Specialist Homelessness Services Program Evaluation

Department of Communities and Justice

Final Report

26 October 2023

Building a better working world

NOTICE

Ernst & Young was engaged on the instructions of the Department of Communities and Justice (DCJ) ("Client") to undertake a process, outcomes and economic evaluation of the Specialist Homelessness Services (SHS) Program in NSW ("Project"), in accordance with the Engagement Agreement dated 3 May 2022.

The results of Ernst & Young's work, including the assumptions and qualifications made in preparing the report, are set out in Ernst & Young's report dated 26 October 2023 ("Report"). The Report should be read in its entirety including the transmittal letter, the applicable scope of the work and any limitations. A reference to the Report includes any part of the Report. No further work has been undertaken by Ernst & Young since the date of the Report to update it.

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In preparing this Report Ernst & Young has considered and relied upon information from a range of sources believed to be reliable and accurate. We have not been informed that any information supplied to it, or obtained from public sources, was false or that any material information has been withheld from it. Our findings are based, in part, on the assumptions stated and on information provided by the Department and other information sources used during the course of the engagement. The modelled outcomes are contingent on the collection of assumptions as agreed with the Department and no consideration of other events or changing circumstances are reflected in this Report. Neither Ernst & Young nor any member or employee thereof undertakes responsibility in any way whatsoever to any person in respect of errors in this Report arising from incorrect information provided to Ernst & Young.

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Building a better working world

26 October 2023

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Specialist Homelessness Services Program Evaluation

Dear Stephen,

In accordance with our Engagement Agreement dated 3 May 2022 ("Agreement"), Ernst & Young ("we" or "EY") has been engaged by the Department of Communities and Justice (DCJ) ("you", "the Department" or the "Client") to undertake a process, outcomes and economic evaluation of the Specialist Homelessness Services (SHS) Program in NSW (the "Services").

The enclosed report (the "Report") sets out the outcomes of our work. You should read the Report in its entirety. A reference to the report includes any part of the Report.

Purpose of our Report and restrictions on its use

Please refer to a copy of the Agreement for the restrictions relating to the use of our Report. We understand that the deliverable by EY will be used by the Department to gain an understanding of where the SHS Program is working well and identify and recommend changes to better assist the Program's homeless and at-risk clients (the "Purpose"). This Report was prepared on the specific instructions of the Department solely for this Purpose and should not be used or relied upon for any other purpose.

This Report and its contents may not be quoted, referred to or shown to any other parties except as provided in the Agreement. We accept no responsibility or liability to any person other than to the Department and accordingly if such other persons choose to rely upon any of the contents of this Report they do so at their own risk.

Nature and scope of our work

The scope of our work, including the basis and limitations, are detailed in our Agreement and in this Report.

Our work commenced on 29 June 2022 and was completed on 26 October 2023. Therefore, our Report does not take account of events or circumstances arising after 26 October 2023 and we have no responsibility to update the Report for such events or circumstances.

In preparing this Report we have considered and relied upon information from a range of sources believed after due enquiry to be reliable and accurate. We have no reason to believe that any

information supplied to us, or obtained from public sources, was false or that any material information has been withheld from us.

We do not imply, and it should not be construed, that we have verified any of the information provided to us, or that our enquiries could have identified any matter that a more extensive examination might disclose. However, we have evaluated the information provided to us by the Department as well as other parties through enquiry, analysis and review and nothing has come to our attention to indicate the information provided was materially mis-stated or would not afford reasonable grounds upon which to base our Report.

Our findings are based, in part, on the assumptions stated and on information provided by the Department and other information sources used during the course of the engagement. The modelled outcomes are contingent on the collection of assumptions as agreed with the Department and no consideration of other events or changing circumstances are reflected in this Report. Neither Ernst & Young nor any member or employee thereof undertakes responsibility in any way whatsoever to any person in respect of errors in this Report arising from incorrect information provided by the Department or other information sources used.

This letter should be read in conjunction with our Report, which is attached.

Thank you for the opportunity to work on this project for you. Should you wish to discuss any aspect of this Report, please do not hesitate to contact me on +61 422 009 718.

Yours sincerely

Mark Galvin
Partner, Government and Public Sector Practice
Oceania Program Evaluation Lead
Ernst & Young

Acknowledgement of Country

EY acknowledges Aboriginal and Torres Strait Islander people as the first peoples of Australia and Traditional Custodians of this land and its waters. We pay our respects to Elders, knowledge holders and leaders past, present and emerging.

We respectfully acknowledge the Traditional Owners of country on which EY's offices are located, including Turrbal, Gadigal, Ngunuawal, Wurundjeri, Karuna, Whajuk, and Larrakia Nations.

We respect Traditional Owners' relationship, connection and association to "country" and that it is an integral part of their identity and cultural expression.

We understand and respect that Country is sacred, and we will work diligently and culturally responsively in partnership to build a strong future for the People and Country.

Contents

Glossary of Acronyms

The table below presents a list of acronyms used throughout this Report:

Acronym	Meaning
ABS	Australian Bureau of Statistics
ACCO	Aboriginal Community-Controlled Organisations
ACT	Australian Capital Territory
AES	Australian Evaluation Society
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
AR	Advanced Rent
ASES	Australian Service Excellence Standards
BA	Bond Assistance
BCR	Benefit Cost Ratio
BNL	By-Name List
BOCSAR	Bureau of Crimes Statistics and Research
CA	Crisis Accommodation
C&P	Commissioning and Planning
CALD	Culturally and Linguistically Diverse
CBA	Cost-Benefit Analysis
CHAMHS	Collaborative Housing and Mental Health Service
CHIMES	Community Housing Information Management E System
CHP	Community Housing Provider
CIMS	Client Information Management System
COAG	Council of Australian Governments
COS	Client Outcomes Survey
COSS	Community of Schools and Services
CPI	Consumer Price Index
DCJ	Department of Communities and Justice
DEX	Data Exchange
DFV	Domestic and Family Violence
DHIG	District Homelessness Implementation Group
ESSC	End Street Sleeping Collaboration
EWG	Evaluation Working Group
FACSIAR	Family and Community Services Insights Analysis and Research
FY	Financial Year

Acronym	Meaning
GHSH	Going Home Staying Home
HOMES	Housing Occupancy Management and Engagement System
HYAP	Homeless Youth Assistance Program
KPI	Key Performance Indicator
L&D	Learning and Development
LGA	Local Government Area
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer (or Questioning), Intersex, Asexual and more
LIACC	Local Implementation and Coordinating Committees
NGO	Non-Government Organisation
NHHA	National Housing and Homelessness Agreement
NHMRC	National Health and Medical Research Council
NPV	Net Present Value
NSW	New South Wales
NWD	No Wrong Door
OOHC	Out-Of-Home-Care
PIAC	Public Interest Advocacy Centre
PTSD	Post-Traumatic Stress Disorder
PWI	Personal Wellbeing Index
PYI	Premiers' Youth Initiative
QALY	Quality of Adjusted Life Year
RCA	Rental Choice Assistance
ROSH	Risk of Significant Harm
SAHF	Social and Affordable Housing Fund
SHS	Specialist Homelessness Services
SHSC	Specialist Homelessness Services Collection
SLK	Statistical Linkage Key
TA	Temporary Accommodation
TAFE	Technical and Further Education
TEI	Targeted Earlier Intervention
TG	Tenancy Guarantee
US	United States
VI-SPDAT	Vulnerability Index – Service Prioritisation Decision Assistance Tool
VMS	Vacancy Management System
WHO	World Health Organisation

1. Executive Summary

1.1 Introduction

Ernst & Young (EY) was engaged by the Department of Communities and Justice ("the Department" or DCJ) to undertake a process, outcomes and economic evaluation ("the Evaluation") of the Specialist Homelessness Service (SHS) Program ("the Program") in New South Wales (NSW) for the Department to gain an understanding of where the SHS Program is working well and identify and recommend changes to better assist the Program's homeless and at-risk clients.

An evaluation of the Program has been a long-standing commitment since the Going Home Staying Home (GHSH) reforms and awarding of services in 2014 and demonstrates the Department's commitment to an independent and evidence-based approach, particularly to key non-government stakeholders such as homelessness peak bodies and SHS funded service providers. The 2021 Census data highlighted that across NSW, there was an approximate 27% increase in the number of people experiencing homelessness from 2011 to 2021, thus highlighting the significance and timeliness of this Evaluation.[1]

The objective of this Evaluation was to develop a comprehensive understanding of the SHS service system to identify and evaluate:

- How well the Program is achieving its intended objectives and whether it is reaching the target population;
- Whether there are any emerging, or growing, client cohorts;
- Potential areas for improvement, how these can be addressed and whether the Program is being implemented effectively;
- Whether the Program is delivering value for money, and its potential economic benefits; and
- Whether resources are being used effectively to achieve the Program's objectives.

The Evaluation adopted a multi-methods approach to examine client and system-level outcomes achieved over the evaluation period from Financial Year (FY) 16/17 to FY 21/22, including the associated costs and benefits. To assess the process, outcomes and economic impacts of the SHS Program, qualitative and quantitative methods were adopted.

The findings of this Evaluation consist of qualitative and quantitative data which were drawn on to articulate the value proposition of the SHS service system, and to support the Department to enable more efficient funding/resourcing, and ultimately improve outcomes for SHS clients and the sector.

1.2 Specialist Homelessness Services

The SHS Program is the primary NSW Government response to homelessness.[2] The Program is supported by 102 non-government organisations (NGOs)[3] who deliver SHS services to support people

[1] Australian Bureau of Statistics (ABS). (2021). Estimating Homelessness: Census. Retrieved 8 June 2023, from Estimating Homelessness: Census, 2021 | Australian Bureau of Statistics (abs.gov.au).

[2] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[3] 2021-2024 Provider and Service Count, provided by DCJ.

experiencing homelessness, or at risk of homelessness, through early intervention, crisis, transitional and post-crisis support services[4].

The objective[5] for SHS service providers is to support clients to:

- Remain safely in their existing housing, or to secure stable housing, which is affordable for the person;
- Be provided with safe and secure accommodation and access stable housing, which is affordable for the person;
- Be re-housed and stay housed after experiencing homelessness;
- Access mainstream and specialist services; and
- Connect with community and family.

1.3 Evaluation questions

The purpose of the SHS Program Evaluation was to develop a comprehensive understanding of the SHS service system, including emerging client cohorts, current client needs, how clients are accessing the services and barriers to access. The Evaluation addressed a range of process, outcomes and economic considerations to better understand and articulate the effectiveness of the SHS Program. For each of these considerations, associated evaluation questions were developed by DCJ and refined alongside the Evaluation Working Group (EWG) to guide the Evaluation of the SHS Program and the extent to which it is achieving its objectives. These evaluation questions are outlined in Figure 1.

Figure 1: Evaluation questions

Process	Outcome	Economic
• P1: What are the pathways people take to access SHS? What are the strengths and barriers for clients accessing SHS and what improvements can be made? How effective is Link2Home at connecting people to the services they need? • P2: What are the cohorts and characteristics of people who need SHS, including any emerging cohorts? Are existing services aligned with these needs? How capable is SHS of adapting to changing needs over time? • P3: Are people who need SHS receiving client-centred and integrated responses?? What are the strengths and barriers, both within SHS and in intersections with the broader service system to provide the services needed by clients? What improvements can be made? • P4: What improvements to data collection and reporting systems are needed to enable improved monitoring of the SHS program?	• O1: Is SHS achieving the intended outcomes? To what extent do outcomes vary across cohorts and locations?	• E1: To what extent is SHS delivering value for money? o What are the economic benefits* of SHS? o What are the costs associated with SHS? *When answering the economic evaluation question, we will evaluate holistic indicators of the economic benefits, including social and community benefits.

[4] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[5] Ibid.

1.4 Overview of Methodology

The evaluation methodology consisted of three phases:

- Phase 1: Co-design of the evaluation approach;
- Phase 2: Data collection and analysis; and
- Phase 3: Reporting.

Initial and ongoing co-design of the Evaluation involved collaboration between key SHS stakeholders, including the DCJ SHS Program team, Family and Community Services Insights Analysis and Research (FACSIAR), the EWG, which included DCJ Commissioning and Planning (C&P) representatives and homelessness peak bodies, lived experience representatives and service providers through the Service Provider Advisory Group ("the Advisory Group"). Initial co-design workshops were conducted by the Evaluation Team with key SHS stakeholders to refine the SHS Program Logic, draft evaluation questions and discuss potential stakeholder engagement and data collection approaches. Ongoing co-design of the Evaluation included refinement of the evaluation methods and tools on the basis of the methodological direction shaped by the Evaluation Plan.

