presented in this report.

Nous also examined information obtained through Wesley Mission’s existing data collection tools, such as care plans, goal setting tools and exit interviews as well as clinical outcome measures (including Kessler10, HoNOS and NCFAS) across the mother’s program involvement. Nous has received data for the following formal assessments out of a possible 42 mothers who have exited the program up to the end of March 2016, and 59 children who have entered the program up to the end of March 2016:

- Pre and post-program NCFAS data for up to 39 mothers (93% of all mums who have exited the program)
- Pre and post-program Kessler10 data for 36 mothers (86% of all mums who have exited the program)
- Pre and post-program HoNOS data for 36 mothers (86% of all mums who have exited the program)
- Pre-program Parents’ Evaluation of Developmental Status (PEDS) data for 59 children, as well as pre and post-program PEDS data for 12 children.

Nous also received data from other formal assessments including The Australian Unity Wellbeing Index (AUWI) and the Pianta Child-Parent Relationship Scale (PIANTA). However, due to limited sample sizes and lack of clarity around the interpretation of the results, Nous has excluded the analysis of the data from this report.

Consultations with the Evaluation Steering Committee and with Nous’ expert advisor, Professor Kim Oates concluded that additional, independent child outcome measures should be considered in addition to PEDS for this program going forward. This will provide greater evidence on the capacity of the Program to support the restoration of children to their families.

Additionally, Nous worked with InforMH and NSW Family and Community Services (FaCS) to obtain aggregated, unidentifiable linked data from the following datasets:

- NSW Admitted Patient Data Collection (APDC)
- NSW Mental Health Ambulatory Data Collection (MH-AMB)
- NSW FaCS datasets including information on Out-of-Home-Care (OOHC) and Risk of Significant Harm (ROSH) reports.

These data sets have been used to draw key insights with respect to service utilisation before and after participation in the MaKM Program.
Finally, Nous conducted an economic appraisal to provide insight into the financial benefit of the Program to the NSW Government. The approach used for the economic appraisal is described below.

**Economic appraisal**

The evaluation includes a limited economic appraisal of the MaKM program to answer the evaluation meta-question:

*“To what extent has service delivery been cost-effective?”*

Nous’ approach to the economic appraisal is similar to an interrupted time series study. The economic benefit of MaKM was determined by comparing the outcomes for participating mothers in terms of Government service use with the case in which mothers did not participate in the program. The evaluation compared the expected lifetime trajectory and implications for government service provision for two pathways:

1. mothers with severe mental illness who do not participate in any intensive form of intervention like the MaKM Program (the counterfactual group)
2. mothers who have completed the MaKM Program (the intervention group).

The intervention group consists of the mothers who participated in the MaKM Program and their children. The counterfactual cohort consists of the same mothers and children, but is based on information prior to the mothers’ admissions into the MaKM Program. These trajectories, or ‘pathways’ determine the expected need for services (e.g. admission to acute inpatient care) for mothers and their children in each of the two scenarios above. Nous consulted with maternal and child health and specialist perinatal mental health advisors to confirm the most likely scenarios for these two pathways.

The services that have been considered in the model include:

- Inpatient care
- Mental health ambulatory care
- Primary care – General Practitioners and psychologists
- Specialist homelessness services
- Justice and correctional services
- Paediatric care for children with developmental delays
- School counsellors and teaching aids for children with developmental delays.

The net cost of NSW government services received by each of these cases was calculated as the average value of government services received by the person, over their lifetime, plus the per capita ongoing cost of the MaKM Program. These costs were then compared with the corresponding costs for the counterfactual cohort. The economic appraisal did not include broader and second round economic costs and benefits or an analysis of Quality-Adjusted Life Years.

Nous’ hypotheses were that mothers with severe mental illness who participate in the MaKM Program require fewer government services over their lifetime and children who participate in the program also require fewer of some types of government services (e.g. acute inpatient hospitalisations, Out-Of-Home-Care, Specialist Homelessness Services). However, mothers would be more likely to use primary care services to manage their health. Nous also hypothesised that this results in significant net savings, even though continuing the MaKM Program adds to annual government expenditure (see Figure 64 below).
The total net benefit to the NSW government in terms of avoided costs was estimated from the individual net costs of each of the cases, and then summed across the average number of mothers and children in the MaKM Program. While a full cost-benefit analysis incorporates other government and non-government costs as well as non-financial benefits, such a study was outside the scope of this project.

The key steps undertaken for the economic appraisal process are outlined below:

1. **Gather and aggregate data on participant outcomes and use of government services**
   
   Nous obtained aggregated data from linked datasets about participant use of government services (APDC, MH-AMB and FaCS linked data) for mothers (and their children) before they had entered into MaKM, as well for the mothers who have completed the program to date. As noted above, the former set of aggregated data (pre-MaKM Program) formed the counterfactual group, while the later (post-MaKM Program) formed the intervention group.

2. **Build evidence base to determine trajectory assumptions**
   
   Nous conducted a literature review to develop an evidence base of pathways for mothers with severe mental illness and their young children. This included research on outcomes from person-centred recovery interventions to establish a possible trajectory for mothers who participate in MaKM.

3. **Engage expert advisors to clarify trajectories for the intervention group and counterfactual cohort**
   
   Nous engaged expert advisers Professor Elisabeth Murphy and Professor Philip Boyce to ensure the driving assumptions and differential trajectories of the intervention and counterfactual cohorts were suitable.

4. **Determine cost of government services**
   
   Nous liaised with MH-CYP to determine a schedule of typical costs of health care services, which could be multiplied by the number of instances that mothers use those health services and the average length of stay in inpatient admissions. With respect to other government services, such

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63 Elisabeth Murphy is Professor and Head of Child Health at the University of Notre Dame and Senior Clinical Advisor and Manager of the Maternity and Child Health Unit, Primary Health and Community Partnerships Branch, NSW Ministry of Health.

64 Philip Boyce is Professor of Psychiatry at the University of Sydney Medical School, Professor of Psychiatry of Westmead Hospital and Head of the Perinatal Psychiatry Clinical Research Unit at Westmead Hospital.
as OOHC, specialist homelessness services and education, existing literature helped determine the differential costs of these services.\textsuperscript{65}

5. Calculate the net economic benefit of the MaKM program

Nous estimated the net economic benefit to the NSW Government from the total ongoing cost of the MaKM Program and the differential lifetime cost of government services for the intervention group and the counterfactual, as outlined above.

\[ \text{Net economic benefit} = \left( \sum_{i} (G_{n} - G_{i}) \right) - C \]

Where:
\begin{itemize}
  \item \( i \) refers to MaKM participants
  \item \( G_{i} \) is the gross (lifetime) cost of government services to MaKM participants
  \item \( G_{n} \) is the gross (lifetime) cost of government services to mothers with severe mental illnesses who do not participate in MaKM or a similar program
  \item \( C \) is the annual operating cost of MaKM.
\end{itemize}

Literature review

Drawing on the expertise of Professor Kim Oates, Nous conducted a literature review of programs nationally and internationally that are comparable to the MaKM Program. These programs were reviewed as a comparator to assess the effectiveness and efficiency of MaKM implementation and the outcomes achieved. The findings in section 4.3.10 identify the extent to which the program elements of the MaKM Program are comparable to the other programs. We also examined how the impact of the MaKM Program compared to the other programs at a participant level and a macro system level. See Appendix 5 for an overview of the comparable programs.

