Evaluation of the Home and Healthy Program

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Abbreviations

AAEH	Australian Alliance to End Homelessness
ABS	

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 ï 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

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

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 programôs pilot phase was intended to

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 clientsô wellbeing was tracked using the Personal Wellbeing Index ï 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

Table 2: Goals achieved, highest to lowest number

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

rolesòand that ñSII is not a panacea and will not be the most appropriate nor effective solution in all casesò(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

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

o 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

o

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 Justiceôs (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 GovernmentsôHomelessness 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,

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	

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, however2convenQq0.000008871 0 595.32 W* nBT

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.ôs (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 recommendsé approximately thirty-fifty participants for ethnographies, grounded theory studies, and ethnoscience studies... Creswellôs (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

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

measurement of the risk of homelessness

assessment of the risk of homelessness

risk of homelessness

complex needs

homelessness.

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-

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

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

Socio-demographic characteristics			
	H&H Clients		AIHW SHS Clients (2020-2021)
	n	Percent	Percent

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 CW* nBo34(t)6(nBo 0 1 M6(d)* n8)4(S)4(

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

exit, but only 22 exited because of program completion. However, some of the other exits may also

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 clientsôpersonal 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

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 ï from NSW Health, MA and the clients themselves ï 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 ï for example, women in hospital due to DFV injuries or others with physical ailments stemming from family conflict or insecure housing situations ï may have been harder to identify. One stakeholder believed that this direct approach was discouraged, ñbecause 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 usò (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

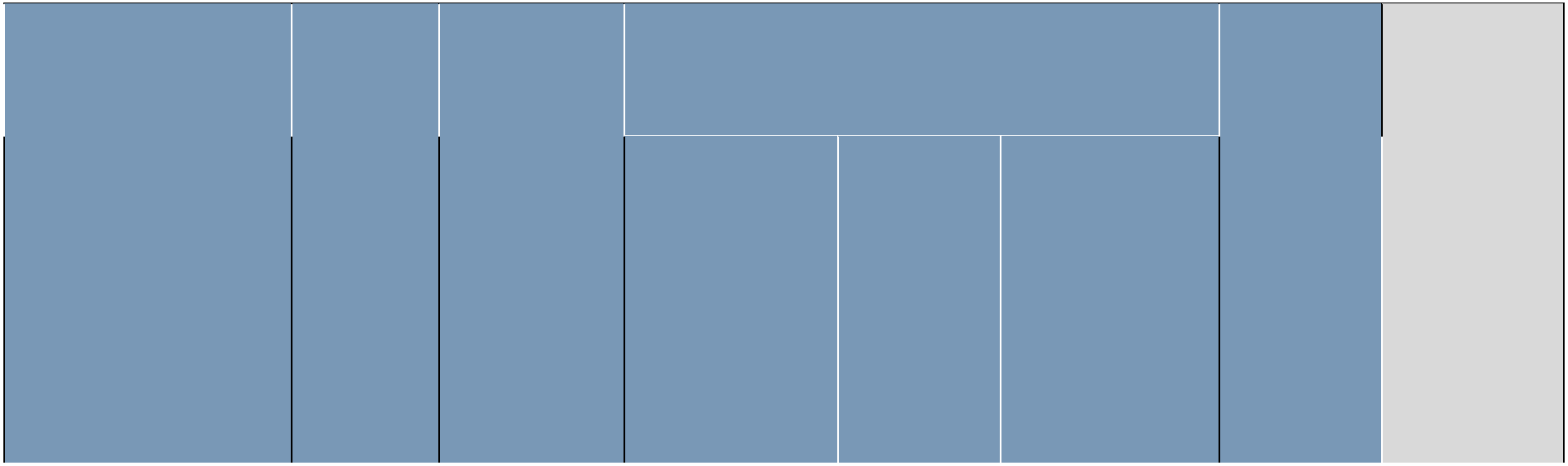
with ñgoal settingò, and ñintensely professionalò (Clients 2, 3, 4, 6, 10,11). Overall clients found the H&H program ñvery well organisedò and felt that they were mostly well matched to their caseworkers, although some they ñclicked withò more than others (Client 3). One client was matched with a H&H caseworker who spoke their language (Client 8). Clients felt the caseworkers really cared and were very helpful in addressing their needs.