Data collection and analysis involved three inter-related components. Firstly, analysis of administrative data and published literature was undertaken to understand the policy context of homelessness support services, approaches to delivering services and the strengths and weaknesses associated with different approaches. Secondly, qualitative data from stakeholder engagement were collected to explore client, service provider and other key stakeholder perspectives on the SHS Program and collaboration with inter-agencies. Quantitative data from administrative SHS client datasets were also analysed to assess key client characteristics, their pathways into support services and information about supports provided. Analysis of cost and benefit data, as well as published literature on the economic benefits related to the SHS Program, was then undertaken to assess the economic, social and community impacts of the SHS Program.

Findings from the literature review and data collection and analysis were then drawn on to develop findings that were tested with key stakeholders and leveraged to inform an economic appraisal of the SHS Program.

1.5 Key Limitations

The Evaluation of the SHS Program relied on the analysis of both quantitative and qualitative data. During the data collection and reporting process, the following limitations were identified and are detailed within the body of the evaluation report:

- Selection bias in SHS client interview nominations, stakeholder nominations and service provider survey responses;
- Limited engagement with some stakeholder groups;
- Limited data on medium- to longer-term outcomes for SHS clients with regard to access to broader housing, homelessness and the community services system;
- The SHS administrative data drawn on for the Evaluation were not representative of the entire population of people experiencing homelessness in NSW, which is likely to be larger than the cohort of SHS clients; and
- Reliance on the accuracy and completeness of administrative data provided by FACSIAR and the DCJ data team for evaluation findings.

1.6 Key Findings

1.6.1 Summary

Analysis of available quantitative and qualitative data suggests that the SHS Program is achieving its intended Program outcomes in the short-term to some extent. Short-term accommodation services have consistently maintained the highest degree of met need across the evaluation period, at approximately 30%, as compared to medium- and long-term accommodation, and many clients achieved successful housing outcomes in community and public housing after first accessing SHS support (28% and over 20% of SHS clients who accessed community and public housing during the evaluation period respectively).

However, more than 1 in 3 SHS clients returned to the Program for repeat support, and of these clients, 60.3% returned in the same financial year for the same reason, suggesting the Program was not able to meet their needs and achieve the intended outcomes in the short-term. Repeat presentations for the same reason were most frequently associated with housing, and Domestic and Family Violence (DFV) and relationship breakdown needs.[6]

A lack of data on medium- to longer-term outcomes for SHS clients with regard to access to broader housing, homelessness and the community services system is a considerable limitation of the economic analysis of the SHS Program. This factor, combined with low rates of met need and high rates of repeat presentations for the same service, results in a marginal benefit cost ratio (BCR) of 1.02 for the central case.

It should be noted that there was some qualitative evidence to suggest that SHS clients are receiving a client-centred and an integrated response to their support needs. However, the extent to which this qualitative evidence can be substantiated with quantitative evidence is limited by the lack of outcomes data and is also negatively impacted by levels of service demand in the sector which exceed sector capacity.

More detailed findings can be found in Section 5, which summarises key findings across the Process, Outcomes and Economic evaluation questions below.

[6] For the purposes of the analysis contained within this Report, the Domestic and Family Violence (DFV) and relationship breakdown category includes the following reported main reasons for assistance: Domestic and family violence (71%); Relationship/family breakdown (23%); Time out from family/other situation (4%); Sexual abuse (<1%); and Non-family violence (1%). A range of related reasons for seeking assistance are reported within the DFV and relationship breakdown category to account for likely under-reporting of DFV.
Estimates indicate that only up to 40% of domestic violence incidents are reported: Morgan A & Chadwick H 2009. Key issues in domestic violence. Research in practice no. 7. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/rip/rip7.

1.6.2 Process

The key process evaluation findings are as follows:

Evaluation subject	Evaluation sub-question	Key Findings
P1. Accessibility of the SHS Program	*What are the pathways people take to access SHS?*	The key referral pathway into SHS was other mainstream service providers, which were responsible for 39% (≡12,409) of all formal referral sources in FY 21/22. • Referrals from Domestic and Family Violence (DFV) services increased from 9% (≡2,410) in FY 19/20 (the first year for which this data were captured) to almost 17% (≡5,357) in FY 21/22. Service provider stakeholders expressed scope for streamlining the assessment and referral process for SHS clients, particularly between Link2Home and SHS service providers, to ensure clients experiencing or at risk of DFV and homelessness can access services in a timely and trauma-informed manner. • Referrals from the justice and hospital systems comprised 10.6% (≡3,373) of all mainstream referrals in FY 21/22, however service provider and inter-agency stakeholders reported particular challenges with these pathways, including incomplete and inefficient referrals and communication breakdowns, suggesting scope for improvement in collaboration and coordination to support client accessibility. SHS service providers cited examples of challenges contacting Corrections Officers, for example, resulting in clients being released into homelessness, as well as capacity constraints in the health sector, resulting in clients being released from the hospital without adequate supports. • Almost 5% (≡1,547) of all mainstream service provider referrals were received from the mental health sector in FY 21/22, a figure which reduced slightly over time from 5.5% (≡1,402) in FY 16/17. This may reflect capacity constraints within the mental health sector, which has experienced increasing demand in recent years and subdued workforce growth.[7] • The second most common referral pathway into SHS in FY 21/22 was self-referrals, which constituted 25.5% (≡10,777) of all formal referral sources in that year, however self-referrals were found to decrease over the course of the evaluation period, from 30% (≡18,797) in FY 16/17.

[7] Australian Institute of Health and Welfare. (n.d.). Mental health services activity monitoring: quarterly data. Retrieved from Mental health services activity monitoring - Mental health - AIHW; Ridoutt, L. (2021). Mental health workforce profile: community managed organisations report 2021. Human Capital Alliance. Retrieved from MHCC_WorkforceSurvey_2021.pdf.

Evaluation subject	Evaluation sub-question	Key Findings
	How accessible are services for the people who need them?	Service providers highlighted that one of the key barriers to access for SHS clients is limited resourcing within the sector relative to current levels of demand. A previous review[8] commissioned by the Department found that the SHS Program served almost 9,000 more clients than budgeted in FY 20/21, resulting in services being 114% over-subscribed on average across the state. • SHS clients interviewed reported varying experiences in accessing SHS, particularly with respect to accommodation options. Some were able to obtain crisis or short-term accommodation soon after being referred, however many others reported needing to access TA or stay at a friend or relative's place of accommodation while they waited for SHS accommodation to become available. At the end of their SHS support period, many SHS clients interviewed shared that they were able to stay at the refuge beyond a three-month period, due to requiring longer-term support and reflective of limited suitable transitional or other longer-term accommodation options. • Service provider stakeholders consulted for this Evaluation also discussed challenges in meeting demand, with many service providers reporting having long waitlists and needing to triage clients to provide support to those who are most vulnerable. Mainstream service providers and inter-agency representatives reported experiencing frequent delays with referrals and intakes which they attributed to high demand relative to service availability. • Stakeholders suggested that service accessibility was inhibited by limited appropriate accommodation options, as evidenced by proportion of met need for short-, medium- and long-term accommodation services in FY 21/22, which were 30.4% (≡5,100), 20.8% (≡2,354) and 1.7% (≡331) respectively.[9] Unmet demand analysis across a range of services is detailed further in Section 5.2.2.
	What are the strengths and barriers for clients accessing SHS and what improvements can be made?	Accessibility of services was found to be dependent on the quality of referrals made and service provider capacity to accept referrals, however service providers reported that client access is generally supported by efficient intake models and collaboration with other key stakeholders.

[8] This review commissioned by the Department was for internal use only and not released publicly.
[9] Long-term housing, as defined in the SHS Collection Manual (2019), includes public housing, private rental accommodation, community housing or owner-occupied housing provided or paid for by an SHS service provider.

Evaluation subject	Evaluation sub-question	Key Findings
		• Many service providers discussed the implementation of self-funded innovative intake models, complemented by fostering collaborative relationships with Community Housing Providers (CHPs) and inter-agency representatives to better meet SHS client needs for accommodation. • Some SHS clients interviewed for this Evaluation reported challenges in accessing refuge-style accommodation immediately, resulting in uncertainty and safety concerns for some. Some clients also cited transportation as a key enabler of access to SHS; a minority of clients interviewed received transportation support from their SHS service provider to access accommodation and also broader supports during their SHS support period, such as medical appointments.
	How effective is Link2Home at connecting people to the services they need?	The uptake in use of Link2Home as a coordinated entry point into SHS services is limited and varies significantly by region, with stakeholders highlighting that there is scope for streamlining the assessment and referral process. • In FY 21/22, almost 4% (≡1,639) of formal referrals into SHS services were from telephone or other crisis referral agencies, and of these, 38.5% (≡490) of clients were referred by Link2Home. • The service was found to be more commonly utilised in metropolitan or more populated regional areas, and more frequently used to access Temporary Accommodation (TA). • A perceived degree of mistrust and communication breakdowns between service providers and Link2Home was reported by stakeholders to create tension, duplication and inefficiency in the referral process, with many stakeholders involved in the referral process citing inconsistencies in and scope for refinement in the assessment and referral process.
	How does Temporary Accommodation (TA) feature in the pathways people take to access SHS?	Over the evaluation period, 20% (≡54,515) of all SHS clients accessed TA at some point during their support period, however the availability of TA was reported to vary by region, impacting its role as a pathway into SHS in those regions. • Limited accommodation and transportation options were reported to impact provision of TA, particularly in rural and remote areas of NSW, with some SHS service providers reporting having established partnerships with CHPs and local accommodation providers to support delivery of accommodation services.

Evaluation subject	Evaluation sub-question	Key Findings
		• SHS client experiences were mixed with respect to TA support. Whilst many appreciated the availability of the accommodation option and described it as of an adequate standard, many also reported experiencing uncertainty in receiving TA support for longer than a couple of days, accommodation options being unsuitable or unsanitary, or even completely unavailable.
P2. Identifying the SHS current and emerging cohorts	*What are the cohorts and characteristics of people who need SHS, including any emerging cohorts?*	For the purposes of this sub-evaluation question, "emerging" should be understood as growing or increasing over time. The administrative data identified single fathers, clients experiencing family violence (both children and adults) and females seeking assistance for DFV and relationship breakdowns as growing cohorts over the evaluation period. • Over half (56.4% ≡153,733) of SHS clients identified as female, over one third (33.24% ≡ 90,615) of SHS clients were single parents with children, and over a quarter (27.6% ≡ 75,231) were children under the age of 16. One quarter (25.01% ≡68,162) identified as Aboriginal and/or Torres Strait Islander. Almost a quarter (24.5% ≡66,781) self-reported having a mental health condition, and 32% (≡87,225) of SHS clients sought assistance for DFV and relationship breakdown.[10] • Female clients whose main reason for seeking assistance was DFV and relationship breakdown, increased from approximately 18% (≡27,672) to 22% (≡33,821) over the evaluation period. • Children aged 12-15 years were also more likely to seek support from SHS to access services for DFV and relationship breakdown, with 39% of this cohort (≡7,726 of 19,811) citing this as the main reason for presentation[11], compared with over 31% for other SHS clients (≡78,357 of 252,766). Presentations amongst this cohort for support to access services for DFV increased by 5% (≡41) over the evaluation period, highlighting the need to tailor early intervention supports for this vulnerable cohort. • Single fathers increased as a proportion of the total SHS population, by approximately 2 percentage points (≡5,972 of 62,910 in FY 16/17 to 5,064 of 42,269 in FY 21/22). Two thirds of single parents who presented

[10] For the purposes of the analysis contained within this Report, the Domestic and Family Violence (DFV) and relationship breakdown category includes the following reported main reasons for assistance: Domestic and family violence (71%); Relationship/family breakdown (23%); Time out from family/other situation (4%); Sexual abuse (<1%); and Non-family violence (1%). A range of related reasons for seeking assistance are reported within the DFV and relationship breakdown category to account for likely under-reporting of DFV. Estimates indicate that only up to 40% of domestic violence incidents are reported: Morgan A & Chadwick H 2009. Key issues in domestic violence. Research in practice no. 7. Canberra: Australian Institute of Criminology. Retrieved from https://www.aic.gov.au/publications/rip/rip7.

[11] Approximately 42% of children aged 12-15 presented to SHS unaccompanied. The main reason for seeking assistance for those children who are accompanied by a parent or guardian may reflect the circumstances of the parent or guardian.