Qualitative data collection and analysis

Stakeholders have a crucial role in the MaKM Program evaluation. A comprehensive plan guided our engagement with stakeholders and ensured the necessary information was obtained to enable insight into the Program’s delivery, effectiveness and achievement against KPIs. It also informed our recommendations.

Group interviews were conducted with MaKM program staff in January and February 2016 and with MH – Children and Young People (MH-CYP) on 15 March 2016. The purpose of the interviews was to gain insights around the MaKM Program implementation, progress to date and opportunities for improvement.

The online survey for program referrer and partner agencies, including public mental health units, services, and other interacting agencies, was distributed on 1 March 2016 and closed on 17 March 2016. It was distributed to 54 stakeholders. Nous received 16 full or partial responses.

The purpose of the online survey was to explore views about the effectiveness of the MaKM Program delivery, linkages and partnerships, the benefits realised through the MaKM Program and opportunities for program improvement. The survey results helped target our focus group consultations on the critical issues raised.

\textsuperscript{65} Sources include the Productivity Commission’s Report on Government Services and the Medicare Benefits Schedule.
Following the online survey, three two-hour focus groups were held between 6 April and 8 April 2016. A total of 17 referral and partner agency representatives participated from across 11 LHDs. The focus groups provided an opportunity to test findings from the online survey and collect additional insights on the MaKM Program, the effectiveness of its implementation and opportunities for improvement.

Face to face interviews with six MaKM Program participants were conducted in May and June 2016. The purpose of the participant interviews was to understand how mothers experience the MaKM program and the outcomes achieved. Interviewees represented a mix of women from metropolitan and regional communities who each received different program services.
## Appendix 3 Economic appraisal assumptions

### Constant model assumptions

<table>
<thead>
<tr>
<th>Measure</th>
<th>Unit</th>
<th>Assumption</th>
<th>Explanation / reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inflation - Consumer Price Index (CPI)</td>
<td>% p.a.</td>
<td>1.55</td>
<td>Year-on-year (March Q 15 to March Q 16) average of Weighted CPI and Trimmed CPI.</td>
</tr>
<tr>
<td>Discount rate used to determine present</td>
<td>% p.a.</td>
<td>5.61</td>
<td>Based on the lower assumption of a 4% real discount rate (inflated to a nominal rate)</td>
</tr>
<tr>
<td>value - base rate</td>
<td></td>
<td></td>
<td>recommended for economic appraisals in NSW Treasury TPP07-05.</td>
</tr>
<tr>
<td>Discount rate used to determine present</td>
<td>% p.a.</td>
<td>2.52</td>
<td>NSW T-Corp 10 year bond rate, May 2016.</td>
</tr>
<tr>
<td>value - low rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discount rate used to determine present</td>
<td>% p.a.</td>
<td>8.66</td>
<td>Based on the base assumption of 7% real discount rate (inflated to a nominal rate)</td>
</tr>
<tr>
<td>value – high rate</td>
<td></td>
<td></td>
<td>recommended for economic appraisals in NSW Treasury TPP07-05.</td>
</tr>
<tr>
<td>Reduction in mothers’ service utilisation</td>
<td>% p.a.</td>
<td>1.0</td>
<td>Utilisation of all services by mothers is assumed to fall by 1% each year, reflecting</td>
</tr>
<tr>
<td>over time</td>
<td></td>
<td></td>
<td>non-linearity in service utilisation over a lifetime. This trend assumption abstracts</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>away from peaks and troughs that may arise in response to particular events in the</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>mother’s life.</td>
</tr>
<tr>
<td>Cost of MaKM Program</td>
<td>AUD</td>
<td>4,000,000</td>
<td>Annual funding amount.</td>
</tr>
<tr>
<td>Typical age of mother at beginning of</td>
<td>years</td>
<td>23</td>
<td>The median age of mothers in the MaKM cohort to date is 27.5. Advice from expert</td>
</tr>
<tr>
<td>pathway</td>
<td></td>
<td></td>
<td>advisor Dr Phil Boyce (27/06/16) is that the typical mother accessing similar programs</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>is more likely to be in her early twenties. Consequently, 23 was chosen as the typical</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>age.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Measure</th>
<th>Unit</th>
<th>Assumption</th>
<th>Explanation / reference</th>
</tr>
</thead>
</table>
| Life expectancy of women with severe mental illness (MI) at age 23   | years  | 73         | Life expectancy at age 23 (typical MaKM mother’s age) = 85  
See: ABS, 2016, 3302.0.55.001 - Life Tables, States, Territories and Australia, 2012-2014  
Reduction in life expectancy for women attributable to severe mental illness: 12 years  
(See: RANZCP, 2016, The economic cost of serious mental illness and comorbidities in Australia and New Zealand). |
| Average number of mothers in cohort                                 | count  | 23         | 42 mothers exited MaKM in the 22 months to 31 March 2016.  
* 42 / (22/12) = 22.9.  
* Similarly, 22 mothers began and exited MaKM in the 12 months to 31 March 2016. |
| Average number of children in cohort                                | count  | 37         | Average number of children (93) per mother (58) = 1.6 in the MaKM program up to 31 March 2016.  
* 1.6 x 23 = 36.8. |
## Mother and child pathway assumptions