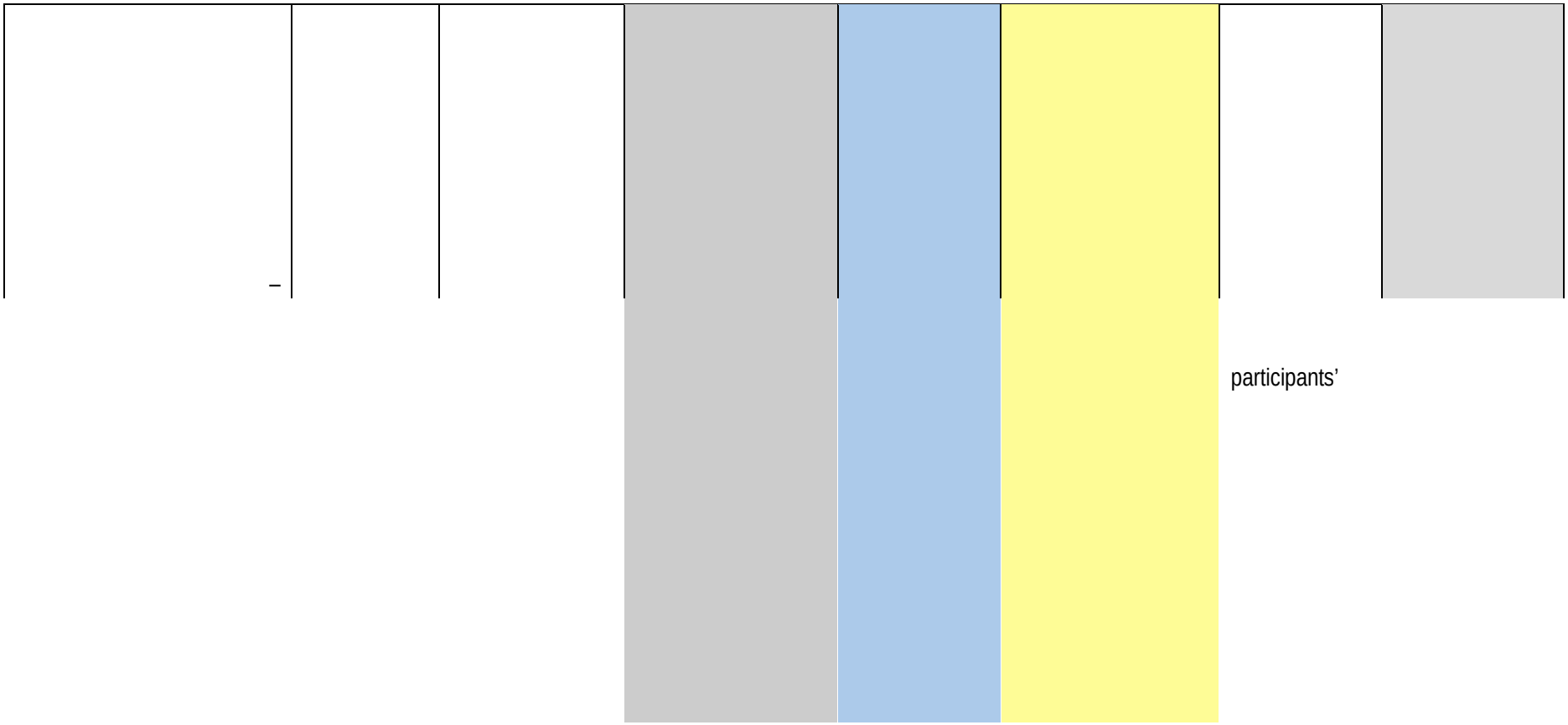
> *If he says he is going to do something, he would do it. And he'll call me back a couple of days later and tell me the outcome. (Client 11)*

Regular proactive contact from the H&H caseworker was appreciated, even just to check ñwhether the client was OKò (Client 4, Client 6). Clients appreciated meeting up in person and having a coffee and conversation, and ñsort things there at the caféò (Client 11).

Clients needed support to negotiate the often fragmented systems and supports provided by