Evaluation subject	Evaluation sub-question	Key Findings
		for support identified as single mothers (≡61,209) and one third as single fathers (≡28,937). Service providers reported experiencing challenges in providing accommodation to parents with children, particularly larger families. • Administrative data indicates an increase in the proportion of clients presenting with a self-reported diagnosed mental health condition from just over 24% (≡15,115) in FY 16/17 to almost 26% (≡10,982) in FY 21/22.[12] Service providers suggested that they are witnessing an increase in presenting clients who have mental health conditions, whether diagnosed or undiagnosed, which is presenting a challenge for them in the provision of support to access appropriate trauma-informed and clinical supports.
	Are existing services aligned with these needs?	Administrative data indicate that the SHS Program is not meeting client need across a range of service provision categories, which suggests that existing services are not aligned with demand and client support needs. • SHS administrative data suggested that 30.4% (≡5,100) of clients who reported a need for short-term accommodation had their needs met; almost 21% (≡2,354) of clients who reported a need for medium-term housing had their needs met; and 1.7% (≡331) of clients who reported a need for long-term housing had their needs met. • Administrative data also suggest that existing services faced difficulties in facilitating clients' access to a range of requested mental health-related supports.[13] In FY 21/22, needs were met need for: 26% (≡587) and 27% (≡293) of SHS clients seeking support to access psychological and psychiatric services respectively; close to 36% (≡1,647) of clients seeking support to access mental health services; and just over 46% (≡383) of clients requesting connection into specialist counselling services. • Analysis of the administrative data highlighted that the sector is not meeting need in supporting Aboriginal and Torres Strait Islander clients to access mental health services with 31.3% (≡1,593) of needs met over the evaluation period and 20.1% (≡84) of needs met for support for children aged 12-15 years to access psychiatric services.

[12] This variable refers to clients with a self-reported diagnosed mental health condition; hence the percentage of clients in this cohort may appear low when compared to AIHW counts, which use additional criteria and were approximately 40% in FY 21/22.

[13] In the interpretation of met and unmet need analysis throughout the Report with respect to support from SHS to access mainstream services, it is worth noting that met need may be impacted by the capacity of mainstream service sectors to accept referrals from SHS and provide services to SHS clients. It may also be impacted by the closure of SHS support periods by SHS service providers prior to the SHS client being provided with a service from an external service provider.

Evaluation subject	Evaluation sub-question	Key Findings
		• Over 10,000 unique clients requested assistance to access domestic and family violence services in FY 21/22, equivalent to almost 24% of all unique SHS clients in that year. The sector's ability to meet these needs was comparatively strong, with just over 80% (≡8,136) of needs met.
	How capable is SHS (the Program and services) of adapting to changing needs over time?	The SHS Program's ability to meet client needs remained consistent over the evaluation period, even where demand increased, as in the case of assistance for trauma, support to access mental health services and short-term accommodation. This demonstrates a degree of responsiveness from the SHS sector, however it must be noted that met need across many categories, particularly accommodation and mental health-related needs, remained low to moderate. • Service providers consistently met approximately 30% (≡5,100) of clients' short-term accommodation needs, however have not met growing demand for long-term accommodation, having met approximately 1.7% (≡331) of these needs in FY 21/22, likely impacted by contextual factors such as lack of exit pathways due to housing unaffordability.
P3. Review the processes and approaches in SHS provided response	*Are people who need SHS receiving client-centred and integrated responses?*	Evidence to assess the extent to which SHS clients received client-centred and integrated responses varied considerably, with qualitative evidence from SHS client interviews suggesting that supports received were adaptive and integrated, whilst qualitative evidence from service providers and other inter-agency representatives suggested that significant barriers to delivering client-centred and integrated responses existed (refer to key findings under the next evaluation sub-question). • Clients interviewed reported the responsiveness of service providers to individual needs and their ability to connect clients into support services beyond those requested to meet the holistic needs of clients and their families (noting the positive bias present in this evidence as discussed in Section 3.9). • Analysis of quantitative evidence shows that during the evaluation period, more than 1 in 5 clients (21% ≡57,341) withdrew their request for assistance and service providers lost contact with almost 14% (≡38,161) of clients, suggesting client dissatisfaction with services or an inability to engage with supports.
	What are the strengths and barriers, both within SHS and in intersections with	Strategic partnerships (refer to Section 5.2.4) and co-location or provision of allied services on-site at SHS accommodation were found to enable delivery of holistic and integrated responses, whilst workforce challenges, sector competition, limited capacity and resourcing relative to demand were reported to create ongoing challenges for the sector.

Evaluation subject	Evaluation sub-question	Key Findings
	the broader service system, to provide the services needed by clients?	• Service providers and DCJ stakeholders highlighted significant challenges providing case management support for periods less than three months, due to clients requiring support beyond this timeframe to address their complex needs. Many SHS clients interviewed reported being enabled to remain in refuges for longer than a three-month period, demonstrating some providers have responded flexibly to deliver client-centred support despite capacity and resourcing challenges. • Lack of transparency and minimal flexibility in current contracting arrangements were also cited as impediments to collaboration and delivery of client-centred responses to clients. Several SHS service providers consulted with for this Evaluation suggested that additional clarity as to how contractual requirements vary across providers and geographies would be beneficial to improve understanding of roles and responsibilities across the sector and increase collaboration, whereas it was suggested that increased flexibility in contracting would allow providers to determine the most optimal way to deliver client outcomes within their funding agreements. • Many stakeholders suggested that SHS staff frequently operate beyond capacity, and at times are not trained appropriately to support clients with increasingly complex needs and manage risk of burnout, leading to high turnover and associated workforce challenges.
	What improvements can be made?	Resourcing that is better aligned with service demand was frequently cited by service providers as a potential enabler to support meeting demand in referrals and client needs and may improve the sector's ability to deliver client-centred and integrated supports, including supporting the identification of appropriate exit options. • Staff training for data capture and monitoring was also raised by service providers as an enabler of more efficient service delivery.
	How effective are the networks and governance mechanisms in place, such as District Homelessness Implementation Groups (DHIGs), at	Opinions on effective collaboration across the service system varied widely by geography and service and cohort types, with many stakeholders citing that they faced the greatest challenges in collaborating with the health and mental health sectors, leading to receipt of inappropriate referrals which may impact existing clients. • Opinions on the effectiveness of higher-level more strategic forums, such as District Homelessness Implementation Groups (DHIGs), also varied widely, often impacted by the size of the relevant District, with larger DCJ Districts comprising multiple Local Government Areas (LGAs) and therefore potentially multiple similar meetings. Many stakeholders suggested that increased clarity regarding the purpose of and

Evaluation subject	Evaluation sub-question	Key Findings
	working collaboratively to resolve implementation issues and consider practice principles and how they are applied when supporting clients?	appropriate level of attendance at these forums would support the achievement of more productive service coordination. • Tailored, place-based, collaboratively designed approaches to meeting client needs were highlighted by stakeholders as supporting collaboration to resolve implementation issues to support clients, whereas limited time and capacity was the most cited challenge impeding sector collaboration, followed by limited knowledge sharing and integration between SHS and mainstream service providers.
P4. Effectiveness of the networks and governance mechanisms	*How effective are current data collection and reporting mechanisms?*	The key SHS data collection and reporting mechanism, the Client Information Management System (CIMS), was perceived by some stakeholders to be best suited and easiest to use for case management, however its limitation in reporting functionality and flexibility were noted, with opportunities for refinement. • Although there is an expectation that SHS providers are progressively transitioning towards collecting greater client outcomes data and service providers expressed a desire to be able to better track the client's journey, they also generally perceived there was limited ability to do so through the current data collection tools. • There were some examples cited in consultations of tools currently being used to collect and track client outcomes, including the Housing Occupancy Management and Engagement System (HOMES) data system (to track referrals), a "TA register" allowing providers to capture referral pathways and outcomes, the Personal Wellbeing Index (PWI) and Client Outcomes Survey (COS) tools, and the Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) tool as part of involvement with the End Street Sleeping Collaboration (ESSC), however the overall effectiveness of these tools was reported to be constrained by limited integration ability and reporting features.
P5. Data collection	*What improvements to data collection and reporting systems are needed to enable improved monitoring of the SHS Program?*	Lack of time and capacity to adequately meet reporting obligations and limited training on how to use reporting systems appeared to be the main challenges with the current SHS data reporting mechanisms, reflected in both survey and consultation findings, suggesting that improvements, including automation, dashboard reporting features and increased training opportunities may be required.

Evaluation subject	Evaluation sub-question	Key Findings
		• Stakeholders also expressed desire for a streamlined, performance-based data collection and monitoring system linked to key agreed outcomes. The Data Exchange (DEX) tool used by the Targeted Earlier Intervention (TEI) program was highlighted as an exemplar of such a system.

1.6.3 Outcomes

The key outcomes evaluation findings are as follows:

Evaluation subject	Evaluation sub-question	Key Findings
O1. SHS intended outcomes	*Is SHS achieving the intended outcomes?*	Although the degree of met need across SHS accommodation services remained low relative to demand, linkage of SHS data with social housing data suggests achievement of some of the intended SHS program outcomes related to housing. • Almost 14% (≡37,321) of SHS clients accessed community housing during the evaluation period. Over 28% (≡10,596) of these clients were successfully housed in community housing while being supported by SHS, with the vast majority (82% (≡8,689)) of this cohort able to be housed in a community housing property within six months. Clients who accessed a community housing property before their SHS support ended were more commonly single parents, compared to lone persons and Aboriginal and/or Torres Strait Islander clients, who were identified as more commonly accessing community housing after their SHS support ended. • Over 12% (≡33,765) of SHS clients accessed public housing during the evaluation period and over 1 in 5 (≡6,955) of those clients were successfully housed in public housing after having first accessed SHS.[14] Aboriginal and Torres Strait Islander clients more commonly required SHS support, while being housed in a property and more commonly sought SHS support after their tenancy ended when compared to other SHS client cohorts. Other SHS outcomes, linked to the Program Logic, were more challenging to analyse due to data limitations present for this Evaluation (detailed in Section 3.9). However, some outcomes related to the Safety and

[14] Community housing and public housing are social housing properties. Public housing is managed by DCJ and Aboriginal Housing Office while community housing properties are managed by not-for-profit, non-government registered community housing organisations.

Evaluation subject	Evaluation sub-question	Key Findings
		Wellbeing domains were observed with the limited client outcomes data available, coupled with insights from SHS client interviews. • In the Safety domain, assistance for DFV and relationship breakdown was frequently associated with repeated presentations to SHS, with over 7 out of 10 return clients (≡22,955 of 33,384) returning the same year and for the same reason. • In the Wellbeing domain, SHS clients interviewed reported an improved sense of confidence, independence and connection to family, friends and community as a result of their support from SHS. The administrative data also indicated that nearly 9 out of 10 students in primary (≡22,964 of 25,695) and secondary schools (≡23,685 of 26,939) were able to successfully continue their studies throughout their SHS support periods. Another indicator to assess achievement of outcomes may be return to services.[15] Whilst the majority of SHS clients did not return for support, more than 1 in 3 clients (≡102,656) re-presented to SHS over the evaluation period.[16] Of those who re-presented to SHS in the same year, 60.3% (≡25,494) re-presented with the same service need most. Clients returning in the same year most often sought housing and support to access services for DFV and relationship breakdown needs.
	To what extent do outcomes vary across cohorts and locations?	Variation in outcomes was observed across a range of key cohorts. Analysis was conducted for children aged 12-15 years, young adults aged 16-24 years and Aboriginal and Torres Strait Islander clients, across the domains of housing, safety (DFV and relationship breakdown), and wellbeing (education and cultural accessibility), with trends also observed across DCJ Districts.

[15] It is important to consider that returning to SHS may not be a negative outcome, particularly if it is for a different reason than the initial reason for support; it could be an indication of the provision of trauma-informed support and the client's trust in the system. Similarly, a client may choose not to return to SHS, even if they still have support needs, as they may have had a negative experience with the service provided.

[16] As per AIHW data, 59% of clients in FY21/22 had previously received SHS support at some point since the Specialist Homelessness Service Collection (SHSC) began in July 2011. The variance in the number of re-presenting clients between AIHW data and the evaluation data may be attributed to the differing start date for the analysis periods, being FY 11/12 for AIHW analysis, and FY 16/17 for evaluation analysis.