<table>
<thead>
<tr>
<th>Mother / Child</th>
<th>Driver</th>
<th>Measure</th>
<th>Unit</th>
<th>Counterfactual (pre-MaKM)</th>
<th>Intervention (post-MaKM)</th>
<th>Explanation / reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>Inpatient care</td>
<td>Average number of episodes of care</td>
<td>number</td>
<td>0.99 p.a.</td>
<td>0.76 p.a.</td>
<td>Linked data drawn from the APDC dataset; Nous calculations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average length of stay</td>
<td>days</td>
<td>8.3</td>
<td>6.1</td>
<td>Linked data drawn from the APDC dataset; Nous calculations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average adjusted bed day cost</td>
<td>AUD</td>
<td>1,126</td>
<td></td>
<td>Average adult acute inpatient bed day expenditure, AIHW Mental Health in Australia (2013-14) inflated to 2015-16 dollars.</td>
</tr>
<tr>
<td></td>
<td>Ambulatory care</td>
<td>Average number of ambulatory health care contacts</td>
<td>number</td>
<td>51.1 p.a.</td>
<td>19.1 p.a.</td>
<td>Linked data; Data provided by Senior Data Analyst, InforMH on 1 June 2016; Nous calculations.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average cost per contact</td>
<td>AUD</td>
<td>190</td>
<td></td>
<td>Data sourced from the Mental Health Establishments National Minimum Data Set, InforMH, 2013-14 – inflated to 2015-16 dollars.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average number of visits - GP</td>
<td>number</td>
<td>12 p.a.</td>
<td>16 p.a.</td>
<td>Expert advisor suggestion from Phil Boyce (27/06/16).</td>
</tr>
<tr>
<td>Mother / Child</td>
<td>Driver</td>
<td>Measure</td>
<td>Unit</td>
<td>Counterfactual (pre-MaKM)</td>
<td>Intervention (post-MaKM)</td>
<td>Explanation / reference</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td>care – Mental health</td>
<td>Average number of visits - Psychologist</td>
<td>number</td>
<td>12 p.a.</td>
<td>16 p.a.</td>
<td>Expert advisor Phil Boyce (27/06/16) indicated that case management can require up to bi-monthly visits (i.e. 24). The counterfactual assumption halves this figure (i.e. 12) to reflect mothers not receiving or adhering to case management.</td>
<td></td>
</tr>
<tr>
<td>Homelessness – NSW Specialist Homelessness Services</td>
<td>Likelihood of homelessness</td>
<td>%</td>
<td>26.2</td>
<td>5</td>
<td>Counterfactual assumption based on MaKM cohort data received (7/04/16) and email received (3/06/16) from Team Leader, Community Transitions and Connections, MaKM. Intervention assumption small likelihood &gt; 0%.</td>
<td></td>
</tr>
<tr>
<td>Child</td>
<td>Likelihood of OOHC</td>
<td>%</td>
<td>17.6%</td>
<td>11.3%</td>
<td>Linked data obtained from NSW FACS.</td>
<td></td>
</tr>
<tr>
<td>Out of Home Care (OOHC)</td>
<td>Average length of stay</td>
<td>Days</td>
<td>301.6 days</td>
<td></td>
<td>Linked data obtained from NSW FACS. It is the average of the OOHC periods for the children of mothers who were part of the MaKM program and for whom data could be linked. It only represents OOHC based on the 12 month period pre and post MaKM.</td>
<td></td>
</tr>
<tr>
<td>Mother / Child</td>
<td>Driver</td>
<td>Measure</td>
<td>Unit</td>
<td>Counterfactual (pre-MaKM)</td>
<td>Intervention (post-MaKM)</td>
<td>Explanation / reference</td>
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<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average length of stay</td>
<td>days</td>
<td>161</td>
<td></td>
<td>BOCSAR, Criminal Court Statistics - Local Courts, 2014. M: 177 days F: 144 days</td>
</tr>
<tr>
<td>Inpatient care (due to self-harm)</td>
<td></td>
<td>Hospitalisation due to self-harm (male)</td>
<td>%</td>
<td>0 (ages 0-9) 0.01 (ages 10-14) 0.15 (ages 15-17) 0.16 (ages 18+)</td>
<td></td>
<td>AIHW, Suicide and hospitalised self-harm in Australia 2010-11.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospitalisation due to self-harm (female)</td>
<td>%</td>
<td>0 (ages 0-9) 0.08 (ages 10-14) 0.43 (ages 15-17) 0.29 (ages 18+)</td>
<td></td>
<td>AIHW (2014), <em>Suicide and hospitalised self-harm in Australia: trends and analysis</em>. Injury research and statistics series no. 93. Cat. no. INJCAT 169.</td>
</tr>
<tr>
<td>Mother / Child</td>
<td>Driver</td>
<td>Measure</td>
<td>Unit</td>
<td>Counterfactual (pre-MaKM)</td>
<td>Intervention (post-MaKM)</td>
<td>Explanation / reference</td>
</tr>
<tr>
<td>---------------</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Likelihood of inpatient admission (if OOHC)</td>
<td>%</td>
<td>0 (ages 0-9) 0.27 (ages 10-14) 1.74 (ages 15-17) 1.01 (ages 18+)</td>
<td>Calculation based on the above general population hospitalisation rates, and the OOHC risk ratios.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average adjusted bed day cost</td>
<td>AUD</td>
<td>2,302</td>
<td>CAMHS Acute Inpatient 2013/14 provided by NSW InforMH – inflated to 2015-16 dollars.</td>
<td></td>
</tr>
<tr>
<td>Developmental delay</td>
<td></td>
<td>Average length of stay</td>
<td>days</td>
<td>8</td>
<td>Linked data drawn from the APDC dataset; Nous calculations. No inpatient data available for children</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Likelihood of developmental delay</td>
<td>%</td>
<td>31</td>
<td>15.5 • MaKM PEDS data: 31%. • Intervention group assumption is half the likelihood of developmental delay (i.e. 15.5%).</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average number of visits - GP</td>
<td>number</td>
<td>2 p.a. (ages 6-12) 2 p.a. (ages 0-5)</td>
<td>This assumption has been confirmed by Dr Elisabeth Murphy (20/06/16).</td>
<td></td>
</tr>
<tr>
<td>Mother / Child</td>
<td>Driver</td>
<td>Measure</td>
<td>Unit</td>
<td>Counterfactual (pre-MaKM)</td>
<td>Intervention (post-MaKM)</td>
<td>Explanation / reference</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>Average number of visits - Paediatrician</td>
<td>number</td>
<td>2 p.a. (ages 6-12)</td>
<td>2 p.a. (ages 0-5)</td>
<td>This assumption has been confirmed by Dr Elisabeth Murphy (20/06/16).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost of Teacher’s Aide per hour</td>
<td>AUD</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of Teacher’s Aide</td>
<td>number</td>
<td>1 hour a week (ages 6-12)</td>
<td>0</td>
<td>Counterfactual assumes developmental delay is not diagnosed early, requiring school support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cost of School Counsellor per hour</td>
<td>AUD</td>
<td>38</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use of School Counsellor</td>
<td>number</td>
<td>1 hour a week (ages 6-12)</td>
<td>0</td>
<td>Counterfactual assumes developmental delay is not diagnosed early, requiring school support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Average number of Speech Therapist visits</td>
<td>number</td>
<td>10 p.a. (ages 6-12)</td>
<td>10 p.a. (ages 1-5)</td>
<td>Counterfactual assumes developmental delay is not diagnosed early, requiring specialists later on.</td>
</tr>
<tr>
<td>Mother / Child</td>
<td>Driver</td>
<td>Measure</td>
<td>Unit</td>
<td>Counterfactual (pre-MaKM)</td>
<td>Intervention (post-MaKM)</td>
<td>Explanation / reference</td>
</tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Average number of Audiologist visits</td>
<td>number</td>
<td>2 p.a. (ages 6-12)</td>
<td>2 p.a. (ages 1-5)</td>
<td>Counterfactual assumes developmental delay is not diagnosed early, requiring specialists later on.</td>
</tr>
</tbody>
</table>
Appendix 4  Ethical guidelines

Between January and February 2016, Nous submitted ethics applications to three committees to seek approval to conduct participant interviews and access linked data from the Department of Family and Community Services (FACS) and the MoH data sets.

- Nous submitted a National Ethics Application Form (NEAF) to South West Sydney Local Health District (SWSLHD) Ethics Committee on 22 January 2015 for ethics approval to conduct the participant interviews. Nous received approval from SWSLHD ethics committee on 5 April 2016.

- Nous submitted an application to the Aboriginal Health and Medical Research Council (AH&MRC) on 25 January 2016 for ethics approval to conduct the participant interviews. This is due to the higher proportion of Aboriginal and Torres Strait Islander people involved in the MaKM program. Nous received approval from AH&MRC on 15 February 2016.

