SPRC UNSW Social Policy Research Centre

Evaluation of the Home and Healthy Program

Prepared for the New South Wales Department of Communities and Justice

February 2023

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Acknowledgements

Thank you to the evaluation participants from Mission Australia, NSW Health, NSW Department of Communities and Justice and the NSW Office of Social Impact Investment who contributed their views to the report. Special thanks to clients of the Home and Healthy program who participated in interviews to share their lived experiences with the research team.

Thanks also to Michael Fotheringham, Australian Housing and Urban Research Institute (peer reviewer).

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Disclaimer

This Evaluation Report includes discussion and analysis around the Home and Healthy program's payable outcomes under the agreements between the Department of Communities and Justice and the service provider. It acknowledges feedback from stakeholders that there is a difference regarding payable outcomes compared to client outcomes/goals set out within the client support plan. Stakeholders involved in the delivery of the program were consulted on the contents of this report. Where possible, this evaluation report notes where stakeholders hold or have held differing views to those expressed throughout this document.

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The Social Policy Research Centre is based in the Faculty of Arts, Design and Architecture at UNSW Sydney. This report is an output of the Home and Healthy Evaluation research project, funded by the New South Wales Department of Communities and Justice.

Suggested citation:
Blunden, H, Mao, L., Bates, S., and Katz, I. (2023). Evaluation of the *Home and Healthy Program: Final Report,* Sydney: UNSW Social Policy Research Centre.

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Abbreviations

AAEH	Australian Alliance to End Homelessness
ABS	Australian Bureau of Statistics
AIAD	Australian Index of Adolescent Development
AOD	Alcohol and Other Drugs
AMS	Aboriginal Medical Service
CALD	Culturally and Linguistically Diverse
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CBA	Cost benefit analysis
CE	Coordinated Entry
CHAT	Community Housing Assessment Tool
CHP	Community Housing Provider
CLS	Community Living Supports
CIMS	Client Information Management System
DCJ	NSW Department of Communities and Justice
DESC VAT	Downtown Emergency Service Centre Vulnerability Assessment Tool
DFV	Domestic and family violence
DSP	Disability Support Pension
FACSIAR	DCJ Family and Community Services Insights, Analysis and Research
FG	Focus group
F-SPDAT	Families - Service Prioritization Decision Assistance Tool
HASI	Housing and Accommodation Support Initiative
H&H	Home and Healthy
HREC	Human Research Ethics Committee
HUD	Department of Housing and Urban Development
K-10	K-10 Kessler psychological distress scale
KPI	Key performance indicator

KRC	Kirketon Road Clinic
JWG	Joint Working Group
MA	Mission Australia
NDIS	National Disability Insurance Scheme
NDT	New Directions Team
NGOs	Non-government organisations
OSII	Office of Social Impact Investment
PISCF	Participant Information Statement and Consent Form
PWI-A	Personal Wellbeing Index – Adult
RFT	Request for tender
RFP	Request for proposal
RPAH	Royal Prince Alfred Hospital
SATT	Short Assessment Triage Tool
SHPP	Stable Housing Pilot Project
SLHD	Sydney Local Health District
SESLHD	South-East Sydney Local Health District
SHS	Specialist Homelessness Services
SII	Social Impact Investment
SOMIH	State Owned and Managed Indigenous Housing
SPDAT	Service Prioritization Decision Assistance Tool
SVHN	St Vincent Hospital Network
TAY	Transition Age Youth Triage Tool
USS	Universal Screening and Support Service program
VAT	Vulnerability Assessment Tool
VI-SPDAT	Vulnerability Index - Service Prioritization Decision Assistance Tool
Y-SPDAT	Youth - Prioritization Decision Assistance Tool

1 Executive Summary

1.1 The evaluation

The NSW Department of Communities and Justice (DCJ) appointed a team from UNSW to evaluate the pilot of the Home and Healthy (H&H) program. The program was part of the NSW Homelessness Strategy 2018-2023.

The evaluation commenced in June 2020 and concluded in July 2022. It included implementation, process, and outcome elements. The evaluation outputs included an evaluation plan, a revised Program Logic, and a final report (this report). The final report focuses on the key evaluation elements, includes a review of existing tools used to assess complexity of need and triage persons experiencing homelessness, and discusses what lessons can be learned from this pilot program for future similar programs.

1.2 The context

The NSW Government's Homelessness Strategy 2018-2023 outlines a "framework for action that will enable government agencies, the non-government sector, and the community to collaborate and act to reduce the impact of homelessness on individuals and improve outcomes for people and families" (NSW Government, 2018). It included an initial investment of $61 million of new funding over four years.

As part of this $61 million expenditure, $20 million was allocated for a homelessness social impact investment (NSW Government, 2018). Social impact investment (SII) is investment intending to generate social and financial returns, while actively measuring both (SIIT 2014; GIIN 2016, cited in Muir et al., 2018). Under the SII model used in NSW, services receive both a base payment and payments linked to achieving certain outcomes (based on KPIs codified into the service delivery contract).

The H&H program was a SII under the NSW Homelessness Strategy 2018-2023, which commenced on 1 July 2019 and ran until 30 June 2021. It was not extended beyond the pilot phase. The purpose of the H&H program was to reduce the prevalence and impacts of homelessness for people exiting health facilities in NSW and aimed to prevent people exiting health facilities in the Sydney and South Eastern Sydney Local Health Districts (LHD) into homelessness. Its target cohort were people aged 18-65 exiting or engaged with a hospital or community health service who are at risk of or experiencing homelessness.

The program was delivered by Mission Australia (MA) who were the successful tenderers. The program's core approach was to intercept people in hospital/mental health and AOD settings, picking up those who may otherwise not be encountered by a service. Casework support was offered for up to 24 months. Outcomes were assessed according to goals being reached for set periods (e.g., 3, 6, 12, 18, 24 months).

The Service Delivery Agreement specified base payments plus payments per result for specified outcomes (for example, a client maintaining a tenancy for 3 months). Key performance indicators and linked payments were specified in the agreement between the parties. The intent of the pilot was to test whether increased investment would produce better outcomes than 'business as usual' (BAU), as typified by the collectivity of government services and programs, including the Specialist Homelessness Service (SHS) program. The SHS program is grants-based, and while monitoring of outcomes is part of the contract review process, funding is not linked to achieving specific client outcomes.

A total of 227 clients engaged with the H&H program, of whom two-thirds were male, a fifth were Aboriginal, a quarter were from Culturally and Linguistically Diverse (CALD) backgrounds, and the median age was 44.

1.3 H&H pilot program outcomes

The H&H program had nine payable outcomes with four of those related to housing, while the rest related to employment, training and structured activities, as well as a (non-payable) health goal.

Participants achieved mainly short-term housing and health goals, however, most (134) did not achieve a program outcome during the 24 month pilot. The NSW Government and Independent Certifiers' Report (BDO, 2021) noted the program did not meet stated objectives to an adequate level based on performance metrics. The early closure of the program was a significant factor in this. Outcomes are summarised below (and reported on in detail later in the report).

Housing

- 41 per cent reached at least one housing goal (i.e. remained in a tenancy for a specified time period).

Health

- 79 per cent reached a health goal (i.e. connected with a General Practitioner or other clinical support).

Employment

- One (0.1 per cent) reached an employment goal (i.e. obtained employment, or increased employment hours by 14+ hours, for a specified period of time).

Education

- None (0 per cent) reached an education or training goal (i.e. completed an approved education or training course).

Structured activity

- None (0 per cent) reached a structured activity goal (i.e. participated in an approved structured activity for a specified period of time).

No payable goals

- 59 per cent did not reach any payable goal (i.e. health goal excluded).

1.4 Methods

The evaluation used a mixed methods design including the following data collection method/s:

1. Program and other document review

2. Interviews with clients (n=12)

3. Interviews and focus groups with stakeholders (NSW Government agencies: n=16; Mission Australia: n=5; total n = 21)

4. Analysis of client data (from the Client Information Management System) (n=227), cross referenced with the Independent Certifiers' Report (BDA, 2021).

1.5 Findings

The key lines of inquiry and major findings are summarised below.

1. How well did the program reach and engage the target population?

   The H&H program targeted persons at risk of experiencing homelessness in health facilities (hospitals, mental health units, and drug and alcohol treatment facilities).

   - The program did reach and engage with the target population effectively. Clients were recruited in health settings, and faced multiple challenges related to housing, health and mental health, and other issues like substance use.

   - Based on MA CIMS client data supplied to the evaluators, 280 persons were referred into the H&H program, and of these, 227 were assigned to the program as of 30 June 2021. 80 per cent of the clients assigned to the program had medium-high to high intensity support needs (as defined by the support level checklist in the referral form in the H&H Operations Manual).

   - About half of the 227 clients assigned to the program were over 45 years of age (median = 44, standard deviation = 11). Nearly two-thirds were male. About one-fifth of the clients were Aboriginal. Close to one quarter had Culturally and Linguistically diverse backgrounds (CALD).

   - Close to one-third of the clients reported past or current experiences of domestic and family violence. Most clients (84 per cent) reported having disabilities, mostly related to mental health or psychiatric conditions (65 per cent).

   - Compared with SHS clients, the cohort appeared to be more disadvantaged, older, more likely to be male, unemployed or on the Disability Support Pension (DSP), or from a CALD background.

Overall, the clientele was highly socio-economically disadvantaged with extra burdens of chronic illnesses (physical and mental), co-morbid substance use issues, and mental health disorders.

2. Were the anticipated numbers of referrals received against the predicted number of referrals and dropout rate?

Program entrants were consistent with eligibility criteria: 227 out of the 280 referred (81 per cent) were assigned to the H&H program. The program's pilot phase was intended to support 173 clients in Year 1 and 136 in Year 2, however the overall client number was 227 (73 per cent of the 309 clients expected). This may have been due to the fact that MA stopped taking referrals in May of that year, and reported there was a lower than anticipated program drop-out rate, which resulted in less spaces becoming available.

3. How well was the program implemented as initially designed by Mission Australia in response to the RFP, and adapted as needed to achieve the objectives agreed by the parties and specified in the contract?

The program was implemented as agreed. It targeted persons in health settings and built up a client base. Changes were made to the model based on the high and complex support needs of the cohort and in discussion with Joint Working Group members. In terms of components and activities, components/activities that were delivered versus what was designed is detailed in 'Table 10: Program logic components and components only partially or not implemented/reached'. Of note were several deviations from the model:

- The original program logic required a mental health specialist worker. Based on the needs of the cohort in the program, MA made the decision to employ a housing specialist worker in place of the mental health specialist worker. MA's experience was that due to the significantly complex support needs of the cohort many clients already had clinical supports in place, or could access these with support from the program, and that rapid access to housing was identified as a more urgent need.

- No specialist employment support worker was employed. Again, based on the significant support needs of the cohort in the program, MA determined that most clients' complex and chronic health needs meant they would be unable to gain employment. In light of this, MA decided that a specialist housing worker who could rapidly access and secure housing options was more valuable for the program.

- A specialist housing support worker, not included in the original design, was prioritised for the reasons stated above.

- Due to the fact that goals were not being met to adequate payment levels, and the administrative load on both staff and clients to evidence outcome achievement, the parties made adaptations to the way outcomes were documented (such as verification of tenancy maintenance via a statement form a housing caseworker).

- Due to the unanticipated number of referrals of clients with high needs, MA and the Joint Working Group decided to work with NSW Health contacts to recruit clients with lower needs.

  It is not clear how consistently clients' wellbeing was tracked using the Personal Wellbeing Index – Adult (PWI-A) tool or other tools. MA assessed clients quarterly using the Camberwell Assessment of Need Short Appraisal Schedule (CANSAS). MA reported its support workers found it difficult to engage with clients to complete the PWI-A.

4. To what extent did the program meet the needs of participants as set out in participants support plans and their individual program goals?

The H&H program was structured around assessing client needs and then setting goals in various domains. The researchers note that clients had many and varied goals that MA assisted with, but not all of these were payable goals. Table 1 below summarises achievements related to the payable goals relating to housing, employment, structured activities and health, for which data was available for.

Table 1: Clients' payable goal achievements - numbers and percentages

	Sustained Independent Housing		Sustained Non-Independent Housing		Sustained Employment			Engaged in Structured Activity/s (64 Hours)	Engaged with GP/ other clinical supports
	3 Months	12 Months	3 Months	12 Months	13 Weeks	26 Weeks	52 Weeks		
Achieved this goal - number	39	14	61	18	1	1	0	0	179
Achieved this goal - % (n=227 clients)	17%	6%	27%	8%	0%	0%	0%	0%	79%

Note: outcomes concur with the Independent Certifiers' report (BDO, 2021).

5. To what extent did the program meet the needs of key stakeholders in accordance with the program objectives?

   - The program filled a gap by intercepting clients at risk of homelessness in health settings.
   - NSW Health stakeholders felt the program did fill a need and its core strengths were:
     - ease of access (including the relatively broad criteria)
     - no need to provide complex documentary evidence, and
     - MA's timely referral and intake of referred patients.

- MA was able to work with clients to achieve some of their goals, but was unable to achieve the required level of performance on payable outcomes and make the program financially viable for its own organisational purposes.

6. How well are staff/organisations working together to achieve participant outcomes/ program objectives? What is working well? What isn't working well? Why isn't it working well? And for whom?

- Synergies created between NSW Health staff and MA allowed them to intercept vulnerable persons in health settings and quickly transition them into the H&H program.

- The other aspect that MA reported worked well was assertive outreach. This involved deliberate and persistent effort to engage clients, especially in the early stages of the program, and when clients dropped out of contact.

- While the majority of clients did not meet any of the payable program goals, the H&H clients who were interviewed indicated the program did work well for them (noting the small sample of 12 clients) which could reflect that the program also met unpayable goals for clients.

- What did not work so well was that performance targets were not being met (i.e. clients were not achieving the intended outcomes).

- While documenting outcomes and indicators was acknowledged to be important for the SII model, service providers and clients reported that the process of evidencing outcomes was burdensome.

- In terms of people the program worked well for, there was a correlation between the length of time they spent in the program and better outcomes being achieved.

7. Did the program achieve the intended outcomes in the short, medium and longer term (3, 6, and 12 months)? If so, for whom, to what extent and in what circumstances?

The program's highest number of goals achieved was for health and short-term housing. As Table 2 below illustrates (also discussed later in the report), there were 134 incidences of 'no goal achieved'. 179 'connect with GP' goals were achieved, followed by 100 incidences of '3-month housing' goals, 32 incidences of 12-month housing goals, 2 incidences of employment goals, (noting these 2 goals were achieved by one person), followed by structured activity and education/training goals, which were not achieved by any clients. It should be noted that some clients were only in the program for a short period and did not have enough time to achieve any payable goals.

Table 2: Goals achieved, highest to lowest number

Type of goal	Number of achieved goals
None	134
Connect with GP	179
3 months sustained non-independent housing	61
3 months sustained independent housing	39
12 months sustained non-independent housing	18
12 months sustained independent housing	14
13 Weeks Sustained Employment	1
26 Weeks Sustained Employment	1
64 hours of engagement in structured activity/s	0
Training completion / 26 weeks participation in training	0

8. What unintended outcomes – positive and negative – did the program produce? How did these occur?

There were no unintended outcomes for clients relating to housing, employment, training, and structured activity.

One issue identified was the crowded service landscape where several similar programs aimed at reducing homelessness were running concurrently, with a small number of clients enrolled in more than one similar program at the same time.

9. Did the program have an impact on the broader service system? If so, in what ways and how?

- Overall, stakeholders agreed that H&H successfully assisted NSW Health to reduce the incidence of discharge into homelessness because it boosted capacity and created a new referral point.
- As the program was discontinued at pilot phase, the evaluators were not able to progress to the quasi-experimental phase of the evaluation and the planned economic analysis based on linked data to check differences in outcomes for the intervention and control groups. Therefore, the question of whether the program was more effective than 'business as usual' remains unanswerable in terms of whole-of-system costs.
- Similarly, any longer-term impact on the service system cannot be assessed.

10. What and how can client complexity be defined so that it can be consistently applied in future programs?

Typically, client complexity is conceptualised as the presence of multiple issues or challenges, which may include a combination of factors that produce risk. For example, clients may have alcohol and drug related issues, a diagnosed mental illness, low income, few social supports, reside in forms of marginal housing forms or be street sleeping.

Tools that attempt to understand the nature of housing situations and other risk factors can indicate risk of (or experience of) homelessness and complexity of needs.

11. How and what assessment tools could be used to:
    a. measure risk of homelessness
    b. assess complex client needs
    c. support triage
    d. monitor progress of future programs?

Assessment and screening processes can be used for different purposes including initial engagement, determining eligibility for a service and/or prioritising those with the highest need, and monitoring progress and outcomes (Aubry et al., 2015b). Research has highlighted the need for the development of consistent and comprehensive assessment tools that are validated and appropriate to the circumstances of people experiencing homelessness (Gordon et al., 2019).

- Tools producing scores or ratings (such as high, medium and low needs) can be used to triage and ensure a specific client mix depending on the type of service and desired client mix.

- A screening tool should include three or four questions that indicate risk, as well as determine eligibility. MA's tool was fit for purpose as it determined eligibility via a short series of questions. Other examples could include a tool developed by Doran et al. (2012) which was utilised in an emergency department setting and contained key questions found to be predictive of future shelter use.

A more complex tool could be used following intake. The following tools may be worthy of further research into their appropriateness:

- The Vulnerability Assessment Tool (VAT) has been favourably reviewed for reliability and validity (Ginzler & Monroe-DeVita, 2010), and was ranked first out of 15 assessment tools used by the U.S. Department of Housing and Urban Development (HUD) (Aubry et al., 2015)

- The Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) is widely used in Australia and easy to administer. This tool gathers information on clients' risk factors to produce a vulnerability score. However, Brown et al. (2018)

found there are challenges with the reliability and validity of the VI-SPDAT in practical use.

Any tool will need high test-retest reliability to be useful in monitoring progress. Tools that have been subject to rigorous studies to determine reliability and validity are discussed later in the report and presented in Appendix D.

One example of a tool used to monitor client wellbeing is the Personal Wellbeing Index - Adult (PWI-A), used in Australia and internationally. However, this provides an overview of self-reported wellbeing, as opposed to progress towards specific goals (such as achieving and maintaining a tenancy etc.) Likewise, the CANSAS tool used by MA, is useful for generally identifying met and unmet needs.

The H&H program measured outcomes using the Client Information Management System (CIMS) to record completion of the agreed outcomes as per Service Delivery Agreement. In addition to this data collection, outcomes were independently certified by BDO (2021). In terms of validating outcomes, recommendations have been made elsewhere on using linked data rather than relying on client self-report wherever possible.

12. What lessons can be learnt from H&H for future Social Impact Investments that target similar cohorts?

In summary (also see the relevant section later in the report for a full discussion):

- The program filled a gap by intercepting clients at risk of homelessness in health settings.
- Payable outcomes should be realistic for the cohort.
- Assumptions should not be made about a ‘balanced’ client mix in terms of need.
- Client goals were not always the program’s specified goals.
- A simple screening tool, and a longer-form triage tool, could be used with clients.
- Availability of affordable housing is key.
- The NSW Government should continue to co-ordinate homelessness interventions at the State level.

1.6 Conclusion

The H&H was a social impact investment program that sought outcomes over and above the regular Government and NGO services typifying ‘business as usual’. H&H was largely implemented as intended, intercepting people experiencing homelessness in health settings and diverting them into the program, assisting 227 individuals. However, the expected payable client outcomes were not achieved to the required level. This poses key questions - were the expected outcomes realistic and achievable for this cohort, which was characterised in many cases by significant physical and mental health issues, alcohol and

other drug related challenges, chronic homelessness and street sleeping backgrounds? What did MA do differently from normal service provision to attempt to achieve better outcomes with these clients?

Overall, this pilot demonstrated that even with increased resources, case management and clear KPIs, this model was not successful in achieving the payable housing and participation goals of the program. Many people at risk of or experiencing homelessness have complex needs that may impact their ability to achieve many of the payable goals, at least within a two-year period. However, client data analysis indicates that longevity of support did, on aggregate, contribute to positive outcomes i.e. the longer clients were in the program, the more likely they were to reach more payable goals (including those who were classified as 'high level' needs clients).

The program filled a gap between services and helped people transition from medical care settings to the community. 94 clients out of 227 fully achieved a housing goal (although still fell short of performance targets).

The H&H program highlights many of the barriers people face in engaging in social participation and accessing government safety nets.

It may be that SII programs are more effective when they are based on outcomes for the cohort which relate to maintaining tenancies, and avoidance of expensive institutional settings such as hospitals/mental health facilities and prisons, rather than pursuing employment and education/training outcomes. According to the evidence base on Housing First programs such as ASPIRE and data from the Productivity Commission (2022) on the effects of SHS support on employment outcomes, these outcomes are never or very seldom achieved.

If the intent of SII is to obtain better outcomes and decrease government spending over the long term, the NSW Government needs to consider whether the primary aim of these types of programs is to reduce spending associated with institutional episodes (like hospitalisation, incarceration) and/or also to reduce consumption of social security payments and social housing provision. The aims will influence the choice of KPIs used in future similar programs.

At the individual level, goals that are set by government may not be highly valued by clients, and this will continue to be a challenge for programs that engage with this high-needs cohort.

1.7 Recommendations

1. There is a continuing need for a program which intercepts people experiencing or at risk of homelessness who are in hospitals or medical settings. The program was valued by NSW Health clinicians because it provided them with a timely and easily accessible referral point for at risk people leaving health settings. Close links between health, support services and housing sectors should be maintained and strengthened.

2. For SII programs, payable outcomes should be based on evidence of the success rate of particular outcomes and tailored to the cohort, recognising their level of complexity. Governments and other commissioning agents should recognise that:

    i. housing outcomes are more likely than employment and education outcomes.

    ii. client-centred practice may conflict with pre-determined goal setting as clients may not value the goals that governments wish to achieve – for example, participating in the formal labour market, enrolling in educational courses.

    iii. KPIs should be easily measurable and not place a significant load on clients or service providers. KPIs should ideally be measured through secondary data sources including Centrelink, Housing NSW, community housing providers and the ATO, rather than requiring the client and service provider to collect burdensome amounts of data. Using secondary data sources would also allow government to measure longer-term outcomes that occur after support ends or clients disengage. However, it is recognised that not all data is obtainable via secondary sources (such as leases and rental payments for private rental; enrolment in education institutions) so some data will still be required from clients.

3. More research and analysis should be conducted on whether there is an 'untapped' lower needs group in health settings as most of those referred into the program were higher needs, and this would avoid assumptions being made about likely client mix.

4. A short simple screening tool is appropriate for determining eligibility and facilitating referral, however there is no triage function. However key questions can be included that are highly predictive of future emergency housing need (Doran, 2021).

    Following referral a more comprehensive complexity assessment tool could be used at intake to assess clients and be used for triage purposes. Recommended tools include:

    i. VAT (USA) - this has been favourably reviewed for reliability and validity (Ginzler & Monroe-DeVita, 2010), and was ranked first out of 15 assessment tools used by the U.S. Department of Housing and Urban Development (HUD) (Aubry et al., 2015). It has been adapted by other countries for local use (Canada).

    ii. VI-SPDAT - this is widely used in Australia and easy to administer. It gathers information on the clients' risk factors and produces a vulnerability score. However, Brown et al. (2018) found there are challenges to the reliability and validity of the VI-SPDAT in practical use.

5. Availability of affordable housing stock is key to achieving outcomes. Service providers should ideally manage subsidised housing and/or have easy access to appropriate affordable housing for the clientele. Private rentals tend to be expensive and less accessible for this cohort.

6. The 24-month support period resulted in better client outcomes and should be retained for future similar programs. The length of support and its consistency was valued by clients, even if they did not need help for that length of time. Low-need clients could be discharged earlier, creating space to take in more clients, and improving client throughput.

7. Better co-ordination of homelessness interventions at the State level is important. This involves improving vertical integration of services and reducing the overlap and gaps in services.

2 Introduction

2.1 The evaluation

The Department of Communities and Justice (DCJ) appointed a team from UNSW to evaluate the pilot of the Home and Healthy (H&H) program. The program was part of the NSW Homelessness Strategy 2018-2023.

The evaluation commenced in June 2020 and concluded in July 2022 and included implementation, process and outcome elements. The evaluation outputs included an evaluation plan, a revised Program Logic, and this final report. The final report focuses on the key evaluation elements, includes a review of existing tools used to assess complexity of need and triage persons experiencing homelessness, and discusses what lessons can be learned from this pilot program for future similar programs.

2.2 About Social Impact Investments

Social impact investment (SII) is investment intending to generate social and financial returns, while actively measuring both (SIIT 2014; GIIN 2016, cited in Muir et al., 2018).

NSW Treasury set up its SII program to bring together capital and expertise from the public, private and not-for-profit sectors to achieve targeted social outcomes. Investments can be made into companies, organisations or funds, whether they be not-for-profit or for-profit (NSW OSII, 2021). Under the SII model used in NSW, services receive both a base payment and payments linked to achieving certain outcomes (based on KPIs codified into the service delivery contract).

As the NSW Government's Homelessness Strategy explains:

> Research has identified opportunities for SII to drive change in housing and homelessness through its focus on prevention and early intervention, as well as payment for outcomes (rather than activities and outputs). SII increases accountability for outcomes through measurement and increased transparency, and can incentivise greater coordination and integration of service delivery and housing solutions by designing investment to include both property provision and support services (NSW Government (2018:16).

SII could be part of the solution for tackling difficult social issues (Muir et al., 2018) as SIIs focus on measurable outcomes.

Some challenges and barriers associated with using SIIs include: the extent of risk that suppliers of capital may need to take on, difficulties in scaling, potential for poor design and implementation of SII initiatives, and the potential for negative impact on vulnerable beneficiaries if the SII market fails. Muir and colleagues note that "the success of SII depends on the role of government, stable policy conditions, effective infrastructure, better outcomes measurement, and understanding between different stakeholders of each other's

roles" and that "SII is not a panacea and will not be the most appropriate nor effective solution in all cases" (Muir et al., 2018: 1).

SIIs have been structured in NSW as payment-by-result contracts, consisting of advance payments and payments per outcome, with a reconciliation of the payments process at the end of each payment period. The contract (the Home and Healthy Program Implementation Agreement) between the NSW Government and the service provider, Mission Australia (MA) specifies services and payments.

2.3 The context

Australia faces numerous and complex housing and homelessness challenges. One indication of housing need is that the demand for social housing and housing assistance in general continues to be high. The 2016 Census indicated that 37,000 people were experiencing homelessness in NSW, an increase of 37 per cent from 27,479 people in 2011 (Homelessness NSW, n.d.). At 30 June 2020, the number of households on the waiting list (excluding transfers) were: 155,100 households waiting for public housing (up from 154,600 at 30 June 2014), and 10,900 households waiting for State Owned and Managed Indigenous Housing (SOMIH dwellings) (up from 8,000 at 30 June 2014) (AIHWa, 2021). Another indicator is the number of people seeking assistance from Specialist Homelessness Services (SHS). Clients assisted by SHS has risen from 52,105 in 2011-12 to 70,588 in 2020-21 (AIHWb, 2021b) - a rise of 26 per cent.

The NSW Government's Homelessness Strategy 2018-2023 outlines a "framework for action that will enable government agencies, the non-government sector, and the community to collaborate and act to reduce the impact of homelessness on individuals, and improve outcomes for people and families" (NSW Government, 2018). It initially included an investment of $61 million of new funding over four years for more assertive outreach services for people sleeping rough, strengthened risk assessment to address the underlying complexity behind each person's homelessness and more support to maintain a tenancy. As part of the total expenditure, $20 million was allocated for a homelessness SII (NSW Government, 2018).