Evaluation subject	Evaluation sub-question	Key Findings
		• For all three examined cohorts of interest, the majority of clients remained in the same type of accommodation from the beginning to the end of their SHS support period, whether that be an improvised or inadequate dwelling, an institutional setting, or some other form of more stable housing. • A higher share of children aged 12-15 who were staying in short-term temporary accommodation at the beginning of their SHS support transitioned to more stable housing by the end of their SHS support as compared to the total SHS cohort (39% (≡630) compared to 33% (≡11,426) respectively).[17] Children aged 12-15 were also more likely to be living in public, community or transitional housing upon presentation to SHS than the total SHS cohort (26% (≡5,224) compared to 17% (≡48,106) respectively). • Sustained housing during the SHS support period for young adults aged 16-24 years varied considerably across DCJ Districts, from 10.4% (≡298) in Northern Sydney to 23.2% (≡692) in Murrumbidgee, with low rates of sustained housing outcomes compared to the total SHS cohort (24% (≡65,476)) consistent with stakeholder sentiment of the challenges in provision of suitable accommodation for young adults.[18] • Sustained housing outcomes were also varied for Aboriginal and Torres Strait Islander clients across DCJ Districts, with the largest share of Aboriginal and Torres Strait Islander clients sustaining housing in Western Sydney (30% (≡1,412)) and the lowest in Northern Sydney (11.7% (≡67)), demonstrating notable cohort differences compared to the total SHS cohort (24% (≡65,476)). • The overall rates of re-presentation to SHS varied between the three cohorts selected for the detailed cohort analysis. The lowest rates of return to services amongst these cohorts were observed for children aged 12-15 (35.0% (≡6,932) of all children re-presented), followed by young people aged 16-24 (42.0% (≡25,259)) and the highest rate of re-presentation was observed for Aboriginal and Torres Strait Islander clients (47.3% (≡34,731)), all compared to 37.7% (≡10,656) of the total SHS cohort. • Of the three cohorts, children aged 12-15 more commonly presented to SHS seeking support with DFV and relationship breakdown as their main reason for seeking assistance (39.6% (≡7,797) of the cohort) compared to young people aged 16-24, 30.7% (=18,371) or Aboriginal and Torres Strait Islanders 27.2% (=19,967).

[17] More stable housing is considered to be 'public, community or transitional housing - renter or rent free' or 'private or other housing – renter or owner.'
[18] It is considered that the client 'sustained housing' if the client reported being housed as a renter or owner in private, public, community or transitional housing at the beginning and end of their SHS support.

Evaluation subject	Evaluation sub-question	Key Findings
		• The majority of children aged 12-15 were able to remain in schooling throughout their SHS support period, from 65% (≡86) in Murrumbidgee to 92% (≡761) in Far West NSW. • The SHS Program met almost 84% (≡4,632) of needs requested by Aboriginal and Torres Strait Islander clients for culturally specific services, and almost 81% (≡2,913) of needs for assistance to connect culturally, which demonstrates strength in culturally appropriate service provision across the Program.

1.6.4 Economic

The key economic evaluation findings are as follows:

Evaluation subject	Evaluation sub-question	Key Findings
E1. Economic	*To what extent is SHS delivering value for money?*	The economic appraisal estimates total benefits of the SHS Program at $1,106.5m and a benefit to cost ratio (BCR) of 1.02. This suggests that the estimated benefits of the SHS Program marginally outweigh its estimated costs. The result reflects a lack of outcomes data in combination of with the low proportion of met need and high proportion of clients re-presenting for the same service. • This is not an unexpected result given modelling assumptions and that SHS tends to address more immediate and acute needs of clients which means modelling a longer than 5-year benefit horizon is difficult to justify for many clients, particularly the 22% who return to SHS seeking the same service.
	What are the economic benefits of SHS?	The total value of modelled benefits in present value terms is estimated at $1,106.5m comprising Health benefits ($449.8m), Justice and Safety benefits ($692.4m) and housing benefits that represent a disbenefit of $35.7m through the provision of private rental assistance.
	What are the costs associated with SHS?	The SHS Program provided services to SHS clients between FY 16/17 and FY 21/22 at a total primary estimated cost of $1,086.4m or approximately $4,000 per client in present value terms. • The funding provided by DCJ captures approximately 93% of primary SHS costs based on the findings of the Unit Costing Project. This suggests that service providers subsidise the SHS Program using other funding sources to levels in the order of 7% above the total funded amount.

1.7 Recommendations

Recommendations arising from this Evaluation relate to key evaluation themes, including service accessibility, client needs and demand, networks and governance, and data collection and reporting. It is recommended that:

1. The implementation of the refined Link2Home assessment process is closely monitored by the Department with regard to its efficacy, alongside Link2Home's function as a centralised intake process.

2. The Link2Home assessment is refined, by the Department in partnership with service providers, to align closely with the SHS Common Assessment tool, and that Link2Home assessments are able to be shared in full with service providers to enhance the referral process. Digital enhancements to facilitate automatic upload of the Link2Home assessment into CIMS could also be considered.

3. Compliance with the contractual requirement to record and maintain Vacancy Management System (VMS) listings is prioritised by service providers and closely monitored by DCJ Commissioning and Planning representatives to ensure more current vacancy data and further support the referral process.

4. The VMS be reviewed, by the Department in partnership with service providers, to optimise user interface and additional training is introduced by the Department to support uptake of more consistent and standardised approaches to assessing vacancies and referrals.

5. DCJ consider mechanisms for mainstream service providers and other referrers to access information with regard to SHS services, which could coincide with additional effort in awareness raising, and could involve a technology solution, such as a portal for mainstream services to access additional information.

6. DCJ, in close consultation with service providers and the sector, develop a standardised prioritisation framework(s) to further support greater consistency in prioritising clients where demand for services outweighs capacity, and to support efficiencies in the client assessment and intake process.

7. Investment into SHS accommodation services is prioritised by the Department and based on evidence related to unmet need and client characteristics, with consideration of provision of greater flexibility within contractual arrangements to enable service providers to account for changing client needs over time.

8. A review of supply and demand factors pertaining to the utilisation of the TA scheme is undertaken by the Department to identify and understand key drivers, particularly in areas of low utilisation, and develop recommendations for investment prioritisation, including in pathways to stable accommodation options.

9. The Department review alternative models to provision of TA in rural areas, including consideration of the expansion of the brokerage component of SHS funding to further support rural SHS service providers to partner with local external accommodation providers to temporarily accommodate people experiencing homelessness.

10. Collaboration between agencies, such as Corrective Services and NSW Health, and SHS, is further strengthened by the Department through the implementation of a standardised pre-release screening process to identify people exiting institutional facilities and care who are at risk of homelessness and support SHS services to engage with these clients with sufficient notice and information prior to exit.

11. SHS providers and mainstream health and mental health service providers in their DCJ Districts form strategic partnerships to further improve referrals and provision of supports to clients with complex needs, which could include multi-disciplinary co-location models.

12. The SHS mental health training curriculum is reviewed by the Department to ensure relevance and efficacy, and is provided on an ongoing basis to enable continuous improvement, with consideration of mandating training under the SHS program specifications.

13. The Department revise contractual arrangements with SHS service providers to include additional flexibility in service delivery and increase the proportion of brokerage funding to be used at the service provider's discretion to further enable more client-centric outcomes, which may require ongoing monitoring and reporting according to the transition towards outcomes-based commissioning.

14. The Department continue to prioritise building the capacity of Aboriginal Community Controlled Organisations (ACCOs) to deliver SHS services, in addition to building cultural safety and capability in non-Aboriginal organisations, to ensure clients continued to be provided with culturally appropriate and client-centred support.

15. The Department undertake awareness raising initiatives to ensure further clarity amongst service providers of the removal of standard case management timeframes, in addition to best practices in balancing non-time-limited case management with meeting contractual targets.

16. The Department conduct a comprehensive review to identify the specific purpose of forums and work with key stakeholders to determine the most appropriate audience for each forum to foster a more collaborative environment in meetings and facilitate maximum productivity.

17. The Department conduct a review of the implementation of place-based approaches in local communities, including Local Implementation and Coordinating Committees (LIACCs), considering how elements of the ESSC's coordinated and place-based methodology can be further leveraged.

18. The Department undertake a review to understand the data needs of various stakeholder groups, and consider the potential integration of CIMS, VMS and Link2Home with other DCJ datasets including the CHIMES portal and the DEX to better track client journeys through the service system.

19. The Department, in collaboration with SHS service providers, design and implement a pilot to engage with a sample of SHS clients at fixed intervals after exiting services to better understand ongoing achievement of client outcomes.

20. The automation of outcomes data collected through mechanisms such as the Personal Wellbeing Index (PWI) and Client Outcomes Survey (COS) is prioritised by the Department to support service providers.

21. Reporting functions are updated by the Department in collaboration with service providers for ease-of-use, such as a dashboard or downloadable templates.

22. A regular compulsory SHS data training calendar be implemented by service providers for new starters and a refresher course for current staff, and that greater effort be placed on promotion of available online training options to staff.

23. The Department explore opportunities to leverage existing data collection tools and consider the development of new tools to facilitate improved information sharing across the sector to best meet the needs of clients.

Further detail on these recommendations arising from the Evaluation are presented within the recommendations section of this Evaluation Report ("the Report").

1.8 Report Structure

The following sections of this Report detail the SHS Program Evaluation activities and findings, including:

- Introduction – context and background of homelessness and homelessness policy in Australia, SHS in NSW and previous SHS reviews, as well as the evaluation scope, objectives and questions;
- Evaluation Methodology – phases of the evaluation approach, including co-design, literature review, data collection and analysis, and economic appraisal, as well as stakeholder engagement, ethical considerations and limitations;
- Literature Review – summary of findings from the literature on homelessness and addressing homelessness;
- Evaluation Findings – detailed findings of the process, outcomes and economic evaluation; and
- Key Recommendations – key recommendations based on identified key areas of opportunity for SHS.

2. Introduction

2.1 Homelessness in Australia

There is no single definition of homelessness. The Specialist Homelessness Services Collection (SHSC) defines a person as homeless if they are living in either:

- Non-conventional accommodation or sleeping rough (such as living on the street); or
- Short-term or emergency accommodation due to a lack of other options (such as living temporarily with friends and relatives).[19]

The Australian Bureau of Statistics (ABS) defines homelessness as the lack of one or more elements that represent 'home'. According to the ABS' statistical definition, 'when a person does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

- Is in a dwelling that is inadequate;
- Has no tenure, or if their initial tenure is short and not extendable; or
- Does not allow them to have control of, and access to space for social relations.'[20]

Survey evidence suggests that just over 1 in 10 Australians have been homeless at some time in their lives.[21] It was estimated that over 122,000 people were experiencing homelessness on Census night in 2021, an increase of 5.2% people since the 2016 Census, however there was a decrease in the rate of homelessness from 50 to 48 people per 10,000 over the same period.[22]

2.2 Policy context

The National Housing and Homelessness Agreement

In the Financial Year (FY) 17/18 Budget, the Australian Government formed a National Housing and Homelessness Agreement (NHHA) which came into effect on 1 July 2018. The purpose of this agreement is to improve housing outcomes across Australia, including for those who are homeless or at risk of homelessness.[23]

The NHHA provides more than $1.6 billion in Commonwealth funding to the states and territories per year, with an additional $67.5 million funding boost to support the provision of homelessness services in FY 23/24.[24] States and territories are required to match the funding received from the Australian Government, with most required to report data to the SHSC as part of the funding agreement.[25]

The NHHA was established to the following national outcomes:

[19] AIHW. (2023). Glossary. Retrieved 10 July 2023, from https://www.aihw.gov.au/reports-data/australias-welfare/australias-welfare-snapshots/glossary

[20] ABS. (2012). Information Paper – A Statistical Definition of Homelessness. Retrieved 8 June 2023, from 4922.0 - Information Paper - A Statistical Definition of Homelessness, 2012 (abs.gov.au).

[21] ABS. (2019). General Social Survey: Summary Results, Australia. Retrieved 30 June 2022, from https://www.abs.gov.au/statistics/people/people-and-communities/general-social-survey-summary-results-australia/2019.

[22] ABS. (2023). Estimating Homelessness: Census. Retrieved 16 May 2023, from https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/2021.

[23] National Housing and Homelessness Agreement. (2018). Federal Financial Relations. Retrieved 25 June 2022, from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHHA_Final.pdf.

[24] The Commonwealth of Australia. (2023). Budget 2023-24: Budget Measures (Budget Paper No. 2). Retrieved 16 May 2022, from https://budget.gov.au/content/bp2/download/bp2_2023-24.pdf.

[25] National Housing and Homelessness Agreement. (2018). Federal Financial Relations. Retrieved 25 June 2022, from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHHA_Final.pdf.

- A well-functioning social housing system that operates efficiently, sustainably and is effective in assisting low-income households and priority homelessness cohorts to manage their needs;
- Affordable housing options for people on low-to-moderate incomes;
- An effective homelessness service system, which responds to and supports people who are homeless or at risk of homelessness to achieve and maintain housing, and addresses the incidence and prevalence of homelessness;
- Improved housing outcomes for Aboriginal and Torres Strait Islander Australians;
- A well-functioning housing market that responds to local conditions; and
- Improved transparency and accountability in respect of housing and homelessness strategies, spending and outcomes.[26]

The roles of each level of government, as set out in the NHHA, are outlined in Table 1.