- Nous submitted an application to NSW Population and Health Services Research Ethics Committee (PHSREC) for approval to access linked data through FACS and the MoH. Nous received approval from PHSREC on 14 April 2016. Nous received data custodian approval for the MoH datasets from MHDAO 24 March 2016 and the data custodian approval for the FACS datasets was received on 30 May 2016.
Appendix 5  Data limitations

Various data issues and limitations have restricted the analysis presented in this evaluation. The main data limitations encountered included:

- limited or no recording of some activities prior to Financial Year (FY) 1667
- inconsistent time periods used in reporting (e.g. monthly, quarterly)
- some activities are measured by the number of sessions, while others are measured by the number of participants accessing the service
- measurement errors resulting from inconsistent reporting of activities by staff
- no recording of activities by package type (e.g. residential vs. in-home/community)
- some measurement tools have limited sample sizes (AUWI, PEDS), lack of clarity around interpretation of results (Pianta), or use out-of-date versions of the measurement tool (NCFAS)
- Interviews were unable to be conducted with Aboriginal and/or Torres Strait Islander participants in the program.

The table below contains an expanded list of the data limitations outlined above. Despite the limitations, MaKM Program staff have worked diligently to help Nous develop the data required to draw meaningful insights from the analysis of MaKM Program service delivery. This activity has had the dual benefit of improving the analysis presented in this report and building a precedent for MaKM Program staff to continue to improve its recording and data collection. Moreover, a recent upgrade to the clinical IT system used by the program, CareLink, is expected to enable the MaKM Program staff to overcome a number of the data limitations that currently exist.

<table>
<thead>
<tr>
<th>Data / variable name</th>
<th>Limitation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>(All) service data by package type</td>
<td>There is no split by package type</td>
<td>The IT system that is used to support service delivery, Carelink, has not had capability to track this split. The system has recently undergone an upgrade and has been tailored to the needs of the MaKM program. Going forward, this split should be able to be tracked.</td>
</tr>
<tr>
<td>(Direct/non-direct) hours by package type</td>
<td>There is no split by package type</td>
<td>The IT system that is used to support service delivery, Carelink, has not had capability to track this split. The system has recently undergone an upgrade and has been tailored to the needs of the MaKM program. Going forward, this split should be able to be tracked.</td>
</tr>
</tbody>
</table>

MaKM Program staff have assured Nous that there is evidence in clinical notes of all activities being delivered.
<table>
<thead>
<tr>
<th>Data / variable name</th>
<th>Limitation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of hours of services delivered to families and carers</td>
<td>Data not recorded</td>
<td>This work has been undertaken since inception of the program. However the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Number and percentage of mothers receiving other home living support</td>
<td>“Activities of daily living support” data only available for Dec Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Dec Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Parent education sessions</td>
<td>Data not recorded before March 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to March 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>Quarterly data available from Jun Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Parent support sessions</td>
<td>Quarterly data available from Jun Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Early childhood check-ups for children</td>
<td>Quarterly data available from Jun Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Home visits</td>
<td>Quarterly data available from Jun Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Data / variable name</td>
<td>Limitation</td>
<td>Explanation</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Facilitating community integration</td>
<td>Quarterly data available from Jun Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Parent education (usage data)</td>
<td>Data not available before April 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to April 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>External playgroup at exit (usage data)</td>
<td>Data not available before March 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to March 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
<tr>
<td>Child care in their local community (usage data)</td>
<td>Data not available before March 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to March 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
</tbody>
</table>
| Additional specialist services (usage data) | 1. Quarterly data available from Jun Q 2015  
2. Inconsistent / gaps in reporting over time | This work has been undertaken since inception of the program. However, prior to March 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past. |
<p>| Travel alone                               | Quarterly data available for Dec Q 2015                                  | This work has been undertaken since inception of the program. However, prior to March 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past. |
| Number of direct hours                     | Quarterly data available from Jun Q 2015                                  | This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past. |</p>
<table>
<thead>
<tr>
<th>Data / variable name</th>
<th>Limitation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of non-direct hours</td>
<td>Quarterly data available from Jun Q 2015</td>
<td>This work has been undertaken since inception of the program. However, prior to Jun Q 2015, the content is only embedded in clinical notes. It has not been recorded in the Carelink system and, therefore, it has not been possible to provide this information in the past.</td>
</tr>
</tbody>
</table>
| MaKM Program participant perspectives | Small sample size and representation of MaKM Program participants, particularly Aboriginal and Torres Strait Islander perspectives | Nous intended on interviewing up to 15 program participants. Following a detailed ethics process, 11 past Program participants expressed an interest in being interviewed. However, only six participants were able to attend the interview. Given the higher proportion of Aboriginal and/or Torres Strait Islander women involved in the MaKM Program, the evaluation intended to include the perspectives of Aboriginal and/or Torres Strait Islander participants. In order to account for this the Nous team undertook the following as part of the interview preparation process:  
  - Nous submitted an application to the Aboriginal Health and Medical Research Council (AH&MRC) and received approval on 15 February 2016  
  - In collaboration with MaKM Program staff, Nous prepared a culturally appropriate interview guide.  
  - Nous drew on the expertise of Gillian Shaw, who has experience working with Aboriginal and Torres Strait Islander people and communities since 1989, to design the interview guide and carry out the interview process. |
| NCFAS | Not latest version of tool | The MaKM Program is using an older, paper-based version of the NCFAS. Staff have indicated that the subscales, particularly parenting skills and child characteristics subscales, are not sensitive enough to capture outcomes. |

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68 The main focus of Gill Shaw’s work has been the issues of health, young people, substance use, and family and domestic violence. In her roles in service delivery and evaluation, she has interviewed many Aboriginal and Torres Strait Islander people about sensitive issues such as petrol sniffing, violence and complex family issues. She has learned to conduct herself respectfully, and with a sense of humour in order to facilitate in depth discussions on deeply personal issues.
<table>
<thead>
<tr>
<th>Data / variable name</th>
<th>Limitation</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pianta</td>
<td>Lack of clarification around measurement</td>
<td>There has been confusion between the consultant administering the Pianta and MaKM staff with respect to how the scores should be interpreted.</td>
</tr>
<tr>
<td>PEDS</td>
<td>1. Self-reported tool</td>
<td>The PEDS tool relies on the mother’s assessment of the child’s needs, which can result in misleading interpretation of outcomes. Additionally, MaKM only recently began administering the tool at both entry and exit into the program.</td>
</tr>
<tr>
<td></td>
<td>2. Historically not administered after child exit from program</td>
<td></td>
</tr>
<tr>
<td>AUWI</td>
<td>Limited sample size</td>
<td>There is a very limited sample size of paired before-after results to assess improvements.</td>
</tr>
<tr>
<td>Counterfactual cohort in economic appraisal consists of the same mothers and children</td>
<td>The mother and child outcomes post-MaKM could be a result of other factors or an event occurring at a similar time to the MaKM Program intervention.</td>
<td>The economic appraisal, as outlined on page 82, notes that the counterfactual cohort consists of the same mothers and children, but is based on information prior to the mothers’ admissions into the MaKM Program. For an evaluation of this size, the time delay in receiving ethics approval for Program participant data prevented the evaluators from exploring options to request additional data on mothers and children who were similar to the MaKM Program cohort but not part of the MaKM Program.</td>
</tr>
</tbody>
</table>
## Appendix 6  Stakeholders consulted