As one of the Premier's Priorities, the NSW Government has committed to reducing street homelessness in NSW by 50 per cent by 2025. This includes engaging with people who are experiencing street homelessness to transition them into secure, stable and long-term housing; and focusing on prevention and early intervention (NSW Government, n.d).

2.4 About the Home and Healthy Program

The purpose of the Home and Healthy (H&H) program was to reduce the prevalence and impacts of homelessness for people exiting health services facilities in NSW. Its target cohort was people aged 18-65 who were exiting or engaged with a hospital or community health service and were at risk of or experiencing homelessness. The program logic articulates the theory of change by which the program was predicted to have an impact on pre-determined client outcomes. There were five core components:

- Identification and Engagement:
    - Building rapport with people eligible for the program by obtaining informed consent to participate in the program.
    - Accepting potential participants using an assessment tool to guide process.
    - Engaging with clients whilst they are engaged with the health facility to support proactive planning for housing.
    - Assertive outreach – meeting clients where they are at in the community and building a trusting relationship over time to foster engagement with the program to identify persons at risk or experiencing homelessness.
- Person-centred and coordinated support
    - Support Facilitators to coordinate support using multidisciplinary approach as determined with the participant.
    - A multidisciplinary team approach coordinated by a client's support facilitator.
    - A personalised wellbeing plan developed in partnership with the client.
    - Responsive stepped care which can increase or decrease in intensity.
    - Client-centred practice – clients are supported to take responsibility for their supports and make decisions on how they receive support.
    - Trauma-informed principles and practices.
- Accommodation
    - A range of housing options to match tenant needs – scattered housing approach.
    - Rapid Re-housing Worker – focuses on working with clients to secure housing options and expedite the housing process.
    - Proactive tenancy support.
    - Partnerships with housing providers and real estate agents.
- Intensive wellbeing management / Wrap around support
    - Support facilitator assists client to access external support services, including building a relationship with local GP and specialists, and maintaining supports established during engagement with health service.
    - Continuity of care highlighted by integrated and coordinated wellbeing management across settings and throughout the program. Example activities:

        - Cultural/community engagement
        - Social or familial connection/ reconnection
        - Training or employment
        - Development of independent living skills
        - Financial literacy.

    - Wrap around support may include referral to a number of services:

        - Income management services
        - Mental health treatment
        - Physical health treatment
        - Substance use treatment
        - Daily living skills and financial management support.

- Employment

    - Specialist employment worker to work with the client on employment and training options.

    - building employment motivation and readiness.

The desired outcomes were:

- To decrease the number of people currently exiting into homelessness from health services.

- To ensure participants independently sustain housing in the long term.

- To increase participants' engagement with health services, education, training, employment and community/social activities, and foster greater social connection.

- To improve participants' overall wellbeing (see Appendix A - H&H Program Logic).

The initial pilot stage (1 July 2019 - 30 June 2021) involved MA operating the program in partnership with Sydney Local Health District (LHD), South Eastern Sydney LHD and St Vincent Health Network. The scale-up phase (1 July 2021 - 30 June 2025) would have expanded the program to include two additional LHDs: South West Sydney LHD and Western Sydney LHD.

The H&H program was intended to support 309 clients in the pilot period (173 in Year 1; an additional 136 in Year 2), and then an additional 403 clients by Year 3, 410 clients in year 4 and 99 clients in year 5 during the scale up period - a total of 1221 clients (DCJ, 2019).

2.5 Implementation

The program was largely implemented as intended. Based on MA client data supplied to the evaluators as of 17 May 2021, 280 persons were referred to the program; 227 were assigned to the program as of 30 June 2021 (against the original proposed target of 310).

Near the end of the pilot program period, 93 active clients remained. All clients were then successfully transitioned to other support services over a five-month transition-out period.

2.6 Outcomes

Outcomes were documented and certified by MA. The data was provided to the evaluators and outcomes were also independently certified by BDO in 2021.

Ultimately, the payable outcomes were not achieved, leading to the decision to discontinue the program at completion of the pilot phase.

The Findings section provides details on the outcomes achieved including the goals set versus the outcomes achieved, and the number of outcomes achieved in each of the nine outcome categories.

2.7 Discontinuation of the H&H program

At the program's first Annual Performance Review, the parties mutually agreed not to extend the Home and Healthy program beyond the pilot period (ending 30 June 2021) despite all efforts that had been made to improve the lower-than-expected performance. As a result of this decision, referrals into the H&H program ceased on 17 May 2021. A transition-out process was undertaken to appropriately support the remaining clients over a 5-month transition-out period ending 30 November 2021 (BDO, 2021).

As mentioned above, the most important consideration was that client payable outcome KPIs associated with housing, employment, education and training and structured activity goals were not met.

3 Evaluation purpose, design and methods

This section explains:

- the purpose of the evaluation
- the research questions
- the methods that were used to undertake the evaluation
- the data that was obtained to address each research question
- data analysis
- limitations.

3.1 Purpose of evaluation and research questions

The aim was to evaluate the implementation/process and outcomes of the H&H pilot program in NSW. The NSW Government is committed to evaluation to support program improvement and direct investment to what works best to improve client outcomes. The H&H evaluation is part of the Department of Community and Justice's (DCJ) broader commitment to evaluate programs under the NSW Homelessness Strategy, as well as the Strategy itself.

As the program did not continue past the pilot phase, the scope of the evaluation was amended to remove the economic evaluation component, and include a review of tools used with people experiencing or at risk of homelessness to assess client complexity, triage clients, and consider what lessons can be learned for future programs under the NSW Governments' Homelessness Strategy.

Data collection was designed to allow the researchers to answer the evaluation questions (see Table 3 matching questions to data sources later in this section). This included using available quantitative data supplied by MA, the Independent Certifiers Report by BDO, and focus groups and interviews with all relevant stakeholders from NSW Health, DCJ, OSII, MA, and H&H clients.

Findings are intended to be relevant for the NSW Government and inform future homelessness policy and programs. The evaluation contributes to supporting continuous improvement, as well as reflecting on the use of SII processes and design to procure and fund future programs targeted at reducing homelessness and improving social participation.

The evaluation includes reflections from key stakeholders on the SII service delivery model as operationalised in this specific program, funded by the NSW Government and carried out by MA. It provides an assessment of the program's efforts and successes in achieving benefits for clients, the community, and the Government, and its inability to provide the payable outcomes overall. It also focuses on the aspects of policy orientation, expectations,

procurement, program design (including its payable outcomes within the SII framework), and service provider performance, which may have contributed to its discontinuation beyond the pilot phase. The evaluation assessed the implementation (e.g. referrals, participants, engagement and services/supports provided) and the extent to which the objectives of the H&H program were achieved, and identified improvements that can made be to future similar programs.

The H&H program had a number of objectives, including improved access to housing, health services, and participation in education and training, employment and structured activities. The evaluation comments on (a) whether the referred clients were able to achieve (or amenable to) achieving some of these goals, and (b) whether the program outcome KPIs for this client group were realistic, given that referred clients often had complex and sometimes lengthy histories of homelessness, and challenges related to health/mental health and drug and alcohol abuse.

3.2 Research questions and data sources

This project used qualitative and quantitative research methods that included the following data collection methods:

- Program and other document review
- Interviews with clients
- Interviews and focus groups with stakeholders
- Analysis of client data (from the Client Information Management System), cross referenced with the Independent Certifiers' report (BDO, 2021).

The research questions that this study seeks to address, and the data sources, are outlined in Table 3 (below).

Table 3: Evaluation questions and data sources

Evaluation questions	Data sources
1. How well did the program reach and engage the target population?	• Program client data on referral pathways, client characteristics • Focus groups and interviews with MA staff, NSW Health staff
2. Were the anticipated numbers of referrals received against the predicted number of referrals and dropout rate?	• Program client data on referrals, exit pathways, client characteristics • Focus groups and interviews with MA staff

3. How well was the program implemented as initially designed by Mission Australia in response to the Request for Proposal (RFP), and adapted as needed to achieve the objectives agreed by the parties and specified in the contract?	• Program data • Focus groups and interviews with MA staff
4. To what extent did the program meet the needs of participants as set out in participants' support plans and their individual program goals?	• Program data on engagement and outcomes across a range of domains (housing, health, employment, education, structured activity) • Focus groups and interviews with MA staff • Interviews with a subset of program participants
5. To what extent did the program meet the needs of key stakeholders in accordance with the program objectives?	• Focus groups and interviews MA staff, NSW Health staff, DCJ staff
6. How well are staff/organisations working together to achieve participant outcomes/ program objectives? What is working well? What isn't working well? Why isn't it working well? And for whom?	• Focus groups and interviews MA staff, NSW Health staff, DCJ staff • Interviews with a subset of program participants
7. Did the program achieve the intended outcomes in the short, medium and longer term (3, 6, and 12 months)? If so, for whom, to what extent and in what circumstances?	• Program outcomes data • Focus groups and interviews with MA staff • Interviews with a subset of program participants
8. What unintended outcomes – positive and negative – did the program produce? How did these occur?	• Program outcomes data • Focus groups and interviews MA staff, NSW Health staff, DCJ staff • Interviews with a subset of program participants
9. Did the program have an impact on the broader service system? If so, in what ways and how?	• Focus groups and interviews with key stakeholders (MA staff, NSW Health, DCJ)

10. What and how can client complexity be defined so that it can be consistently applied in future programs? This includes exploration of how client complexity is already defined under existing assessment tools and assess whether those definitions can have broader applications.	• Focus groups and interviews with key stakeholders (MA staff, NSW Health, DCJ) • Literature review on client complexity tools
11. What and how assessment tools could be used to: a. measure risk of homelessness; b. assess complex client needs; c. support triage; d. monitor progress of future programs?	• Literature review on client complexity tools
12. What lessons can be learnt from H&H for future SIIs that target similar cohorts?	• Focus groups and interviews MA staff, NSW Health staff, DCJ staff

As the aim was to perform a program evaluation, a combination of qualitative and quantitative data collection and document analysis provided a range of data sources on program implementation and outcomes.

3.3 Elements of the evaluation

The process evaluation focused on program implementation using a mixed method relying on focus groups and interviews with stakeholders (NGO service providers, NSW Health and other medical clinicians, and interviews with Home and Healthy program clients), as well as MA CIMS client data indicating client numbers and characteristics.

The outcomes evaluation used mixed methods, again relying on focus groups and interviews with stakeholders, the MA CIMS client data and quarterly reports, as well as the Independent Certifier's report, to look at client program goals set and achieved across the domains.

3.4 Ethics

Ethics approval was obtained from UNSW HREC (HC200895) and via NSW Health Site Access Request Forms.

3.5 Sites

Data collection occurred in 2021 across the sites of the pilot program which were:

- Sydney LHD
- South-Eastern Sydney LHD.

3.6 Sampling strategy

Sampling strategy was aimed at gaining a representative sample of all the stakeholder groups. This involved purposive sampling via key agency contacts, who assisted in recruitment of relevant staff, and MA assisting with client recruitment. Numbers of stakeholders reflected a reasonably representative number of staff from each of the agencies (DCJ, OSII, NSW Health, MA) and client interview target (n = 25) was set at a level considered to be a reasonable number to reach data saturation.

3.6.1 Stakeholders - inclusion criteria

'Stakeholder' refers to service provider staff from a range of NGOs and government and other agencies that were involved in the policy area, management, or operations of the H&H program.

Inclusion criteria for stakeholder participants were:

- persons involved in the delivery, management, administration, or implementation of the H&H program
- employees of NSW Government (Treasury/OSII, DCJ, NSW Health); Mission Australia; any other relevant NGO bodies.

While all stakeholders directly involved in the program were included, no NGOs apart from MA or peak bodies were included due to scope and budgetary constraints.

3.6.2 Home and Healthy clients – inclusion criteria

'Home and Healthy client' referred to any person who was currently, or had been, a H&H client.

Inclusion criteria for client participants were:

- 18 years of age or older
- were receiving or had received support as part of the H&H program
- who had been in the program for six months or more, or who had exited.

As the researchers were dependent on MA to recruit participants, and they chose clients by convenience, it is possible that there was selection bias, however the researchers instructed MA to contact all clients who met the eligibility criteria and indicated they were willing to be contacted.

3.6.3 H&H client data

Inclusion criteria:

- All existing client records in the H&H CIMS database held by Mission Australia
- The Independent Certifiers' report (BDO, 2021) on outcomes

Data was de-identified before being shared with the researchers.

3.6.4 Sample sizes

Stakeholders

- NSW Government: n=16 (DCJ 5; OSII 2, NSW Health 9), comprising of one focus group with DCJ staff, one focus group with OSII staff, and one focus group and five individual interviews with NSW Health staff.
- Mission Australia: n = 5, comprising of two focus groups and one individual interview with MA staff.

H&H clients

- H&H clients: n = 12. All were interviewed.

The researchers sought assistance from MA to recruit clients who had been in the program for six months or more, or who had exited. MA provided with a list of 14 persons who MA had managed to contact and were willing to be interviewed. The final number of interviews was 12 (two could not be contacted). Our original target was 25 H&H client interviews however this was not met.

3.6.5 Rationale for sample sizes

In terms of the numbers of participants in interviews and focus groups for the client and stakeholder cohorts, typically around 30 interviews are thought to be sufficient to reach saturation (either code saturation or theoretical saturation). Guest at al.'s (2006) review of the literature on saturation notes that:

> Bernard (2000:178) observed that most ethnographic studies are based on thirty-sixty interviews, while Bertaux (1981) argued that fifteen is the smallest acceptable sample size in qualitative research. Morse (1994: 225) outlined more detailed guidelines. She recommends… approximately thirty-fifty participants for ethnographies, grounded theory studies, and ethnoscience studies... Creswell's (1998) ranges are a little different. He recommended between five and twenty-five interviews for a phenomenological study and twenty-thirty for a grounded theory study. (Guest, Bunce and Johnson, 2006, p.61).

As this was a small program, we included as many stakeholders who were delivering the program as possible in focus groups, and individual interviews for senior staff from Mission Australia, government, service providers and clinicians who were directly and indirectly involved with the program. Therefore, the target sample (n = 30) represents a high proportion (depending on people's availability to participate) of the total stakeholders.

For H&H client interviews, the intended sample size (n = 25) was selected in line with this literature. For client data, 100 per cent of available client data was included as the sample. The total number was therefore equal to the total number of H&H clients throughout the entire program.

Finally, the sample sizes were influenced by constraints of time and budget, and by maximising fieldwork efficiency based on the research team personnel time allocation.

3.7 Recruitment

Service providers and other stakeholders

Key stakeholder contacts were requested to assist with recruitment. This was at arm's length to avoid coercion. Government and MA key contacts sent out an email to all relevant staff, and if people were interested, they could directly contact the research team. Accompanying the recruitment email was the Participant Information Statement and Consent Form (PISCF). No more than three attempts were made to contact potential stakeholder participants after they expressed interest - if they did not respond, they were excluded. Following recruitment, interviews and focus groups were arranged with stakeholders to take place using MS Teams or telephone on a time/day most convenient for them.

H&H clients

The researchers were dependent on MA to assist with participant recruitment. MA was provided with inclusion criteria. Recruitment of participants was at arm's length to avoid coercion.

Program clients who fit the inclusion criteria and were deemed by MA to be able to give active and informed consent were contacted by caseworkers who provided information about the evaluation supplied by the researchers (flier, PISCF) and obtained permission from clients to pass client contact details onto the evaluators. Recruitment occurred around August 2021. MA provided UNSW with a list of 14 contacts. Of these, the researchers successfully recruited and interviewed 12 clients/former clients. No more than a total of three attempts (utilising all methods of communication) were made to contact the potential client participants after which they excluded.

It is likely this recruitment method unavoidably skewed the sample towards more functional clients who were more inclined to give positive feedback and may have missed accessing highly complex clients (those deemed unable to give informed consent) or those who had a negative experience.

Following recruitment, interviews were arranged with the client to take place using telephone (and in one case, Zoom) on a time/day most convenient for the client.

3.8 Consent

All participants were required to consent verbally or in writing using standard UNSW HREC forms and procedures. Consent forms were sent, signed and returned via email. Where this was technically challenging (for H&H clients), the PISCF was emailed or posted, and verbal consent was sought and audio recorded. No participant withdrew consent.

3.9 Data formats

Data was collected in the following formats:

- As de-identified client outcomes data (from MA's CIMS) – export from database in report format at a unit record level
- As audio recordings and transcripts thereof – as MP3 files and Word files.

3.10 Qualitative data collection - interviews

The qualitative data collection occurred in Q2 and Q3, 2021.

Qualitative data came from focus groups and individual interviews with government (DCJ, OSII and NSW Health), the service delivery agency (MA), and from interviews with H&H program clients/former clients.

For stakeholders, the decision to run a focus group or interview was based on the seniority of the person, and convenience (i.e. who was available at the time). Interviews lasted around 45-60 minutes and focus groups lasted around 60-80 minutes. Interviews and focus groups were all held online via MS Teams or on the telephone due to COVID-safe practices being followed at the time (NSW was in lockdown). All sessions were audio or MS Teams recorded, de-identified and transcribed.

For H&H clients, interviews were used. These lasted 30-45 minutes. Telephone interviews were most commonly used, with one Zoom interview at the request of the client. All sessions were audio recorded, de-identified and transcribed.

Stakeholder participants in the evaluation were not reimbursed, as they participated as part of their employment, in business hours.

H&H clients were reimbursed for their participation with a $30 Coles gift voucher (delivered electronically via text and/or email or printed out and posted to a nominated address). These can be scanned and used to purchase goods at any Coles outlet.

Semi-structured interviews/focus groups were used. Interview schedules for stakeholders and clients were informed by the aims of the evaluation and research questions, ensuring the collected data was related directly to these, as well as allowing for other issues to be brought up, including unintended consequences.

3.11 Quantitative data collection: client outcomes data

The researchers analysed client outcomes based on MA reports and raw data extraction from the CIMS. All clients were de-identified by MA beforehand.

Datasets provided by MA included sociodemographic information on all clients on intake, including demographics and housing, employment and income status. Client goal setting and status (whether goal/s were reached and what goals were reached) was also provided.

Outcomes data for clients was based on reporting on all program assigned (participating) clients (N=227, including one client entering the program in two separate periods), and the goals they achieved.

Descriptive statistical analysis was used to present client characteristics. H&H clients were compared, wherever possible, with the general SHS population (2020-21) using AIHW data.

3.12 Document data collection: Complexity measurement tools

As part of the re-scoping of the evaluation, an extra component was added at the requirement of the funder. A literature search was undertaken to find measurement tools aimed at people experiencing or at risk of homelessness to determine client complexity, including those used for triage. These tools were located using Google Scholar using these search terms:

- measurement of the risk of homelessness
- assessment of the risk of homelessness
- risk of homelessness
- complex needs
- homelessness.

A number of relevant sources and tools were identified and downloaded.

3.13 Document data collection: relevant policy and program service delivery documents

The funders provided guidance on key documents that were relevant. Documents informing this evaluation included:

- The H&H Program Logic
- The NSW Homelessness Strategy 2018-2023
- The Deed of Implementation Agreement – Social Impact Investment Transaction – Home and Healthy Program
- The Operations Manual
- MA quarterly reports to the funder
- MA CIMS data on client demographics, goals and outcomes
- The Independent Certifier's report produced by BDO (2021).

3.14 Data analysis

Data collection and analysis occurred in parallel. Data analysis activities were guided by the evaluation questions and indicators identified in the evaluation plan.

3.14.1 Interview and focus group transcript analysis

Interviews and focus groups were transcribed by a professional transcriber working under a confidentiality agreement with UNSW. Transcripts were de-identified and analysed using an iterative thematic analysis approach whereby the research team read subsets of transcripts and developed a coding frame which closely follow the research questions. Interpretive research methods were used, informed by Realistic Evaluation methods (Pawson and Tilley, 1997). NVivo software was used.

3.14.2 Client outcome data analysis

Client outcome data from MA CIMS were combined and analysed using Excel and further exported into STATA to provide basic descriptive statistics (e.g., means, medians, summary scores), regarding key sociodemographic profiles of the clientele and key program outcome indicators. Bivariate chi-square tests and subsequent multivariable logistic regression analysis were used to identify factors associated with clients who had fully achieved any payable outcomes. Client outcomes data supplied by MA was cross referenced against the Independent Certifier's Report (BDO, 2021) which was provided to the evaluators on a confidential basis.

3.14.3 Complexity tool analysis

Once key documents were identified the original source for each tool was located and referenced. Preference was given to tools widely used in Australia and similar countries, and those that had been validated. This data was arranged into a table format (see Appendix D).

3.14.4 Data triangulation

The analysis triangulated the qualitative and quantitative findings to estimate whether the program had been implemented as intended, and whether intended outcomes had been achieved. Findings focus on addressing each research question, from which conclusions and recommendations follow.

3.15 Limitations

Data quality: MA data quality appeared complete with no substantial missing data in data fields, except sexual orientation self-identification (71 per cent missing).

Data reliability: MA-supplied outcomes data and quarterly reports were cross referenced with the Independent Certifiers' report.

Comparing H&H clients with SHS clients: Compared to the SHS population, H&H clients were older; more likely to be homeless, male, report a current mental health issue and/or report problematic alcohol and other drug use, be in public/ community housing or institutional settings, or be sleeping rough. They were less likely to be Aboriginal, female, young, to report domestic or family violence, and be in private or other housing (renter, rent free or owner).

The researchers note these differences and acknowledge that it could be misleading to simply compare MA H&H program clients against the average SHS national clients. The H&H program targeted a sub-population of persons at risk of experiencing homelessness, however those referred were more disadvantaged than the 'average' SHS client.

Bias/selection bias: Parties may have had different interests and opinions from other parties; however, these were cross referenced with client data, the terms of the service

delivery agreement, operations manual and agreed outcomes measures/KPIs. Parties sought to rationally discuss and understand why the program was not continued past the pilot phase, and learnings for future programs.

In terms of H&H client recruitment, while the researchers specified criteria for interviewees, the researchers were dependent on MA to contact clients on our behalf. As this was a small pool of clients to choose from, and it was not made clear how clients were selected (randomly or via choosing clients on another basis), there is a possibility of selection bias. Also, the interview sample size was relatively small, limiting the possible range of views.

Sample sizes: There was no statistical difference when comparing the demographic characteristics of clients who were referred and engaged (n=227) vs those who were referred but did not engage in the program (n=53). This may result from the lack of statistical power to detect differences due to small sample sizes.

Client interviews: The researchers only interviewed 12 H&H clients/former clients. The original target was 25. While a range of views was expressed, ideally more client interviews would have enhanced the richness of data available from this stakeholder group.

4 Findings

4.1 Process evaluation: program implementation

This section focuses on program implementation including program objectives, reach, how well stakeholders worked together to achieve participant outcomes.

4.2 How well did the program reach and engage the target population?

The H&H program targeted persons at risk of experiencing homelessness in health settings (hospitals, mental health units, drug and alcohol treatment facilities). Clinicians were able to refer people to MA using a simple referral tool. MA quickly responded and offered these individuals support through the H&H program.

The quantitative findings below are based on MA CIMS data and cross referenced against the Independent Certifiers' Report.

Based on MA CIMS client data supplied to the evaluators, as of 17 May 2021, 280 persons were referred into the H&H program, and of these, 227 were assigned to the program as of 30 June 2021. 80 per cent of the clients assigned to the program had medium-high to high intensity support needs (as defined by the support level checklist in the referral form in the H&H Operations Manual).

4.2.1 Client characteristics

About half of the 227 clients who had ever been assigned to the program were over 45 years of age (median = 44, standard deviation = 11). Nearly two-thirds were male. About one-fifth of the clients were Aboriginal. Close to one quarter had Culturally and Linguistically Diverse (CALD) backgrounds. Only one-third voluntarily disclosed their sexual identity with the majority of those respondents self-identifying as heterosexual.

Close to one-third of the clients reported past or current experiences of domestic and family violence. A majority of the clients (84 per cent) reported having disabilities, mostly related to mental health or psychiatric conditions (65 per cent). This largely reflects a substantial proportion of client referrals coming from the mental health and alcohol and other drugs service sector. Over two-thirds of the clients reported alcohol and other drugs use. Close to half of the clients actively involved in the program had both mental health conditions and substance use issues. This suggests a highly disadvantaged and vulnerable clientele with substantial negative life experiences.

Table 4 shows the sociodemographic profile of all H&H clients (N=227, as of 30 June 2021) and compares this to SHS clients (using AIHW 2021 data where available). Compared with SHS clients, the cohort appeared to be more disadvantaged, older, more likely to be male, unemployed or on DSP, from a CALD background.

Table 4: Home and Healthy and Specialist Homelessness Service clients socio-demographic characteristics

Socio-demographic characteristics			
	H&H Clients		AIHW SHS Clients (2020-2021)
	n	Percent	Percent
Gender			
Male	143	63%	40%
Female	84	37%	60%
Age (years)			
18-24	22	8%	14.4%
25-34	42	15%	18.7%
35-44	77	28%	17.9%
45 and older	139	49%	17.8%
Ethnicity			
Aboriginal status	42	19%	28%
CALD	47	21%	13%
Sexual orientation			
Not stated	150	66%	n/a
Heterosexual/straight	67	30%	n/a
Other: gay, bisexual	10	4%	n/a
Housing status on presentation/first reported			
Improvised dwelling/Street/Park/no shelter/inadequate dwelling	27	12%	9%
Emergency Accommodation/Short term temporary accommodation	40	18%	21%
House/Unit - couch surfer	40	18%	14%
Institutional settings	7	3%	3%
(House/Unit) Living Fee Free With Relative/Friend	29	13%	n/a
Boarding House	24	11%	n/a
Motor Vehicle/Boat	7	3%	n/a
Hotel/Motel Bed Breakfast	4	2%	n/a
House/Unit (CHP-Transitional)	2	1%	n/a
Employment status on presentation/first reported			
Employed	11	5%	12%
Unemployed	141	62%	53%
Not in labour force	4	2%	35%
Not applicable	71	31%	n/a
Main income source on presentation/first reported			
Jobseeker	124	55%	32.7%
Disability Support Pension	78	34%	15%

Socio-demographic characteristics			
	H&H Clients		AIHW SHS Clients (2020-2021)
	n	Percent	Percent
Employment income	6	3%	8.7%
Other government pensions and allowances (not elsewhere classified)	4	2%	1.6%
Youth Allowance	7	3%	7.3%
Parenting Payment	2	1%	16.7
Carer Allowance	1	0.5%	0.6%
Carer Payment	2	1%	1.6%
Nil income	1	0.4%	9.1%
Sickness Allowance	2	1%	0.1%
Enrolled in formal adult education			
No	220	97%	96%
Yes	7	3%	4%
Negative life experiences, disadvantages, vulnerabilities			
Domestic or family violence			
No	166	73%	n/a
Experienced (past)	38	17%	n/a
Experiencing (current)	16	7%	n/a
Suspected	7	3%	n/a
Primary disability			
Mental health/psychiatric	147	65%	n/a
Medical	23	10%	n/a
Physical	16	7%	n/a
Acquired brain injury, intellectual	3	2%	n/a
None	36	16%	n/a
AoD (use/concern)	156	69%	n/a
Comorbidity			
AoD + any disability	131	58%	n/a
AoD + mental health	103	45%	n/a

Source: MA CIMS client data; AIHW Specialist Homeless Services (SHS) 2021, Data tables, accessed at: https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/data; and Infographics, https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/on-any-given-day-infographics

Note: The percentages from the AIHW SHS dataset were inserted wherever as applicable (N/A indicates not directly comparable. For example, MA recorded DFV presence and the primary disability/health issue, while AIHW records multiple reasons for seeking assistance).