Table 1: Roles and responsibilities for housing and homelessness in Australia

Australian Government	Shared responsibilities	State and territory governments
• Funding to states and territories under the NHHA. • Income support and Commonwealth Rent Assistance for low-income people. • Providing Government-owned purpose housing and homelessness programs and services.	• Housing, homelessness and housing affordability policy. • Identifying and sharing best practices and policy for housing, homelessness and housing affordability. • Collecting and sharing data. • Evaluation.	• Publishing and implementing a homelessness strategy to address priority cohorts. • Funding homelessness services to support local needs. • Collecting data from homelessness service providers. • Administration and delivery of social housing and homelessness services.

NSW Homelessness Strategy 2018-2023

In response to the NHHA, the NSW Government developed the NSW Homelessness Strategy 2018-2023 ("the Strategy") which outlines its plan to prevent and improve NSW's response to homelessness.[27] The Strategy builds on a range of reforms, including Future Directions for Social Housing in NSW, with a focus on reducing the impact of homelessness on individuals and improving outcomes for people and families.[28] The Strategy has three focus areas[29]:

- Intervening early and preventing crisis;

[26] National Housing and Homelessness Agreement (NHHA). (2018). Federal Financial Relations. Retrieved 27 June 2022, from https://federalfinancialrelations.gov.au/sites/federalfinancialrelations.gov.au/files/2021-07/NHHA_Final.pdf.

[27] Department of Communities and Justice (DCJ). NSW Homelessness Strategy 2018-2023. NSW Government. Retrieved 27 June 2022, from https://www.facs.nsw.gov.au/__data/assets/pdf_file/0007/590515/NSW-Homelessness-Strategy-2018-2023.pdf.

[28] NSW Land and Housing Corporation (LAHC). Future Directions for Social Housing in NSW. Retrieved 15 June 2023, from, Future Directions for Social Housing in NSW | NSW Land and Housing Corporation

[29] Department of Communities and Justice (DCJ). NSW Homelessness Strategy 2018-2023. NSW Government. Retrieved 27 June 2022, from https://www.facs.nsw.gov.au/__data/assets/pdf_file/0007/590515/NSW-Homelessness-Strategy-2018-2023.pdf.

- Providing effective supports and responses; and
- Creating an integrated, person-centred service system.

As part of the NSW Government's FY 19/20 Budget, $61 million of new funding was committed over a period of four years to implement the Homelessness Strategy, with more assertive outreach services for rough sleepers, strengthened risk assessment to address the underlying complexity behind each person's homelessness and more support to maintain a tenancy.. The Strategy also supports the Social and Affordable Housing Fund (SAHF) by investing in social housing.[32]

2.3 Previous SHS evaluations and reviews

Previous evaluations and reviews of Specialist Homelessness Services (SHS) conducted by third parties have provided insight into the design, delivery and outcomes measurement of the SHS Program. These include:

- The Early Review of the SHS Program (2017);
- SHS Commissioning Outcomes Pilot (2019); and
- SHS Program Capacity and Utilisation Review (2021).

Early Review of the SHS Program (2017)

The Early Review of the SHS Program was the first assessment of the Going Home Staying Home (GHSH) reform transition and focused on the early implementation of key strategies associated with the reform, including service delivery design, planning and resource allocation industry and workforce development and streamlined access.[33] The Early Review found that the number of people in NSW being supported by SHS was increasing above the national rate and that support for families had increased at a higher rate than for other client groups, indicating a change in composition in post-reform client mix.[34]

The review also found that since the reform was implemented, there had been a substantial increase in the demand for short-, medium- and long-term housing, and a corresponding increase in unmet demand.[35] Further, the review found that SHS cannot provide effective support across all intended service responses, however, stakeholders reported improvements in prevention and early intervention as a result of the reform.[36] Key recommendations from the Early Review included:

- Development of a shared understanding of the required skills and capacities of the SHS workforce;
- Building the capacity of Aboriginal organisations and the cultural safety and competence of non-Aboriginal organisations in working with Aboriginal people

[30] Department of Communities and Justice (DCJ). NSW Homelessness Strategy 2018-2023. NSW Government. Retrieved 27 June 2022, from https://www.facs.nsw.gov.au/__data/assets/pdf_file/0007/590515/NSW-Homelessness-Strategy-2018-2023.pdf.
[31] Ibid.
[32] Department of Communities and Justice (DCJ). NSW Homelessness Strategy 2018-2023. NSW Government. Retrieved 27 June 2022, from https://www.facs.nsw.gov.au/__data/assets/pdf_file/0007/590515/NSW-Homelessness-Strategy-2018-2023.pdf.
[33] Valentine, K., Zmudzki, F., Fotheringham, M., & Smyth, C. (2017). Early Review of the Specialist Homelessness Services Program. Sydney: Social Policy Research Centre, UNSW Sydney. Retrieved from Early Review of Specialist Homelessness Services Program | Social Policy Research Centre – UNSW Sydney.
[34] Ibid.
[35] Ibid.
[36] Ibid.

- Development of a shared understanding of the key reform principle of No Wrong Door and consistent practices in its use;

- Development of shared definitions of prevention and early intervention, and how this should be operationalised for different client groups and in different contexts; and

- Consolidation and development of SHS data with initial priority to integrating Client Information Management System (CIMS) and non-CIMS service providers.[37]

SHS Commissioning Outcomes Pilot (2019)

Outcomes-based commissioning places the outcomes being achieved for clients at the centre of the contracting relationship.[38] Focus area three of the NSW Homelessness Strategy 2018-2023 focuses on outcomes-based commissioning in order to shift emphasis in the contracting environment from the services offered by a provider to the outcomes they achieve for their clients.[39] Outcomes-based commissioning is driven by data and achieved through the implementation of new reporting mechanisms to encourage greater collaboration across the sector and increase accountability and reporting by agencies and services.[40]

On the basis of this focus area, over six months in 2019, the Department of Communities and Justice (DCJ or the Department) worked with SHS service providers across 19 sites to pilot the use of outcomes measures in service delivery regarding safety, housing and wellbeing. The pilot aimed to improve service quality, transparency and accountability amongst SHS providers by driving reform to shift SHS funding arrangements from a focus on outputs to outcomes.[41] An evaluation of this pilot was subsequently undertaken, which demonstrated that careful implementation of the tools and outcomes indicators could be useful for informing evidence-based discussions between DCJ and providers regarding contracts and district and state strategies.[42]

Key recommendations emerging from the pilot included:

- Reconciliation of issues relating to comparability, attribution and volatility, and implementation of safeguards against perverse incentives;

- Addition of outcomes indicators to other information to inform contracting and strategy discussions between DCJ and providers; and

- Use of outcomes data, alongside other information, in contracting discussions to agree on actions the provider will take to improve outcomes, and a shift in accountability to be focussed on the delivery of those agreed actions rather than primarily on changes in the outcomes data.[43]

SHS Program Capacity and Utilisation Review (2021)

The Department commissioned a review[44] of the utilisation of the SHS Program within and across DCJ Districts in NSW, with a particular focus on the under- or over-utilisation of services and possible reasons why, as well as to identify opportunities for improvement with respect to the SHS service and funding model, and data collection. The SHS Program Capacity and Utilisation Review confirmed

[37] Valentine, K., Zmudzki, F., Fotheringham, M., & Smyth, C. (2017). Early Review of the Specialist Homelessness Services Program. Sydney: Social Policy Research Centre, UNSW Sydney. Retrieved from Early Review of Specialist Homelessness Services Program | Social Policy Research Centre – UNSW Sydney.

[38] Department of Communities and Justice (2019). Homelessness Commissioning for Outcomes Pilot Evaluation Report. Retrieved from Outcomes based commissioning | Family & Community Services (nsw.gov.au).

[39] Ibid.

[40] Ibid.

[41] Department of Communities and Justice (2019). Homelessness Commissioning for Outcomes Pilot Evaluation Report. Retrieved from Outcomes based commissioning | Family & Community Services (nsw.gov.au).

[42] Ibid.

[43] Ibid.

[44] This review commissioned by the Department was for internal use only and not released publicly.

NSW SHS providers supported a greater number of clients than funded to.[45] The NSW SHS Program was found to be oversubscribed with average utilisation of 114% in FY 20/21.[46]

A key theme identified in the review was the mismatch between available accommodation and support services and client cohorts presenting, ultimately contributing to capacity and utilisation issues.[47] At the time of the review, funding and contract allocations per DCJ District were based on allocations determined during the GHSH reform period of 2012-2014.[48] As a result of changes in demographics and needs of client cohorts since the GHSH reforms, accommodation and supports were found to be no longer fit-for-purpose.[49] Stakeholders also reported that clients had increasingly complex needs. Subsequently, it was found in the review that SHS providers may decline referrals for clients with complex needs due to not having the resources to support them.

2.4 Scope and objective of this Evaluation

The SHS Program currently funds and supports 102 non-government organisations (NGOs) to deliver 195 SHS services to people who are homeless or at risk of homelessness across NSW.[50] These services include early intervention, crisis, transitional and post-crisis services.[51]

The purpose of the current SHS Program Evaluation was to develop a comprehensive understanding of the SHS service system, including emerging client cohorts, current client needs, how clients are accessing the services and barriers to access. These findings will be leveraged to articulate the value proposition of the SHS service system, enable more efficient funding/resourcing, and ultimately improve outcomes for SHS clients and the sector.

The Evaluation adopted a multi-methods approach, with the objective of identifying and evaluating:

- How well the Program is achieving its intended objectives and whether it is reaching the target population;
- Whether there are any emerging client cohorts;
- Potential areas for improvement, how these can be addressed and whether the Program is implemented effectively;
- Whether the Program is delivering value for money, and the potential economic benefits; and
- Whether resources are being used effectively to achieve the Program's objectives.

The Evaluation addressed a range of process, outcomes and economic considerations to better understand and articulate the effectiveness of the SHS Program. The outcome, process and economic considerations for the Evaluation included, but were not limited to:

Process evaluation

- Identifying enabling factors and barriers which drive successful program delivery; and
- Identifying opportunities for improvement that may influence the future design and delivery of the Program and other homelessness services.

[45] Ibid
[46] Ibid.
[47] Ibid.
[48] Ibid.
[49] Ibid.
[50] 2021-2024 Service and Provider Count, provided by DCJ.
[51] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

Outcomes evaluation

- Assessing the Program outcomes for its intended target cohorts; and
- Drawing insights on impacts the Program had on target cohorts.

Economic evaluation

- Identifying the SHS cohorts that benefit from SHS and assessing the population reach;
- Identifying the benefits that the SHS Program delivered to SHS clients, the NSW Government and the broader community;
- Quantifying the potential economic/financial benefits where feasible and qualitatively assessing wider economic, social and community benefits; and
- Evaluating whether the estimated potential benefits of the SHS Program exceeded its estimated costs.

2.5 Specialist Homelessness Services in NSW

SHS is the primary NSW Government response to homelessness.[52] The SHS sector is a part of the broader service system that is working towards ending homelessness. SHS service providers support those experiencing or at risk of homelessness through early intervention, crisis and transitional support and post crisis support services.[53]

The objective[54] for SHS providers is to support clients to:

- Remain safely in their existing housing, or to secure stable housing, which is affordable for the person;
- Be provided with safe and secure accommodation and access stable housing, which is affordable for the person;
- Be re-housed and stay housed after experiencing homelessness;
- Access mainstream and specialist services; and
- Connect with community and family.

The SHS Program (the "Program") has three key expectations on service providers as part of the current contract term (ending 2024). Those expectations[55] are to:

- Obtain Australian Service Excellence Standards (ASES) Accreditation;
- Collect data to measure and drive client outcomes; and
- Contribute to the achievement of the Premier's Priority of halving street sleeping by 2025.

[52] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[53] Ibid.

[54] Ibid.

[55] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

Throughout the evaluation period, DCJ was in the process of concurrently developing the SHS commissioning approach commencing July 2024, with the findings of this Evaluation intended to support DCJ in informing its future approach to delivery of services.

2.6 Evaluation questions

The evaluation questions were developed by DCJ to enable a process, outcomes and economic evaluation of the SHS Program that provides a holistic understanding of current needs and barriers within the sector, and with the intention to inform DCJ on the SHS contracting approach. The evaluation questions were further refined by the Evaluation Team to integrate feedback received from DCJ stakeholders and Homelessness Peak Bodies during the evaluation co-design phase (please refer to Section 3.2 for further detail on the Evaluation Team's approach to co-design). The questions, as well as the section of the Report that addresses them, are provided in

Table 2.