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

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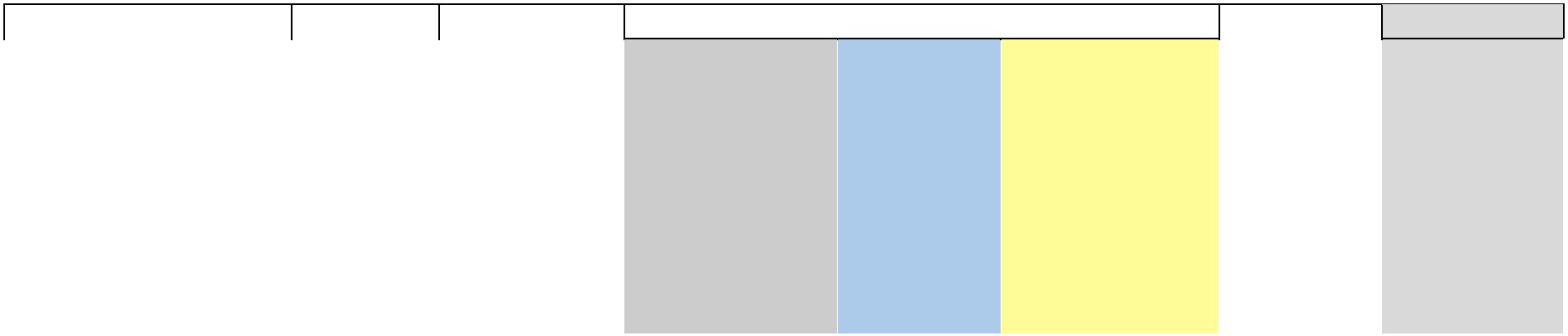

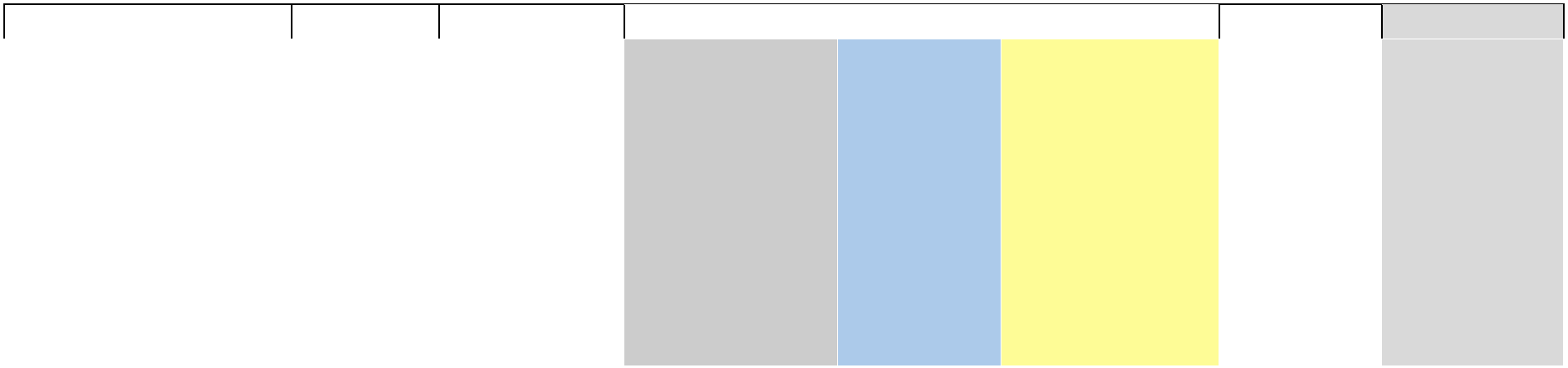

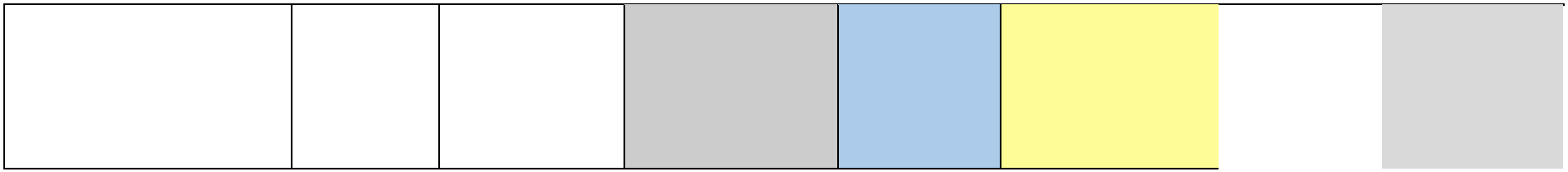

Figure 4: Client payable goal achievement

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'

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

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, ópartial achievementô 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

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 óJobKeeperô payments and the Centrelink payment supplement due to mass job losses.