Overall, the clients were highly socio-economically disadvantaged with extra challenges of chronic illnesses, substance use issues and mental health disorders. They faced significantly higher challenges than the general SHS population

4.2.2 Client referral and retention

Figure 1 provides an overview of H&H program client referral source. As of 17 May 2021, 89 clients (31.8 per cent) were referred from South-East Sydney Local Health District (SESLHD) (hospital social workers, mental health, Kirketon Road Clinic (KRC), Drug and Alcohol), 98 clients (35 per cent) were referred from Sydney Local Health District (SLHD) (Royal Prince Albert Hospital/Marie Bashir, Canterbury Hospital, Concord Centre for Mental Health), and 93 (33.2 per cent) clients were referred from St Vincent Hospital Network Sydney (SVHN).

Figure 1: Referral source

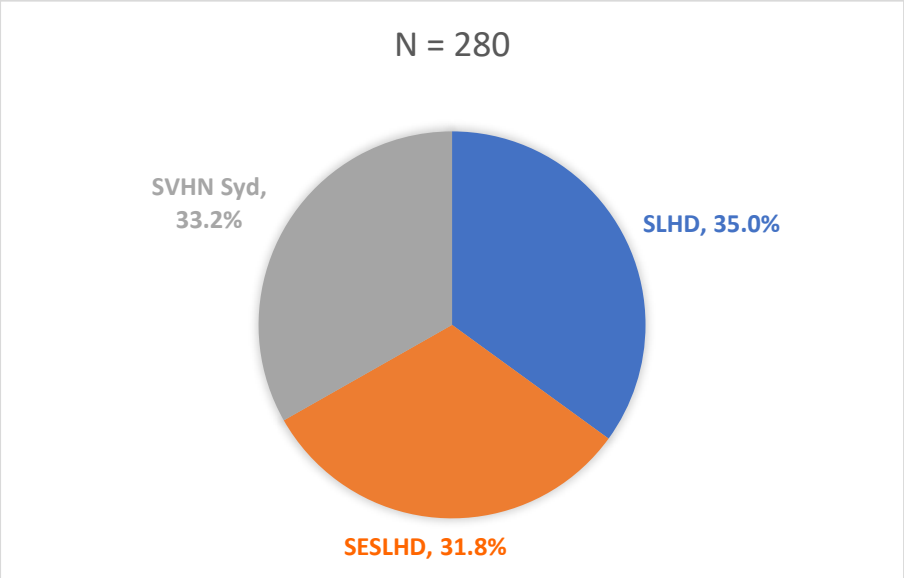
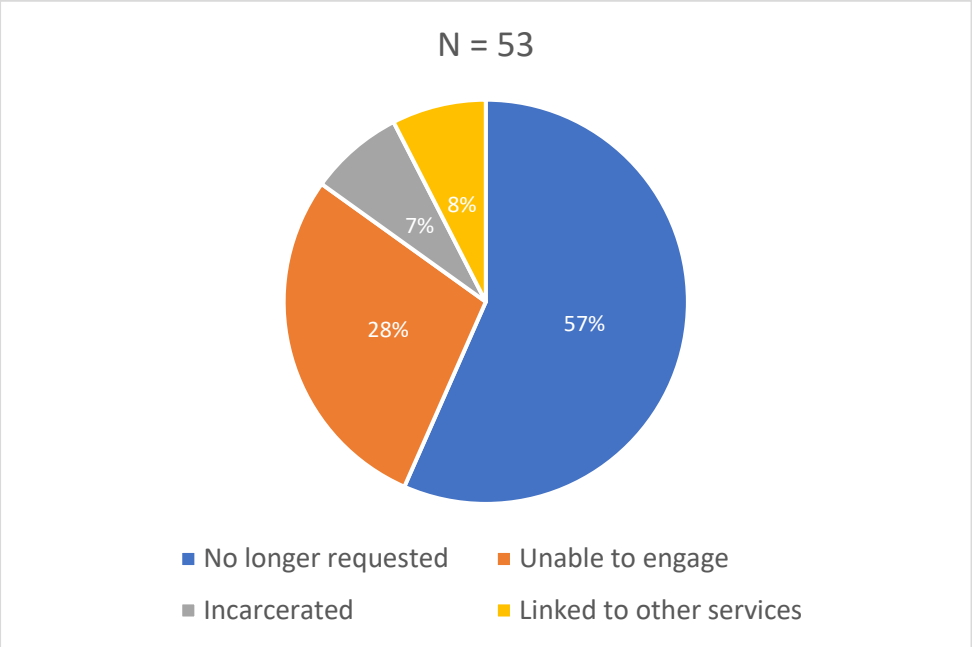


Figure 2 depicts the reasons why 53 people did not progress into the program after referral, with over 50 per cent classified as ‘no longer requested’.

Figure 2: Non-progressors after referral



Note: as of 30 June 2021.

Table 5 depicts engagement numbers and demographics. Of the 227 people who progressed into the program, 93 did not engage (41 per cent) and 134 (59 per cent) were actively engaged with the program.

Fifty-three people were referred but did not enter the program, which means that there is no detailed MA CIMS demographic data for these people. There was little difference in demographics and characteristics for those that did engage and the 93 of 227 who entered the program by consenting and providing personal information, but did not engage, using selected indicators. Those that did engage tended to be slightly younger, slightly more likely to have a mental health/psychiatric disability, more likely to be sleeping rough (improvised dwelling/street/park) and be on Disability Support Pension.

Table 5: Engagement - engagement numbers and demographics

Selected indicators	In program - did not engage (n=93)	In program - engaged (n = 134)
Average age	46	43
Gender - male	70%	58%
Gender - female	30%	42%
Aboriginal	17%	19%
Mental health/psychiatric disability	62%	66%
Disability support pension (Centrelink)	30%	37%
Employee income	3%	2%
Housing status at presentation - Emergency accommodation	17%	18%
Housing status at presentation - Boarding house	11%	10%
Housing status at presentation - House/unit private rental	18%	11%
Housing status at presentation - Improvised dwelling/street/park	5%	16%

4.2.3 Duration of Support Period

The intended support periods were up to 24 months. Only those that began the program between July-December 2019 had the possibility of remaining in the program for 24 months as it ended as of 30 June 2021.

For the 134 people that engaged with the program (93 did not), as Table 6 below indicates, the mean duration was 282 days (9.4 months) and the median 257 days (8.6 months).

Table 6: Duration of program engagement: mean, median and mode

	Days	Months
Average	282.06	9.4
Median	257.5	8.6
Mode	126	4.2

Table 7 below indicates length in time in program for clients split into four cohorts: July-December 2019; January-June 2020; July-December 2021; January-May 2021. About a quarter, or 24 per cent, spent 1-6 months in the program, followed by 19 per cent who spent 7-12 months in the program, 11 per cent who spent 13-18 months in the program. Only those who started in July-December 2019 had the chance of staying in the program for up to 24 months. Only 6 per cent spent 19-24 months in the program (which was towards the maximum support period).

Table 7: Length of time in program

	July-Dec 2019	Jan-June 2020	July-Dec 2020	Jan-June 2021	Total	%
Zero time	18	29	29	17	93	41%
1-6 months	9	24	10	11	54	24%
7-12 months	13	20	9	N/A	42	19%
13-18 months	11	13	N/A	N/A	24	11%
19-24 months	14	N/A	N/A	N/A	14	6%
	65	86	48	28	**227**	**100%**

In summary, for the 227 clients assigned throughout the program, the minimum and maximum length of the intervention period was from about 9 days (about 0.25 of a month) to 679 days (i.e., up to 22.6 months), with a median of 8.6 months. The cessation of the program was a key factor in the median time clients spent within it.

4.2.4 Program exits and length of time in program

There was a range of reasons that clients left the program. As indicated above, a significant percentage (41 per cent or 93 clients) never engaged with the program after signing up for it. Of those that engaged with the program (n=134) there were various reasons for program

exit, but only 22 exited because of program completion. However, some of the other exits may also have been ‘positive’ ones (e.g. disengaging due to receiving support/housing).

Table 8 below reports on duration in the program by the type of exit. It indicates the average length of time (days/months) in the program by exit reason, from lowest to highest. No exit date was recorded for non-engagers. Those who spent the least amount of time in the program were those that moved out of the area, did not state why/no reason adequately described, withdrew themselves from the program or became ineligible for the program. Those who stayed longest were those who had been incarcerated, died, did not utilise the program for an extended period (perhaps indicating they no longer felt they needed support), and those who completed the program.

Table 8: Length of time in program by exit reason

	n	Average days in program	Average months in program
Zero days in program/exit date not recorded	93	0	0.0
Client has moved out of area	9	184	6.1
Not stated/inadequately described	1	198	6.6
Client has withdrawn from the program / service	35	216	7.2
Client has become ineligible to continue with the service / program	9	219	7.3
Client incarcerated	14	241	8.0
Client is deceased	4	268	8.9
Client has not utilised service for an extended period	40	323	10.8
Client has completed the program	22	411	13.7
Total	**227**		

The chronic and complex nature of poor physical and mental health coupled with problematic substance use in this group of clients poses a myriad of challenges to achieve stable housing, employment and participation in structured activities, even as medium-term goals. This is despite the fact that in response to COVID-19, a growing number of long-term temporary emergency accommodation options became available.

4.3 Were the anticipated numbers of referrals received against the predicted number of referrals and dropout rate?

Program entrants were consistent with eligibility criteria: 227 out of the 280 referred (81 per cent) were assigned to the H&H program. According to DCJs' specifications for the evaluation, Year 1 of the program's pilot phase was intended to support 173 clients, and Year 2 was intended to support 136 clients.

Given the pilot ran to 24 months (Year 2 of the pilot period), we would expect there to be 309 clients cumulatively, however the overall client number was 227 (see Table below).

Table 9: Original planned and actual H&H program client numbers

Pilot period	Expected	Actual
Year 1 (July 2019-June 2020)	173	152
Year 2 (July 2020-June 2021)	136	75
Total	309	227*

Note: 'Actual client numbers is 'date client started the service episode' data field, MA CIMS data.

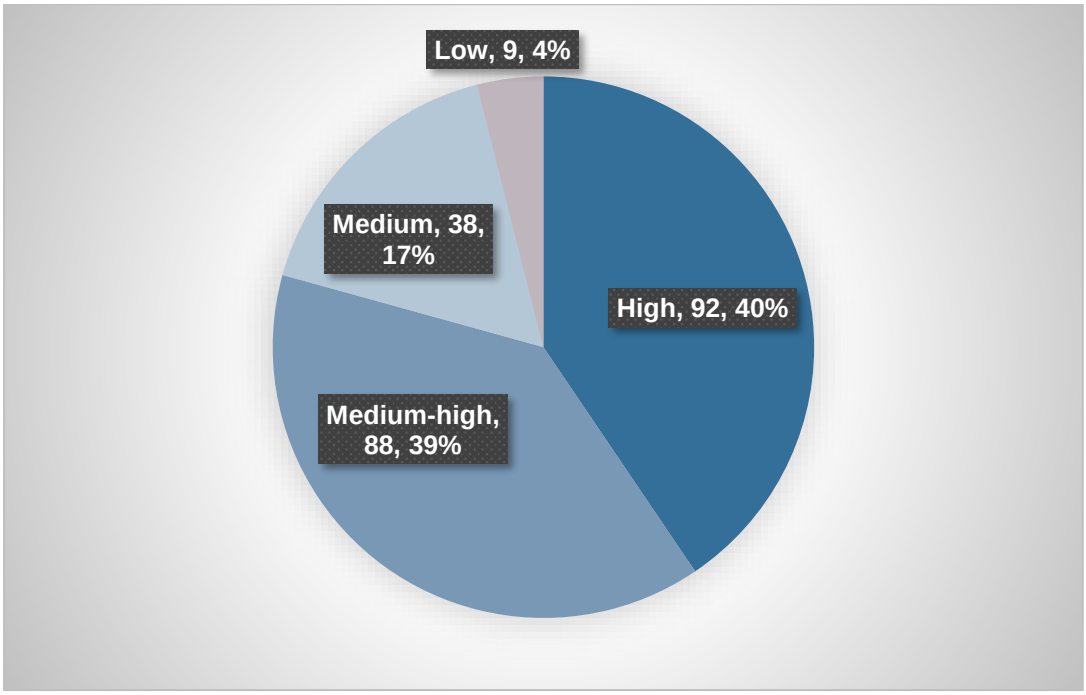
*Including one client entered the program twice separately.

The overall drop-out rate was 49 per cent, which was slightly lower than anticipated. Throughput was lower than anticipated due to the lower drop-out rate.

In summary, 115 (51 per cent) out of the 227 assigned either completed (n=22) or had remained active in the program by 30 June 2021 (n=93). A further 31 per cent (n=70) had either become ineligible or had voluntarily withdrawn from the program. The remaining 18 per cent (n=42) were no longer engaged with the program for at least 3 months (that is, the actual lost to follow-up rate was 18 per cent). This was not unexpected in a sample of clients with complex needs, particularly those with AOD and mental health challenges.

The majority of clients (n = 180, 79 per cent) had medium high to high intensity needs illustrated in the Figure below. Client support needs were determined by data collected on the intake referral form.

Figure 3: Client support needs



Apart from clients' personal reasons for disengagement, exogenous reasons like public health orders due to the COVID-19 pandemic limited face-to-face contact with clients in 2020 and 2021 which impacted program delivery may have caused more clients to exit than would otherwise have been the case.

Professional stakeholder views

Referral process and the referral tool were described in the operations manual.

Briefly, the referral form sought to determine eligibility using five key questions:

- age (between 18-65)
- currently experiencing homelessness or at risk (including some sub-questions about their current accommodation status)
- currently receiving treatment at one of the LHDs that were part of the program

- whether they would be willing to reside in the LHDs and receive support, and
- whether they could sustain independent accommodation with supports.

In addition, the details of the referrer and the potential client were recorded, and there was a space for notes.

Referrals came from the agreed health facilities (hospitals, mental health units and alcohol and other drug facilities) within the participating LHDs. A health professional in an agreed health facility/service assessed if a person was eligible to be referred into the program against the eligibility checklist in the referral form.

Clinicians identified patients with complex needs who would not necessarily be eligible for programs such as the Housing and Support Initiative (HASI) or Community Living Supports (CLS) program:

> *[Our patients], they have mental health issues, but they don't have a diagnosis, or they don't want to really address it and they're not engaged in mental health. (Stakeholder 11)*

> *So that group, that population, there's often a real gap for who is able to support them in the community on discharge to reduce the risk of them, re-presenting to hospital, and to support them to access temporary or permanent housing. So, that's sort of the key gap that they [H&H] filled. (Stakeholder 17)*

From all accounts – from NSW Health, MA and the clients themselves – the targeting and referral process worked as intended. The ideal was to have MA workers in hospital settings, having the ability to assist clinicians in identifying someone who might be at risk. While the pandemic undermined that face-to-face work, referrals were still made.

Referrals from hospitals were initially solicited on a first-come, first-served basis, after administering the screening tool to determine eligibility. This meant that people who were easily identifiable as experiencing homelessness or at risk of homelessness were a high proportion of those referred. Less obvious candidates who could be at risk of homelessness – for example, women in hospital due to DFV injuries or others with physical ailments stemming from family conflict or insecure housing situations – may have been harder to identify. One stakeholder believed that this direct approach was discouraged, “because there was concern from OSII that potentially we might be choosing clients, which is not our ethos. We work for clients who need us, and that's how we work. We don't choose them. They choose us”. (Stakeholder 6)

Using Zoom and other means, as well as on-site work, led to H&H client numbers increasing as intended towards the target number for the pilot phase Years 1 and 2.

The H&H program was designed as an earlier intervention and prevention approach to support a range of clients including those with significant support needs, but also those who were at risk of homelessness and potentially less visible to the health services. Intervention for this cohort would mean their needs were identified and addressed early before they

escalate into homelessness. The high number of complex needs clients accessing the program was unanticipated or underestimated by MA, This led to an agreement by all parties to attempt to alter the mix of clients by asking NSW Health staff to identify and refer patients who may be at risk of homelessness but did not have significantly high and complex support needs. One stakeholder thought this form of direct communication was not appropriate, however the direct communication between MA and Health was agreed and endorsed by all parties including DCJ before there was any communication of this. Two NSW Health staff reflected on this change:

> *And then somewhere in there, it all shifted that, "no, we can't see complex people. We need to see people who are less complex." The Home and Healthy Services program, that's the message we were getting, which is what we were asking to start with, but they didn't give us that information and I think, that did create some problems. So, perhaps there were people that went through that they weren't able to achieve things that they intended with, and it maybe affected their KPI. (Stakeholder 18)*

> *I believe were trying to narrow down the client group to a specific type of client. So, they were asking for more information around mental health, income, drug and alcohol, behavioural issues. And I think, my understanding was so that they could access clients who had less complex health and social needs. So that added another page to the referral form and social workers were required to tick boxes, like a scaling system to help us to understand the client a little better… (Stakeholder 15)*

As these clinicians experienced, MA was seeking a range of clients who were at risk of homelessness, rather than clients only with significant and complex needs. The program was designed for a range of clients, including those with less complex needs who required an early intervention approach. The program was designed to assist health services to identify and find support for clients who may not otherwise have been picked up and supported due to being less visible in the health system. MA reported the high concentration of clients with high and complex needs original assumptions about achievement of outcomes, particularly those related to education, employment and independent housing, were not achievable. NSW Health staff were subsequently asked to apply more criteria to patients they selected to refer into the program. Soliciting referral of lower needs clients was in some ways not responding to demand, instead attempting to select lower-needs clients more likely to achieve the KPIs. NSW Health staff wanted to refer patients who needed help without necessarily having to select for lower needs.

> *I guess as I say it's very difficult in this position because we're getting the referrals from the ground and the demand is saying, “look, this is what we need”. (Stakeholder 10)*

This evaluation suggests that MA may have made assumptions about the existence of an untapped lower-needs population in health settings presenting with illnesses or injuries that potentially could have been referred into the program, however there was no evidence to suggest this was the case. In one view, the eligibility criteria did not specify clearly enough:

> *…what percentage of people from different levels of complexity there should have been. So, if we were to do this again and make it more early intervention, we would probably not go to the AOD and mental health units. We would probably stick to the main wards in hospitals and link in and have our magenta T-shirted case workers working in the paediatrics ward, the orthopaedic ward, the general hospital, to be working alongside the hospital social workers, side by side, to identify those lower complexity people that still had a risk of homelessness. (Stakeholder 5).*

There is little research based on screening for risk of homelessness in the population of patients admitted to hospitals/health care settings in NSW. Doran et al. (2021) surveyed 1993 random people in New York hospital emergency departments. They found 9.7 per cent had been homeless or were couch surfing with family/friends in the last 12 months and 21.4 had a history of homelessness in their lifetimes. Although these findings may not directly translate into the Australian emergency department context, they have relevance for NSW and inner-city Sydney in particular. The NSW Health emergency department and admitted patient datasets contain no variables on housing status/homelessness. In practice hospitals and social workers attempt to assist people to not be discharged back into homelessness.

Whether a pool of untapped or potential lower-needs clients actually existed is an untested hypothesis as there is no data from health facilities on homelessness 'flags' for admitted patients. If we consider drivers of homelessness, like domestic and family violence, there may well have been people presenting for injuries, illnesses or low-level mental health issues that could have been eligible for the program but were identified as hospitals do not screen for homelessness. NSW Health staff were able to independently nominate patients into the program thus avoiding cherry-picking of clients, however MA did attempt to seek lower-needs clients. These contestations highlight the need to clearly define the target group, eligibility criteria and referral process (and design programs to suit specific target cohorts).

Once in the H&H program, MA had to keep clients engaged. People with high levels of complexity tend to disengage, so MA placed a very strong emphasis on maintaining the engagement.

> *I guess you could call it being assertive. Being assertive in their approach. And that seems to have paid off. (Stakeholder 5)*

This is in line with the Housing First philosophy that stresses 'assertive outreach' – that is, regular, persistent attempts to contact the client via a variety of means including going to places where the client may be, instead of just leaving a voice message and awaiting client call back: "staff seem to have really doubled down on that effort of finding the person and having the contact, celebrating the small wins" (Stakeholder 5).

Client views

Clients interviewed were referred into the program from both inpatient and outpatient hospital settings. Many interview participants were vague about when and how they were referred to the program.

> *I don't know how I managed to be hooked up with them, but it was almost like, thank God…It was a relief. Like I said, just the words 'Home and Healthy'. It sounded good, right? It's like, 'home, healthy'. Oh my God. Right. Those two words together… Just reflecting on it, it just felt like it was going be okay. All we want is just to be safe in our home. Yeah. And healthy. (Client 3)*

Others only became clear about being in the program when program staff started to contact them.

> *That's the first I knew. Yeah, was when he called, and I was like, 'who is this?' … he introduced himself perfectly well, but I wasn't expecting the call. (Client 2)*

Some clients were very clear about how the referral came about and the process involved. For example:

> *They came to see me before I was discharged in hospital. I started with a social worker in hospital, and she arranged [caseworker], who was the original person from Home and Healthy. And we had a meeting in the rehabilitation, and it was three of us at the table. (Client 5)*

Most of the clients interviewed had not received this kind of support previously and therefore could not make comparisons with other referral processes. They all commented that the period of support (up to two years) was beneficial and helped them address different needs over time. They also highlighted the importance of intercepting people in the hospital system.

> *You have to, you have to grab people when they're... you have to catch them when they're vulnerable, which I was. (Client 2)*

Most clients interviewed had relative stability in who was providing support from H&H (given many were receiving support for up to two years).

> *There's nothing worse sort of having a different caseworker every week. … It's building rapport, so important. I think. ...It was great, because it was sort of rock solid. While the lockdowns weren't on, he would come and visit me, but also he made it clear that I could call him if ever I needed something or just needed to talk. (Client 2)*

Many had received support from more than one caseworker. Where there had been a change in contact, this was well managed, and the new person was introduced, allowing services to continue easily.

Many clients commented on the quality and characteristics of H&H staff, saying they were "fantastic", "helped me with everything", "asked what I needed", "guided me", "keep me above everything", went "above and beyond", "fantastic listener", "non-judgmental", helped

with “goal setting”, and “intensely professional” (Clients 2, 3, 4, 6, 10,11). Overall clients found the H&H program “very well organised” and felt that they were mostly well matched to their caseworkers, although some they “clicked with” more than others (Client 3). One client was matched with a H&H caseworker who spoke their language (Client 8). Clients felt the caseworkers really cared and were very helpful in addressing their needs.

> *If he says he is going to do something, he would do it. And he'll call me back a couple of days later and tell me the outcome. (Client 11)*

Regular proactive contact from the H&H caseworker was appreciated, even just to check “whether the client was OK” (Client 4, Client 6). Clients appreciated meeting up in person and having a coffee and conversation, and “sort things there at the café” (Client 11).

Clients needed support to negotiate the often fragmented systems and supports provided by government agencies. H&H staff helped facilitate access to other systems and services, including public housing, health care, employment services, the National Disability Insurance Scheme (NDIS) and financial supports. These were supports clients could not easily access themselves, due to complex application processes requiring high levels of literacy, a computer and internet. For example, clients did not have access to a computer to complete forms, or request bank statements or other documents by email (Client 10). Clients had to physically go to different institutions to request hard copies of evidence to support applications (Client 10). They may have had difficulty seeking various referrals or presenting their case. H&H staff helped clients navigate systems and often brought their computer to complete and submit forms.

> *He's so genuine and well versed in how to navigate the system. Which I don't have the computer skills or the background. (Client 7)*

4.4 How well was the program implemented as initially designed by Mission Australia in response to the RFP, and adapted as needed to achieve the objectives agreed by the parties and specified in the contract?

The program was implemented as agreed. It targeted people in the health settings and built up a client base. The cohort were relatively disadvantaged, older, more likely to be male, unemployed or on DSP, and from a CALD background than the average SHS client.

In terms of components and activities, Table 10 (below) reports on what was designed into the program (using the Program Logic as a reference point) and what program components were delivered. Of note:

- It is not clear how consistently clients’ wellbeing was tracked using the PWI-A tool or other tools. MA used CANSAS quarterly with clients which contains 22 questions about various personal issues such as nutrition, physical and mental health, social activities, personal safety, drug and alcohol use, and highlights whether a client may be having difficulties or have unmet needs. However, it does not perform the same

function as the PWI-A which allows clients to ‘score’ wellbeing on a scale of 0-10 over various domains, and therefore allows for monitoring.

- The original program logic required a mental health specialist worker. Based on the needs of the cohort in the program, MA decided this was not necessary and instead employed a housing specialist worker. MA’s experience was that due to the significantly complex support needs of the cohort many clients did have clinical supports in place or could access these with support from the program and that rapid access to housing was a more urgent need.

- No specialist employment support worker was employed. Again, based on the significant support needs of the cohort in the program, MA identified that for most clients, their complex and chronic health needs meant they were unable to gain employment. A specialist housing worker who could rapidly access and secure housing options was deemed more valuable for the program.

- A specialist housing support worker, not included in the original design, was prioritised for the reasons stated above.

- Housing goals were reached for 41 per cent of clients. Health goals (connect with GP) were reached for 79 per cent of clients. The other goals (employment, education/training and structured activities were not reached (except by one individual who reached two employment goals). This has been discussed elsewhere in the report.

- As goals were not being met to adequate payment levels, and due to the administrative burden on both staff and clients to evidence outcome achievement, the parties made adaptations to how outcomes were documented (such as verification of tenancy maintenance via a statement form a housing caseworker).

- MA tried to recruit ‘lower needs’ clients via health settings.