Table 2: Evaluation questions, sub-questions and the Report section in which they are addressed

Evaluation type	Evaluation subject	Evaluation questions	Section
Process (P)	P1. Accessibility of the SHS Program	1. What are the pathways people take to access SHS? 2. How accessible are services for the people who need them? 3. What are the strengths and barriers for clients accessing SHS and what improvements can be made? 4. How effective is Link2Home at connecting people to the services they need? 5. How does Temporary Accommodation feature in the pathways people take to access SHS?	5.2.1
	P2. Identifying the SHS current and emerging cohorts	1. What are the cohorts and characteristics of people who need SHS, including any emerging cohorts? 2. Are existing services aligned with these needs? 3. How capable is SHS (the Program and services) of adapting to changing needs over time?	5.2.2
	P3. Review the processes and approaches in SHS provided response	1. Are people who need SHS receiving client-centred and integrated responses? 2. What are the strengths and barriers, both within SHS and in intersections with the broader service system, to provide the services needed by clients? 3. What improvements can be made?	5.2.3
	P4. Effectiveness of the networks and governance mechanisms	1. How effective are the networks and governance mechanisms in place, such as District Homelessness Implementation Groups (DHIGs), at working collaboratively to resolve implementation issues and consider practice principles and how they are applied when supporting clients?	5.2.4
	P5. Data collection	1. How effective are current data collection and reporting mechanisms? 2. What improvements to data collection and reporting systems are needed to enable improved monitoring of the SHS Program?	5.2.5
Outcomes (O)	O1. Review of the SHS intended outcomes	1. Is SHS achieving the intended outcomes? 2. To what extent do outcomes vary across cohorts and locations?	5.3
Economic (E)	E1. Economic appraisal of the SHS Program	1. What are the economic benefits of SHS? 2. What are the costs associated with SHS?	5.4

3. Methodology

3.1 Evaluation Governance

Throughout the Evaluation, the Evaluation Team met with the DCJ Project Team on a fortnightly basis for progress meetings to regularly coordinate and monitor evaluation activities, including monitoring of key risks, ethics considerations and engaging key stakeholders. During the data analysis phase, separate data meetings were arranged with data experts within the DCJ Project Team to regularly review and collectively agree on administrative data-related decisions shaping the analysis.

The Evaluation was supported by a number of advisory bodies to provide a forum for key SHS stakeholders to shape the design and delivery of the Evaluation, including the Evaluation Working Group (EWG), StreetCare, and the Service Provider Advisory Group ("the Advisory Group"). The EWG was composed of DCJ representatives from various units including Homelessness Program Management and Commissioning and Planning, Family and Community Services Insights Analysis and Research (FACSIAR), and the NSW Homelessness Industry Partnership peak bodies, Homelessness NSW, YFoundations and Domestic Violence NSW. EWG membership was determined by the DCJ Project Team, ensuring core stakeholder voices were captured.

The EWG, StreetCare and the Advisory Group participated in preliminary and ongoing co-design activities and at other key phases throughout the evaluation process. Additional context on engagement of the EWG, Advisory Group and StreetCare are provided in Section 3.2.

3.2 Co-design

The evaluation approach was underpinned by collaborative design with key SHS stakeholder groups including the EWG, people with lived experience of homelessness and the Advisory Group. This was to ensure that the overall evaluation approach met the needs of the Department and key stakeholders, captured the value of the services provided under the Program and provided an opportunity for ongoing program development and innovation.

Adopting a collaborative approach also ensured that the data collection methods and tools were appropriate to the stakeholder groups in capturing data relevant to the evaluation questions. The evaluation methodology was also developed in alignment with the NSW Government Program Evaluation Guidelines 2023.

Further details on the approach to evaluation co-design are provided below.

3.2.1 Initial co-design

Two co-design workshops were held over August and September with members of the EWG. The primary purpose of the first co-design workshop was to refine the SHS Program Logic ("the Program Logic") developed in June 2021, with a specific focus on capturing the breadth of program activities in the Program Logic. The purpose of the second co-design workshop was to test and refine the draft evaluation questions to ensure they would enable a robust evaluation of the Program, as well as discuss the potential stakeholder engagement and data collection approaches.

The insights discussed in these workshops shaped the design of the Evaluation and indicators to report against.

3.2.2 Ongoing co-design

To elevate lived experience voice in the Evaluation, the EY Evaluation Team consulted with a group of people with lived experience of homelessness, known as StreetCare, established by the Public Interest Advocacy Centre (PIAC). StreetCare brings together a diverse group of people with

experiences of homelessness, including men, women, young people, Aboriginal people, people with a disability and representatives from inner Sydney, regional and rural areas.

Members of StreetCare were invited to participate in evaluation co-design activities, specifically to support shaping the Evaluation Team's approach to engagement with people with lived experience throughout data collection in Phase 2. The Evaluation Team also met with StreetCare members to test interim findings, as well as to support with the translation of insights into recommendations with a lived experience lens.

Ongoing co-design activities also involved refinement of the evaluation methods as well as specific evaluation tools (such as surveys and interview schedules), where appropriate, on the basis of the methodological direction shaped by the Evaluation Plan. This process also supported the development of stakeholder relationships necessary to enable the Evaluation to be undertaken in partnership with these key groups.

Through this ongoing collaborative refinement process, the Evaluation Team and DCJ committed to establishing an advisory group composed of SHS service providers. The Advisory Group was established, following discussions with the DCJ Project Team, to maximise the input of SHS service providers in the evaluation process. The group was composed of 15 SHS service provider representatives from a range of DCJ Districts, services and target cohorts. Service providers were asked to nominate themselves to participate in the Advisory Group, and Advisory Group members were selected by DCJ.

The Advisory Group was critical in developing the approach to engaging with SHS clients in interviews, recruiting clients to participate in interviews, and ensuring they were well-supported throughout the entire process. The Advisory Group was also engaged to test interim findings and support with the translation of insights from data collection into findings and actionable recommendations.

3.3 Literature Review

A literature review was undertaken to identify papers which had relevance to best practice programs and services to support people experiencing homelessness and the key outcomes associated with SHS. Key documents provided by DCJ were also reviewed.

Best practice can be defined as an intervention, method or technique that has consistently proven effective through the most rigorous scientific research and which has been replicated across several cases or examples.[56]

The search drew on a range of databases to identify articles which were of relevance. Initial search strategies were developed using combinations of various terms that are outlined in Table 3.

[56] Homeless Hub Canada (2021), Best, Promising and Emerging Practices, Retrieved 26 July 2022, from https://www.homelesshub.ca/solutions/best-promising-and-emerging-practices#:~:text=A%20Best%20Practice%20is%20an%20intervention%2C%20method%20or,has%20been%20replicated%20across%20several%20cases%20or%20examples.

Table 3: Literature review search strategies

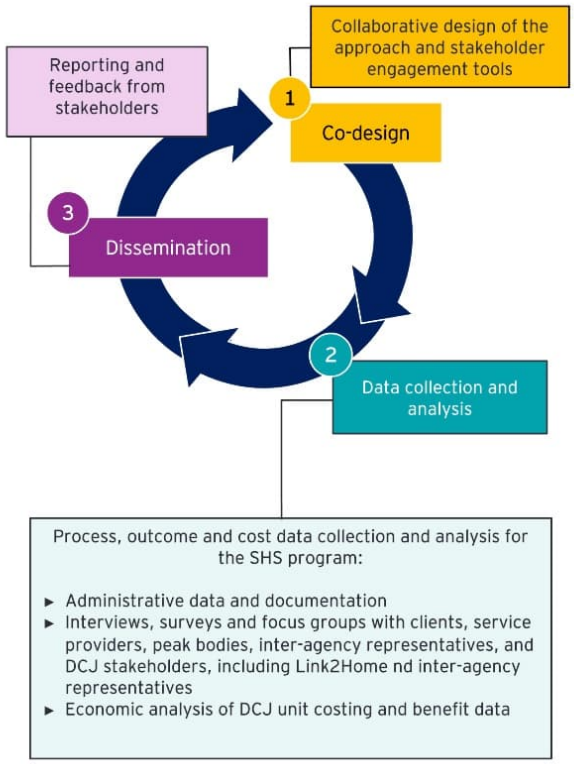
Key search terms:	Combined with:
• Homelessness/homelessness programs • Specialist homelessness services • Best practices • Interventions • Australia/International outcomes-based funding/commissioning • Embedding outcomes	• Aboriginal and Torres Strait Islander • Mental health • Children and young people • Older people • Older women • LGBTQIA+ • Disability • Family and domestic violence • Substance abuse • Incarceration • Culturally and Linguistically Diverse backgrounds • Women with or without children • Street sleeping

This literature review provided a high-level analysis focused on similar programs to:

- Understand the policy context;
- Identify approaches (service planning, service models, funding and commissioning) used in other jurisdictions; and
- Highlight key strengths and weakness associated with different approaches identified.

3.4 Approach

Figure 2 : Evaluation Methodology



An overview of the key activities for the Evaluation is presented in Figure 2.

Details on the co-design activities undertaken in the first Phase are outlined in Section 3.2. The second Phase in the evaluation methodology was data collection and analysis, which involved three inter-related components:

1. Analysis of administrative data and published literature to determine the impact of the SHS Program across a variety of outcome domains and at the system-level to identify the impact of the Program on clients and learnings for the future delivery of the Program.

2. Qualitative data collection to explore client and service provider experiences on the ground (including referral pathways), as well as to identify service system improvements, best practice approaches in the sector and lessons learned for SHS contracting.

3. Analysis of costs and benefit data, and published literature on the economic

benefits of the SHS Program, to assess the economic, social and community impacts of the Program.

Findings from the data collection and analysis activities from Phase 2: Data Analysis were drawn on to develop this Final Evaluation Report ("the Report"), with findings tested with key stakeholders, including the EWG, StreetCare and Advisory Group prior to finalisation of the Report.

3.5 Qualitative Analysis: Stakeholder Engagement

Qualitative data were collected to explore client and service provider experiences on the ground, as well as to identify potential service system improvements, best practice approaches in the sector and lessons learned for SHS resourcing.

Key stakeholders for the purpose of data collection were collectively identified with the Department, the EWG and peak bodies to ensure a broad range of stakeholder voices were captured in the design and delivery of the Evaluation and data collection. The most appropriate stakeholders to participate in stakeholder engagement activities were determined by DCJ and provided with context on the Evaluation by DCJ, prior to being contacted by the Evaluation Team to request their participation in data collection activities.

Qualitative data collected through stakeholder engagement followed an iterative and phased process whereby thematic analysis was applied to identify emerging themes. The emerging themes and findings from qualitative data collection activities were drawn on to inform the questions asked in the subsequent consultations with key stakeholder groups. Phases 1 and 2 were undertaken concurrently to enable findings to be explored in depth as they emerged.

The Advisory Group played an important role in developing the approach to conducting client interviews. The Evaluation Team, in conjunction with the Advisory Group and DCJ, determined a sample size of approximately 30 SHS clients to participate in interviews for evaluation purposes. This was selected to enable a sufficient sample size for ensuring representation of the diversity of SHS client cohorts in the interviews and that the unique facilitators and barriers to accessing services based on geographic location could be explored, whilst being cautious not to over-sample given the consultation fatigue described to be impacting the sector.

The Advisory Group and other SHS service providers that participated in evaluation focus groups also played a critical role in recruiting SHS clients capable of consenting to and participating in interviews and ensuring they were well supported throughout the process. A targeted approach to recruiting clients to participate in interviews was applied to ensure that a broad representation of client cohorts was achieved in client interviews. Thematic analysis of client interview insights was conducted on an iterative basis and, after conducting 28 interviews, the Evaluation Team deemed that thematic saturation had been reached.

3.5.1 Phase 1: Data Collection

To develop an understanding of the accessibility of the SHS Program, its ability to meet the evolving needs of client cohorts and its effectiveness in achieving outcomes for clients, data were collected from a range of stakeholders which were identified collaboratively by DCJ and EY. A staggered primary data collection approach enabled the Evaluation Team to collect data from stakeholders, applying various approaches to iteratively analyse the emerging qualitative data centred in thematic analysis methodology, and to test the key findings with DCJ, EWG and the Advisory Group.

The data collection phase of the Evaluation was comprised of two key components, including a survey of SHS service providers across NSW to explore program implementation, collaboration and client outcomes from the perspectives of those delivering SHS services to clients. The second component of stakeholder engagement undertaken as part of Phase 1 data collection was a series of workshops, focus groups and small-group interviews with a diverse range of internal and external stakeholders of the SHS Program.

The approach taken for collecting data from key stakeholders is detailed herein.

Service provider survey

To gain further insights into the SHS Program and its underlying activities from a service delivery perspective, the Evaluation Team administered a short, targeted, survey to SHS providers. An overview of the purpose of the survey and evaluation question alignment is provided in Table 4.