This analysis show

> *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*

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-

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 Centrel entrel

Health outcomes

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:

> *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

> *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 serviceé 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 ósthrengthôwhich 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)*

Certifying payable outcomes

clientsôneeds

The assertiveness, so our ability to be really assertive with clients and to

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)

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  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 met. One person also shared the conce

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 taxpayersô money on programs and that while this was cast as a partnership, ñthe reality is theyõre contract providersò (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 2.000008871 1 (] TJET2/F1)11( )- expen

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. ñIt 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 servicesò (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 programôs 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
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

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*

. or

It also as I say

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-

Assessment and screening processes can be used for different purposes: initial

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 assessment[4]. 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 individualôs 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

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 governmentsô 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 MAôs 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 Commissionôs 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 ñmodest employment outcomesòfor program clients (Coram et al., 2022:99). Given this pattern in the national data, and considering H&H client abilities and disabilities, the

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

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 ï 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.

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

Canadian Observatory on Homelessness. (2016). *Vulnerability Assessment Tool for Determining Eligibility and Allocating Services and Housing for Adults Experiencing Homelessness. Training Manual for Conducting Assessment Interviews*. Canadian version adapted from DESCôs manual (June 2015 edition). Toronto: The Canadian Observatory on Homelessness Press [Accessed 22/12/21 at: https://homelesshub.ca/sites/default/files/COH_VAT_Manual_Online.pdf]

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Ginzler, J., & Monroe-DeVita, M. (2010). Downtown Emergency Service Centerôs Vulnerability Assessment Tool for Individuals Coping with Chronic Homelessness: A Psychometric Analysis. Seattle. Retrieved from http://www.desc.org/research.html

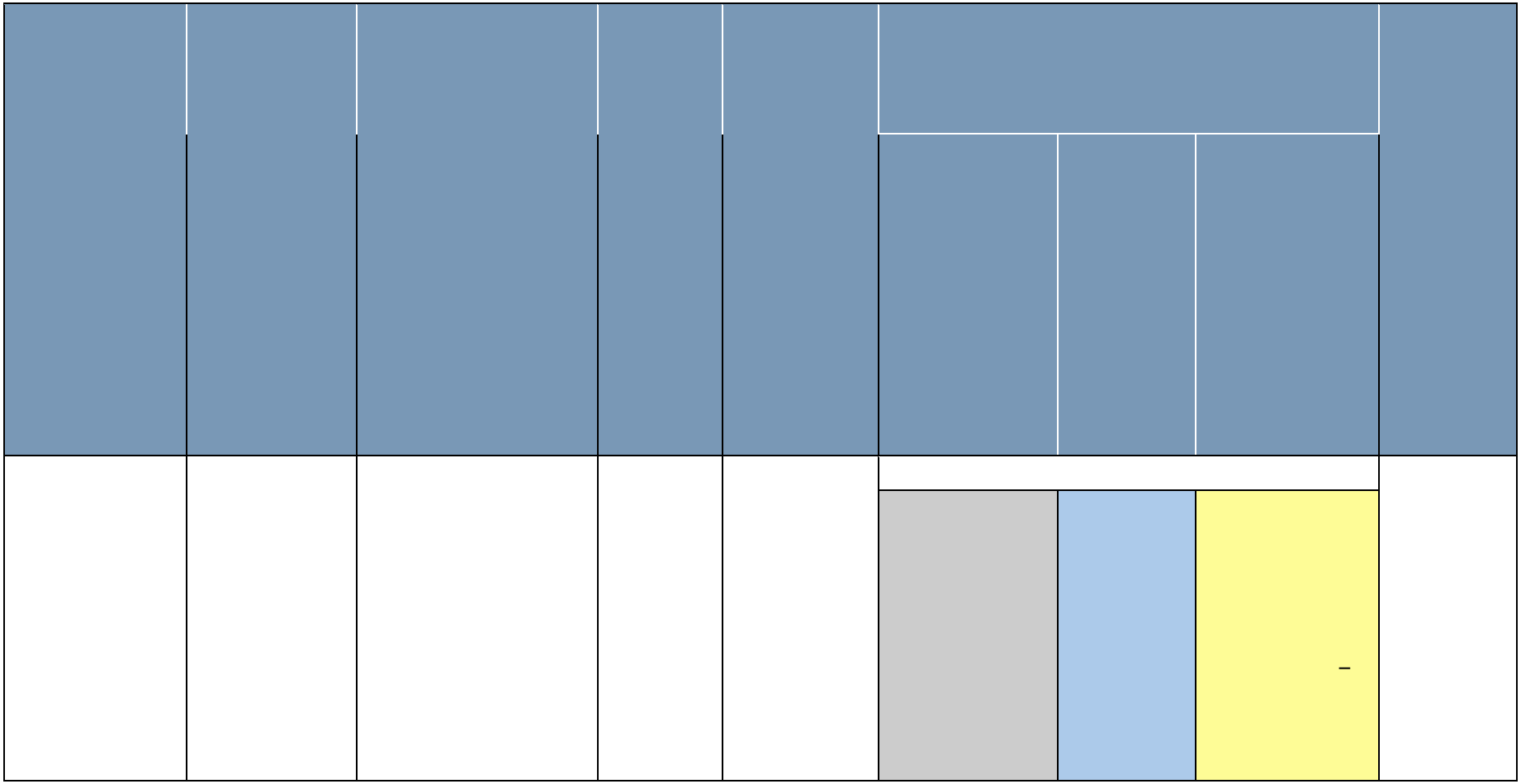
Gordon S, Grimmer K, Bradley A, Direen T, Baker N, Marin T, Kelly M, Gardner S, Steffens M, Burgess T, Hume C, and Oliffe, J (2019) ôHealth assessments and screening tools for adults experiencing homelessness: a systematic reviewô, *BMC Public Health*, 19:994