<table>
<thead>
<tr>
<th>Data collection method</th>
<th>Stakeholders</th>
</tr>
</thead>
</table>
| Interviews with nine MaKM Program and MH-CYP representatives and six past Program participants | MaKM Program staff:  
- Penny Mayson - Operations and Clinical Manager  
- Jodie Watson - Operations Assistant  
- Marion Delaney - Team Leader Mental Health Nurse  
- Praveena Rajeswaran - Psychologist, Psychological Therapies Team  
- Lydia McMillan - Team Leader Community Transition & Connections  
- Felicity Webster - Family Coach  
MH-CYP:  
- Tania Skippen  
- Karen Raine  
- Dannielle Byers  
Nous interviewed six Program participants across the following LHDs:  
- Hunter New England  
- North Sydney  
- Sydney  
- Western Sydney |

| Survey of 54 referrer and partner agencies | Of the 54 individuals who received the survey (see below), Nous received 16 responses:  
- Director, Central Coast LHD Mental Health  
- Director, Illawarra Shoalhaven LHD Mental Health  
- A/GM, Nepean Blue Mountains LHD Mental Health  
- Director, Northern Sydney LHD Mental Health  
- A/Director, South Eastern Sydney LHD Mental Health  
- Director, South Western Sydney LHD Mental Health  
- Director, Sydney LHD Mental Health  
- A/Exec Manager, Western Sydney LHD Mental Health  
- Director, Far West LHD Mental Health  
- Director, Hunter New England LHD Mental Health  
- Director, Mid North Coast LHD Mental Health  
- Director, Murrumbidgee LHD Mental Health  
- Director, Northern NSW LHD Mental Health  
- Director, Southern NSW LHD Mental Health  
- Director, Western NSW LHD Mental Health |

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69 Of the 16 responses; 9 responses were from staff in LHDs, 3 were from partners in other government agencies and 4 were from partner non-government agencies.
<table>
<thead>
<tr>
<th>Data collection method</th>
<th>Stakeholders</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Case Worker Newcastle, Family &amp; Community Services (FACS)</td>
<td>• Clinical Leader Perinatal Infant Mental Health/ Safe Start, Murrumbidgee LHD</td>
</tr>
<tr>
<td>• Case Worker Bankstown, Family &amp; Community Services (FACS)</td>
<td>• Social Worker / Clinical Care Coordinator, Liverpool Community Mental Health Team</td>
</tr>
<tr>
<td>• Case Worker Lithgow, Family &amp; Community Services (FACS)</td>
<td>• Clinical Psychologist, Case Manager, Perinatal Infant Mental Health Service , MHDA, Northern Beaches</td>
</tr>
<tr>
<td>• Child Protection Prenatal Caseworker Central Sydney, Family and Community Services (FACS)</td>
<td>• Clinical Nurse Consultant, Illawarra Community Mental Health Service</td>
</tr>
<tr>
<td>• Clinical Leader Perinatal Infant Mental Health/ Safe Start, Murrumbidgee LHD</td>
<td>• Psychologist, Case Manager, Bankstown Mental Health Service</td>
</tr>
<tr>
<td>• Social Worker / Clinical Care Coordinator, Liverpool Community Mental Health Team</td>
<td>• Coordinator/SAFESTART C/L, Perinatal Infant Mental Health Service Northern Sydney</td>
</tr>
<tr>
<td>• Clinical Psychologist, Case Manager, Perinatal Infant Mental Health Service , MHDA, Northern Beaches</td>
<td>• Child &amp; Family Health Nurse, Dubbo Child and Family Health Service</td>
</tr>
<tr>
<td>• Clinical Nurse Consultant, Illawarra Community Mental Health Service</td>
<td>• Case Manager, Perinatal Infant Mental Health Service Illawarra</td>
</tr>
<tr>
<td>• Psychologist, Case Manager, Bankstown Mental Health Service</td>
<td>• NUM, Hoxton Park Child and Family Health Service</td>
</tr>
<tr>
<td>• Coordinator/SAFESTART C/L, Perinatal Infant Mental Health Service Northern Sydney</td>
<td>• NUM Mother Baby Unit or CEO, St John of God, Burwood</td>
</tr>
<tr>
<td>• Child &amp; Family Health Nurse, Dubbo Child and Family Health Service</td>
<td>• St John of God, Burwood</td>
</tr>
<tr>
<td>• Case Manager, Perinatal Infant Mental Health Service Illawarra</td>
<td>• District Senior Social Worker</td>
</tr>
<tr>
<td>• NUM, Hoxton Park Child and Family Health Service</td>
<td>• Team Leader, Partners in Recovery, Richmond PRA</td>
</tr>
<tr>
<td>• NUM Mother Baby Unit or CEO, St John of God, Burwood</td>
<td>• District Clinical Coordinator Perinatal Mental Health / safe start, Western NSW LHD</td>
</tr>
<tr>
<td>• St John of God, Burwood</td>
<td>• Clinical Nurse Consultant, Aboriginal Mental Health Unit</td>
</tr>
<tr>
<td>• District Senior Social Worker</td>
<td>Concord Centre for Mental Health, Sydney Local Health District</td>
</tr>
<tr>
<td>• Team Leader, Partners in Recovery, Richmond PRA</td>
<td>• Senior Social Worker, The Royal Hospital for Women</td>
</tr>
<tr>
<td>• District Clinical Coordinator Perinatal Mental Health / safe start, Western NSW LHD</td>
<td>• Clinical Nurse Consultant</td>
</tr>
<tr>
<td>• Clinical Nurse Consultant, Aboriginal Mental Health Unit</td>
<td>Sydney Local Health District</td>
</tr>
<tr>
<td>• Senior Social Worker, The Royal Hospital for Women</td>
<td>• Chair &amp; Director Perinatal and Women’s Mental Health Unit (PWMHU),</td>
</tr>
<tr>
<td>• Clinical Nurse Consultant</td>
<td>COPMI Sydney Local Health District</td>
</tr>
<tr>
<td>• Chair &amp; Director Perinatal and Women’s Mental Health Unit (PWMHU),</td>
<td>• CNC Perinatal &amp; Family Drug Health, South Western Sydney Local Health District</td>
</tr>
<tr>
<td>• CNC Perinatal &amp; Family Drug Health, South Western Sydney Local Health District</td>
<td>• Senior Client Service Officer Specialist, Department of Family and Community Services</td>
</tr>
<tr>
<td>• Senior Client Service Officer Specialist, Department of Family and Community Services</td>
<td>Housing Services South Western Sydney District (Focused on Housing, based in Bankstown)</td>
</tr>
<tr>
<td>• Southern Cross Housing</td>
<td>• Caseworker, Samaritans Foundation (Specialist Homelessness Service)</td>
</tr>
<tr>
<td>• Diabetes Educator, Dubbo Diabetes Service</td>
<td>• PHAMS, Benevolent Society</td>
</tr>
<tr>
<td>• PHAMS, Benevolent Society</td>
<td>• Manager, Liverpool Women’s Resource Centre</td>
</tr>
<tr>
<td>• Manager, Liverpool Women’s Resource Centre</td>
<td></td>
</tr>
<tr>
<td>Data collection method</td>
<td>Stakeholders</td>
</tr>
<tr>
<td>------------------------</td>
<td>--------------</td>
</tr>
</tbody>
</table>

- City and Country Community Engagement Officer, Liverpool, Fairfield and Cabramatta Federal Department of Human Services (Centrelink)
- Caseworker, Wesley Brighter Futures Nepean
- Manager, Food For Life
- Support Coordinator, Dial an Angel
- Financial Counsellor, Wesley Counselling Services - Kingswood
- Operations Manager, Wesley Community Housing, Wesley Mission
- Family Support Worker, Miller Pathways, Mission Australia
- Psychologist, Institute for Healthy Living
- Director of Social Work/Psychology Services, Tresillian
- President, Dandelion Support Network