Table 4: Service provider survey stakeholder engagement

Stakeholder group	Purpose of engagement	Method of engagement	Evaluation question alignment	Number of representatives engaged
Service Providers	To explore the effectiveness of networks and partnerships, the effectiveness of collaboration across the sector, and the ability of service providers to meet client needs of various client cohorts in various geographic locations.	Survey	P1-P5, O1, E1	80 approached 41 responded 51.3% response rate

The Evaluation Team worked collaboratively with DCJ to identify service providers to develop and distribute the survey, leveraging the list of service providers to complete the FACSIAR unit costing survey, as well as service providers who responded to the sector communication from DCJ indicating their interest in participating.[57]

The EY SHS Evaluation Team coordinated with FACSIAR and the Evaluation Team for the NSW Homelessness Strategy Evaluation in designing and delivering the survey to ensure alignment and avoid duplication and consultation fatigue amongst stakeholders to the greatest extent possible.

The survey was distributed to service providers that indicated their interest in participating in the survey in December 2022, and it was open for completion for a period of approximately six weeks. By the closing date, 41 service providers had responded to the survey, yielding a response rate of 51.3%.

The survey data were analysed using various methods as described in Phase 2: Data analysis. Free-text responses were thematically analysed using a grounded theory approach aligned to evaluation questions, and the Likert responses were analysed quantitatively.[58]

Findings from the survey informed the structure and design of the Service Provider workshops which provided an opportunity to explore key themes in further detail, in addition to identifying gaps that existed in the data collection approach alongside opportunities to address any gaps.

Workshops, focus groups and interviews

To develop an understanding of the accessibility of the SHS Program, the effectiveness of collaboration across the service system, and the ability of the SHS Program to meet the evolving needs of client cohorts, data were collected from a range of stakeholders via workshops, focus groups and interviews. As described above, all stakeholders, with the exception of SHS clients and StreetCare, were identified and contacted in the first instance by DCJ.

Throughout the Evaluation, the Evaluation Team thematically analysed the data collected and presented emerging findings to the DCJ SHS Project Team and EWG, StreetCare and the Advisory

[57] The SHS Unit Costing Project, being delivered by FACSIAR, is a separate piece of work to the SHS Evaluation, and is responding to distinct but complementary questions.
[58] A Likert scale is a rating system used in surveys to measure respondent's attitudes, opinions, or perceptions on a sliding scale with multiple response options.

Group. This approach allowed the Evaluation Team to continually test and refine findings as the Evaluation evolved. An overview of workshops, focus groups and interviews conducted is provided in Table 5.

Table 5: Overview of stakeholder engagement activities

Stakeholder group	Method of engagement	Purpose of engagement	Evaluation question alignment	Number of representatives engaged
Service Providers	Service Provider Advisory Group Focus groups x 3 (one metro, one regional and one rural)	Capture perspectives on SHS service delivery and perceived impacts of the Program.	P1-P5, O1, E1	44
NSW DCJ Stakeholders	EWG working sessions x 3 Group workshops x 2	Understand the design and structure of the SHS Program, in addition to the effectiveness of collaboration across the service sector.	P2-P5, E1	15
Peaks and other homelessness representative bodies	EWG working sessions x 3 Specific purpose meetings Focus group x 1	Capture perspectives on housing and homelessness policy, the SHS Program and emerging cohorts and needs.	P1-P4, O1	11
People with lived experience	Lived experience representative group meeting x 2 SHS client interviews x 28	Capture lived experience voice in the evaluation approach. Gain a deeper understanding of clients' interactions with the SHS Program, including pathways and outcomes.	P1-P3, O1	40
Community Housing Providers	Small group interviews x 2	Better understand the referrals process and flow-through of SHS clients to social and affordable housing, as well as any opportunities for improvement with current leasing and contractual models.	P1, P2, P4, O1	9
Inter-agency representatives (NSW Police, Corrections /Justice, Health, Education)	Small group interviews x 4	Develop a deeper understanding of the broader service system and housing landscape, as well as pathways to accessing SHS.	P1, P2, P4, O1	16
Link2Home	Focus group x 1 Specific purpose meetings	Better understand the referrals process to SHS, and any barriers to linking clients with necessary supports.	P1-P3, P5	5

3.5.2 Phase 2: Data analysis

The outputs of Phase 1: Data Collection were analysed using the analysis methods broadly described below.

Thematic analysis

Transcripts and other session notes from stakeholder consultations were analysed in detail to identify key themes. The Evaluation Team applied an inductive approach, allowing the responses and notes to identify key themes identified. To analyse the data further, emerging themes were grouped and analysed in relation to key evaluation questions.

Survey analysis

Given the survey included a combination of free-text and Likert scale questions, the breadth of insights was analysed via two methods. Free-text answers were analysed using the thematic approach described above and were specifically leveraged to answer the evaluation questions that were mapped to the survey questions. Likert scale questions were analysed quantitatively using frequency analysis.

Key findings

Throughout the qualitative data collection phase, key findings were presented to the DCJ SHS Project Team. The findings from the qualitative analysis were interpreted in conjunction with the quantitative analysis. The Evaluation Team tested emerging findings with the EWG, StreetCare and the Advisory Group. This approach allowed the Evaluation Team to test and refine data with key stakeholders prior to incorporating into final findings.

Survey data collected and transcribed insights from workshops were thematically organised and de-identified before being incorporated into reporting.

3.6 Ethical considerations

At all times, the Evaluation Team centred the evaluation conduct in the Australian Evaluation Society (AES), the Human Research Ethics Committee and the National Health and Medical Research Council (NHMRC) guidelines for ethical conduct of evaluations. The Evaluation Team was also guided by the Australian Institute of Aboriginal and Torres Strait Islander Studies Code of Ethics, NHMRC's National Statement on Ethical Conduct in Human Research and the Indigenous Evaluation Strategy.

As agreed with DCJ in considering ethical processes required to support evaluation delivery, the Evaluation Team conducted the Evaluation in ways that align to best practice ethical evaluation approaches and adhere to the aforementioned guidelines. These guidelines are not firm in mandating ethical clearance for evaluations, instead suggesting that decisions on evaluation conduct should be based on the benefits and risks to participants, power differentials, engagement approaches, dissemination of findings, and other relevant considerations.

In considering the need for ethics approval, the Evaluation Team weighed a range of factors, including the level and means of engagement with vulnerable cohorts, the risk of re-identification in data, the processes and supports to be applied in client engagement, and dissemination plans for evaluation reporting. In light of these considerations, the Evaluation Team, collaboratively with DCJ, determined that the Evaluation could be conducted ethically and in a way that adhered to the aforementioned guidelines without seeking ethics approval.

EY's approach to stakeholder engagement was underpinned by the following principles:

- Adherence to the AES Guidelines for Ethical Conduct of Evaluations;
- Informed consent;

- Voluntary participation;
- Confidentiality;
- Adequate, timely and easily comprehensible information provided prior to engagement, including nature of involvement and how data will be used; and
- Access to essential supports if required.

In addition, the Evaluation Team adhered to StreetCare's principles for safe, meaningful and effective engagement when engaging with StreetCare representatives. These include:

- Mutual respect;
- Meaningful group discussions;
- Collaborate and start early;
- Follow up and report back; and
- Walk the walk, talk the talk.

In line with these principles, all stakeholders were provided with clear and accessible written information about participating in the Evaluation and were required to voluntarily consent to participate. Stakeholders were advised that they were able to withdraw from the Evaluation at any point in time. The Evaluation Team prepared a Participant Information and Consent Form for SHS clients/people with lived experience of homelessness to complete to ensure they had sufficient context on the Evaluation and how their insights would be used. Where stakeholders were not able to complete the form or preferred to provide verbal consent, it was preferred that this consent was audio-recorded; where this was not possible nor preferred by the client, verbal consent was communicated via email to the Evaluation Team.

3.7 Quantitative Analysis: Data Review

3.7.1 Phase 1: Data Collection

The Evaluation drew on administrative SHS client data capturing key SHS client characteristics, SHS client pathways into support services and information about the support provided. This information was collected from each homelessness service provider via CIMS and other equivalent systems (the "NSW Homelessness Data") and was provided from FY 16/17 to FY 21/22 (the "evaluation period").

The NSW Homelessness Data served as the master dataset which was linked with other datasets held by DCJ to build the evidence base for a comprehensive evaluation. For the purposes of this Evaluation, the sample of the SHS cohort (the "analysis sample") was constructed based on a number of data-related decisions which were discussed and agreed with the DCJ data team.[59] The decision to construct this analysis sample aimed to identify the majority of unique SHS clients over the evaluation period with a small share of exclusions due to data misreporting. The Evaluation Team met with the DCJ data team on a weekly basis throughout Phase 2: Data analysis of the Evaluation to discuss data-related decisions. Such decisions included consideration of the analysis sample and the key data cleaning processes needed to exclude duplicative information captured in the NSW Homelessness Data.

Using the outlined sample selection rules, the quantitative analysis identified the SHS client's first observable interaction with the SHS system. The results of the quantitative analysis largely rely on this first interaction with SHS, however, analysis related to return to services also considers the client's subsequent interaction with the SHS system. The analysis sample included approximately

[59] Data analysis was performed using Stata/Standard Edition 17.0 (64-bit x86-64).

270,000 unique clients from FY 16/17 to FY 21/22. The full list of data-related decisions is available in Appendix 1. The analysis sample included the following components of information:

- Client demographic characteristics (i.e., age, gender, Indigenous status, country of birth, disability status, previous history of homelessness, living arrangements, etc.);
- Information on client needs, including indicators for 55 client needs and the service response (provided, referred and provided, referred, not provided);
- Service-related characteristics (i.e., formal source of referral, main reason for seeking assistance, dates when the service commenced and ended, etc.); and
- Service provider-related characteristics (i.e., provider ID, geographical location, Local Government Area (LGA)).

The NSW Homelessness Data include a Statistical Linkage Key (SLK) which is a unique client identifier. Using the SLK, the Evaluation Team linked the analysis sample with information on various housing supports and interactions with the child protection system. The following DCJ data collections informed this Evaluation:

- Housing Occupancy Management and Engagement System (HOMES) which records information about tenancies of public housing and Temporary Accommodation (TA) and includes comprehensive information on private rental assistance;
- Community Housing Information Management and Engagement System (CHIMES) which contains information on community housing tenancies;
- Child Protection and Out-of-Home Care Data ("ChildStory") which include information on child protection and Out-of-Home Care (OOHC) clients and relatives, their care events, placements and care pathways; and
- Link2Home data which capture the referral information detailed by the state-wide homelessness information and referral telephone service, Link2Home. Whilst the Link2Home dataset included the unique client identifier, due to the nature of the data, linkage to this dataset also relied on the date of referral.

For further information on how these datasets were processed and prepared for linkage, please refer to the Data-related Decision Register in Appendix 1. The process included necessary cleaning processes and data quality checks, such as:

- Reviewing the data for missing, duplicate and irrelevant client entries, particularly after linkage with other DCJ datasets;
- Assessing data structures to identify any structural errors, i.e., incorrect naming conventions and typographical errors;
- Identifying outliers in the data that represented clients and their information significantly differently from the rest of the population;
- Identifying the key information required for the analysis and building the analysis dataset with all relevant key variables; and
- Recoding and labelling binary, categorical, ordinal and continuous variables to ensure representative encodings and that the variations were captured within each variable.

3.7.2 Phase 2: Data Analysis

To assess the progress of the SHS Program over time in delivering services to SHS clients, the Evaluation drew insights from in-depth statistical analysis using the administrative data described in Section 3.7.1. The statistical analysis employed various methods such as descriptive, graphical and inferential analysis to support the evidence to evaluation questions outlined in Section 1.3.

The findings of this statistical analysis were interpreted in conjunction with the findings of the qualitative analysis to strengthen the robustness of the Evaluation, and ensure quantitative findings were contextualised with lived experience voice.

The quantitative analysis was performed in two steps:

Step 1

The purpose of the Step 1 analysis was to examine the SHS cohort and SHS services. The analysis built on the trends and patterns in client characteristics and their needs at the time of presenting and the SHS response. The analysis also reviewed support pathways to describe the main service entry points and assess how the client was supported through the SHS Program.

Step 2

Focused on analysing patterns of client characteristics and service provision at the DCJ District level, Step 2 analysis investigated regional variation in homelessness supports. This analysis provided in-depth findings on observable differences between DCJ Districts and shed light on the areas that are overserviced or underserviced when analysing how client's unmet needs vary by region. Table 6 presents a detailed description of the analysis that was performed in each step and data sources employed in the analysis.