Guest, G., Bunce A. and Laura Johnson L. H. (2006) ôHow Many Interviews Are Enough?: An Experiment with Data Saturation and Variabilityô*Field Methods*, 18, 39, DOI: 10.1177/1525822X05279903

Help, Hope and Home (2018) Southern Nevada Coordinated Entry System Policies and Procedures [accessed 1/12/21 at: https://helphopehome.org/wp0 0 D≥4<000 1 301.82 4/ 1 466.

_Boroondara__Manningham_Housing_and_Homelessness_Network__Redacted.pdf]

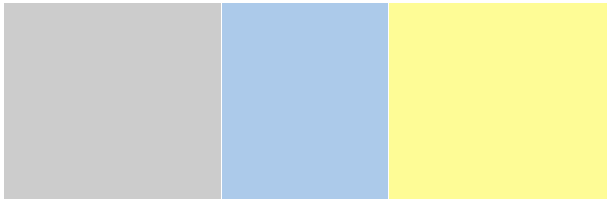
Appendix A Home and Healthy program logic



“health shocks” in

need for “short,

homelessness.”



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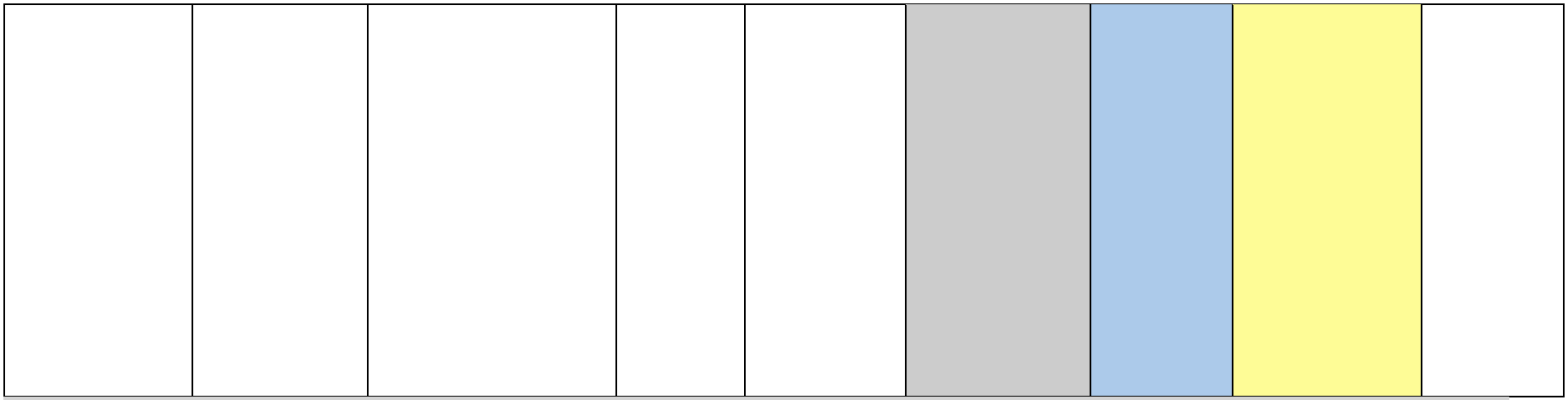


*Mission Australia Wellbeing Survey includes Personal Wellbeing Index ï Adult (PWI-A) questions, Developing and Achieving questions; Skills and Confidence questions; Housing questions; Camberwell Assessment of Need Short Appraisal Schedule (CANSAS) question