Focus group attendees included:

**Tuesday 5 April**
- Parent and Infant Mental Health Coordinator, Northern Sydney
- Safe Start, South Eastern Sydney
- Nurse Manager for CAMHS Service, Hunter New England
- Clinical Leader Perinatal Infant Mental Health, Murrumbidgee
- Mental Health Services, Northern NSW
- Maternity Unit Manager, Far West NSW
- Acting Director, Mental Health Drug and Alcohol, Far West NSW

**Wednesday 6 April**
- Director, Mental Health, Central Coast
- Perinatal Mental Health Service Clinician, South West Sydney
- Child and Family Health Nurse, Western NSW

**Thursday 7 April**
- Perinatal Mental Health Liaison Midwife, Nepean Blue Mountains
- Coordinator Promotion Prevention Early Intervention, Mental Health Drug and Alcohol, Southern NSW
- Director of Nursing, St John of God Burwood Hospital
- Clinical Nurse Consultant Children of Parents with Mental Illness, Sydney
- Team Leader, Women and Children’s Health, Sydney
- District Clinical Coordinator Perinatal Mental Health, Western NSW
- Karitane Parenting Centre Liverpool, South West Sydney

3 focus groups with 17 referrer and partner agencies representatives
## Appendix 7  Overview of MaKM programs

<table>
<thead>
<tr>
<th>Service</th>
<th>Purpose</th>
<th>Activities involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood check-ups for children</td>
<td>To ensure healthy development of the children in the program.</td>
<td>These include baby health check-ups conducted by Early Childhood Nurses from external organisations such as Karitane, the Community Health Centre (Hoxton Park) and also include organised visits to external services.</td>
</tr>
<tr>
<td>Additional specialist services</td>
<td>To ensure that each mother and her children are provided with tailored packages of care that meet the mother’s individual needs.</td>
<td>This refers to the number of mothers who were provided with referrals to additional specialist services, including paediatricians, speech pathologists or lactation specialists</td>
</tr>
<tr>
<td><strong>Mental Health support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychoeducation</td>
<td>To help empower mothers manage their condition in an optimal way.</td>
<td>This refers to educational sessions provided to mothers in a group/individual setting on a range of topics relating to mental health and general well-being. May occur in the mother’s natural setting on a daily basis. Also occurs in weekly group sessions where MaKM provides a healthy lifestyle group including exercise, health topic discussions and cooking</td>
</tr>
</tbody>
</table>
| Focussed Psychological strategies | Focussed psychological strategies delivered by Family coaches (allied health professionals) in the mother’s natural setting to help improve her mental health and strengthen coping skills. | 1. **Motivational interviewing**  
2. **Cognitive-behavioural interventions** including: Behavioural interventions, Exposure techniques, Activity scheduling, Cognitive interventions  
3. **Relaxation strategies** including: Progressive muscle relaxation, Controlled breathing  
4. **Skills training** including: problem solving skills, anger management training, social skills training, Communication training, stress management |
<p>| Psychological therapy sessions   | To improve mother’s mental health e.g. process trauma to improve individual functioning and strengthen parenting capacity | Individual or group therapy sessions delivered by the psychological therapies team (clinical psychology registrars). These are predominantly centred within a DBT framework; however also draw from Cognitive Behavioural and Acceptance and Commitment Therapy models. Weekly individual sessions as well as |</p>
<table>
<thead>
<tr>
<th>Service</th>
<th>Purpose</th>
<th>Activities involved</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Weekly group therapy sessions</strong></td>
<td></td>
<td>weekly group therapy sessions</td>
</tr>
<tr>
<td><strong>Parenting and skills development</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Supported playgroup sessions</strong></td>
<td>To develop parenting skills and support the healthy development of children.</td>
<td>Supported playgroup sessions include informal sessions which mothers and their children participate in. These sessions occur onsite at least once a week.</td>
</tr>
<tr>
<td><strong>Home visits</strong></td>
<td>To improve mother’s mental health and strengthen parenting and independent living skills.</td>
<td>This includes visits to mothers’ homes in the community to provide coaching, conduct Cognitive Behavioural Therapy (CBT) and other therapeutic interventions, and early childhood coaching.</td>
</tr>
<tr>
<td><strong>Parent support sessions</strong></td>
<td>To develop parenting skills.</td>
<td>Refers to any informal and practical parenting strategies modelled to the parents (e.g. settling, feeding, wrapping baby). This activity takes place in the mother’s natural setting e.g. her home and may be delivered by any of the trained MaKM team members.</td>
</tr>
<tr>
<td><strong>Parent education sessions</strong></td>
<td>To strengthen parenting skills.</td>
<td>Parent education sessions refer to parenting sessions delivered in a group or individual setting that have a theoretical basis.</td>
</tr>
<tr>
<td><strong>Community engagement</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Child care in the local community</strong></td>
<td>MaKM sets up for mothers exiting the program</td>
<td>Local childcare in the mother’s community</td>
</tr>
<tr>
<td><strong>External playgroup at exit</strong></td>
<td>MaKM sets up for mothers exiting the program</td>
<td>Playgroup for children in the mother’s community</td>
</tr>
<tr>
<td><strong>Facilitating community integration</strong></td>
<td>To provide mothers with every opportunity to fully participate in community life by linking them and their families to various local resources and services.</td>
<td>The number of links and/or supported introductions made to local and other relevant community services/resources to help meet the needs of each mother and her family e.g., supporting mothers’ first visit to a local playgroup, addressing housing and financial issues). This also includes number of referrals made.</td>
</tr>
<tr>
<td><strong>Other support</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Peer consultation</strong></td>
<td>To instil hope and promote recovery.</td>
<td>This refers to the number of mothers who engaged with MaKM’s peer support worker.</td>
</tr>
<tr>
<td><strong>Social group sessions</strong></td>
<td>To help parents in the program develop their social skills, increase connectedness and reduce</td>
<td>Social group sessions include social gatherings, for example, Mothers and Bubs breakfasts/morning teas and Family Fun Days. These social gatherings are</td>
</tr>
<tr>
<td>Service</td>
<td>Purpose</td>
<td>Activities involved</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-------------------------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td></td>
<td>isolation.</td>
<td>informal These sessions occur onsite at least once week.</td>
</tr>
<tr>
<td>Activities of daily living support</td>
<td>Improve daily living skills in an informal, ad-hoc basis.</td>
<td>Activities include any informal activity supporting the mother in her daily living skills. For example, cooking a meal, developing a family routine, assistance with and attending a shopping trip (activities that exclude a focus on parenting support). These activities could go from 15min to a few hours at a time.</td>
</tr>
</tbody>
</table>
## Appendix 8  Analysis of programs with comparable elements