Table 10: Program logic components and components only partially or not implemented/reached

INTERVENTION Core components and flexible activities	MECHANISMS OF CHANGE	OUTPUTS AND IMPLEMENTATION OUTCOMES	CLIENT OUTCOMES Describe the specific client outcomes likely to result from each program component across the NSW Human Services Outcome Framework domains			GOALS	Components partially or not implemented
			Immediate outcomes (outcome measure) Primarily attributed to the program	Intermediate outcomes (outcome measure) Partly attributed to program, beginning of shared attribution	Long-term outcomes (outcome measure) Shared attribution across agencies/NGOs		
Core component one: Identification and Engagement • Building rapport with people eligible for the program by obtaining informed consent to participate in the program • Accepting potential participants using an	Successful identification and early engagement with participants ensures sufficient exposure to program components.	Immediate outputs • Number of referrals to H & H • Number of participants engaged • Participant satisfaction	Home The provider facilitates timely access to appropriate and safe accommodation (within 3 months) MA CRM & Pathways; private rental lease agreement or	Participants are demonstrating daily living skills necessary to maintain a tenancy and maintain a tenancy for 6 - 12 months	Participants are safely, sustainably and securely housed and maintain tenancy for 12 – 24 months MA CRM & Pathways; private rental lease	To decrease the number of people currently exiting into homelessness from health services.	**Less than half of all clients (41%) reached a housing goal**

assessment tool to guide process • Engaging with clients whilst they are engaged with the health facility to support proactive planning for housing • Assertive outreach – meeting clients where they are at in the community and building a trusting relationship over time to foster engagement with the program Core component two: Person-centred and coordinated support • Support Facilitators to coordinate support using multidisciplinary approach as determined with the participant	A coordinated approach to care planning ensures clients receive the services they need in a timely and coordinated manner, maximising wellbeing outcomes. Providing housing to clients will enable them to feel safe, stable and allow them to focus on	with housing provided • Participant satisfaction with support provided • Number of times participant engages with planned support per week Implementation outcomes	social/community housing rental agreement	MA CRM & Pathways; private rental lease agreement or social/community housing rental agreement	agreement or social/community housing rental agreement	To ensure participants independently sustain housing in the long term. To improve participants' overall wellbeing. To increase participants' engagement with health	
			Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey* MA CRM	Participant standard of living and future security scores have improved in PWI/IMT at 6-12 months MA Wellbeing survey MA CRM	Participant has maintained an improved score in standard of living and future security domains of the PWI/IMT MA Wellbeing survey MA CRM		**Wellbeing survey not administered consistently. No tracking of wellbeing over time. CANSAS was used.**
			Health (physical & mental)				
			Participants have maintained or have been reconnected/introduced to a GP and primary physical and mental (if required)	Participants are engaging with stable primary and mental (if required)	Participants report improved physical/mental health outcomes or improved management of physical/mental		**While 79% of clients were connected to a GP, 21% of clients were not.**

• A multidisciplinary team approach coordinated by a client's support facilitator • A personalised wellbeing plan developed in partnership with the client • Responsive stepped care which can increase or decrease in intensity • Client-centred practice – clients are supported to take responsibility for their supports and make decisions on how they receive support	improving other aspects of their well-being to build resilience and ensure long term self-management and tenancy sustainment Prioritising participants' most immediate issues (e.g., mental health), and developing pragmatic solutions to these issues, allows participants to focus on		health care within 3 months. MA CRM	health supports at 6-12 months An increase in the use of primary health care services and reduction in drug and alcohol and/or mental health related Emergency Department presentations MA CRM	health issues at 12-24 months An increase in the use of primary health care services and reduction in drug and alcohol and/or mental health related Emergency Department presentations MA CRM	services, education, training, employment and community/social activities, and fostering greater social connection.	**Original program logic provided for a specialist mental health care worker – this was not implemented with MA reporting clients already had clinical supports in place or could access these CANSAS was used.** **One client reached employment goals.** **No clients undertook education/training or structured activities.**
			Participants have engaged in a	Participants report improvements	Participants report sustained improvements in		**Wellbeing survey not**

• Trauma informed principles and practices Core component three: Accommodation • A range of housing options to match tenant needs – scattered housing approach • Rapid Re-housing Worker – focuses on working with clients to secure housing options and expedite the housing process. • Proactive tenancy support	pro-social activities. Embedding the use of evidence-based practice e.g. (recovery approach, harm reduction approach, and trauma informed care) in the delivery of the program with participants ensures that individuals are supported to maximise well-being outcomes.		PWI/IMT within 3 months MA Wellbeing survey MA CRM	in overall wellbeing 6-12 months MA Wellbeing survey MA CRM	overall wellbeing at 12 -24 months MA Wellbeing survey MA CRM		**administered consistently. No tracking of wellbeing over time.**
			Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant report improvements in health-specific score PWI/IMT at 6-12 months MA Wellbeing survey MA CRM	Participants report sustained improvements in health-specific score in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM		**Wellbeing survey not administered consistently. No tracking of wellbeing over time.**
			Participants have maintained or have been reconnected/introduced to substance use support specialist if required within 3 months MA CRM	Participants are engaging with substance use support if required and have shown reduction in harms associated with use at 6-12 months	Participants are engaging with substance use support if required and show sustained reduction of harms associated with use at 12-24 months. MA CRM		**No data made available to researchers on this.**

• Partnerships with housing providers and real estate agents Core component four: Intensive wellbeing management /Wrap around support • Support facilitator assists client to access external support services, including building a relationship with local GP and specialists, and maintaining supports established during engagement				MA CRM			
			Participants have completed a self-reported measure of suicide ideation and the within 3 months CANSAS MA CRM	Participants are demonstrating reduction in suicidal ideation and or psychological distress if applicable at 6-12 months CANSAS MA CRM	Participants are maintaining a reduction in suicidal ideation and/or psychological distress if applicable at 12-24 months. CANSAS MA CRM		**CANSAS was used however no CANSAS data has been made available**
			Participants have engaged in a wellbeing survey within 3 months MA Wellbeing survey MA CRM	Participants report improved wellbeing at 6-12 months MA Wellbeing survey MA CRM	Participants maintain an improvement in wellbeing at 12-24 months. MA Wellbeing survey MA CRM		**Wellbeing survey not administered consistently. No tracking of wellbeing over time.**
			Social & Community				
			Participants have maintained or have been reconnected/introduced to supportive	Participants are engaging with supportive cultural and/or community	Participants are maintaining engagement with attachment/commitment to social and/or		**No client reached structured activity goals.**

with health service. • Continuity of care highlighted by integrated and coordinated wellbeing management across settings and throughout the program. Example activities: • Cultural/community engagement • Social or familial connection/ reconnection • Training or employment • Development of independent living skills • Financial literacy			cultural and/or community networks and/or structured activities within 3 months MA CRM	networks and/or structured activities at 6-12 months. MA CRM	cultural network; and/or structured activities at 12-24 months MA CRM		
			Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant community connectedness and relationship specific scores have improved in PWI/IMT at 6-12 months MA Wellbeing survey MA CRM	Participant has maintained an improved social connectedness and relationship specific scores in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM		**Wellbeing survey not administered consistently. No tracking of wellbeing over time.**
			Employment				
			People identify employment goals based on capacity and needs within 3 months MA CRM	People engage in employment based on capacity and needs at 6 -12 months MA CRM	People engage in employment based on capacity and needs at 12-24 months MA CRM		**One client reached employment goals.**

Wrap around support may include referral to a number of services: • Income management services • Mental health treatment • Physical health treatment • Substance use treatment • Daily living skills and financial management support Core component five: Employment • Specialist employment worker to work with the client on employment and training options • building employment motivation and readiness.			Education & Skills				
			People identify study goals based on capacity and needs within 3 months MA CRM	People engage in study activities based on capacity and needs at 6 -12 months MA CRM	People maintain engagement in study activities based on capacity and needs at 12-24 months MA CRM		**No clients reached education/training goals**
			Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant achieving in life specific score has improved in PWI/IMT at 6-12 months MA Wellbeing survey MA CRM	Participant has maintained an improved achieving in life specific score in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM		**Wellbeing survey not administered consistently. No tracking of wellbeing over time.**
			Economic				
			Participants are connected with emergency funds; access to Centrelink or employment within 3 months MA CRM	Participants maintain financial stability for 6-12 months MA CRM	Participants maintain financial stability for 12-24 months MA CRM		**No specialist employment worker.**

			Safety				
			Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant safety specific score has improved in PWI/IMT at 6-12 months MA Wellbeing survey MA CRM	Participant has maintained an improved safety specific score in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM		**Wellbeing survey not administered consistently. No tracking of wellbeing over time.**
			Empowerment				
			Participants have engaged in IMT within 3 months	Participants report that they feel clients feel more self-efficacy, more control over their life, that they have choices, they can make decisions and manage their health/substance abuse issues at 6-12 months	Participants maintain feelings of self-efficacy, more control over their life, that they have choices, they can make decisions and manage their health/substance abuse issues at 12-24 months		**Wellbeing survey not administered consistently. No tracking of wellbeing over time.**

			MA Wellbeing survey MA CRM	MA Wellbeing survey MA CRM	MA Wellbeing survey MA CRM		

4.5 Outcome evaluation: Extent to which the pilot achieved the intended outcomes

This section focuses on outcomes including whether the pilot achieved the intended outcomes, and the reasons / factors that contributed to the shortfall against outcomes targets and the appropriateness of the outcomes.

4.6 To what extent did the program meet the needs of participants as set out in participants support plans and their individual program goals?

The H&H program was structured around assessing client needs then setting goals in various domains. The program had nine payable outcomes with four related to housing, and the rest related to employment, training and structured activities. The payable outcomes were as follows:

1. 3 x Months Sustained Independent Housing
2. 12 x Months Sustained Independent Housing
3. 3 x Months Sustained Non-Independent Housing
4. 12 x Months Sustained Non-Independent Housing
5. 13 x Weeks Sustained Employment
6. 26 x Weeks Sustained Employment
7. 52 x Weeks Sustained Employment
8. 64 x Hours of Engagement in Structured Activity/s
9. Training Completion / 26 Weeks Participation in Training

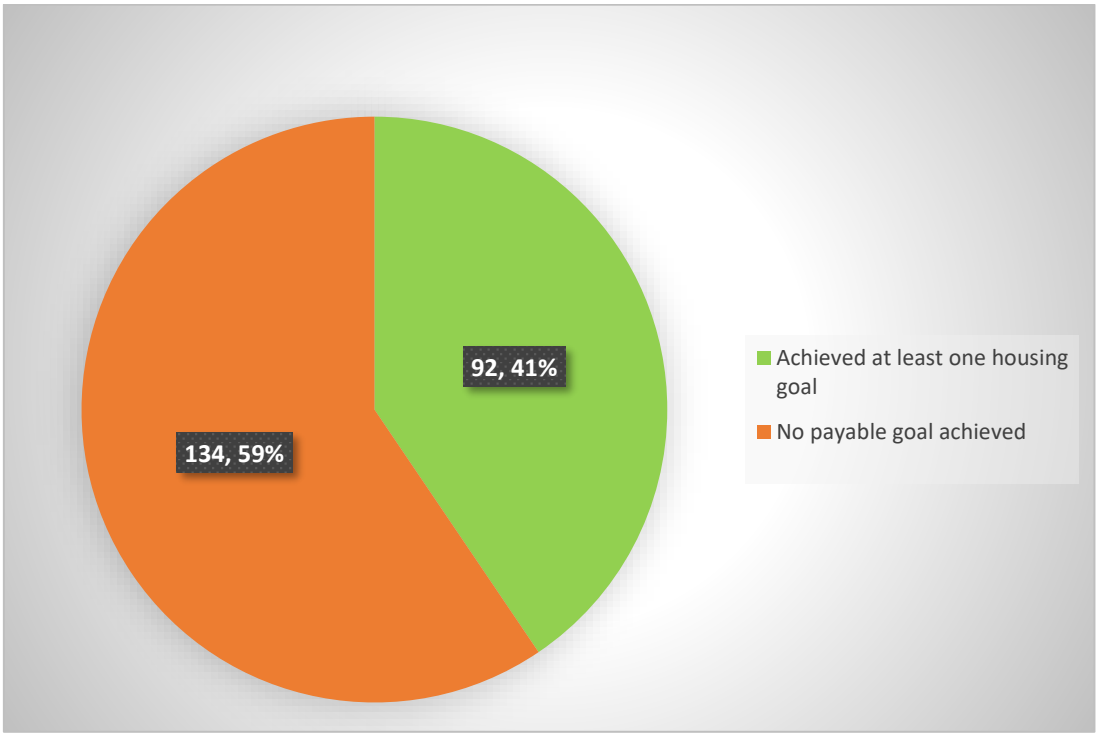
There was also a health goal which was met by 79 per cent of clients by being connected with a General Practitioner, however this was a non-payable outcome so has been excluded here.

The following analysis based on data supplied by MA from their client outcomes CIMS database. When reading this section, it is important to note that one individual could set up multiple goals and achieve multiple outcomes.

Clients needed assistance with housing so setting housing goals was common.

Out of 227 clients, 92 clients (41 per cent) achieved at least one housing goal. 134 clients (59 per cent) did not achieve any goal (excluding the non-payable health goal) (see Figure below).

Figure 4: Client payable goal achievement



A further analysis in Table 11 below indicates the number of clients that achieved the various goals, and the percent of the total clients that achieved that goal.

Table 11: Clients' goal achievements - numbers and percentages

	3 Months Sustained Independent Housing	12 Months Sustained Independent Housing	3 Months Sustained Non-Independent Housing	12 Months Sustained Non-Independent Housing	13 Weeks Sustained Employment	26 Weeks Sustained Employment	52 Weeks Sustained Employment	64 Hours of Engagement in Structured Activity/s	Engaged with GP/other clinical supports
Achieved this goal - number	39	14	61	18	1	1	0	0	179
Achieved this goal - % (n=227 clients)	17%	6%	27%	8%	0%	0%	0%	0%	79%

Note: Any given client may have achieved more than one goal. These outcomes (based on analysis of MA-supplied CIMS data) concurs with the independent certifiers' report (BDO, 2021).

Table 12 below shows a summary of numbers of achieved goals per client (a full client-by-client analysis is included in Appendix C). One client achieved four goals - 3 months sustained independent housing; 12 months sustained independent housing; 13 weeks sustained employment; 26 weeks sustained employment. This

client was the only client that achieved employment goals. One client achieved three goals: 3 months sustained independent housing; 3 months sustained non-independent housing; 12 months sustained non-independent housing. This client went from unemployment into employment. 37 clients achieved two goals, and 53 achieved one goal, all of which were housing goals. No client achieved education/training or structured activity goals.

Table 12: Clients - numbers of goals achieved

	No. of clients	Per cent
4 goals achieved	1	0.4%
3 goals achieved	1	0.4%
2 goals achieved	37	16.7%
1 goal achieved	54	23.3%
0 goals achieved	134	59.0%
Total	227	100%

While 11 people reported being in full time or part time work on entry[1], none of them achieved the employment goals of the program, which required sustained employment, or an increase of 14 hours paid work a week. While seven clients on intake were recorded as being engaged in formal study, no clients reached the education/training goals.

In addition to the payable goals reported on here, the CIMS included a being 'connected with GP' goal[2]. MA reported that 179 out of the 227 clients (79 per cent) actively engaged in the program met this target by continuously engaging either with a General Practitioner or any local health services post clinical discharge.

Client characteristics were not strongly predictive of who achieved housing goals. For clients classed as 'homeless' on presentation (in emergency accommodation, boarding houses, couch surfing, living in car or boat, improvised dwelling/park/street or couch surfing), of 178 clients, 69 or 39 per cent achieved at least one housing goal. For those presenting as adequately housed (that is, in private rental, social housing rental or transitional accommodation), of 49 clients, 22 or 45 per cent achieved at least one housing goal.

For those with some form of physical, medical, mental illness/psychiatric disability, or acquired brain injury, of 191 clients, 81 or 42 per cent achieved at least one housing goal. For those that had no declared disability, out of 36 clients, 12 or 33 per cent achieved at least one housing goal (i.e., at a lower rate than those with a disability).

[1] Six of these nominated 'employee income' as their main source of income while the other five nominated various Centrelink payments as their main source of income, indicating low hours of employment.
[2] This goal was requested just prior to the program starting and development of the Operations Manual. Therefore, it became a reportable "goal" but not a payable outcome.

For those with alcohol and other drug issues, of 156 clients, 71 or 46 per cent achieved at least one housing goal. Of those who declared no AOD issues, of 71 clients, 23 or 32 per cent achieved at least one housing goal, i.e., at a lower rate than those with an AOD issue.

For Aboriginal clients, of 35 clients,13 or 37 per cent achieved at least one housing goal. For non-Aboriginal clients, of 121 clients, 55 or 45 per cent achieved at least one housing goal (i.e. at a higher rate than Aboriginal clients).

Bivariate chi-square tests and multivariable logistic regression analysis were conducted to assess factors associated with the 92 clients who had fully achieved any housing outcomes (versus the remaining 133 clients without fully achieving any payable outcomes), two significant factors were identified:

- Factor 1 support level: higher levels of program support were associated with fully achieving any housing outcomes (adjusted odds ratio=1.83; 95 per cent, CI 1.02-3.28, p=0.041). This was reflected by 50 per cent of clients with 'high' support needs had fully achieved any housing outcomes, whereas 36 per cent of clients with other levels of support had done so (p=0.03).

- Factor 2 year of program referral: those referred into the program in 2019 calendar year (vs. 2020-2021) were more likely to have fully achieved any housing outcomes (adjusted odds ratio=2.09 95 per cent, CI 1.14-3.83, p=0.017). This was reflected by 55 per cent of clients referred in 2019 calendar year (i.e., the first six months of the Year 1 Pilot stage) had fully achieved any housing outcomes, whereas 42 per cent in 2020 calendar year and 7 per cent in 2021 calendar year (p<0.001).

- Other factors including age, Aboriginality, domestic and family violence experiences, disability and referral agencies (predictor variables likely to be associated with the outcome variable on the basis of literature and bivariate associations) were not related to being able to achieve at least one housing outcome.

Goals are examined in Table 13 below. Of the 499 payable program goals initially set by the 227 clients, about one-fifth to one-quarter were housing goals: 3 months sustained independent housing (26 per cent); 12 months sustained independent housing (25 per cent); 3 months sustained non-independent housing (22 per cent) and 12 months sustained non-independent housing (22 per cent).

Only 5 per cent of the original 499 goals set by 17 clients (7 per cent of 227) were related to employment, participation in structured activities or training. Only one client fully achieved two goals in the employment domain.

In terms of client numbers (as clients had multiple goals), only two clients partially achieved an employment goal, one client partially achieved two education/training goals and one client partially achieved a structured activity goal. Table 13 below illustrates goal attainment. MA included a category, 'partial achievement' which has been included here. This meant that, for example, a client had been housed, but not for 3 months (i.e. had not reached a metric under the terms of the program documentation and contract). However, it has been included here. It should also be noted that clients coming to the program later had less time to achieve payable goals. The early closure of the program was key factor in this case.

Table 13: Client goal setting at intake and goal achievement by number of goals (N=499) and number of clients (N=227)*

Total number of goals=499 Total number of participating clients=227	Fully achieved	Partially achieved	Subtotal (%)
3 months sustained independent housing			
Number of goals	39	11	128 (26%)
Number of clients	39	2	41 (18%)
12 months sustained independent housing			
Number of goals	14	34	124 (25%)
Number of clients	14	16	30 (13%)
3 months sustained non-independent housing			
Number of goals	61	6	111 (22%)
Number of clients	61	4	65 (29%)
12 months sustained non-independent housing			
Number of goals	18	49	112 (22%)
Number of clients	18	36	54 (24%)
13, 26 or 52 weeks sustained employment			
Number of goals	2	4	19 (4%)
Number of clients	2	1	3 (1%)

64 hours structured activity engagement or participation in training for 26 weeks or till completion			
Number of goals	0	2	5 (1%)
Number of clients	0	1	1 (<1%)

*Allowing multiple counting of per client in the number of clients columns.

In relation to the low numbers of employment, education and training, and structured activity outcomes, it should be noted that in 2020 and 2021 calendar years the delivery of the H&H program was affected by lockdowns associated with the COVID-19 pandemic, preventing face-to-face client contact. In addition, the employment situation was significantly affected by the lockdown periods, necessitating introduction of emergency 'JobKeeper' payments and the Centrelink payment supplement due to mass job losses.

This analysis shows relatively better outcomes for housing goals than for all the other goals. Housing First models strive to achieve permanent housing first, and thereafter clients are supported to reach other goals once in stable and affordable accommodation.

Given the client profile (older, with complex mental health and alcohol and other drug issues, and unemployed and not in the labour force), the macroeconomic conditions in the economy at the time (including mass job loss in the pandemic's initial phases in 2020), non-housing goals may have been more challenging to achieve. In addition, there was a supposition on MA's part that a percentage of H&H clients would be lower needs, however this was not the case.

Professional stakeholder views

Caseworkers worked with H&H clients to meet their immediate needs for shelter (housing), and then progressed to discuss other possible goals like employment, education/training and structured activities. Health care was also a goal and MA claimed most clients had a GP and/or other clinical supports.

Housing outcomes

Housing outcomes were in a hierarchy with some types of marginal housing not linked to a payment at all, including SHS temporary accommodation and boarding houses, while social housing tenancies and private rental tenancies classed as 'non-independent' providing a lesser payment paid at a certain level, while 'independent housing' classed as non-subsidised private rental attracting the biggest payment, (double the payment for non-independent housing outcomes).

Housing goals were to sustain a tenancy in independent housing (i.e., private rental with no private rental subsidy or home ownership) or in non-independent housing (i.e., social housing or private rental housing with a private rental subsidy) for 3 or 12 months.

MA met the most basic need of all for 41 per cent of clients – supporting them to find relatively stable housing, either in the private rental market or in social housing.

Some clients chose housing forms classified as secondary homelessness "for whatever reason…they don't want to leave their boarding house, they're very happy there. But it's not classified as an outcome in terms of what we can claim" (Stakeholder 9). Other clients chose to minimise housing costs to keep their incomes for other purposes.

> *Quite often, you're going to have a client that says, "I'm happy to couch surf on my friend's sofas sporadically, and I'm not willing to accept your offer." In that way, we're giving them what DCJ would deem affordable private rental. In other words, we're showing them affordable, private rental within what DCJ deemed to be affordable. But it's almost 40 per cent of their Newstart allowance. They're not happy because they know that at this point in time, that's going to take a significant chunk of it, and that's going to inhibit their social life… and that's what's really important to them. (Stakeholder 7)*

Private rentals in inner Sydney are relatively expensive for people on low incomes. The situation is usually quite constrained, but there was a slight window of opportunity due to the pandemic, which put downward pressure on rents in certain areas in Sydney.

> *Like $220, $230 [a week]. And we only got them because of COVID. Otherwise, they would have been $250, $260…. They weren't [in a] boarding house. There were like studios, but they were not much bigger than... they were pretty much a bathroom, little, tiny kitchenette. And we're talking about a little stove and a fridge. That's it. (Stakeholder 7)*

For someone on Centrelink payments only, and as alluded to by MA staff above, such rents represent a high percentage of total income. Where clients did move into private rental but had complex needs and low incomes, MA said they often used a private rental as a 'holding pattern' until they could work with the client to lodge a social housing application. However only six clients achieved both an Independent and Non-Independent Housing Outcome which would fit this trajectory.

An NSW Health worker recounted:

> *I know one person was, it was probably a very success story. He was an Aboriginal man, supported by what seemed to be a really good support*

> *worker. She was the one who, we kept up each other up to date and she supported him with getting to community housing, temporary accommodations, and then an application for a permanent house. (Stakeholder 11)*

However, she also mentioned others that she did not know the outcome for, or instances of, clients going into correctional centres.

Some elected to exit the program after they found housing. They may have felt they had met their personal goals but did not allow MA to reach them as per a key KPI.

> *So, they basically said, "look you know what, I'm fine, I'm doing okay, I don't need your service anymore. I'm doing all right at maintaining my tenancy." So, after getting me the 12-month outcome, or they've made it clear even before the 12-month outcome, they're like, "go, see you later, don't want you anymore, bye." (Stakeholder 7)*

Sometimes MA found that clients were with another service at the same time as H&H. MA found that for some clients who were referred to H&H but were already engaged with another homelessness program, it was in their interests to remain in that program, “but they liked having us there as well, [and] we were doing the work as well that we were not going to be paid for. So, it did cause a lot of issues in the first early implementation time, and then sort of spattered throughout as we began to work out how we could find out who was with who” (Stakeholder 6). Transitioning clients to other programs meant MA did not always receive an outcomes payment, despite undertaking work with the client.

Health outcomes

MA reported that 79 per cent of clients self-reported they were connected with a General Practitioner. The health goal was not a payable outcome. Clients had various physical and mental health issues and a high rate of comorbidity. Many had probably experienced trauma, which “takes them out of health system” (Stakeholder 16).

MA indicated they were achieving client health goals (79 per cent achieving this goal) by stabilising clients, and ensuring they were in touch with a General Practitioner, specialists, mental health specialists and community care-based programs. Another person thought MA did not focus so much on physical health issues: “I think our focus was predominantly on psychosocial support, but getting them stabilised enough to get beyond their physical stuff” (Stakeholder 8). A stakeholder thought the program had had an “enormous change in a person's life because of the impact on their wellbeing” (Stakeholder 7).

A stakeholder from NSW Health observed that Home and Healthy staff “did contact mental health staff, and vice versa. That was happening” (Stakeholder 18). Clients

also had other pressing needs. Unfortunately, there were some clients that “just disengaged, so it didn't matter what we did, we couldn't get through to them…I think we had three or four, maybe that passed away” (Stakeholder 6). This was due to a number of reasons including chronic disease and one suicide.

Employment, training and structured activity outcomes

Employment goals involved sustaining employment for 13, 26 or 52 weeks (and if a person worked 14 hours more than at baseline). Education/training goals were 26 weeks continuous involvement in a training course or completion thereof, for courses listed in the Smart and Skilled NSW Training List.

Only one client fully achieved sustained employment goals, maintaining employment for 13 and 26 weeks. The client did not sustain his employment to 52 weeks despite having good supports and appearing to be “doing really well” (Stakeholder 7).

Intermittency or employment abandonment was an issue for the small number of clients that attempted the employment goals:

> *Not all of them have been sustained… would say the big things, factoring not sustaining employment, is mental health, drug use, alcohol use that tends to be the biggest impact and tends to be the biggest impact in gaining employment in the first place. (Stakeholder 7)*

Many clients were on DSP (or wanted support to apply for DSP) which meant they were not working or could not work; “A lot of them didn't have a work history… for ones who were dealing with alcohol issues, they, in a sense, have exemption from JobSeeker because they're treatment-seeking and they're focusing on their treatment” (Stakeholder 6).

Involvement in the informal economy to supplement income from Centrelink may be a factor in the poor sustained employment outcomes. This would need to further explored with clients to understand the factors influencing such decisions and behaviour. Reportedly, some clients were doing various forms of work for cash:

> *To be honest and be frank, we had people who were sex workers… people who don't declare their income…. We had a lot of masseuses, so we have quite a few people who work, but they don't declare their work… undeclared labouring…removalist work. I think we have got a couple of drivers… (Stakeholder 7)*

In summary much of the cohort was on DSP and effectively not in the labour force. Others were involved in the cash economy, so their income-generating activities did not count. Those small number who did attempt sustained employed did not meet the goals (except for one client).

The cohort tended to struggle with obtaining and sustaining employment. As one government stakeholder reflected:

> *So, there's no avoiding the cost to government… There's no employment outcomes for those people. And with younger people, if you can support them to change their lives, such that they can keep housing and go into employment, then the lifetime of savings for government, the lifetime avoided costs can be so much longer. (Stakeholder 5)*

With regard to education, no client achieved any education or training goals. One person stated they thought MA they missed an opportunity with encouraging clients into education because due to the COVID-19 pandemic, there were free courses available which could have been suggested. MA contended that due to the significantly complex nature of this cohort, clients were unable to engage in these courses. Clients would have been receiving the COVID-19 supplement payments for a period which "could have gone into training and education there as well. So, they didn't do anything there" (Stakeholder 3). However, the lack of face-to-face learning options during lockdown would have been a major barrier for many clients due to low levels of literacy and IT skills.

MA staff spoke of the need to stabilise clients first, get them housing, which was difficult in itself.

> *Engaging clients in in structured activities, or in volunteering, or in community, those sorts of things, it's almost like the last cab off the rank once you've done the work. Then any of them with mental health issues and those sorts of things, and the cyclical nature of that, meant that we had to be monitoring them for if they were not doing very well or if they were falling behind in arrears and things like that. So, it was something that was an aspiration, but not always able to be achieved. (Stakeholder 6)*

If the program had gone beyond the 24-month pilot period into the scale up phase, MA staff felt they could have achieved more of the employment, training and structured activity goals, post housing and stabilisation of clients: "if you could stabilise and support somebody for two years, then those other goals became realistic goals rather than unattainable goals" (Stakeholder 12).

Client views

Supports were accessed by clients based on the urgency of their needs and their current health. For most, housing was an immediate need. Once any health concerns had stabilised (Client 12), H&H staff were then also able to identify and support other goals including training, and other needs. For this reason, the period of support (up to two years) was considered necessary and appropriate.