Appendix B MA CIMS data fields used for data analysis

Client identifier. (randomly assigned)	No. of payable goals fully achieved		
69	2	3 months sustained independent housing	12 months sustained independent housing
71			

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	

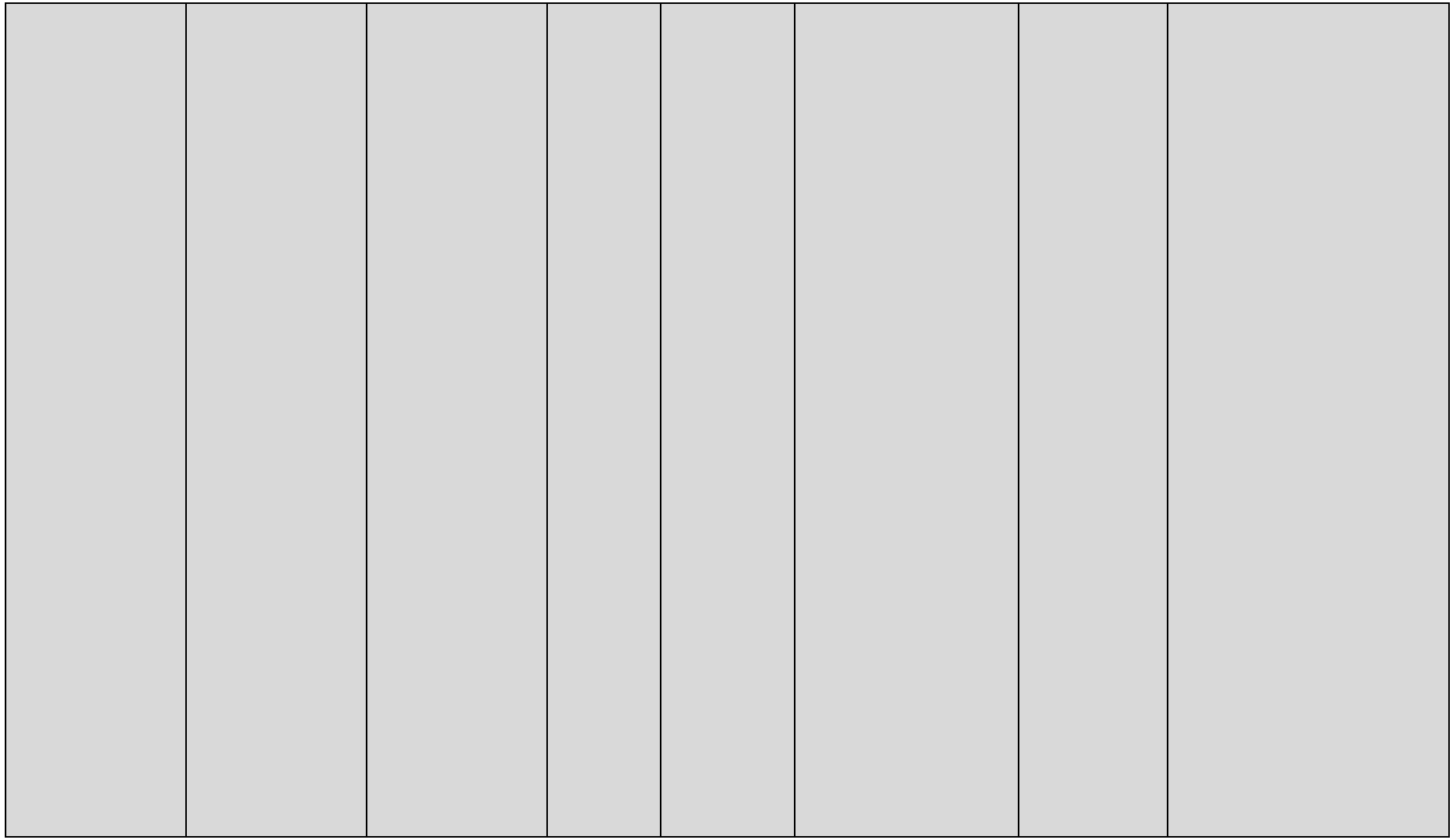
Client identifier. (randomly assigned)	No. of payable goals fully achieved		

independent

Client
identifier

Client identifier. (randomly assigned)	No. of payable goals fully achieved				
258	0				
259	0				
264	0				

o



		a young person's					