<table>
<thead>
<tr>
<th>Program</th>
<th>Mums and Kids Matter</th>
<th>Doorways</th>
<th>Women and Children’s Program, Richmond PRA</th>
</tr>
</thead>
</table>
| Services provided, e.g. mental health education, parenting skills, drug and alcohol education, child education, housing stability, employment opportunities | Focused psychological strategies, psychological therapy sessions, parent education sessions, psychoeducation, parent support sessions, supported playgroup sessions, social group sessions, early childhood checkups, home visits | Doorway supports individuals to find suitable and affordable housing in the private rental market, maintain their tenancy, develop life skills for the long term and gain employment. Doorway provides a Housing and Recovery Worker who supports participants to:  
• find a suitable, affordable home in the private rental market  
• maintain their tenancy, utility payments and property  
• look at how they could pay their rent independently  
• develop their skills to manage their mental illness and plan for the future, including finding employment  
• get involved in local activities and build connections in their community to support their tenancy and their recovery.  
Mental health education, housing stability, employment opportunities | RichmondPRA’s Women and Children’s Program gives mothers experiencing a mental illness safe and stable accommodation and support, enabling them to recover with their children by their side. Includes parenting skills predominantly and a psychologist who visits fortnightly |
| Day entry method, e.g. residential, home visits, day education programs | Residential for up to three months, community care packages (delivered in people’s homes) and inpatient services | Doorway is a housing program for people who are homeless or at risk of homelessness. Residential! | Residential services up to three months |
| Geographic reach, e.g. One location, multiple locations, state wide, national, overseas | One residential location, community care NSW state wide | Housing is provided within the following catchment areas in Victoria: Alfred Health, Latrobe Regional Hospital, Peninsula Health or St Vincent’s Mental Health Limited locations based on health catchment area | Residential program is in Western Sydney (Blacktown) |
| Eligibility, e.g. severe mental illness, referred from health case manager, mother with a child | Mothers must have a severe and persistent mental health illness, have a dependent child under 5 years old, be referred through health care pathway | To be eligible for referral to the Doorway program an individual must:  
• be homeless or at risk of homelessness  
• have a serious mental illness  
• have a current case manager at either Alfred Health, Latrobe Regional Hospital, Peninsula Health or St Vincent’s Mental Health  
• want to live within one of the catchment areas of the above health services  
• accept support by meeting weekly with their Housing and Recovery Worker to work on their tenancy and recovery goals  
• give consent for de-identified results of assessments they complete being used for research  
Serious mental illness, health manager | To be eligible, mothers must have * a mental illness (including a serious mental illness)  
• a dependent child in their care  
• be homeless or at risk of homelessness |
<p>| Referral reach, e.g. state wide or specific to LHD | Participants can be referred from any LHD in NSW | Referrals are specific to specific catchment areas | Participants can be referred from all over NSW, but they must prioritise mothers from Western Sydney (LHD) |</p>
<table>
<thead>
<tr>
<th>Program</th>
<th>Newpin</th>
<th>Jade House, Karitane</th>
<th>Tresilian</th>
</tr>
</thead>
</table>
| Services provided, e.g. mental health education, parenting skills, drug and alcohol education, child education, housing stability, employment opportunities | * Specialises in engaging parents whose children are in the NSW foster/kinship care system.  
* Works with families for 9 months prior to restoration then up to nine months post-restoration  
* An 18-month intensive centre-based parenting program or a one-term intensive group work course that guides parents the insight, skills and support to improve their parenting  
* Counselling and group work on family relationship issues  
* Structured play sessions where parents and children learn to play together and develop attachment with the support of staff  
* Daily support for newborns or toddlers to help them acquire social and gross motor skills  
* School preparation support for four year olds  
No residential component, focus on parenting skills and support, no focus on mental health training | Overnight residential stays provide an intensive program that guides parents through difficult parenting issues with the support of qualified Child and Family Health Nurses, paediatricians, psychiatrists and social workers. Day services are for those with perinatal mental health issues, such as depression and anxiety  
**Parenting skills, depression and anxiety (not specific to severe mental health)** | Tresilian Outreach is a free child and family health home visiting service that provides a maximum of three visits to families with adjustment to parenting issues and associated parenting difficulties.  
**Parenting skills** |
| Delivery method, e.g. residential, home visits, day education programs | The family attends a Newpin Centre for a minimum of two days per week for 18 months | Residential for four nights, | Two locations, Canterbury and Woolstoncroft |
| Geographic reach, e.g. One location, multiple locations, state wide, national, overseas | Newpin programs operate across Australia in NSW (5), ACT (1), Western Australia (1), Tasmania (3) and Victoria (2) | Residential Units are located at Carramar and Camden, both of which are in the southwest of the Sydney greater metropolitan area | Service is available to those families that reside in the inner West and Lower North Shore areas of Sydney |
| Eligibility, e.g. severe mental illness, referred from health case manager, mother with a child | Cohort of new mothers experiencing issues such as isolation, mental illness, family violence, social disadvantage, low self-esteem | People must 1) live in Western Sydney Local Health District (WSLHD) 2) be pregnant or have a child aged up to 12 months 3) be well during the stay for the program to be effective | Service is available to those families that reside in the inner West and Lower North Shore areas of Sydney |
| Referral reach, e.g. state wide or specific to LHD | *Parents are referred through Community Services, Mental Health providers and other sources.  
* Families must face actual or potential child protection issues | Referral from a health care professional, such as a Child and Family Health Nurse or doctor | Referral from a health professional such as Child and Family Health Nurse or local Doctor is required (inner west or lower north shore) |
<table>
<thead>
<tr>
<th>Program</th>
<th>Mental Health Positive Parenting</th>
<th>Mother and Child Program, Portage, Canada</th>
<th>Mother and Child Residential Services, Phoenix House USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services provided, e.g. mental health education, parenting skills, drug and alcohol education, child education, housing stability, employment opportunities</td>
<td>A 10-week skills-based parenting intervention tailored for parents who have mental health problems. It consists of a 6 week group parenting program followed by 4 weekly home visits. It was established in 2005.</td>
<td>The program allows mothers with young children and pregnant women suffering from drug addiction to maintain child custody while in treatment. Services provided include:</td>
<td>Phoenix House offers comprehensive and professional drug and alcohol addiction treatment services for pregnant women and mothers and their young children in residential settings. Services include parent coaching, child development education, relapse prevention skills, and recovery training. Phoenix House Mother and Child and Family Treatment programs may also provide outpatient services. Additional services may include: dental and mental health care, case management, supervised recreational activities and vocational training. Residential, parenting skills, child development education, some mental health care</td>
</tr>
<tr>
<td>Delivery method, e.g. residential, home visits, day education programs</td>
<td>Day programs for 10 weeks, followed by four weeks of weekly home visits</td>
<td>Residential, for 6-8 months</td>
<td>Residential</td>
</tr>
<tr>
<td>Geographic reach, e.g. One location, multiple locations, state wide, national, overseas</td>
<td>Specific to Central Coast</td>
<td>One location in Montreal</td>
<td>One location in New York</td>
</tr>
<tr>
<td>Eligibility, e.g. severe mental illness, referred from health case manager, mother with a child</td>
<td>Tailored to mothers with a dependent who have a mental health illness.</td>
<td>The program is intended for pregnant women and mothers with substance abuse problems along with their young children. The mother can have up to two children with her, aged between 0 and 6 years</td>
<td></td>
</tr>
<tr>
<td>Referral reach, e.g. state wide or specific to LHD</td>
<td>Program is specific to Central Coast region</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Program</td>
<td>Forty Carrots</td>
<td>Holding Tight, Finland</td>
<td></td>
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<tr>
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<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Parenting Program: Forty Carrots’ Kane Campus on Tuttle Avenue houses our</td>
<td>The main target audiences of the activity are substance abusing pregnant women and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Parenting Center where we offer a wide variety of classes each week that</td>
<td>families with infants, both babies and parents. The program offers specialised</td>
<td></td>
</tr>
<tr>
<td></td>
<td>provide opportunities for parents and their children to learn and grow</td>
<td>treatment for pregnant mothers and mothers with small babies, in order to create</td>
<td></td>
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<td></td>
<td>together. From unique parent/child play experiences to evening classes for</td>
<td>a safer growth environment for the baby.</td>
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<tr>
<td></td>
<td>adults needing help with discipline strategies for their children, family</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>bonds are truly nourished.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>* Child and Family Therapy: Forty Carrots offers a range of therapeutic</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>services to families and children, as well as adolescents. Through child and</td>
<td></td>
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<tr>
<td></td>
<td>family centered approaches we serve young children who are demonstrating</td>
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<tr>
<td></td>
<td>social, emotional, developmental and/or behavioral problems including infant</td>
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<tr>
<td></td>
<td>mental health, depression and anxiety, challenging behaviours etc. Parenting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>training, child and adolescent mental health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>Day programs</td>
<td>Residential for 6-12 months, followed by outpatient services</td>
<td></td>
</tr>
<tr>
<td>method</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic</td>
<td>One location in Sarasota, USA</td>
<td>One location, followed by outpatient services</td>
<td></td>
</tr>
<tr>
<td>reach</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eligibility</td>
<td>Drop in classes, targeted at specific ages of children but otherwise no</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>criteria</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral</td>
<td>Drop in service and no registration required, $10/family</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>reach</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<nousgroup.com>
Appendix 9  Goal Setting Tool