And the fact that it was for two years, I think was really helpful… it was a government funded initiative for the long haul. It wasn't just like a next in line, next, next, in, out, kind of experience. It was like, we're committed to you for two years to get results and to get you out of this hole that you're in. (Client 3)

Housing outcomes

While not all clients may have had pressing housing needs when they joined the H&H program, all the clients interviewed for this evaluation were facing a health crisis at the point of referral into the program. Some clients were already in temporary or emergency accommodation, facilitated by other agencies (Client 1), staying at youth hostels (Client 7), or couch surfing (Client 3). Others had nowhere to go once discharged from hospital and asserted that they would have been homeless without the support provided by the program (Client 2). Therefore, the immediate support provided focused on meeting both short and long-term housing needs.

To address immediate needs, H&H staff supported clients in identifying options, and providing practical solutions like organising storage for belongings while their housing situation was resolved (Client 3). H&H staff also worked with other agencies to help find short-term accommodation, such as through the Wesley Mission (Client 8), or transitional housing provided by a SHS or social housing provider (Client 9).

Many clients reported the inadequacies of interim or boarding house accommodation, such as not being accessible (Client 4), not having access to a kitchen (Client 5, Client 12), or being of very poor standard with leaks and black mould (Client 5). H&H staff worked with them to apply for more suitable short-term accommodation before looking for a longer-term solution in a more favourable location.

I ended up moving to [accommodation] where it was only about four steps to get up. And it was on the lower floor. So that was... What's the name? What they call a studio apartment (Client 4).

So, I'd do all sorts of food on the sandwich press. But if I had to do pasta, I had to carry all the induction cook top, all the pots and the pans for the pasta, all the ingredients to this little room with the power points. And it would take me an hour just to do a plate of pasta, and I'd have to carry everything back. It was terrible… It wasn't even a kitchen. It didn't even have cooking appliances. (Client 5)

Others needed to be closer to family, for example to support elderly parents (Client 1), or for their own supports including doctors and other health care services (Client 1).

Most clients interviewed were currently in private rental accommodation while some were in social housing (either capital stock or head-leased). While private rental is relatively expensive compared to public housing, it provided choice in terms of location (both proximity to family, health providers, and public transport), and safety and wellbeing benefits (Client 1), was in the community or environment they wanted to be a part of (Client 12) and was more readily available. H&H staff were also able to provide letters of support, financial support, and assistance with rental applications and interviews (Client 10). In some Sydney areas, rents had started to reduce due to COVID.

> *I noticed a lot of people were moving out because of COVID. And the prices of the rent seemed to go down slightly. And I just waited and waited until one of the apartments came up and I applied, and it was down by $40 a week. (Client 3)*

For many, private rental consumed most of their funds, particularly when COVID-19 impacted on cost of living and work opportunities. This meant they were more at risk if their income dropped further (Client 3) as it did when Centrelink's COVID-19 supplement ended and they were reliant on other forms of support for basic needs such as food.

Staff also supported clients in applying for longer-term social housing, which was more affordable than private accommodation, and sometimes more accessible (in terms of home modifications; Client 4), but had long waiting lists. This assistance was appreciated by clients who had either had negative experiences with DCJ housing, were unable to attend appointments in person, or were unable to complete the forms required without assistance (Client 5). One person had successfully moved into DCJ housing accommodation within the program period. However, one client moved to private accommodation in a middle ring suburb with the assistance of their H&H support worker, as he was prepared to move outward to find something bigger than the one room he had been living in previously:

> *After I talked with her and I say I need to looking for something like a granny flat, because I like cooking… This is why this granny flat have like a... It's not big, but it's like have a room, kitchen, plus a laundry and the bathroom, everything in one small apartment. It's not expensive, it's perfect, and she found it for me. (Client 6)*

All the clients interviewed had positive outcomes in relation to housing, which is not representative of the majority. Many had to move from short to longer term accommodation, and this was supported by the H&H program in terms of removalist costs, setting up bill payments, sourcing white goods and other furniture, either directly, or through other organisations (Client 8, Client 11). Often H&H staff reached out to other organisations, or worked in partnership with other organisations, such as drug and alcohol services, who were also supporting their client.

Health outcomes

Health outcomes were achieved by 79 per cent of clients (connecting with a General Practitioner or other clinician). Other health outcomes were largely attributed to accommodation – both reducing anxiety about potential homelessness or improving living arrangements and removing stressors (other people, drugs, environmental). Health outcomes were also attributed to more accessible housing (Client 5), or proximity to social and health supports (Client 6).

H&H staff were also proactive in supporting clients to access specialist health services such as clinical psychologists (Client 9) or liaising with health services when clients moved (Client 11). H&H staff also provided support to clients in applying for the disability support pension and the NDIS (Client 4).

Assistance accessing healthcare was provided as health issues arose. For example, staff were able to provide support for those requiring dental care (Client 7).

Many clients commented on their improvement in mental health as the Home and Healthy program had supported them to address problems, such as housing. As one client said:

> *Oh, my mental health – it's like not having to worry about all the major things. (Client 11)*

Diet and nutrition were also mentioned in relation to maintaining positive health. Some commented on support for food costs – although this support was less frequent and sometimes one-off (Client 5).

> *But fresh produce, the most expensive is fruit and vegetables. (Client 5)*

Employment, training, and structured activity outcomes

Once housing needs were addressed, and clients' health stabilised, some clients interviewed started to explore employment (or returning to a previous type of work). In some cases, clients said that H&H staff had initiated conversations about employment. In other cases, clients said they sought help from H&H staff about dealing with Centrelink and looking for work (Client 6). H&H staff worked with clients to identify training and employment opportunities, supported them with interactions with Centrelink to meet JobSeeker requirements, and supported them find jobs – and were more successful in doing so than other government providers (Client 6). H&H staff also provided support with resumes, writing applications, work clothes, and petrol money to get to interviews – either directly or with other agencies (Client 6, Client 11).

Not everyone interviewed was able to look for work due to ongoing health needs (Client 4). One client spoke about assistance provided by H&H staff to build

confidence prior to looking for work, recognising their anxiety about the interview process (Client 8).

> *[The H&H caseworker] realised, okay, this is not a simple matter of finding a job. It's got to be a process of, you got to see a psychologist, got to check your antidepressants, get extra support, you need to get into, build your confidence and all this really helped. And it's not a case that it's just simple, getting a job is going to change your life. It's more than that. (Client 8)*

Likewise, not everyone interviewed needed support looking for work (Client 1). Many had professional training and were looking to return to their industries. Some clients reported needing support in preparing to return to the workforce, such as updating first aid certification, as well as looking for work (Client 12). One client became self-employed as it suited their personal circumstances:

> *It works out well for me, because I don't have to get up early in the morning. I can wait until I'm ready to get up and I'm not too dazed, and so on. Yeah, it works out good for me. (Client 12)*

Another client was encouraged to enrol in TAFE, and while they had to pull out part way for health reasons, they intended to return the following semester (Client 2).

Many clients interviewed were impacted by COVID-19 when looking for work, either due to the impact on the job market (lack of demand for employees) or the public health orders in place in LGAs of concern (Client 9).

While clients mostly talked about housing, some mentioned other activities H&H staff had encouraged them to engage in such as going for a walk with them to talk about their needs. Clients mentioned meeting their caseworker in a café or other public setting like a park. Clients were offered social activities with others, such as walking groups, basketball or picnics (Client 1, Client 4). However one client did not feel that suited their circumstances (Client 1). Many of the activities that were on offer had also been put on hold due to public health orders, such as a community choir (Client 4).

In conclusion, clients did not achieve many of the program's goals. Client data and reporting on outcomes shows that MA fell short on all KPIs except health goals, which consisted of being connected with a General Practitioner or other clinician (this was self-reported by clients, as opposed to being independently verified via provision of documentation[3]). This client cohort was characterised by being older, having long histories of chronic homelessness and drug/alcohol and mental health comorbidities, higher reliance on Centrelink payments like DSP and less engagement with employment than even the average SHS client (AIHW, 2021). Aside from whether all of the program goals and associated expected payable outcomes were realistic, the nature of the client cohort may have impacted the

[3] The Independent Certifiers' Report (BDO, 2021) did not cover health goals.

achievement of payable outcomes that would have been considered desirable prior to the commencement of the program. In addition, the COVID-19 lockdown periods and spike in unemployment due to the pandemic were external factors that may have impacted on opportunities for clients.

4.7 To what extent did the program meet the needs of key stakeholders in accordance with the program objectives?

Professional stakeholder views

NSW Health is a key stakeholder. Hospital and mental health units, and alcohol and other drug clinicians and social workers face the daily challenge of assisting people with complex mental health and alcohol and other drug issues, plus a variety of physical illnesses including chronic conditions. While policy is not to discharge people into homelessness from clinical settings, if a patient indicates they have housing to go to, the social worker takes this at face value. However the person may only be going back to insecure accommodation, staying with friends temporarily, to a boarding house or sleeping on the street. NSW Health staff have no special conduit to the SHS system – they know how to refer and assist patients to access SHS, but ultimately the responsibility for housing lies elsewhere. Therefore, any programs that are rapid, and that can be easily accessed without having to navigate complex eligibility criteria and paperwork, are highly valued.

We found that in relation to H&H this was the case and that clinical staff were generally appreciative of the H&H program and referred many patients to it. They found the referral process streamlined and simple, including the rapid ‘first cab off the rank’ process (there was no waiting list). Operationally, the referral process adopted an easy-to-read weekly email with a spreadsheet which let NSW Health staff know at a glance where the program was up to and the number of vacancies. Clinicians found this easy to use and helpful: “as soon as we got that, we would then contact our respective teams and be like, 'hey, there's three vacancies this week, and it was a first-come-best-dressed system. So, people would then refer” (Stakeholder 14). Another conduit was via the social worker at the hospital who directly communicated with MA, and informed clinicians who then nominated persons for the program. Instead of keeping a wait list, referrals were made as vacancies came up, as a better way of operating in an environment where patients come and go. Clinicians felt that they “could refer anyone” without having to meet complex criteria or jump through too many hoops.

Referral criteria were very broad to include the widest possible range of potential clients. The referral process was viewed as simple and less convoluted than some clinicians were used to.

> *I really appreciated the process, because housing is a nightmare generally for us because we end up spending a lot of time dealing with the bureaucracy that essentially takes us away from our core business. My recollection of the referral process was that it was straightforward, and it was simple, and that the client was ultimately involved quite quickly. (Stakeholder 16)*

This reinforces that NSW Health staff valued the timeliness of the intervention. If there was a vacancy and a nomination, MA would often be in contact within 24-36 hours and was much faster moving than other programs like HASI.

> *Their [HASI and CLS] referral review triage process so accepting is much slower. It's often considered on a monthly or quarterly basis. So sometimes there's not that time factor available for consumers who are on acute units. Whereas I think the rapid nature of Home and Healthy to respond differentiates it from some of those other services that I'm speaking about. So, I think that ability to come onboard quickly and visit the consumer with often a social worker or other staff is something that sets it apart. (Stakeholder 10)*

In hospital settings, where patients can suddenly be discharged (or discharge themselves), speedy and opportunistic interception while the vulnerable person is there and accessible is of the essence:

we're needing a quick response. Otherwise, we can't get people out of hospital if they're relying on that service… And I think it was working well for us in terms of discharge planning and helping to get people out of hospital safely, quicker, more quickly, because there's not many services like this that exist. (Stakeholder 15)

MA seems to have made the most of this and clinicians were overwhelmingly positive about the timeliness for the response.

Clinicians favoured onsite visits from MA staff and viewed this as a ‘strength’ which fostered working relationships to develop between hospital/AOD facility staff and MA.

A clinician in a management position said:

> *In my career in this position, I've never come across a program that's been so well liked by the team both in terms of the email and meeting feedback that I have from staff in terms of its responsiveness, its ability to engage the clinicians and getting people into the program. So, I've had a lot of positive feedback and I continue to get that via email and in person. So, from that respect I would obviously love for the program to continue. (Stakeholder 10)*

A NSW Government stakeholder agreed that the program was unique because it provided “a direct line from Health into the program. And certainly, that’s something the Health people have appreciated” (Stakeholder 4). Another government stakeholder pointed out that this innovative referral straight from NSW Health to an NGO was not dependent on the SII model.

NSW Health staff wanted to know more about the outcomes for the people they had referred into H&H, as sometimes “post referral, we didn’t hear back about what happened... The feedback, overwhelmingly, was good, was positive, that the clients that were referred ... the feedback that I did get tended to be very positive, that the clients themselves found it very useful, that they actually did manage to secure housing, and a bunch of ancillary support around that” (Stakeholder 14). This emphasises the importance of communication back to NSW Health referrers, both for their information and as an incentive to keep referring if they are aware of client outcomes. This meant they could feel confident they had not discharged a patient into homelessness and allow clinicians to focus on their core job.

> *I care about the client, so I need to know that they've properly been picked up. But once I had the sense that they were and they were with a worker that I felt a lot of trust for, then that's enough for me. I'm happy. They can do their job now and I can get back to doing mine. (Stakeholder 16)*

From a NSW Health viewpoint, as well as from MA, the program did pick up persons that, to use a cliché, would otherwise have ‘fallen through the gaps’, as some H&H clients identified this was the first time they had actually received any assistance.

> *So certainly, I think our hypothesis at the start has been proven to be correct, which is that there's a gap between the health system and the homelessness system, or the housing system. So, people do fall between the gaps when they exit health institutions. So, I think there's certainly a need for a program that fills that gap. (Stakeholder 5)*

An NGO staff member said H&H is “partly a system response” (Stakeholder 9) because NSW Health “does not have screening processes or ways to identify people who are not… obviously homeless” and that their dialogue with NSW Health indicated they were keen to “do further work on” (Stakeholder 9).

In summary, NSW Health stakeholders felt the program did fill a need and its core strength was ease of access (including the relatively broad criteria), no need of complex documentary evidence such as that required by the HASI program, and the speediness of referral and action by MA in picking up referred patients.

The NSW Government noted the program did not meet stated objectives to an adequate level based on performance metrics.

There was discussion about verification of the outcomes (that is proof of, for example, outcomes like sustaining a tenancy over a 3- or 12-month period).

Certifying payable outcomes necessitated production of documents that had to be obtained by MA staff from clients (e.g., a residential tenancy agreement, evidence of enrolment in an approved course, a payslip from an employer, etc). Clients' consent to enter into the H&H program included a provision that involved meeting with caseworkers and sharing such documents. However according to MA, collecting this documentation clashed with client-centred practices, and if clients disengaged once they had reached a housing goal, the documentation could not always be obtained. MA could not force the client to give them the documents and nor could they require the client to stay in contact with them. One person reflected:

> *Needing to have that rigour around evidence, which we fully understand, but also being person-centred. And making decisions about what's best for individual clients. So, and we will always make decisions about what's best for individual clients. So, if a client doesn't want to provide payslips or doesn't want to be... Is in a good place and doesn't want to have to give us their rent contracts or whatever that might be, then we don't want to be doing that. That's that client's choice. (Stakeholder 9)*

A government stakeholder however also noted that this could risk client disengagement and undermine worker-client trust.

> *It goes against person centred practise and empowering somebody in terms of wellbeing because you're basically saying "I don't believe you. You need to prove it." (Stakeholder 13)*

The need for MA to engage the client long-term meant that even if a client had "moved on" (MA stakeholder's characterisation) with their life, they would be asked for certain documents like rent statements, "By someone you engaged with a year ago… I can understand why social impact investment needs to have that auditing component, but it's very challenging for programs like this" (Stakeholder 5). Another went so far as to say the requirements "really hindered staff's ability to focus on the client. [What] I could say that … is that staff were really challenged … with the outcomes nature of the program. We don't get paid unless you [i.e., the caseworker] get the lease. And that is a really horrible… I'm task oriented and solution focused, but I never ever want to do that again" (Stakeholder 7). Government asserted that MA was bound by the contract and operations manual, and thus needed to find ways to evidence outcomes and these needed to stand up to the scrutiny of independent certifiers, "because again it does have a pretty strict process at the end of the day for performance around the certification" (Stakeholder 4).

To complicate things further, the COVID-19 pandemic prevented the usual face-to-face contact between MA and their clients such as home visits during much of the program period which may have had an effect on outcomes and weakened the bonds they may have had with clients, as well as the opportunity to sight (and take copies of) the required documents for outcome verification. An MA staff member

pointed out that the program was modelled under different circumstances and due to the pandemic, “certain arrangements… it’s just gone out the window” (Stakeholder 8).

One stakeholder felt that MA was applying a ‘typical case management’ model and hoping payable outcomes would result rather than implementing specific strategies with clients to achieve the more challenging outcomes (like employment or training).

> *So, in terms of their case model – the case management model is no different. We have spoken to them about this – about the incentive payments and how that might change their model, make them innovate. But they said… “We’ve developed this case management model and we’re confident it works and that’s what we’re using.” So, in terms of that side of it it’s not very different. (Stakeholder 3)*

MA disputed this view, pointing to their strong track record of delivering housing and homelessness programs, and using the best practices with this cohort, adapting its practices during implementation as needed. The underperformance on non-housing goals indicates that perhaps more support or encouragement could have been given to clients to pursue these. However, MA prioritised ‘stabilising’ clients in housing, and then wanted to move onto discussions about other goals with clients (however as the program ended at 24 months, it is unknown whether more clients would have reached non-housing goals like education/training and employment over time).

Given some of the components were not being successfully implemented as per the intent of the program design, negotiation and adaptation was attempted by the parties to the service delivery agreement (which was a mechanism within the contract). However, there are probity issues around significantly varying agreed contractual terms and outcomes. As a government stakeholder explained:

> *We also have a merit list, so that's one or two proposals that came very close to being selected, but the winning proposal had something slightly more in terms of potential value for money. Therefore, once we enter into contract with the main proponent, we can't for probity reasons, just say, "Hey, we selected you as the winner because you set the bar really high. Now that we have given you the contract, we're just going to drop the bar” … “Just change KPI” – but wait a second. You were the winning proposal because of what you told us you can achieve… with the rate card, government said, "These are the outcomes we are interested in. This is the price we will pay. Tell us what you can achieve." The government didn't say the bar is here. The proponents set the bar. (Stakeholder 2)*

There was evidence that the requirement to provide documents such as lease agreements, payslips or bank statements, proof of attainment from an education institution (required documentation was specified in the Operations Manual), showing outcomes had been reached was, at times, stressful for MA caseworkers to obtain from clients. Given the clients’ right to privacy and right to disengage or inability to provide documentation, there was a clear tension between the need for certification of outcomes requiring official documentation and MA’s focus on the

clients' needs and respect for their privacy and right to disengage, when they had reached a goal (like obtained housing). Government offered flexibility on some forms of evidence, for example by allowing a statement from a housing worker on whether a tenancy had been established, instead of a lease agreement.

It is possible that another way of certifying outcomes (discussed in more detail later) could have been used, such as permission to access this data from government agencies, however this would entail complex client consent and data access provisions from agencies like the Rental Bond Board, the Australian Taxation Office and Centrelink, and have privacy implications under the Privacy Act.

Interviews revealed different views among stakeholders as to whether the expected outcomes of the program were realistic and at what point the service delivery agency should have contested the contract or given greater consideration before signing it of its capacity to deliver. As a government stakeholder rhetorically asked, if the service delivery agency has misgivings about the level of client complexity or the contract settings,

> *Why didn't you embed that? Why wasn't that your starting negotiating position? Or this is what you must have had in the contract in order for your program to work… (Stakeholder 2)*

In other words, MA signed up to the contract but according to some stakeholders came into what was "designed to be new and innovative program but expected to run it as if it were a grant program" (Stakeholder 3). Efforts to renegotiate operations and outcomes did not solve the issues. Some felt there was a lack of 'flexibility' under the SII model and that eventually they found, due to the lack of payable outcomes achieved, that "the finances didn't stack up" (Stakeholder 5). For government, adaptation opportunities were finite – larger changes (such as to the outcomes themselves) would have meant a major variation to the program and contract.

In this instance the SII model had not worked for MA or the government as MA could not deliver the agreed outcomes to the level required to make the program financially viable for them and nor was government getting value for money in terms of desired outcomes.

> *I mean, I think that's one of the theoretical benefits of a payment by results mechanism that, and in the literature, it says that payment by results, social impact investments, are meant to encourage innovation by service providers. In practice, in this example, it was the opposite. (Stakeholder 5)*

At the Annual Performance Review, MA's performance was classified as 'poor' (based on progress against outcomes that formed part of the implementation agreement in s. 16 – performance review).

When it became clear that what was tried in negotiations following the annual performance review had not produced significant changes to results, the parties agreed to end the program in the pilot phase, as per the termination clause in the contract.

In summary, in some aspects program was largely implemented as planned, in relation to the referral process, client recruitment and securing of housing outcomes for 41 per cent of clients. However, there were some notable deviations: MA was able to work with clients to achieve some of their goals, but not able to achieve the required level of performance or make the program financially viable for its' own organisational purposes.

Note: client views were not sought on this question.

4.8 How well did staff/organisations work together to achieve participant outcomes/ program objectives? What worked well? What did not work well? Why didn't it work well? And for whom?

Professional stakeholder views

What worked well

What worked well, as discussed above, were the synergies created between NSW Health staff and MA which allowed them to intercept people at risk in health settings and quickly transition them into the H&H program. Timeliness and ease of access (avoiding entry hurdles) were identified as key positives of the H&H program, according to health professionals. MA valued being able to access clients who may not have been in touch with any services beforehand and identified that taking in people via health settings was working well.

> *Okay, so what worked well was the referral pathway from health to us, it's absolutely amazing. That swiftness was absolutely amazing. That worked really, really well. (Stakeholder 7)*

NSW Health preferred MA staff going on-site which strengthened professional working relationships. MA staff also indicated they found this optimal, as it not only built these working relationships but potentially allowed them to identify a range of potential H&H clients, not just those most obviously in need. However, the pandemic restricted the ability of MA workers to enter hospitals and other health facilities, as visitors were necessarily excluded.

The other aspect that MA thought worked well was assertive outreach. The assertive outreach model is ingrained in many other programs aimed at reaching out to rough sleepers.

> *The assertiveness, so our ability to be really assertive with clients and to really sort of be able to get out there and sort of to be quite assertive… we didn't wait for clients come to us, we were assertive in calling up clients to make sure that they didn't want to engage with us, rather than waiting for them to say they didn't want to engage with us. (Stakeholder 7)*

What did not work so well

What did not work so well were the parties' differing interpretations and approaches to program operations, which often occurred in cross sectoral governance structures. The Joint Working Group which included Treasury's OSII, DCJ and Mission Australia (LHDs were invited as required) provided oversight and met quarterly. The Joint Working Group was the forum in which "contentious issues that can't be resolved at an operational level" (Stakeholder 1) were addressed. Sitting under this was an Operations Group, whose role was to manage day to day operations and interagency co-operation. It included Mission Australia, DCJ and the LHDs, that shared minutes with the Joint Working Group. The Operations Group met much more frequently. At these, issues were raised and escalated by MA. The process towards resolution necessitated time and discussions at those meetings. One person observed the amount of negotiation and time spent in the Joint Working Group and operational group meetings was time intensive, where "every move" MA made was scrutinised (Stakeholder 13).

> *It was policing every step of the way, even so much as staffing. How many staff have you got on board? Or why have you got that staff and not that staff? It's like, because we've seen that the model needs to be readapted so that you've got an employment advisor and a housing officer, as opposed to just facilitating partners. So, we have that flexibility and agility everywhere else, but every step of the way, you're critiqued and questioned… (Stakeholder 6)*

There was some disagreement about staff roles. The program logic suggested a mental health clinician and employment specialist as part of the MA support response and peer support mechanisms for clients. However, MA employed rapid rehousing officers instead, on the basis that they considered supports like HASI and community mental health teams were already in place and many of their workers were already mental health trained. If clients were not already accessing a clinician, MA quickly connected them with one. While data suggests 79 per cent of clients reached their health goal, the funder had another view:

> *We had some disagreement between us and Mission Australia on whether that would provide them with benefit. So, we would say definitely you're seeing high levels of mental health, you need a mental health worker. Whereas they saw the need for lower caseloads so wanted to spread that out with extra workers. (Stakeholder 3)*

Not employing a specialist worker was a deviation from the Program Logic. Another person also shared the concern that for this cohort, a mental health clinician was required as part of a multidisciplinary team.

> *I felt that there was a lot of emphasis that needed to be placed on the mental health role because that was the additionality – if that's even a word – that's the additional service that they were bringing to – and allowing us to test not only the effectiveness of payment by outcomes in that sort of structure but also how this program might be different from generalised SHS. (Stakeholder 13)*

It is noted that the health goal of connecting clients with a General Practitioner or other clinical support was not a payable outcome, whereas the housing and employment and training goals were. This may explain why MA chose to employ specialist workers for these aspects.

Decision to discontinue the program

In 2020 in the period leading up to the annual review, an early review of data indicated likely 'poor performance' (as per clause 16.4 of the contract, which outlined the performance review process). Prior to this data review, there were months of discussion and proactive actions in an attempt to improve performance. Despite the efforts of the parties the required performance benchmarks could not be met. A report endorsed by both parties was produced close to the end of the 18-month pilot period (to 30 June 2021). Considerations included (i) whether the program would provide value for money for government and (ii) whether it would be financially viable for MA (Stakeholder 1). A mutual decision was made to not continue beyond the pilot. Following this, there was a transition period from July 2021-30 November 2021 where clients were transitioned out of the program.

Some participants referred to tensions between government agencies and MA, who stated they were putting their clients' needs at the centre of their considerations, finding it hard to obtain and/or certify some of the specified payable outcomes for their clients. One stakeholder thought MA used this argument to avoid introspection and change, treating the program like a grant exercise, while MA stakeholders tended to refer to the difficultly of caseworkers trying to 'push' clients towards goals that clients did not really want. Participants discussed tensions on the JWG:

> *I think between funded organisations and the government – it almost feels like in the Working Group that there's really an adversarial relationship and at points I feel like it's been brinkmanship about who's going to give in or break first. (Stakeholder 19)*

> *I just wanted to also support [Stakeholder 19's] comments around the cultural differences or almost what seems like combative nature. (Stakeholder 13)*

Another view was that:

> *The governance structure performed well for the purpose for which it was put in place. It was put in place to raise issues at an earlier stage. It performed that. It was a platform to start discussion how we could mitigate some of the risk. We did that. (Stakeholder 2)*

The role of government staff was to manage a contract. Government pointed out that they had to accountably spend taxpayers' money on programs and that while this was cast as a partnership, "the reality is they're contract providers" (Stakeholder 13).

Stakeholders raised the issue of the influence of NSW Treasury (which OSII sits within) and the Department of Premier and Cabinet on program expenditures and structuring. There was a view that Treasury made the ultimate decisions even though DCJ were managing the program contract. A stakeholder commented:

> *They [Treasury] say that they're supporting us and that's their role. They are the funders. But they definitely have a veto. So that's something that's in the back of my mind is when we put a position to them and they'll say "Yeah, yeah sure. What do you want to do?" And then you say, "Well we want to do this," and they'll say "No, no you're not doing that." So, you do have to be careful. (Stakeholder 3)*

While this analysis presents frank views from participants, and notes tensions between government departments, and between government and MA, it should also be highlighted that despite disagreements and differences in organisational cultures, the different stakeholders could see and understand each other's rationales and worked together to try to make the program work for all parties.