To be completed with each mother:

**Part 1**
Mother’s Name: ___________________________         Date: ___________________________

<table>
<thead>
<tr>
<th>Housing/Financial/Legal</th>
<th>Very Important</th>
<th>Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important to you is help to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arrange secure, safe and stable housing?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sort out your finances and budgeting?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Organise arrangements with Centrelink?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Save some money?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sort out legal issues?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Identify one key goal in this category:

<table>
<thead>
<tr>
<th>Vocational</th>
<th>Very Important</th>
<th>Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important to you is help to:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Train or study?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Obtain work?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Identify one key goal in this category:

<table>
<thead>
<tr>
<th>Health</th>
<th>Very Important</th>
<th>Important</th>
<th>Not Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>How important to you is help to:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Improve your physical health? ☐ ☐ ☐
Improve your eating and nutritional habits? ☐ ☐ ☐
Manage your medication? ☐ ☐ ☐
Improve your mental health? ☐ ☐ ☐
Manage unhelpful feelings / thoughts / behaviours? ☐ ☐ ☐
Improve the way you feel about yourself? ☐ ☐ ☐
Manage any addiction issues (Drug/alcohol/gambling etc.)? ☐ ☐ ☐
Deal with any experiences of domestic violence and/or help avoid future experiences of it? ☐ ☐ ☐
Deal with any grief or trauma experiences? ☐ ☐ ☐

Identify one key goal in this category:

Skills

How important to you is help to:

Improve your daily living skills? ☐ ☐ ☐
Improve your parenting skills? ☐ ☐ ☐
Improve your social skills? ☐ ☐ ☐

Identify one key goal in this category:

Relationships

How important to you is help to:

Improve your relationship with your child/children? ☐ ☐ ☐
Improve relationships with family members? ☐ ☐ ☐
Improve other relationships? ☐ ☐ ☐
Improve your relationship with key services like FACS, Community Mental Health etc.? ☐ ☐ ☐
Develop new social networks? ☐ ☐ ☐

Identify one key goal in this category:

Other

How important to you is help to: 
Part 2

When you think about the changes that you will need to make, you are confident:

<table>
<thead>
<tr>
<th>Change</th>
<th>Very Confident</th>
<th>Confident</th>
<th>Not Confident</th>
</tr>
</thead>
<tbody>
<tr>
<td>You will learn what you need to learn</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You will develop and practise new skills</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You will make lifestyle changes</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You will think and feel differently</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>You will change your behaviour</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Part 3

Please leave this section blank – Mums and Kids Matter staff to complete:

1. 

2. 

3. 
## Appendix 10 Grouping of MaKM Mental Health Diagnoses

<table>
<thead>
<tr>
<th>Anxiety disorders</th>
<th>Mood disorders</th>
<th>Substance use disorders</th>
<th>Personality disorders</th>
<th>Trauma</th>
<th>Psychotic disorders</th>
<th>Eating disorders</th>
<th>Developmental disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obsessive compulsive disorder (OCD)</td>
<td>Bipolar affective disorder (BAD)</td>
<td>Drug induced psychosis</td>
<td>Borderline Personality Disorder (BPD)</td>
<td>Complex trauma</td>
<td>Schizophrenia</td>
<td>Eating disorder</td>
<td>Attention Deficit Hyperactivity Disorder (ADHD)</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Depression</td>
<td>Substance abuse</td>
<td>Borderline traits</td>
<td>Post-traumatic stress disorder (PTSD)</td>
<td>Postpartum psychotic episode</td>
<td>Bulimia</td>
<td></td>
</tr>
<tr>
<td>Social phobia</td>
<td>Chronic depression</td>
<td>Cluster B traits</td>
<td>Complex PTSD</td>
<td>Postpartum psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generalised anxiety disorder (GAD)</td>
<td>Major depression</td>
<td></td>
<td>Childhood trauma</td>
<td>Paranoid schizophrenia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustment disorder</td>
<td>Perinatal depression</td>
<td></td>
<td></td>
<td>Schizoaffective disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Panic attacks</td>
<td></td>
<td></td>
<td></td>
<td>Psychosis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

70 Disorders in this cluster share problems with impulse control and emotional regulation.
Appendix 11 Care Planning Checklist

Mother’s Name:

MaKM Packages

<table>
<thead>
<tr>
<th>Date</th>
<th>Package</th>
<th>Date</th>
<th>Package</th>
<th>Date</th>
<th>Package</th>
<th>Date</th>
<th>Package</th>
<th>Date</th>
<th>Package</th>
<th>Date</th>
<th>Package</th>
<th>Close</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mental and Physical Health and Wellbeing

Clinical Diagnosis(es):

Mother’s management of her mental illness:

Yes = compliance
No = noncompliance
<table>
<thead>
<tr>
<th>Compliance with medication and treatment plan</th>
<th>Upon entry Y/N</th>
<th>Details/comments</th>
<th>Upon exit Y/N</th>
<th>Details/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compliance with MaKM care plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seeks assistance when unwell (e.g. compliance with safety plan)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**While in the Mums and Kids Matter program, did mother attend?**

<table>
<thead>
<tr>
<th>Health needs</th>
<th>Y/N</th>
<th>If Yes, enter date</th>
<th>Details/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>A full health screening</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A GP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A dentist (or, in the last 12 months)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A women’s health/sexual health clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Additional specialist services appointments (mother or child/ren)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Early childhood check-ups (child/ren)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Psychosocial factors**
<table>
<thead>
<tr>
<th>Local community connections</th>
<th>Upon entry</th>
<th>Details/comments</th>
<th>At exit</th>
<th>Details/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early childhood education (childcare)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Playgroup</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public library</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreation facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Organised sport / exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Group / class to foster special interests – dance, crafts</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other community group activity</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>