In terms of on-the-ground co-operation, MA generally had a positive working relationship with NSW Health social workers and clinicians during the referral process. However, there were the different views on what agency had the expertise to lead on certain aspects such as clinical and other support to clients to assist them with goals like structured activity, training and employment, and taking a strengths-based approach. A clinician noted:

> *I think that from the support facilitator of Mission Australia having joint meetings with care coordinators and the health team I think is a gap at the moment and often the only interaction between the two is when a problem arises or when they're exiting the program… I think that health need to better understand Mission Australia and vice versa because sometimes - and I've been involved in these partnership meetings. It's like speaking two foreign languages together. There's different expectations and one group's understanding of complexity is different to another's. The same is true in the development of wellness plans and case plans as well. So, I think that health needs to lead that more than Mission Australia because I think clinical expertise is stronger with us obviously for the range of specialists that we have. So, I think health should take that lead role. (Stakeholder 10)*

While the to-ing and fro-ing between the parties on the Joint Working Group did not affect the basic functioning of the H&H program in terms of operations, none of the outcomes were achieved to the desired performance level. This was likely not due to the governance structure, but more to do with the nature of clients in the program, external factors like the impact of the pandemic, and the payable outcomes, some of which (e.g. entering into and sustaining employment) may have been unrealistic for this cohort, despite the additional resources provided to the program.

Housing outcomes were not achieved for the majority of clients. Some NSW Health staff expressed the view that the program would work better if it had additional housing attached.

> *Look, I think if it had the housing stock or properties available within the program or maybe attached to Mission Australia within the program that would be an added strength or benefit of it. (Stakeholder 10)*

The process of applying for private rental and/or social housing was reportedly time consuming. “It felt like basically they were just doing case management in trying to find a house from somewhere, which then just didn't seem different to a lot of other services” (Stakeholder 20).

Client views

What worked well

H&H client interviews indicated the program worked well for the individuals assisted, however with the caveat that only 12 individuals were interviewed and were not representative of the overall cohort as they generally had achieved sustained housing outcomes. Firstly, it found them when they needed help. Secondly, it was supportive and resulted in a minority getting into some form of stable housing. Finally, it provided long-term (24 month) support, which the clients really valued and allowed them to develop relationships of trust based on regularity and persistence of contact. They generally spoke highly of the empathetic nature of their caseworkers.

The clients we interviewed strongly endorsed the program’s housing and wellbeing outcomes. Many of the clients interviewed highlighted that the program had a profound impact on their circumstances and their lives, as some had never received any assistance previously. Many said they would have been homeless without the support of H&H.

> *If I didn't have them, I would be literally on the street. So, I can't thank them enough. (Client 9)*

Others highlighted the positive impact of the program on their life.

> *I just want to be clear that the program is fantastic, and they're helping a lot of people and make sure the government don't cut any more programs like*

this, because at the end of the day, it's helping people to stay alive. In my case, if it wasn't for [H&H], I don't think I was strong enough to continue. … all I can say, that if you're recording this, and someone is listening to this, I hope no cutting any more programs from the government… They're seriously helping and saving lives. (Client 8)

I don't know where I'd be without them actually. I think I'd be laying in a gutter somewhere in the city on drugs again. (Client 11)

While the program itself appeared to be performing best in obtaining housing outcomes, interview data highlighted the broader inadequacies and complexities of social supports, including housing stress cause by high housing costs, financial vulnerability, food insecurity, complexity of navigating and accessing fragmented services, long wait times for social housing and low Centrelink payment rates.

It's so expensive now. It's hard to live on $120 a fortnight, that's what I'm left with. How can you live on that when you got fares and food and you've got a phone and the rest of it? It's hard. (Client 10)

They also highlighted the limitations of the care offered by clinicians in busy health settings, where dispensing medication was the main intervention:

The only thing that they cared about was, and it's important to make sure my medication and all that was... But that's where the buck stopped for them. (Client 12)

In contrast, H&H provided long term and holistic support.

Everything was professional and organised. They've done everything that met my needs, helped me mentally and physically. (Client 4)

In some cases, clients were unsure who was doing what, only that H&H staff were coordinating support from other organisations.

There were a couple of charities involved, but I really don't know who provided what items. (Client 5)

This was of concern to one client who was unsure about warranties for items (Client 5).

Other clients were aware of who else was providing support.

when I moved to the granny flat ... I think [H&H] contact St Vincent de Paul. ...and they bring to my granny flat, like a bed with a mattress, they bring some, like, drawers, you know, the chest of drawers. ...Yeah, I think it was from St Vincent de Paul, yeah. But through Mission Australia. (Client 6)

[H&H caseworker] is from Mission Australia, but she got in contact with Wesley [Mission]. Wesley's the one that found me an accommodation. And

> *the person that actually finds the accommodation is actually a volunteer at OBK [Our Big Kitchen] and we prepare food for homeless people, and I volunteer there at least three or four times a week. So that helped me to clear my head and make me feel useful. (Client 8)*

In some cases, H&H worked with other organisations to provide supports, in other cases H&H provided referrals to other programs such as HASI, which was able to provide more intensive mental health support (Client 12). Many clients highlighted how H&H were good at solving problems and/or finding the most appropriate organisation to help.

> *[H&H caseworker] is very good at coming up with solutions to anything and everything... if I had a problem to be sorted out, I'd still go back to [them] and ask [them] first. (Client 12)*

What did not work so well

COVID-19 had a significant impact on how people experienced the H&H program, and placed additional constraints on their day-to-day life, from mobility and transport, to accessing employment and services, to cost of living. It also resulted in some aspects of support by H&H staff taking longer time.

> *It's impossible over phones. Where if he came with a computer, whack, whack, whack, we could do it in an hour. We're going to do it in about three or four hours over the phone. (Client 10)*

> *What really stuffed me up, they're good people, everything, everything, COVID stuffed me up, really fucked me up, I'll be honest. When you can't see a person and you're not good with computers or phones and shit like that, or you've got phone troubles, you're stuffed then in this period. I'm chasing my tail, everywhere I've got to go on foot and this and that. Trains and buses and helicopters. It's crazy. Trying to get from A to B and having to show ID just to get in that place. It's embarrassing. (Client 10)*

While the majority of clients did not meet any of the payable program goals, the H&H clients who were interviewed indicated the program did work well for them (noting the small sample of 12 clients). We note that COVID-19 did cut clients off from face-to-face contact with their caseworker during much of 2020 and into 2021 reducing the level of support received.

In terms of who the program worked well for, there was a correlation between time in program and better outcomes being achieved.

4.9 Did the program achieve the intended outcomes in the short, medium and longer term (3, 6, and 12 months)? If

so, for whom, to what extent and in what circumstances?

The program achieved mainly health and short-term goals. Table 14 below ranks goals by order of frequency. There were 134 incidences of 'no goal achieved', 179 incidences of 'connect with GP' goals achieved, 100 incidences of 3-month housing goals achieved, 32 incidences of 12-month housing goals, 2 incidences of employment goals achieved (noting these 2 goals were achieved by one person) and no incidences of structured activity and education/training goals achieved.

Table 14: Goals achieved, highest to lowest number

Type of goal	Number of goal achievements
Connect with GP o goal achieved	179
No goal achieved	134
3 months sustained non-independent housing	61
3 months sustained independent housing	39
12 months sustained non-independent housing	18
12 months sustained independent housing	14
13 Weeks Sustained Employment	1
26 Weeks Sustained Employment	1
64 hours of engagement in structured activity/s	0
Training completion / 26 weeks participation in training	0

While the data indicates that the health goal and 3 month sustained housing goal achievements were higher, the 32 incidences of 12 month sustained housing goals, could have been higher on the basis that those entering the program less than 12 months before the pilot phase ended would not have been able to achieve these goals (which has been analysed elsewhere). Employment, education/training and structured activity outcomes were more elusive.

The client cohort faced multiple health and other challenges. For many clients with high levels of co-morbidity with mental health and drug and alcohol issues:

> *the reality is for this cohort is that they are going to have a need or reliance on government funded programs, probably all of their life, and will be a high user of government funded programs. So, the cost savings to government, even though we may be getting them housed, quantifiably those outcomes, probably as high potential cost savings for the government, because they're always going to be reliant on those mainstream allied health services, clinical services, social housing, because that is the pathway, that's where they're at in their lives. (Stakeholder 9)*

For some clients the H&H program was the first time they had ever received assistance from support services:

> *Some clients, they've gone from sleeping on the streets and never been even in the service system at all… Not even seeing a Centrelink payment… First ever [intervention]… Being in hospital, and now they're living in accommodation long term… Their quality of life has totally improved because they're now got an income that's more affordable… and also have stable accommodation rather than feeling like they're always moving around and unsettled. Also, a lot of people are feeling engaged with their health services. (Stakeholder 7)*

Disengagement from the program occurred for a variety of reasons. Firstly because the client received what they wanted (i.e. housing) and did not want any more contact with MA staff. Secondly because they left the dwelling or area for some reason - including relocation to another area/interstate, incarceration in a correctional centre, entry into a residential rehab facility, or, in some cases, death (deceased n = 7; MA data).

> *The amount of clients who have either deceased, needed emergency mental health support, or ended up incarcerated is actually quite high, comparative to other programs we deliver…We had a number of deceased clients, a number of clients incarcerated, a number of clients with emergency mental health callouts. So, an interesting cohort. (Stakeholder 8)*

MA's goals were to stabilise the client and support them to access sustainable housing that met their individual needs (whether that be private rental or social housing). However, the highest paid outcomes were for independent housing outcomes. Some stakeholders indicated that the non-housing outcomes were not met due to the nature of the clients who faced multiple challenges including health/mental health conditions and alcohol and other drug issues:

> *That's the path they're on unfortunately. They'll need help. And so, we should be providing it. (Stakeholder 3)*

> *This guy will never work, and the KPIs have just got nothing to do with the real world. (Stakeholder 16)*

> *That was a challenge for us because for the payable outcomes we needed to get from them that they had remained housed, and if they didn't want to engage anymore, because they've moved on with their lives, then that's a structural problem with this instrument. (Stakeholder 5)*

Other stakeholders disagreed as H&H included intensive outreach, ongoing client support, and characterised H&H as 'SHS meets a 'Partners in Recovery' model.

> *It's just ended up being an expensive SHS to me (Stakeholder 13).*

This comment reflects the idea that the H&H program was intended to be unlike the standard SHS model and therefore deliver better outcomes than 'business as usual'.

According to MA, the reality was that very few clients set non-housing payable goals for themselves, and even fewer achieved them because of their significant and complex needs. On the other hand, clients set a range of other goals relating to their drug and alcohol use, living skills and social connections, that they did achieve.

While many government programs are aimed at using early intervention to reduce future reliance on government payments by averting negative outcomes for individuals (such as homelessness, unemployment, incarceration, etc.). It was suggested that for this cohort, this was not ‘early’ intervention and some of the goals may have been too ambitious. While this may seem to be a pessimistic view, evidence suggests that significant employment and training outcomes are unlikely to be achieved even after receiving employment and training assistance as national data shows only modest increases (about 4 per cent for NSW and 3-4 per cent nationally) in participation in either full-time or part-time paid employment in 2020-2021 for clients experiencing homelessness and receiving employment and training assistance (Productivity Commission 2022; see Report on Government Services: Homelessness data tables). An evaluation of the ASPIRE program in South Australia noted "modest improvements in engagement with education, training and employment, but this is a slow process and many participants face significant barriers to engagement in these areas" (Coram et al, 2022: 99). While 82/575 of ASPIRE’s clients (14 per cent) were in employment or training of some sort within the three-year period (Coram et al, 2022) there was no time-specific KPI as there was in H&H (i.e. for ASPIRE, working one hour of casual employment in three years would qualify to be recorded as 'engaging in employment or training'). While the ASPIRE outcomes were higher than those achieved by H&H (14 per cent as opposed to 0.4 per cent) it had less strict KPI relating to employment and training than H&H and was a three-year program. H&H was run during a collapsed labour market due to the lockdowns associated with the pandemic and was discontinued at 24 months, so outcomes are not directly comparable.

Given the high level of need of the H&H client cohort it is challenging to directly compare them to the SHS clients as a whole, however we could assume that employment outcomes for H&H clients would tend to be lower than the entire homeless cohort, if both groups received employment support. Therefore stabilisation in housing and improved health outcomes may have been more realistic outcomes (thus reducing pressure on hospitals), rather than anticipating a transition away from support services/Centrelink payments to complete financial independence. This program was intended to deliver something better than ‘business as usual’, but clearly that was not achieved.

4.10 What unintended outcomes – positive and negative – did the program produce? How did these occur?

Professional stakeholder views

There were no unintended outcomes for clients relating to housing, employment, training, and structured activity.

One issue identified was the crowded service landscape with several similar programs aimed at reducing homelessness running concurrently:

> *Fortunately, or unfortunately for Home and Healthy, [and] great for the people… at risk of homelessness, is that we had programs like STEP and STEP 2, and then we had Together Home. And it just seemed to be a myriad of programs come out in the last two years that affected Home and Healthy, because they were being supported by HOST and HART, and then they'll be supported by STEP and then they'll be supported by Together Home and way down the track we would realise that they were being supported. (Stakeholder 8)*

Some clients were reportedly part of several programs simultaneously and may not have disclosed to MA the full range of support services they were accessing. Others may not have understood what staff worked for what agency, and just knew their case worker(s) by their name(s), rather than their affiliation. MA reported this resulted in a lot of time assisting clients who were accessing another program which then delivered the outcome that MA would have been paid for, had they been responsible for that outcome.

> *The client didn't tell us… and then the HASI worker found Together Home for them, and we were working with them, and then of course, we wouldn't get paid for the work that we did with them. (Stakeholder 6)*

Other clients stated it was the first time they had been offered substantial assistance. Information sharing and communication and eligibility and targeting may be improved, perhaps by a common database of all clients in all similar programs that is accessible by DCJ.

Client views

There were no particular unintended outcomes from the clients' perspective.

4.11 Did the program have an impact on the broader service system? If so, in what ways and how?

Stakeholder views

Overall stakeholders agreed that H&H successfully assisted NSW Health to lessen the incidence of discharging into homelessness because it boosted capacity and created a new referral point.

> *It also as I say enables us to discharge because we have a responsibility to ensure that we're intervening in people who are at risk of homelessness to be eligible for programs. So, it means that as a service we're meeting our criteria there in doing that. So, it's a win/win in that sense. (Stakeholder 10)*

> *…it was working well for us in terms of discharge planning and helping to get people out of hospital safely, quicker, more quickly, because there's not many services like this that exist. (Stakeholder 15)*

Another NSW Health staff member said the H&H program was:

> *very positive, that the clients themselves found it very useful, that they actually did manage to secure housing, and a bunch of ancillary support around that (Stakeholder 14)*

The program provided another door for vulnerable people to access services, often where they are at a low point, having been hospitalised or admitted to an alcohol and other drugs facility. While alcohol and other drugs services do exit planning, hospitals and special workers in those settings can't devote large amounts of time to clients, or act as their caseworker after they have left hospital, so the ability to refer patients into a 24-month program that seemed easy and quick to access was a very welcome addition to their suite of responses.

Insofar as other evidence indicates that stable and secure housing outcomes can lead to improved wellbeing, and reduced hospitalisations and other instances of acute care (for example, see Ly and Latimer, 2015 for a meta-review) the hypothesis was that H&H clients would have improved outcomes than if nothing was done differently ('business as usual'). As the program was discontinued at pilot phase, the evaluators were not able to progress to the quasi-experimental phase of the evaluation and the economic analysis based on linked data to check differences in outcomes for the intervention and control groups. Therefore, this question remains somewhat unanswerable in terms of whole-of-system costs.

Client views

While the program reduced pressure on other services and systems and helped clients navigate housing, health and employment (where possible), discontinuing the program may also place pressure back onto other systems (like the hospitals). As part of the program, H&H staff spent time helping clients to access other systems and supports, including the NDIS, HASI, and other supports. When the program did not go beyond the pilot phase, the program received transition-out funding for five months. MA staff helped clients transition to other services where they required significant ongoing support, such as mental health outreach (Client 2), or provided contacts, should the need for more support arise (Client 4).

The transition was professionally managed by government agencies, the provider and caseworkers actively worked with clients to ensure they had a plan, that their health needs continued to be met, and their casework needs would be met elsewhere (Client 4). However, this meant that clients had to start telling their story again to someone new and form new relationships (Client 8).

4.12 What and how can client complexity be defined so that it can be consistently applied in future programs?

Homelessness services often use tools to measure risk of homelessness, housing insecurity and client complexity. Client complexity describes the types of challenges the client faces in terms of health, mental health, drug and alcohol use, income, and education levels, to name a few. Typically, client complexity is conceptualised as the presence of multiple issues or challenges, which may include a combination of factors that produce vulnerability. For example, clients may have alcohol and other drug issues, a diagnosed mental illness, a low income, few social supports, and be in marginal housing forms or sleeping rough. A lower-order level of complexity may be that the client faces homelessness due to an adverse life event such as divorce or domestic and family violence but faces no significant physical or mental health issues and may have other resources they can draw on (for example monetary or family and social supports).

To assess people presenting to services, the use of assessment tools has become common in many countries. These tools can be used to screen for eligibility for assistance/programs, assess needs, and determine priority for assistance by including questions that produce scores for triage purposes. Typically, tools are questionnaires verbally administered by an assessor or caseworker, who then records the answers (and scores, if applicable). These take the form of a questionnaire, either administered by a professional, or, less often, self-administered by the client. The client is often given a risk category based on the assessment (e.g., low, medium, high-needs/risk). This section reviews existing tools commonly used with people experiencing homelessness in Australia, the USA, UK and Canada. Appendix D presents more detail on commonly used complexity measurement tools, including the name (and link to the actual tool if available), what measures of risk and domains, if these assess complex need, can be used to triage (for example by using a ‘points’ system), and validation/evaluation.

4.12.1 What and how assessment tools could be used to measure risk of homelessness and complexity of need?

Tools that attempt to understand the nature of housing situations and other risk factors can indicate risk of (or experience of) homelessness and complexity of needs.

Assessment and screening processes can be used for different purposes: initial engagement, determining eligibility for a service and/or, prioritising those with the highest need and monitoring progress and outcomes (Aubry et al., 2015b). Research has highlighted the need for the development of consistent and comprehensive assessment tools that are validated and appropriate for the circumstances of people experiencing homelessness (Gordon et al., 2019).

Overview of commonly used assessment and screening tools

A commonly used tool in the United States, Canada and Australia is the Service Prioritization Decision Assistance Tool (SPDAT) created by OrgCode Consulting. It was developed as an in-depth assessment tool to be used by front-line workers to prioritise clients and assist with decision about the allocation of services. Formal training, for which there is an associated cost, is required to administer and interpret the SPDAT. There are several different versions; the latest ones are version 4 for individuals (SPDAT V 4.0), version 2 for families (F-SPDAT V 2.0) and version 1 for youth (Y-SPDAT V 1.0) (OrgCode Consulting, 2016).

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) (versions 1 and 2) is another tool that is widely used with people experiencing homelessness or at risk of homelessness. It was designed as a pre-screening tool for organisations that did not have the capacity to undertake the full SPDAT assessment for all clients (OrgCode Consulting, 2015). It was developed by OrgCode Consulting in collaboration with Community Solutions, which developed the Vulnerability Index. The VI-SPDAT is a short survey to ascertain a client's level of acuity (OrgCode Consulting, 2015). The VI-SPDAT was intended as a triage tool rather than an assessment tool. It was designed to assist with prioritising clients that should undertake the full SPDAT assessment. It does not require formal training to administer the survey, as was designed as a self-reported survey (OrgCode Consulting, 2015). In December 2020 OrgCode Consulting announced that they would phase out the VI-SPDAT (OrgCode Consulting, 2021). According to OrgCode Consulting (2021) in light of continued debates about the use of VI-SPDAT and how it took account of issues such as localised risk factors and race and gender, and despite efforts to improve the tool in version 3, the decision was taken to discontinue further work on the VI-SPDAT. OrgCode continued to provide support for version 3 until 2022, but it no longer supports organisations using version 2 of the tool (OrgCode Consulting, 2021).

In the Unites States a Coordinated Entry (CE) system is used for homeless families and people with the aim of streamlining participant intake, assessment, and the referral process. Implementation of the CE system is a requirement for a number of federal programs in the Department of Housing and Urban Development (HUD). The key principles guiding the development of the CE system, based on a Housing First approach first developed by the Pathways Housing First Institute in New York City, include: easy access for clients, ease of use for agencies, housing focused,

prioritised based on needs, sustainability, client centred, coordination of services, accountability, and streamlined processes. (Help, Hope and Home, 2018).

The VI-SPDAT was commonly used as an assessment tool after the introduction of the CE system into homeless services. However, it was noted that the VI-SPDAT did not take into consideration the local context, for example in Southern Nevada the link between gambling and the risk of homelessness (Bitfocus, 2021). Southern Nevada NGOs put together a team to develop a new assessment tool to address these limitations. In 2017 the Southern Nevada Community Housing Assessment Tool (CHAT) was released. The CHAT is used for single adults and household without children to prioritise them for permanent housing, taking account of acuity and length of time of homelessness (Rice, 2013).

The TAY (transition age youth) Triage Tool is also used widely in the United States. It is a brief and non-invasive tool designed to be delivered in a conversational format that aims to prioritise homeless young people aged 18-24 in need of permanent supportive housing (Rice, 2013).

In Canada, the Canadian Observatory on Homelessness convened a Housing First Assessment Taskforce to provide recommendations on screening and prioritisation tools for homelessness. The taskforce conducted a scan of existing practices and screening tools in use and rated them according to criteria established by the Department of Housing and Urban Development (HUD) in the United States. Seventeen tools were assessed using the HUD criteria. It was noted that the screening process should be as short as possible and assess the following domains: housing status, vulnerability status, service use, severity of need and requirement for further assessment4. Three tools were identified as potentially the most useful: Rehousing, Triage and Assessment Survey (assesses the health and vulnerability of people in the community; Calgary Homeless Foundation), the Calgary Acuity Scale (used to assess the level, intensity and frequency of case manage supported required to end individual's homelessness) and the Vulnerability Assessment Tool (VAT) originally developed in 2003 by the Seattle Downtown Emergency Service Centre (DESC) (Canadian Observatory on Homelessness, 2016; Aubry et al., 2015b). The DESC VAT was determined by the taskforce to be the tool that would be most useful in prioritising clients for the Housing First Programs in Canada as it was easy to use, brief and person-centred (Aubry et al., 2015b). The tool is based on a structured interview conducted with people experiencing or at risk of homelessness covering 10 domains: survival skills, basic needs, indicated mortality risks, medical risks, organization/orientation, mental health, substance use, communication, social behaviours, and homelessness (Aubry et al., 2015b).

The VAT has been revised to take account of the Canadian context and incorporate the Canadian definition of homelessness. The VAT is designed to measure a

[4] A comprehensive summary of each tool and its assessment can be found at: https://homelesshub.ca/sites/default/files/ScreeningforHF-Table-Nov17.pdf

person's risk of continued instability and assist service providers to identify those who would most benefit from interventions including supportive housing and/or intensive case management. The VAT assesses vulnerability within 10 domains: survival skills; basic needs; mortality risk; medical risk; organisation; mental health; substance use; communication; social behaviours; and length of time homeless. Conditions for use of the VAT include training from certified trainers and to adhere to instructions from DESC regarding implementing of the tool (Canadian Observatory on Homelessness, 2016).

Housing First Pilots were also established in England in 2019 in Greater Manchester, Liverpool City Region and West Midlands. The intervention was based on Pathways Housing First Institute in New York City noted above and aimed to support "homeless people with multiple and complex needs to access and maintain independent housing" (MHCLG, 2020: iv). The New Directions Team (NDT) in consultation with the sector developed a client assessment tool called the Chaos Index (MHCLG, 2020). The Chaos Index focuses on 10 areas of behaviour (engagement with frontline services; intentional self-harm; unintentional self-ham; risk to others; risk from others; stress and anxiety; social effectiveness; alcohol/drug use; impulse control; and housing. A vulnerability score is produced to assist in decisions about how to target services and support (Homeless Link, 2020). In addition, staff views are also considered (MHCLG, 2020).

Some of these tools, for example the VI-SPDAT, are used in Australia. The VI-SPDAT is an integral tool used in communities involved in the Australian Alliance to End Homelessness (AAEH) Advance to Zero Campaign (AAEH, 2020). However, according to Riseley et al. (2019:10), there are "no known screening tools developed for the Australian context that both screen for common risk factors and monitor the efficacy of these risk factors in order to facilitate primary homelessness prevention".

The Stable Housing Pilot Project (SHPP) was designed to address this gap and tested "a world first screening tool – the At Risk of Homelessness Screening Tool". The tool was designed to identify homelessness early and it was supported by tailored referral pathways connected to training, services and support (AccessHC, n.d.). An evaluation of the SHPP and the At Risk of Homelessness Screening Tool was conducted by the Centre for Social Impact and Swinburne University by Riseley et al. (2019). The evaluation found that the tool had been used a "few times" by the people interviewed but was not in regular use (Riseley et al. 2019: 14). However, staff reflected the need for such a tool. Overall, the tool was reported to be easy to integrate into agencies' pre-existing processes and could be tailored to suit the agencies' service focus. An additional strength of the tool was its simplicity and staff found the training in the use of the tool and support provided by AccessHC to be beneficial.

Another measurement tool used in Australia for adolescents is the Australian Index of Adolescent Development (AIAD) developed by Swinburne University. The AIAD is based on normative scales. The AIAD contains three core indicators: 1) the risk of

homelessness; 2) risk of disengagement with school; and 3) Kessler K-10 (a normative and validated measure psychological distress) (MacKenzie, 2018). The AIAD is a core tool use in the current pilot of the Universal Screening and Support Program (USS) in several NSW schools. The AIAD generates scores that are indicative of risk of homelessness and/or school disengagement, prompting referral for a full assessment and casework support.

In summary, several tools such as the SPDAT, VI-SPDAT, CHAT, VAT and AIAD provide a 'risk of homelessness', 'vulnerability', 'complexity' or 'risk' score both as an overall score and scores for different domains.

What assessment tools support triage? How?

Tools producing scores or ratings (like high, medium and low needs) can be used to triage and ensure a specific client mix depending on the type of service and desired client mix. Some tools are specifically designed to support triage such as the Vulnerability Assessment Tool (VAT), Short Assessment Triage Tool (SATT), VI-SPDAT and AIAD. Scores indicating risk/vulnerability can assist support service to prioritise clients for assistance and categorise level of support required. Where housing resources are finite, this would mean allocating more vulnerable clients to housing with supports, while lower needs clients may be assisted later/less urgently and require housing without support.

As a review of all available tools is too lengthy to include here, Appendix D presents commonly used complexity measurement tools, including the name (and link to the actual tool if available), description, domains measured, number of items/questions, type of tool, time to administer, target population, measurements-scores, triage utility, if training is required, psychometric properties and validation.

The VAT and VI-SPDAT are favoured due to strong validation (the VAT) and widespread use and comprehensiveness (VI-SPDAT).

4.12.2 What assessment tools can be used to monitor progress of future programs? How?

To be useful in monitoring progress, a tool will need high test-retest reliability. Tools that have been subject to rigorous studies to determine reliability and validity are displayed in Appendix D. One example of a tool used to monitor progress is the PWI-A, used in Australia and internationally. This has been subject to tests and has been modified and is used to monitor personal wellbeing via scoring satisfaction from 0-10 for key life domains. Such tools can be used to monitor wellbeing over time.

If a tool is administered regularly with clients, it may indicate how a program is performing– for example the Camberwell Assessment of Need Short Appraisal

Schedule (CANSAS) tool can indicate the current problems or risks the client is facing and whether 'needs' become 'met needs'. If client mix is part of program metrics, then tools that are used to score complexity or risk can indicate client mix. Tools should ideally assess protective factors as well as risks, so that clients can engage in strengths-based work which can build on these protective factors as well as addressing risks.

To monitor program outcomes, the program did measure outcomes using the Client Information Management System (CIMS) to record completion of the agreed outcomes as per Service Delivery Agreement and these outcomes were independently certified. In terms of validating outcomes, recommendations have been made elsewhere on using linked data rather than relying on client self-report wherever possible.

What tools should be used for programs like Home and Healthy?

It is recommended that for programs like H&H, a brief screening tool be used to determine eligibility, determine current housing status and any other risk factors, to facilitate referral. The tool developed and used by MA was adequate for this purpose.

A screening tool should include three or four questions that indicate risk, as well as determining eligibility. MA's tool was fit for purpose as it determined eligibility via a short series of questions, gathered basic information and facilitated speedy referral. It was to determine eligibility rather than to triage. Other examples could be the tool developed by Doran et al. (2012) which was used in an ED setting and contained key questions found to be predictive of future shelter use.

After intake, a more complex tool could be used. Further research could be done into using one of these tools:

- The VAT has been favourably reviewed for reliability and validity (Ginzler & Monroe-DeVita, 2010), and was ranked the VAT first out of 15 assessment tools used criteria established by the U.S. Department of Housing and Urban Development (HUD) (Aubry et al., 2015)

- VI-SPDAT is widely used in Australia and easy to administer, as well as gathering information on the clients' risk factors and producing a vulnerability score. However, Brown et al. (2018) found there are challenges to the reliability and validity of the VI-SPDAT in practical use.

To monitor program outcomes, the program did measure outcomes using the Client Information Management System (CIMS) to record completion of the agreed outcomes as per Service Delivery Agreement and these outcomes were independently certified. In terms of validating outcomes, recommendations have

been made elsewhere on using linked data rather than relying on client self-report wherever possible.

4.13 What lessons can be learnt from H&H for future Social Impact Investments that target similar cohorts?

This section attempts to reflect on some learnings from the Home and Healthy pilot, including the implications of its discontinuation beyond pilot phase.

4.13.1 The program filled a gap by operating in health settings

From accounts of key players (specifically, NSW Health stakeholders), Home and Healthy filled a gap that has existed in the system, providing an easily accessible and timely pathway for referrals from health settings to MA's program which offered a proactive, assertive and flexible outreach and engagement model, and the ability to provide ongoing support to clients once housed.

Co-location of Health and NGO staff on site at hospitals/mental health/AOD units facilitated collaboration, communication and rapid referrals. NSW Health staff are busy and therefore having NGO staff easily accessible and in regular contact facilitated increased awareness and use of the referral pathway. NSW Health staff appreciated the simplicity of the screening/referral tool, having a clear referral pathway and the speediness of MA's response. Shared information such as how many places were available and proactive inviting of referrals meant that MA built up client numbers.

Given the success of the H&H pilot in identifying individuals who may not have been offered assistance before by intercepting them in health settings, a homelessness risk screening tool could be incorporated into NSW Health everyday practice in ED/hospital admissions procedures.

4.13.2 Payable outcomes should be realistic for the cohort

The service delivery contract specified certain outcomes that were payable, such as a client maintaining a tenancy for a certain period or sustaining employment for a certain period. MA, which delivered the H&H program, did not achieve the payable outcomes for this specific cohort. Specifically, the majority, 134 persons (53 per cent), had not achieved any payable outcomes at the end of the pilot phase of the program.

Factors affecting these outcomes may have been that:

- MA unable to certify outcomes (for example, where a client broke off contact with MA and sustained housing for an outcome period, MA were unable to obtain the lease documentation).

- The pandemic meant that there was a significant period where no face-to-face client support was provided

- The pandemic radically affected the employment market, meaning there were less job opportunities

- The program did not progress past the pilot phase, so those clients joining late in the program may have gone on to achieve payable outcomes had it continues into scale up phase

- The majority of the cohort were not able or amenable to achieving the governments' desired goals (specifically employment, education/training) due to their challenges which included mental health and AOD issues)

- Some of the cohort had other priorities such as minimising spend on housing costs, and/or seeking income from informal sources rather than working in the formal labour market

The SII framework that H&H operated in did not necessarily lead to its discontinuation. The pay per outcome model can work, as evidenced by MA's employment services where the service is paid per outcome (i.e., assisting clients obtain employment). However, there were several problems with the payable outcomes for this specific cohort.

Despite the program seeking to take a different approach to other programs, and working with clients towards specific goals, most H&H clients were not willing, capable or interested in meeting some of the desired goals like independent [private rental] housing, employment, training or participating in structured activities. The clientele were vulnerable and, in many cases, had experienced long histories of homelessness including rough sleeping, mental illness and drug and alcohol problems, as well as physical illnesses.

The Productivity Commission's recently released Report into Government Services - Homelessness (2022, see Table 19A.21) underlines modest increases (about 4 per cent for NSW and 3-4 per cent nationally) in participation in either full-time or part-time paid employment in 2020-2021 for clients experiencing homelessness and receiving employment and training assistance. It is worth noting that the same slight increase in employment activity (circa 3-4 per cent increase) applies for pre-pandemic years also. The ASPIRE evaluation noted "modest employment outcomes" for program clients (Coram et al., 2022:99). Given this pattern in the national data, and considering H&H client abilities and disabilities, the

employment/training goal was always likely to be extremely challenging for this cohort.

This begs the question as to whether the prime goal of these types of programs is: to reduce government expenditure on expensive institutional stays (such as hospitalisation, incarceration) or that clients are expected to complete financial independence from the social security and social housing systems?

Programs need to set KPIs that are achievable given the evidence about outcomes before and after support for clients of homelessness services (as per the Productivity Commission's reports, ASPIRE evaluation and other data sources), and the needs and wishes of the clients themselves.

4.13.3 Assumptions should not be made about a 'balanced' client mix

The Government from the outset targeted the SII opportunity to a cohort of people at risk of or experiencing homelessness upon exiting a health facility. Different levels of client support needs were not distinguished because of this 'whole-of-targeted cohort' approach where clients were referred to into the program on a first come first served basis.

There may have been an assumption made by MA that the 'client mix' would consist of a spectrum of low to high needs clients – however this proved erroneous. Over 80 per cent of the clients were deemed by MA to be 'high needs'. Despite broadening the referral points in the LHDs, MA could not find lower-risk clients in health settings, so did not have a balanced client mix, as they saw it. The assumption that there was an untapped reservoir of lower-needs clients is difficult to sustain, although MA supposed there may be one. However, hospitalisation and AOD facility entry are indicative of crisis and extreme need, which would suggest those most likely to be found in these settings are at a low physical and mental point requiring acute care and therefore may have higher and more complex needs. Patients with lower-level mental or physical issues may seek help elsewhere – for example, women fleeing DFV who have sought care for an injury might contact a GP and a women's refuge, a young person might be in contact with a youth homelessness service, thus these lower needs people may be less likely to access in inpatient health and AOD services. Therefore, to access lower needs clients, it could be best to use outreach to ambulatory or community services rather than hospitals and AOD services. Even then, it is not clear that lower needs clients would require the type of support provided by H&H, nor whether they would be motivated to engage in work or training etc. Some may already be engaged in these activities.

A key lesson for government and service providers is to not make any assumptions about client mix and to obtain an accurate picture of what types of people with what

levels of need/complexity would likely be referred into this type of program, which was essentially a first-come, first-served intake model.

4.13.4 Client goals were not always the NSW Government's goals

MA did not meet any of the KPIs relating to payable outcomes. While MA did relatively better in obtaining housing outcomes than employment, education or structured activities, outcomes still fell short of meeting performance targets. Clients are people with their own preferences, agendas and capacity issues, who may not share government priorities. In addition, the collapse in employment associated with the pandemic lockdown period surely must have affected the chances of clients achieving employment outcomes.

For example, one goal of the program was to transit clients into independent housing in the private rental market. Not irrationally, clients sought affordable and stable housing, often preferring the 'non-independent housing' outcome of a social housing tenancy which is inherently much more affordable as rent is calculated as a percentage of income. Clients also chose lower cost temporary or marginal private housing like boarding houses (a form of private housing not covered by the Residential Tenancies Act) or couch surfing, which were not payable housing outcomes. While some clients were transited into private rentals, a factor for client rejection or abandonment was the amount of their income required for rental payments. According to one MA worker, for those with alcohol and other drugs (AOD) issues, "clients did not always want to pay up to 50 per cent of their income on rent, while being challenged by their addictions" (MA, 2020).

The employment goals were rarely achieved (only one client reached employment goals). The vast majority of clients were reportedly unable to attain employment, were not required to look for work, or their employment hours did not increase by the requisite amount to achieve a payable employment outcome. While 55 per cent were on JobSeeker payments, some of these were on medical exemptions due to their mental health or health issues or disability (MA, 2020). About a third (34 per cent) were on Disability Support Payment and not required to seek employment or were only required to seek employment for minimal hours per week. A further complicating factor was that some clients that were officially 'unemployed' were reportedly earning cash income from informal economic activities (MA, 2020) like cash-in-hand removalist and building site work, sex work and petty drug dealing (MA, pers. comm.) and thus may have lacked motivation to enter the formal economy. Another factor that has been well documented as a formal employment disincentive, especially for those on Centrelink incomes and in social housing, are high effective marginal tax rates (EMTR) resulting in erosion of social security payments and upwards rent adjustments (see research on high EMTRs that disincentivise employment and reduce consumption in low-income households, Ingles and Plunkett, 2016; Stewart & Whiteford 2018).

While government is looking for better outcomes for clients including housing outcomes and financial independence, this cohort faced challenges with homelessness, mental health, physical health, and drug and alcohol addiction and also tended to be older than the average SHS client and face greater challenges to do with mental health and AOD use. The evidence for SHS clients shows very low/low increases in employment activity for these types of clients (Productivity Commission, 2022, see Table 19A.21) and these clients' lack of employment outcomes is in line with this data.

Future program design could include people with lived experience when designing programs and be based on a thorough review of the evidence in relation to employment, education and training outcomes and adjust expectations accordingly.

4.13.5 A simple screening tool, and a longer-form triage tool, could be used with clients

MA used a basic version of a client complexity tool to allow NSW Health to screen people to refer into the program. Other studies used simple eligibility/screening tools like that developed by Doran et al. (2022) for use in emergency departments in New York. At screening stage, a small number of key questions that are most predictive of risk are all that is required. Following referral, more sophisticated tools are available for use with clients at the point of intake. The VAT and VI-SPDAT are comprehensive administered questionnaires covering multiple life domains, producing scores useful for both triage and needs assessment. The advantage of these is they are widely used, the VAT has been assessed for reliability and validity, and they produce a score which helps with triage and needs assessment. The VI-SPDAT however is widely used and easy to administer but has been identified as having some reliability issues.

A simple and short screening tool should be retained for use to refer people into programs, but a more comprehensive tool, like the VAT or VI-SPDAT, should be used on intake to triage clients and assess needs.

4.13.6 Availability of affordable housing is key

Payable housing outcomes were not met for the majority of clients. Out of 227 clients, 41 per cent per cent achieved a housing goal. For clients in social housing, rent was affordable. However, for those in private rental (or who attempted private rental) clients found it hard to pay such a high proportion of income on rent, and/or abandoned the tenancy. Some chose to stay in marginal forms of housing rather than enter into private rental, with cost a factor also. Some people choose marginal yet cheaper forms of housing (like boarding houses) or even rough sleeping, both to maximise disposable income – which could be used for other non-shelter purposes - and due to lack of capacity to maintain a tenancy.

4.13.7 The NSW Government should continue and co-ordinate homelessness interventions at the State level

There are a number of programs with similar aims running throughout NSW including H&H, the Together Home Program, the STEP program, HASI Plus and others. While all of these programs are producing housing outcomes for individuals being assisted, an assessment should be performed when the latest Census data on homelessness is released (later in 2022). While previous Census data (2016) indicated the homelessness rate rose by 27 per cent in New South Wales (Australian Bureau of Statistics, n.d). the most recent SHS data for NSW 2020-2021 shows a flat number of clients seeking assistance (about 75,000 per year 2016-2021) with a slightly declining trend since 2016 (AIHW, 2021b). On the other hand, there is emerging evidence of rising rents, increased competition for rentals and increasing dislocation and homelessness in NSW's regions. Once the Census data becomes available, we will have a better idea of that the cumulative effect of the various programs aimed at reducing homeless are, and what more needs to be done, including the co-ordination of various programs (and any efficiencies, as there are several programs with similar aims running in NSW), targets for social housing expansion, and more assistance with private rental, to reduce homelessness in NSW.

The AIHW data and forthcoming latest Census data will give some indication of whether NSW's Homelessness Strategy and the suite of associated programs are working to reduce homelessness in NSW.

5 Conclusion

H&H was a SII program that sought outcomes over and above 'business as usual' government and NGO-led SHS services. It was largely implemented as intended, intercepting people experiencing homelessness in health settings and diverting them into the program, assisting 227 individuals. However, the desired payable client outcomes were not achieved to satisfactory levels. This poses key questions - were the expected outcomes realistic and achievable for this cohort, which faced greater challenges and were older that the 'average' SHS client? What did MA do differently from normal service provision to achieve better outcomes with clients?

Despite delivering the program as planned, payable outcomes were not achieved to the required level. There were differences in assumptions about the cohort. MA reported it assumed there would be a spectrum of clients with differing levels of need, however Government did not share this assumption or see a basis for it. MA identified that outcomes may have been more achievable if the target group had been less complex or if there was a higher proportion of lower-needs clients. In a first-come, first-served program aimed at referring people from healthcare settings, it was reasonable to assume the cohort would likely have high needs. Targeting a lower needs group would have ignored the existing gap in the system for this complex cohort which would have continued to be the priority for NSW Health service providers.

The impact of lockdowns arising from the COVID-19 pandemic during 2020 may have had a significant impact on clients achieving some of the payable goals as (a) face to face casework was reduced and (b) there was a major contraction in employment opportunities throughout NSW as businesses slowed or closed. Given the program ended in 2021, it is hard to know the degree of this impact as it did not continue for long after restrictions were lifted.

Overall, this pilot demonstrated that even with increased resources, case management and clear KPIs, this model was not successful in achieving the payable housing and participation goals of the program. Many people at risk of or experiencing homelessness have complex needs that impact their ability to achieve most of the payable goals, at least within a two-year period. However, client data analysis indicates that longevity of support did, on aggregate, contribute to positive outcomes – the longer clients were in the program, the more likely they were to reach more payable goals (including those who were classified with 'high level' needs). This suggests that either (a) consistent support over 12-24 months was a key factor in the H&H program's positive client outcomes or (b) the most easy-to-assist clients were the most engaged and therefore had better outcomes, or a combination of a and b.

Another factor which limited the success of the program was that clients' goals often did not align with the KPIs set for H&H. In particular, many clients prioritised low

housing costs over housing stability and/or were reluctant to participate in employment or further training.

The study interviewed a small sample of clients (n=12). While these clients were positive about their experiences, without greater gauging of client experience, and non-inclusion of those that dropped out of the program, it is hard to know if this is a representative view. However, all 12 were enthusiastic and thought it a really important program. They had made significant progress in their lives and were concerned that others would not benefit from such a program. Significantly, the program had reached and engaged persons who had never been offered any assistance before, at a time in their lives where they were in crisis and unwell.

The program engaged people from different inpatient and outpatient settings at a point in their lives when they were at risk, unable to manage, and likely to be homeless without intervention. It was evident from talking to clients that most were unsure how they even came to be in the program and really needed support on exiting other forms of care. They were appreciative of the intervention and agreed that picking people up in hospital and similar settings was a very good approach. For some, it was the first time they had been offered any support at all. Stakeholders also indicated that the program filled an important gap in the system, intercepting people in health settings who were at risk of being discharged into homelessness.

Experience from this pilot program and literature suggests that simple one-page tick-box style screening tools are both efficient for time-poor service providers and clinicians (Riseley et al. 2020) and can contain key variables that are reliably predictive of future risk, such as past shelter use and past criminal justice involvement (Doran et al. 2022). After a client goes through referral to intake, a more complex assessment tool can be used. We suggest that the VAT or the SPDAT are both appropriate, comprehensive triage and assessment tools.

The program filled a gap between services, helped people transition from medical care settings to the community, and 94 clients out of 227 did fully achieve a housing goal (although still falling short of the KPI).

The H&H program highlights many of the barriers people face to engage in social participation and to accessing safety nets provided by government. This also indicates that all homelessness programs, including H&H, operate in the context of a broader service system, and outcomes are dependent on the broader system as well as the specific inputs of the program. In particular, the system must provide access to services for a range of clients from those who are at less immediate risk, but who are likely to escalate into homelessness, as well as those who are currently homeless and have other complex needs. More proactive interventions based on well-crafted and validated screening tools could be predictive of potential future shelter needs of clients (Doran et al., 2022). Secondly the system is dependent on suitable housing options being available for the range of clients who enter the system.

A particular issue for the H&H program was the governance model which was based on the approach that governance should primarily focus on outcomes rather than processes, so the service provider could implement and deliver the program without micromanagement. However, the underperformance of the service provider against agreed-to KPIs necessitated higher scrutiny from government into how the methods and operations of the service were impacting the progam's outcomes. This increased scrutiny, and MA's view that there were challenges in defining, obtaining and measuring the outcomes linked to payments, led to tensions.

It may be that SII programs are more effective when they are based on a smaller range of KPIs for the cohort which relate to maintaining tenancies, and avoidance of expensive institutional settings like hospitals/mental health facilities and prison, rather than pursuing employment and education/training outcomes which according to the evidence base on Housing First programs and data from the Productivity Commission on the effects of SHS support on employment outcomes, are very seldom achieved. If the intent of SII is to obtain better outcomes and decrease government spending over the long term, government needs to consider whether the primary aim of these types of programs is to reduce spending associated with institutional episodes (such as hospitalisation, incarceration) and/or reduce consumption of social security payments and social housing provision. The aims will influence the choice of KPIs used in future similar programs.

The modest outcomes from the program are in line with findings from other studies, for example: "Housing First did not appear to significantly increase income" with factors such as being employed at baseline, being male, and being younger, giving greater odds of employment compared with control participants (Poremski et al., 2016, p.603). Likewise, the Productivity Commission's Report into Government Services - Homelessness (2022, see Table 19A.21) underlines modest increases (about 4 per cent for NSW and 3-4 per cent nationally) in participation in either full-time or part-time paid employment in 2020-2021 for clients experiencing homelessness and receiving employment and training assistance.

At the individual level, goals that are set by government may not be highly valued by clients, and this will continue to be a challenge for programs that engage with this high-needs cohort.

6 Recommendations

1. There is a continuing need for a program which intercepts people experiencing or at risk of homelessness who are in hospitals or medical settings. The program was valued by NSW Health clinicians because it provided them with a timely and easily accessible referral point for extremely vulnerable persons leaving health settings. Close links between health, support services and housing sectors should be maintained and strengthened.

2. For SII programs, payable outcomes should be based on evidence of the success rate of particular outcomes and tailored to the cohort, recognising their level of complexity. Governments and other commissioning agents should recognise that:

    i. housing outcomes are more likely than employment and education outcomes.

    ii. client-centred practice may conflict with pre-determined goal setting as clients may not value the goals that governments wish to achieve – for example, participating in the formal labour market; enrolling in educational courses.

    iii. KPIs should be easily measurable and not place a significant load on clients or service providers. KPIs should ideally be assessed through secondary data sources including Centrelink, Housing NSW, community housing providers, and the ATO, rather than requiring the client and service provider to collect burdensome amounts of data. Using secondary data sources would also allow government to measure longer-term outcomes that occur after support ends or clients disengage. However, it is recognised that not all data is obtainable via secondary sources (such as leases and rental payments for private rental; enrolment in education institutions) so some data will still be required from clients.

3. More research and analysis should be conducted on whether there is an ‘untapped’ lower needs group in health settings. Most of those referred into the program were higher needs and this would avoid assumptions being made about likely client mix.

4. A short simple screening tool is appropriate for determining eligibility and facilitating referral, however there is no triage function. However

key questions could be included that are highly predictive of future emergency housing need (Doran, 2021).

Following referral a more comprehensive complexity assessment tool could be used at intake to assess and triage clients. Recommended tools include:

i. VAT (USA) -this has been favourably reviewed for reliability and validity (Ginzler & Monroe-DeVita, 2010), and was ranked first out of 15 assessment tools used by the U.S. Department of Housing and Urban Development (HUD) (Aubry et al., 2015). It has been adapted by other countries for local use (Canada).

ii. VI-SPDAT - this is widely used in Australia and easy to administer. It gathers information on the clients' risk factors and produces a vulnerability score. However, Brown et al. (2018) found there are challenges to the reliability and validity of the VI-SPDAT in practical use.

5. Availability of affordable housing stock is key to achieving outcomes. Service providers should ideally manage subsidised housing and/or have easy access to appropriate affordable housing for the clientele. Private rentals tend to be expensive and less accessible for this cohort.

6. The 24-month support period resulted in better client outcomes so should be retained for future similar programs. The length of support and its consistency was valued by clients, even if they did not need help for that length of time. Low-need clients could be discharged earlier, creating space to take in more clients, and improving client throughput.

7. Better co-ordination of homelessness interventions at the State level is important. This involves improving vertical integration of services and reducing the overlap and gaps in services.

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Appendix A Home and Healthy program logic

PROBLEM	EVIDENCE	INTERVENTION Core components and flexible activities	MECHANISMS OF CHANGE	OUTPUTS AND IMPLEMENTATION OUTCOMES	CLIENT OUTCOMES Describe the specific client outcomes likely to result from each program component across the NSW Human Services Outcome Framework domains			GOALS
					Immediate outcomes (outcome measure) Primarily attributed to the program	Intermediate outcomes (outcome measure) Partly attributed to program, beginning of shared attribution	Long-term outcomes (outcome measure) Shared attribution across agencies/NGOs	
Home and Healthy: a program to prevent people exiting health facilities into homelessness Target cohort: People aged 18-	The Human Services Outcomes Framework: Application to Homelessness (2017) summarised research and programs that	Core component one: Identification and Engagement • Building rapport with people eligible for the program by obtaining informed consent to	Successful identification and early engagement with participants ensures sufficient exposure to program	Immediate outputs • Number of referrals to H & H • Number of participants engaged	Home The provider facilitates timely access to appropriate and safe accommodation (within 3 months)	Participants are demonstrating daily living skills necessary to maintain a tenancy and maintain a	Participants are safely, sustainably and securely housed and maintain tenancy for 12 – 24 months	To decrease the number of people currently exiting into homelessness from

65 who are exiting or engaged with a hospital or community health service who are at risk of or experiencing homelessness. This cohort has been selected due to its significance: 55 per cent of Specialist Homelessness Service (SHS) referrals in 2016/17 came from government hospitals, mental health and AOD facilities. Furthermore, 27.2 per cent of SHS clients sought SHS due	can effectively intervene to improve outcomes for people experiencing homelessness. Across a number of effective programs, the critical components for success were found to be: • Timely and appropriate support e.g., transition support services • Professional support (e.g., legal	participate in the program • Accepting potential participants using an assessment tool to guide process • Engaging with clients whilst they are engaged with the health facility to support proactive planning for housing • Assertive outreach – meeting clients where they are at in the community and building a trusting	component s. A coordinate d approach to care planning ensures clients receive the services they need in a timely and coordinate d manner, maximising wellbeing outcomes.	• Participant satisfactio n with housing provided • Participant satisfactio n with support provided • Number of times participant engages with planned support per week Implementatio n outcomes	MA CRM & Pathways; private rental lease agreement or social/community housing rental agreement	tenancy for 6 -12 months MA CRM & Pathways; private rental lease agreement or social/comm unity housing rental agreement	MA CRM & Pathways; private rental lease agreement or social/community housing rental agreement	health services. To ensure participants independentl y sustain housing in the long term.
					Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey* MA CRM	Participant standard of living and future security scores have improved in PWI/IMT at 6-12 months MA Wellbeing survey	Participant has maintained an improved score in standard of living and future security domains of the PWI/IMT MA Wellbeing survey MA CRM	To improve participants' overall wellbeing.

to health reasons: 19.5 per cent because of mental health; 9.4 per cent because of medical issues; and 11.8 per cent because of problematic substance use. Transitions from government-funded services are an important intervention point for homelessness prevention and reduction, as noted in the NSW Homelessness Strategy (2018) and Mission Australia's Action Plan to Prevent and Reduce Homelessness.	counsel or debt advice) • Co-ordinated care planning (e.g., case management) • Wrap around support (e.g., Housing first, Critical time intervention) • Targeted support (e.g., mental health treatment) The H&H model incorporates	relationship over time to foster engagement with the program Core component two: Person-centred and coordinated support • Support Facilitators to coordinate support using multidisciplinary approach as determined with the participant • A multidisciplinary team	Providing housing to clients will enable them to feel safe, stable and allow them to focus on improving other aspects of their well-being to build resilience and ensure long term self-management and tenancy sustainment			MA CRM		
					Health (physical & mental)			To increase participants' engagement with health services, education, training, employment and community/social activities, and fostering greater social connection.
					Participants have maintained or have been reconnected/introduced to a GP and primary physical and mental (if required) health care within 3 months. MA CRM	Participants are engaging with stable primary and mental (if required) health supports at 6-12 months An increase in the use of primary health care services and reduction in drug and alcohol and/or mental health related Emergency Department MA CRM	Participants report improved physical/mental health outcomes or improved management of physical/mental health issues at 12-24 months An increase in the use of primary health care services and reduction in drug and alcohol and/or mental health related Emergency Department presentations MA CRM	

The elevated risks of homelessness at these points of instability combined with the collaboration of multiple agencies through this social impact investing initiative provides a unique opportunity to: • effectively address the protective and risk factors for homelessness for individuals; and	accepted best practices for successful interventions for reducing homelessness amongst those exiting institutions and particularly those with mental health and substance use issues. These are captured in the following: Mission Australia's Practice Frameworks: Recovery Oriented Practice Framework (2016); National Case Management	approach coordinated by a client's support facilitator • A personalised wellbeing plan developed in partnership with the client • Responsive stepped care which can increase or decrease in intensity • Client-centred practice – clients are	Prioritising participants' most immediate issues (e.g., mental health), and developing pragmatic solutions to these issues, allows participants to focus on pro-social activities. Embedding the use of evidence-based practice e.g.			presentations MA CRM		
					Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participants report improvements in overall wellbeing 6-12 months MA Wellbeing survey MA CRM	Participants report sustained improvements in overall wellbeing at 12 -24 months MA Wellbeing survey MA CRM	
					Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant report improvements in health-specific score PWI/IMT at 6-12 months MA Wellbeing survey	Participants report sustained improvements in health-specific score in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM	

• achieve significant cost-savings for the NSW economy. People exiting health facilities are particularly vulnerable to homelessness, as shown in the solid evidence base around bi-directional relationships between homelessness and mental health, physical health, mental health and substance use issues.	Approach (2017); Lived Expertise Practice Framework (2018); Clinical Governance Framework (2018); and Partnership Framework (2015). These are based on international literature reviews, were co-designed with MA practitioners through our national Communities of Practice and are regularly updated to incorporate	supported to take responsibility for their supports and make decisions on how they receive support • Trauma informed principles and practices Core component three: Accommodation • A range of housing options to match tenant needs –	(recovery approach, harm reduction approach, and trauma informed care) in the delivery of the program with participants ensures that individuals are supported to maximise well-being outcomes.			MA CRM		
					Participants have maintained or have been reconnected/introduced to substance use support specialist if required within 3 months MA CRM	Participants are engaging with substance use support if required and have shown reduction in harms associated with use at 6-12 months MA CRM	Participants are engaging with substance use support if required and show sustained reduction of harms associated with use at 12-24 months. MA CRM	
					Participants have completed a self-reported measure of suicide ideation and the within 3 months CANSAS MA CRM	Participants are demonstrating reduction in suicidal ideation and or psychological distress if applicable at 6-12 months	Participants are maintaining a reduction in suicidal ideation and/or psychological distress if applicable at 12-24 months.	

Furthermore, evidence is emerging (including from the analysis of Journeys To Home data) on the importance of "health shocks" in driving homelessness, supporting the need for "short, immediate interventions at the moment of vulnerability to prevent their falling into homelessness." Key evidence includes: • People who suddenly experience a big	emerging evidence. Additionally, MA has based the H&H program service model on findings from research including: Evidence Check: Homelessness at Transition, Sax Institute (2017) Evaluation of the HASI Program, Social Policy Research Centre at the University of NSW (2012) Challenging the exclusion of people with mental illness:	scattered housing approach • Rapid Re-housing Worker – focuses on working with clients to secure housing options and expedite the housing process. • Proactive tenancy support • Partnerships with housing providers and real				CANSAS MA CRM	CANSAS MA CRM	
					Participants have engaged in a wellbeing survey within 3 months MA Wellbeing survey MA CRM	Participants report improved wellbeing at 6-12 months MA Wellbeing survey MA CRM	Participants maintain an improvement in wellbeing at 12-24 months. MA Wellbeing survey MA CRM	
					Social & Community			
					Participants have maintained or have been reconnected/introduced to supportive cultural and/or community networks and/or structured activities within 3 months	Participants are engaging with supportive cultural and/or community networks and/or structured activities at	Participants are maintaining engagement with attachment/commitment to social and/or cultural network; and/or structured activities at 12-24 months	

change in their health circumstances with no assistance often find themselves not knowing how to respond. • Those with longer term health conditions are often unable to mobilise the support needed	The Mental Health Housing and Accommodation Support Initiative, Muir et al. (2008) Living Well: A Strategic Plan for Mental Health in NSW 2014 – 2024, NSW Mental Health Commission SHS Clients Leaving Care AIHW (2017) SHS Clients with a Mental Health Issue AIHW (2017) Study of Patient Pathways in Alcohol and Other Drug Treatment,	estate agents Core component four: Intensive wellbeing management /Wrap around support • Support facilitator assists client to access external support services, including building a relationship with local GP and specialists, and maintainin			MA CRM Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM Employment People identify employment goals based on capacity and needs within 3 months	6-12 months. MA CRM Participant community connectedness and relationship specific scores have improved in PWI/IMT at 6-12 months MA Wellbeing survey MA CRM People engage in employment based on capacity and	MA CRM Participant has maintained an improved social connectedness and relationship specific scores in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM People engage in employment based on capacity and needs at 12-24 months	

that prevents them becoming homeless. • Without public housing provision or the Disability Support Pension, poor health becomes a significant predictor of homelessness.	NSW Health (2016) Crucially also, the H&H service model has been co-designed with our expert homelessness and mental health senior practitioners, Mission Australia Housing managers and casework staff across NSW, and includes their reflections on the advice from people with lived experience about the most effective supports to find and sustain housing and/or	g supports established during engagement with health service. • Continuity of care highlighted by integrated and coordinated wellbeing management across settings and throughout the program. Example activities: • Cultural/community			MA CRM	needs at 6 - 12 months MA CRM	MA CRM	
					Education & Skills			
					People identify study goals based on capacity and needs within 3 months MA CRM	People engage in study activities based on capacity and needs at 6 - 12 months MA CRM	People maintain engagement in study activities based on capacity and needs at 12-24 months MA CRM	
					Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant achieving in life specific score has improved in PWI/IMT at 6-12 months MA Wellbeing survey	Participant has maintained an improved achieving in life specific score in PWI/IMT at 12-24 months MA Wellbeing survey	

Multiple factors affecting people experiencing homelessness can significantly impact successful engagement to initiate and sustain tenancies including: • Historical and/or current trauma, abuse, physical, and mental illness (including post-traumatic stress disorder)	live with mental health, physical health or dependency issues. Success factors from the evidence base include: • multi-disciplinary team approach to the holistic management of participants' needs	engagement • Social or familial connection / reconnection • Training or employment • Development of independent living skills • Financial literacy Wrap around support may include referral to a number of services: • Income management services				MA CRM	MA CRM	
					Economic			
					Participants are connected with emergency funds; access to Centrelink or employment within 3 months MA CRM	Participants maintain financial stability for 6-12 months MA CRM	Participants maintain financial stability for 12-24 months MA CRM	
					Safety			
					Participants have engaged in a PWI/IMT within 3 months MA Wellbeing survey MA CRM	Participant safety specific score has improved in PWI/IMT at 6-12 months MA Wellbeing survey MA CRM	Participant has maintained an improved safety specific score in PWI/IMT at 12-24 months MA Wellbeing survey MA CRM	
					Empowerment			

• Problematic substance use • Cognitive impairment • Distrust of authorities or services as a result of institutional or custodial experiences • Housing instability • Financial difficulty (Nooe & Patterson, 2010; Whittaker, 2017).	• use of scattered site housing. • partnerships with housing providers to facilitate early intervention and tenancy support • assisting participants to access the community, developing	• Mental health treatment • Physical health treatment • Substance use treatment • Daily living skills and financial management support Core component five: Employment • Specialist employment worker to work with the client on employment and training options • building employment motivation and readiness.			Participants have engaged in IMT within 3 months MA Wellbeing survey MA CRM	Participants report that they feel clients feel more self-efficacy, more control over their life, that they have choices, they can make decisions and manage their health/substance abuse issues at 6-12 months MA Wellbeing survey MA CRM	Participants maintain feelings of self-efficacy, more control over their life, that they have choices, they can make decisions and manage their health/substance abuse issues at 12-24 months MA Wellbeing survey MA CRM	

	skills in personal self-care, counselling and advocacy							

*Mission Australia Wellbeing Survey includes Personal Wellbeing Index – Adult (PWI-A) questions, Developing and Achieving questions; Skills and Confidence questions; Housing questions; Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) question

Appendix B MA CIMS data fields used for data analysis

Client characteristics	Client goals	Specific goals
Interaction ID	AutoNumber (Interaction) (Interaction)	3 Months Sustained Independent Housing
Client ID	Client ID (Interaction) (Interaction)	6 Months Sustained Independent Housing
H&H Case Count	FLW (Interaction) (Interaction)	3 Months Sustained Non-Independent Housing
Agreed Health Facility	Episode Start Date (Interaction) (Interaction)	6 Months Sustained Non-Independent Housing
Support Level	Date Closed (Interaction) (Interaction)	12 Months Sustained Non-Independent Housing
Referral In Date	Client consent date (Interaction) (Interaction)	13 weeks sustained employment
Client consent date	Goal Category	26 weeks Sustained Employment
Close	Program Goal	52 weeks sustained employment
Date Closed	Progress	64 Hours of Engagement in Structured Activity/s
Close Reason Text	Start Date	Training Completion / 26 Weeks Participation in Training
Date of Birth (Contact) (Contact)	Anticipated Achievement Date	
Age	Date Achieved	
Gender	Review Date	
Aboriginal or Torres Strait Islander Status	All Evidence Attached?	
Culturally and Linguistically Diverse Status	PM Approved?	
LGBTQIA+ Status		
DFV		
Does the client identify as having a disability?		
AOD		
Main source of income when presenting		

Labour force status when presenting		
Employment status when presenting (Primary Detail) (Details)		
Undertaking formal study when presenting		
Housing Status when presenting		

Sources: MA database extraction, Excel worksheets

Appendix C Client goals – client-by client analysis

Client identifier. (randomly assigned)	No. of payable goals fully achieved				
109	4	3 months sustained independent housing	12 months sustained independent housing	13 Weeks Sustained Employment	26 Weeks Sustained Employment
8	3	3 months sustained independent housing	3 months sustained non-independent housing	12 months sustained non-independent housing	
1	2	3 Months Sustained Non-Independent Housing	12 Months Sustained Non-Independent Housing		
3	2	3 Months Sustained Non-Independent Housing	12 Months Sustained Non-Independent Housing		
4	2	3 Months Sustained Independent Housing	12 Months Sustained Independent Housing		
5	2	3 Months Sustained Non-Independent Housing	12 Months Sustained Non-Independent Housing		
7	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
11	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
17	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
21	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
27	2	3 months sustained independent housing	3 months sustained non-independent housing		
30	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
33	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
36	2	3 months sustained independent housing	12 months sustained independent housing		
38	2	3 months sustained independent housing	12 months sustained independent housing		
44	2	3 months sustained independent housing	3 months sustained non-independent housing		
49	2	3 months sustained non-independent housing	12 months sustained non-independent housing		
57	2	3 months sustained non-independent housing	12 months sustained non-independent housing		

Client identifier. (randomly assigned)	No. of payable goals fully achieved		
69	2	3 months sustained independent housing	12 months sustained independent housing
71	2	3 months sustained independent housing	12 months sustained independent housing
90	2	3 months sustained non-independent housing	12 months sustained non-independent housing
96	2	3 months sustained independent housing	12 months sustained independent housing
99	2	3 months sustained independent housing	12 months sustained independent housing
100	2	3 months sustained non-independent housing	12 months sustained non-independent housing
114	2	3 months sustained independent housing	12 months sustained independent housing
117	2	3 months sustained independent housing	12 months sustained independent housing
131	2	3 months sustained independent housing	12 months sustained independent housing
203	2	3 months sustained non-independent housing	12 months sustained non-independent housing
242	2	3 months sustained non-independent housing	12 months sustained non-independent housing
244	2	3 months sustained independent housing	12 months sustained independent housing
245	2	3 months sustained non-independent housing	12 months sustained non-independent housing
257	2	3 months sustained non-independent housing	12 months sustained non-independent housing
261	2	3 months sustained independent housing	3 months sustained non-independent housing
266	2	3 months sustained independent housing	3 months sustained non-independent housing
268	2	3 months sustained independent housing	12 months sustained independent housing
271	2	3 months sustained independent housing	12 months sustained independent housing
272	2	3 months sustained independent housing	12 months sustained independent housing
280	2	3 months sustained non-independent housing	12 months sustained non-independent housing
12	2	3 months sustained independent housing	3 months sustained non-independent housing
16	2	3 months sustained non-independent housing	12 months sustained non-independent housing
14	1	3 months sustained non-independent housing	

Client identifier. (randomly assigned)	No. of payable goals fully achieved			
18	1	3 months sustained non-independent housing		
26	1	3 months sustained non-independent housing		
29	1	3 months sustained non-independent housing		
37	1	3 months sustained non-independent housing		
41	1	3 months sustained non-independent housing		
48	1	3 months sustained non-independent housing		
52	1	3 months sustained independent housing		
54	1	3 months sustained non-independent housing		
56	1	3 months sustained non-independent housing		
61	1	3 months sustained non-independent housing		
75	1	3 months sustained non-independent housing		
76	1	3 months sustained non-independent housing		
91	1	3 months sustained non-independent housing		
94	1	3 months sustained non-independent housing		
95	1	3 months sustained non-independent housing		
103	1	3 months sustained independent housing		
108	1	3 months sustained non-independent housing		
118	1	3 months sustained non-independent housing		
121	1	3 months sustained independent housing		
122	1	3 months sustained		

Client identifier. (randomly assigned)	No. of payable goals fully achieved			
		independent housing		
124	1	3 months sustained independent housing		
138	1	3 months sustained non-independent housing		
144	1	3 months sustained non-independent housing		
154	1	3 months sustained independent housing		
156	1	3 months sustained non-independent housing		
158	1	3 months sustained independent housing		
177	1	3 months sustained independent housing		
182	1	3 months sustained non-independent housing		
183	1	3 months sustained independent housing		
204	1	3 months sustained non-independent housing		
210	1	3 months sustained non-independent housing		
218	1	3 months sustained non-independent housing		
224	1	3 months sustained non-independent housing		
225	1	3 months sustained non-independent housing		
226	1	3 months sustained non-independent housing		
228	1	3 months sustained non-independent housing		
229	1	3 months sustained non-independent housing		

Client identifier. (randomly assigned)	No. of payable goals fully achieved			
234	1	3 months sustained independent housing		
237	1	3 months sustained independent housing		
241	1	3 months sustained non-independent housing		
243	1	3 months sustained non-independent housing		
246	1	3 months sustained non-independent housing		
252	1	3 months sustained independent housing		
256	1	3 months sustained independent housing		
260	1	3 months sustained non-independent housing		
262	1	3 months sustained independent housing		
269	1	3 months sustained independent housing		
274	1	3 months sustained non-independent housing		
275	1	3 months sustained independent housing		
277	1	3 months sustained non-independent housing		
278	1	3 months sustained independent housing		
9	1	3 months sustained non-independent housing		

Client identifier. (randomly assigned)	No. of payable goals fully achieved				
2	0				
10	0				
13	0				
20	0				
22	0				
24	0				
25	0				
28	0				
34	0				
35	0				
39	0				
40	0				
42	0				
43	0				
45	0				
46	0				
47	0				
50	0				
51	0				
53	0				
58	0				
62	0				
64	0				
65	0				
66	0				
70	0				
72	0				
74	0				
78	0				
79	0				
80	0				
82	0				
84	0				
85	0				
86	0				
87	0				
92	0				
97	0				
98	0				
101	0				
104	0				
105	0				

Client identifier. (randomly assigned)	No. of payable goals fully achieved				
106	0				
107	0				
111	0				
112	0				
115	0				
116	0				
119	0				
120	0				
125	0				
126	0				
127	0				
128	0				
132	0				
133	0				
134	0				
135	0				
136	0				
139	0				
142	0				
143	0				
145	0				
146	0				
149	0				
151	0				
152	0				
153	0				
155	0				
159	0				
160	0				
161	0				
162	0				
163	0				
164	0				
165	0				
166	0				
168	0				
169	0				
170	0				
171	0				
174	0				
175	0				
176	0				

Client identifier. (randomly assigned)	No. of payable goals fully achieved				
178	0				
179	0				
181	0				
184	0				
185	0				
186	0				
188	0				
189	0				
190	0				
191	0				
193	0				
195	0				
199	0				
200	0				
201	0				
202	0				
206	0				
207	0				
208	0				
209	0				
211	0				
212	0				
213	0				
214	0				
216	0				
219	0				
220	0				
221	0				
222	0				
227	0				
231	0				
232	0				
233	0				
235	0				
236	0				
238	0				
240	0				
248	0				
250	0				
251	0				
254	0				
255	0				

Client identifier. (randomly assigned)	No. of payable goals fully achieved				
258	0				
259	0				
264	0				
265	0				
267	0				
270	0				
276	0				
15	0				

Appendix D Commonly used client homelessness risk and complexity measurement tools

Name, country of origin and reference	Description	Domains measured; number of items/questions	Type of tool; time to administer	Target population	Measurements - scores, triage utility	Is training required?	Psychometric properties; Validation
United States							
Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) (Version 2.01) Developer: OrgCode Consulting	The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization	4 domains (History of Housing & Homelessness; Risks; Socialization & Daily Functions and Wellness) 27 questions. Questions are mainly yes/no Questions focus on: ○ Service use (health, legal) ○ Risk of harm	Administered survey (all self-report); 7 minutes or less	Versions available for individuals, families, youth	Triage tool High scores indicative of complex needs Total scores range from 0 to 17. Each domain has a subtotal. The overall score is used to triage for intervention, • 0-3: no housing intervention 4-7: an assessment	No	No psychometric properties. The VI-SPDAT has been reviewed for validity and reliability. Brown et al. (2018) found there are challenges to the reliability and validity of the VI-SPDAT in practical use. VI-SPDAT total scores did not significantly predict risk of return to homeless services, while type of housing was a significant predictor. Likewise Park (2019) found ten items had low item-total correlations indicating construct validity of the VI-SPDAT may be improved and hence the VI-

	Decision Assistance Tool. The VI-SPDAT is widely used globally and is triage tool that is designed to quickly assess the health and social service needs of persons. It can be conducted to quickly determine whether a person has high, moderate, or low acuity. The use of this survey can help prioritize which persons should be given a full SPDAT assessment first.	○ Legal issues ○ Risk of exploitation ○ Money management ○ Meaningful daily activities ○ Self-care ○ Social relationships ○ Physical health ○ Mental health ○ Substance use ○ Trauma Note: The demographic section is left intentionally short so communities can include their own demographic questions relevant to their own contexts			for Rapid Re-Housing 8+: an assessment for Permanent Supportive Housing/Housing First		SPDAT has lack of evidence to support of its construct validity.

Service Prioritization Decision Assistance Tool (SPDAT) (Version 4.01) Developer: OrgCode Consulting	Evidence-informed assessment tool for frontline workers to assess an individual's or family's acuity. Helps prioritise which clients should receive what type of assistance intervention, and assist in determining the intensity of case management services	Components: • Mental health and wellness and cognitive functioning • Physical health and wellness • Medication • Substance use • Experience of abuse and/or trauma • Risk of harm to self and others • Involvement in higher	Administered interview.	Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work	Triage tool Includes notes and tick boxes indicative of risk factors. These are used to create scores. High scores indicative of complex needs	Yes	No psychometric elements. The SPDAT has been internally reviewed by OrgCode Consulting, which tests the validity of SPDAT results using control groups, and inter-rater reliability. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used. However, there were no independent studies found that test its reliability and validity.

		risk and/or exploitive situations • Interaction with emergency Services • legal • Managing tenancy • Personal administration & money management • Social relationships & networks • Self-care & daily living skills		supporting people with fetal alcohol spectrum disorders. Versions available for individuals, families, youth			

		• Meaningful daily activity • History of homelessness & housing There are 4-5 interview questions for each domain. Notes are made, and boxes ticked to indicate the presence of a risk factor					
Short Assessment Triage Tool (SATT) Pre-Screen Link to tool unavailable; some information about the tool is here. Developer: Clark County, Southern Nevada.	Community-developed tool for all clients to collect basic information about the individual or family and to identify immediate safety needs. The SATT Pre-Screen is designed to tell assessor which other assessment tool to	Unknown	Assessor conducts interview	Single adults; families	Triage and screening tool	Unknown	No psychometric properties No available studies on reliability or validity

	use and to verify that the client is homeless						
The Southern Nevada Community Housing Assessment Tool (CHAT); and family version (F-CHAT) Link to tool unavailable; some information about the tool is here. Developer: Clark County, Southern Nevada.	The Community Housing Assessment Tool is a community-developed tool that prioritises single adults for available permanent housing based on acuity and chronicity. There is also a family version (F-CHAT)	Unknown	Assessor conducts interview	Single adults (CHAT); families (F-CHAT)	Triage and needs assessment tool Produces scores based on severity of need and determines priority for housing and related services	Unknown	No available studies on reliability or validity
Vulnerability Assessment Tool (VAT), Developer: Downtown Emergency Service Centre	Assessment scale for determining eligibility, allocation of services, and permanent supportive housing units are offered to the most vulnerable chronically homeless individuals	Includes 10 domains: • Survival Skills • Basic Needs • Indicated Mortality Risk	Assessor conducts structured interview	Adults experiencing homelessness	Triage tool Each domain is measured on a 5-point scale Higher scores represent greater risk/ vulnerability and clients can be prioritised for services	Yes	The University of Washington completed an evaluation of the VAT in March 2010, concluding that it held strong properties of both reliability and validity (Ginzler & Monroe-DeVita, 2010). Subsequent analysis has ranked the VAT first out of 15 assessment tools used criteria established by the U.S. Department of Housing and

		• Medical Risk • Organisation/Orientation • Mental Health • Substance Use – A • Substance Use - B • Communication • Social Behaviours • Homelessness A number of questions pertain to each domain					Urban Development (HUD) (Aubry et al., 2015;)

TAY (transition age youth) Triage Tool (TAY) Developer: the Corporation for Supportive Housing (CSH)	The tool was developed to prioritise young adults aged 18-24 for supportive housing in consultation with service providers.	Six experience questions • Have you ever become homeless because: • I ran away from my family home, group home, or foster home • There was violence at home between / from family members • I had differences in religious beliefs with parents/gua	Administered conversational questionnaire	Young adults aged 18-24	Triage tool; needs assessment tool Scores of 4 or greater indicate need for prioritisation for supportive housing; higher level of casework support	None to minimal	No psychometric properties Rice (2015) (the tool's developer) reported on the TAY Triage Tool pilot and found that the data provided a great deal of support for the validity of the TAY Triage Tool. With respect to construct validity, the TAY Triage Tool not only is associated with long term homelessness, but also a host of issues known to be associated with long term homelessness among homeless youth. With respect to face validity, the tool is also highly valid. However no independent assessments were found.

		rdians/caregivers • How old were you when you tried marijuana for the first time? • Before your 18th birthday, did you spend any time in jail/detention? • Have you ever been pregnant or got someone else pregnant?					

A homelessness risk screening tool for emergency department patients Developers: Doran et al. (health and homelessness services consortium)	A practical screener responsive to local needs was developed using a two-stage method: (1) predictive modelling to identify candidate predictor variables and (2) selection among candidate screening tools based on performance and stakeholder conversation.	Questions on: • Socio-demographics • housing (past history as well as recent events such • as eviction and owing rent arrears • other social needs (e.g., food insecurity, • job loss, recent legal issues, and difficulty meeting expenses) • physical and mental health (including chronic medical and psychiatric • conditions, past year physical or	Administered questionnaire 20—40 minutes	ED patients	Specific variables (past shelter use, history of being in jail) were strongly predictive of shelter entry.	Yes	Doran et al. (2021) used then analysed a screening tool at emergency departments of hospitals. They found that the tool consisting of two measures of past shelter use and one of past criminal justice involvement had 83.0 per cent sensitivity and 20.4 per cent positive predictive value for future shelter entry.

		sexual violence, and screeners for • depression, anxiety, pain, and overall health) • substance use (including • types and amounts and validated screening tools for degree of problems • related to alcohol and drug use) • health care use (including specific types • of outpatient and					

		inpatient health care) • criminal justice history (lifetime • and more recent) • social support • whether current ED visit was related to substance use or injury.					
Canada							
Youth Assessment Prioritization Tool (YAP) Tool Developer: Wally Czech, WalRon Consulting, the Canadian Observatory on Homelessness, A Way Home (Vers un Chez-Soi)	A pre-screen tool to identify risk of long-term homelessness. The YAP Tool is a strength-based assessment of youth experiencing, or are at-risk of experiencing, homelessness.	5 'narrative domains: • housing needs • social networks and connections • health and wellness	Administered pre-screen questions focused on identifying the level of risk of long-term homelessness that the youth is facing. The	Youth	Triage tool The final score determines a youth's level of need, and what services the youth should be referred to.	Training?	The YAP tool has been tested in various Canadian provinces (Alberta, Manitoba and Newfoundland and Labrador). Services offered feedback, leading to adaptations. YAP tool seems to have undergone formal validation assessment, by Manoni-Miller, S., Jamshidi, P. and Aubry, T.at University of Ottawa however the

	The YAP aims to be as non-clinical and non-prescriptive as possible	• daily activities • attitudes and behaviours. He 70 questions are designed to highlight a young person's strengths, homelessness risk factors and the complexity of their lives.	subsequent interview delves deeper into strengths.				conference paper was not available. More information was sought from authors.
Re-housing, Triage, And Assessment Survey (RTAS) (see p.28 for tool) Developer: Calgary Homelessness Foundation	The RTAS is a survey that can be used to assess the health and vulnerability of homeless people. It assists in prioritising and matching resources with client needs, by making sure that the supports and housing available are being accessed by those who need them the most.	Approximately 45 questions Questions are about: • Demographics • Educational attainment • Citizenship status • Country of Birth • Indigeneity • Household type	Administered survey Mostly yes/no and multiple-choice questions 30 minutes	Adults	Triage tool No inbuilt scoring system – suggests using Excel or SPSS to analyse data and triage to create a 'most vulnerable list', based on more than six months street homeless AND at least one of: 1. End stage renal disease 2. History of cold weather injuries 3. Liver disease or cirrhosis 4. HIV+/AIDS 5. Over 60	High scores indicative of complex needs	No psychometric attributes. No formal evaluation conducted.

	the Rehousing Triage and Assessment Survey is a process that uses a survey of people experiencing homelessness to assess their vulnerability and their needs and preferences for rehousing.	• Length of street homelessness • Nature and length of shelter use; rough sleeping • Risk to tenancy • Health conditions • Substance use • Mental health • Victim of violence • Physical disability • Brain injury • Hospitalisations • Been in jail • Other health/dental issues • Domestic violence			years old 6. Three or more emergency room visits in prior three months 7. Three or more ER or hospitalizations in prior year		

		• Childhood trauma • Armed forces history • Foster care history • Income sources (including cash-in-hand) • Employment status • Social and family supports • Reason for homelessness • Housing preferences • Household • Support needs • 3 or more ER visits or					

		• hospitalisations in prior year					
United Kingdom							
New Directions Team Assessment (NDTA) (also known as Chaos Index) Developer: South West London and St George's Mental Health NHS Trust	A tool for assessing beneficiary need. It focuses on behaviour across a range of areas to build up a holistic picture of need rather than the traditional demonstration of serious need in a specific area only (for example, mental health). It also explicitly measures involvement with other services, which is not routinely used as a measure of service eligibility otherwise. The result is an index which identifies chaotic people with multiple needs who, despite being ineligible for a	10 domains: 1. Engagement with frontline services 2. Intentional self-harm 3. Unintentional self-harm 4. Risk to others 5. Risk from others 6. Stress and anxiety 7. Social Effectiveness 8. Alcohol / Drug Abuse 9. Impulse control 10. Housing	Assessment of caseworker of client vulnerability and risk	Caseworkers' assessment of individual clients	Triage tool Eligibility assessment tool Each item in the assessment is rated on a 5-point scale with 0 being a low score and 4 being the highest score; there are two areas where the score counts double (0 is the lowest score and 8 is the highest). Produces an overall score out of 28.	Yes	No psychometric attributes No formal evaluation conducted.

	range of services, require targeted support.						
Australia							
At Risk Homelessness Screening Tool Developers: AccessHC and Uniting Harrison.:	Tool consists of questions about homelessness risk assessment, At risk of homelessness score, Housing Situation and Property Information The agency can follow up with the client and help them with their housing and related matters Facilitates referrals to homeless service agencies.	Questions on: Language Relationship status Homelessness risk Housing situation and property information Notes	Administered questionnaire or report on client by caseworker Primarily tick boxes 5-15 minutes	Individuals	Screening tool Designed to identify and respond to a client that may be at risk of homelessness and refer them for services	Unknown	No psychometric properties An article by Risely et al. (2020) discusses the pilot program that used the tool and qualitative accounts from practitioners, but does not example reliability or validation.
Australian Index of Adolescent Development (AIAD) Developed by: David McKenzie/Upstream Australia Based on a Canadian model	The Australian Index of Adolescent Development (AIAD) contains three core indicators: risk of homelessness; risk of disengagement with school and psychological distress (K-10). The	Domains include: • Income • Living situation • Family	Self-administered questionnaire Up to 60 minutes	Adolescent young people	Triage tool. High scores in domains indicative of different types of risk. If a certain risk profile is indicated by the scores, a more detailed interview is undertaken, and student is referred into support program	Some training for explaining the questionnaire to young people. Young people then self-administer the questionnaire.	Has psychometric properties, as includes instruments to measure self-efficacy and psychological distress (K-10). Tool has been assessed for content and construct validity by the authors of the tool. Unclear if any formal validation/evaluation has been conducted of the AIAD but it

	first two were developed within The Geelong Project while the third is widely used in the mental health sector. It is used for early intervention with young people, currently in the Universal Screening Service pilot in several schools in NSW.	• Self-efficacy • Home life • School engagement • Substance use • Involvement in risky or criminal behaviours • Relations with others (teachers, parents, friends) • View of self • Psychological state					contains validated tools (like the K-10).

		14 sections with several questions/items/scales each					