Table 6: Description of analysis steps

Step 1: The determinants of demand and the provision of SHS services		
Analysis	**Sub-analysis**	**Data sources**
Cohort analysis The key aim of the cohort analysis was to describe, summarise and present the client characteristics, review trends and patterns over time and identify emerging and narrowing cohorts.	Describing the SHS client mix The purpose of this analysis was to identify the defining characteristics of SHS clients and sample a cohort or a group of clients who share these characteristics to characterise people who need SHS support. Using recorded information on SHS clients, the Evaluation Team performed a descriptive analysis of SHS client characteristics, including demographic characteristics, housing and living arrangements before presenting to SHS, education, employment status and sources of income. The findings of this sub-analysis drew insights from measures of central tendency and frequency distributions. Trends and patterns of selected characteristics were analysed by financial year to observe changes in SHS client mix over time. All characteristics reported in available data sources are reported by the SHS client to the service provider and recorded by the service provider. The NSW Homelessness Data report the service provision at regular reporting periods and due to reporting errors, available information may vary at different reporting periods. To ensure the accuracy and consistency of reported information, selected characteristics were adjusted during the data cleaning process. For further information, refer to the Data Decision Register in Appendix 1. Findings of this analysis informed the selected cohort analysis and analysis on emerging and narrowing cohorts.	• NSW Homelessness Data • ChildStory • Link2Home
	Selected cohort analysis The Evaluation Team performed an in-depth analysis of selected cohorts to evaluate key differences between the cohorts of interest and the rest of the SHS population. The analysis included a review of demographic characteristics, housing and living arrangements, education, employment status and sources of income. All information was assessed by using measures of central tendency and frequency distributions. The in-depth cohort analysis also explored selected needs that are specific to the needs of the cohorts of interest, and selected characteristics of service provision.	• NSW Homelessness Data • ChildStory • Link2Home

Step 1: The determinants of demand and the provision of SHS services		
Analysis	**Sub-analysis**	**Data sources**
	The cohorts selected for the in-depth cohort analysis were: • Children aged 12-15 years old (accompanied and unaccompanied); • Young people aged 16-24 years old; and • Aboriginal and/or Torres Strait Islander clients. Cohorts of interest were selected upon receipt of feedback from key stakeholders and as advised by DCJ.	
	Identifying emerging and narrowing cohorts The Evaluation Team performed a sub-analysis to identify emerging and narrowing cohorts. Using selected defining characteristics (informed by the findings of the sub-analysis 'Describing the SHS client mix'), this analysis assessed the share of such clients in a given year and explored trends over the evaluation period. Trends over the evaluation period were investigated using a linear regression fit.	• NSW Homelessness Data • ChildStory • Link2Home
Analysis of SHS support, met and unmet needs and welfare migration The key aim of the analysis of support pathways was to describe the main service entry points, client met and unmet needs and patterns of welfare migration.	Entry to the SHS system The Evaluation Team analysed client entry to the SHS Program using data on formal sources of referral. The analysis estimated the share of referrals by five broad categories: 1. Specialist homelessness agency/outreach worker; 2. Telephone and crisis referral agency; 3. Mainstream services and other community supports which include Centrelink or employment services case workers, child protection agencies, family and child support agencies, hospitals, mental health services, disability support services, drug / alcohol services, aged care services, social housing, youth/juvenile justice correctional centres, adult correctional facilities, legal units, school / educational institutions, police, courts, immigration department / refugee support services, family and domestic violence services, and other agencies; 4. Family, friends and other; and 5. Self-referred or no formal referral. Definitions of referral sources were taken from the SHS Collection Manual (July 2019).	• NSW Homelessness Data • Link2Home

Step 1: The determinants of demand and the provision of SHS services		
Analysis	Sub-analysis	Data sources
	To provide further insights into the effectiveness of the Link2Home telephone referral agency, the NSW Homelessness Data were linked with Link2Home data using a fuzzy match. The fuzzy match utilised the unique client identifier SLK, the date of the Link2Home referral and the date when the SHS support commenced. The fuzzy match approach linked the unique SLK identified by varying the date to capture clients who accessed Link2Home and 1, 2 or 3 months later engaged with SHS. Based on this linkage rule, the linkage rate was 93%. For further information on linkage rules, please refer to the Data Decision Register in Appendix 1. The data linkage identified a share of Link2Home referrals that were recorded as telephone and crisis agency in the NSW Homelessness Data and a share of referrals that were recorded as another type of referral defined above. This Evaluation regarded the NSW Homelessness Data as the primary data source and all referrals that were not reported as telephone and crisis referral agency, however, were identified as Link2Home after linkage, were not considered as Link2Home referrals. For further information on this decision, please refer to the Data Decision Register in Appendix 1. Analysis of the source of referrals investigated trends and patterns of referrals to SHS to present the main service entry points and changes over time to inform further integration of the service system and development of referral pathways.	
	Identifying met and unmet needs The purpose of this analysis was to identify SHS client needs and investigate the service response. Based on the information recorded in the NSW Homelessness Data, the following definitions were adopted: • Met need: The client identified a need and it was met at the end of the SHS support period if the service was provided, or referred and provided; • Referral only: The client identified a need, and the service provider provided a referral to another more suitable provider; and • Unmet need: The client identified a need and the service was not provided.	• NSW Homelessness Data

Step 1: The determinants of demand and the provision of SHS services		
Analysis	Sub-analysis	Data sources
	The above definitions were considered in the entire analysis. SHS clients may report multiple needs. On average, a client reported six needs in their first interaction with the SHS Program and more than four needs were met at the end of their SHS support (average across all clients and all financial years). To ensure that client needs (or, in other words, service requests) and the service response to these needs were not over-estimated, the met/unmet need analysis was performed on the 'need' unit level rather than on the 'client' unit level. This ensures that all needs reported by one client are captured in the analysis. For example, if the client reported two needs e.g., 'mental health' and 'financial', the met/unmet need analysis counted this as two individual needs and identified the service response based on above-listed definitions. The service response (met need/referred only/unmet need) was identified for each need individually. For instance, if it is reported that 20% of needs for 'mental health services' are met, the percentage share represents the share of clients who reported this need and their need was met, regardless of any other needs these clients reported. If, in an unlikely scenario, the same group of clients also reported the need for financial support and these needs were not met, the share of met need for financial support will be counted as 0%. Hence, the met/unmet need analysis relies on the 'need' unit level and may consider the client multiple times across individual needs. Client needs and service responses were captured across multiple reporting periods. For example, clients who were supported by SHS for six months are recorded in the CIMS and equivalent systems under six reporting periods. Needs reported by the client may have changed across these periods, i.e., the client requested financial support in the first reporting period and then requested support in accessing mental health services in the second reporting period. All needs and the service response reported across all reporting periods of the first interaction with the SHS Program were considered in the met/unmet need analysis. The met and unmet need analysis was also performed for the selected cohort analysis described above.	

Step 1: The determinants of demand and the provision of SHS services		
Analysis	Sub-analysis	Data sources
	Main reasons for seeking assistance For the purposes of the analysis contained within this Report, the Domestic and Family Violence (DFV) and relationship breakdown category includes the following reported main reasons for assistance: • Domestic family violence (71.3%); • Relationship/family breakdown (23.0%); • Time out from family (3.5%); • Non-family violence (1.5%); and • Sexual abuse (0.6%). These main reasons for seeking assistance were grouped together for a number of reasons. Firstly, research evidence suggests that individuals experiencing DFV are likely to under-report DFV. Based on evidence from Morgan and Chadwick, 2009, only 40% of domestic violence incidents are reported. The 'relationship/family breakdown' and 'time out from family' category has a strong potential for under-reported cases of DFV and hence were included under this category. Secondly, the definitions of each main reason for seeking assistance are not substantially clear and there is potential for misinterpretation by the data recorder. Based on the SHS Collection Manual: • Domestic and family violence: The client sought assistance as a result of physical or emotional abuse inflicted on the client by a family member. • Relationship/family breakdown: The client sought assistance because of the dissolution of a spouse/partner relationship or other family relationship. The Evaluation Team notes that the dissolution of a spouse/partner relationship may be driven by emotional abuse that is often mis-interpreted and under-reported. • Time out from family/other situation: The client needed some time away from their family or needed some time away from non-related individuals. The Evaluation Team notes that	• NSW Homelessness Data

Step 1: The determinants of demand and the provision of SHS services		
Analysis	Sub-analysis	Data sources
	time out from family may be driven by DFV and could be considered as the first course of action to remove the individual from a dangerous situation. • Sexual abuse: The client sought assistance as a result of sexual abuse inflicted on the client by a family member or non-related individual. The Evaluation Team notes that sexual abuse is likely to be carried out by a spouse/partner and is considered as DFV in the AIHW definitions.[60] • Non-family violence: The client sought assistance as a result of physical or emotional abuse inflicted on the client by a non-related individual. The client sought assistance as a result of violence, or a threat of violence inflicted by a non-related individual. The Evaluation Team notes that whilst the definition states non-family violence, the description clearly notes that this may be a non-related individual, and this individual may or may not be living with the family, i.e., partner's children. The category presents only a minor share of individuals and hence the Evaluation Team included it under this broader category of DFV and relationship breakdown.	
	Describing SHS services provided The purpose of this analysis was to investigate the type and level of SHS support provided to the client. The analysis grouped SHS services into four broad categories: • Short-term accommodation services; • Medium-term accommodation services; • Minor engagement services, defined as cases where the SHS support begins and ends on the same day; and	• NSW Homelessness Data • CHIMES • HOMES

[60] The AIHW definition of domestic violence is "A set of violent or intimidating behaviours usually perpetrated by current or former intimate partners, where a partner aims to exert power and control over the other, through fear. Domestic violence can include physical violence, sexual violence, emotional abuse and psychological abuse". The AIHW definition of family violence is "Violent or intimidating behaviours against a person, perpetrated by a family member including a current or previous spouse or domestic partner… It encompasses the broad range of extended family and kinship relationships in which violence may occur". Australian Institute of Health and Welfare. (2019). *Glossary*. Retrieved from https://www.aihw.gov.au/reports-data/behaviours-risk-factors/domestic-violence/glossary.

Step 1: The determinants of demand and the provision of SHS services		
Analysis	Sub-analysis	Data sources
	• Non-accommodation case management services, including all other SHS supports longer than one day.[61] The defined types of services are mutually exclusive categories except for short/medium-term accommodation and draws on the definition of type of SHS services as defined by the Unit Costing Project. A client may have received multiple accommodation services, however this impacted only a small share of clients (<2%). This definition was applied to ensure that the economic analysis was based on all costs of the SHS Program incurred by service providers. The analysis also described the SHS client journey in accessing accommodation. Using the CHIMES and HOMES datasets, a timeline on accessing SHS services and accommodation was developed to investigate the share of clients accessing accommodation after SHS support and the share of clients accessing SHS support while residing in provided accommodation, i.e., public housing. Measures of frequency distributions were further investigated for selected client characteristics. Service provision included the access and provision of private rental assistance. Additional insights were drawn from the HOMES data including information on the provision of private rental subsidies/payments. The analysis estimated measures of frequencies and central tendencies to evaluate the number of clients receiving private rental subsidies and the average/median value of the subsidy.	

[61] The definition of non-accommodation case management services for the purpose of this Evaluation aligns with the SHS Unit Costing definition, being individuals who are engaged for more than one day who do not seek accommodation support.

Step 1: The determinants of demand and the provision of SHS services		
Analysis	Sub-analysis	Data sources
	Client exits from the SHS system To draw insights in short-term client outcomes and exits from the SHS system, the analysis evaluated the client's situation at the time of presenting to SHS and at the end of SHS support. Using recorded information in the NSW Homelessness Data, measures of frequency distributions were estimated for the following short-term outcomes: client's tenancy, education and employment status. The reported statistics were reviewed only for relevant age groups, for example, change in education status for clients with a student status, and change in employment status for clients who would be considered within the working age population based on the Australian Institute of Health and Welfare (AIHW) definition.[62]Additional insights about housing outcomes were drawn from analysis of the SHS client journey accessing accommodation described in the previous sub-analysis. Client returns to the SHS system The Evaluation examined client interactions with the SHS system after their initial SHS support period. An indicator for return to the SHS system was constructed using the recorded commencement and end dates of SHS support. Analysis of return to services also considered the reason for return as an additional indicator for the effectiveness of SHS support. It was assumed that clients who returned for the same reason of support did not achieve their intended outcomes as a result of the SHS support.	• NSW Homelessness Data • CHIMES • HOMES

[62] Australian Institute of Health and Welfare. (2021). Employment and unemployment. Retrieved on 13 June, 2023, from Employment and unemployment - Australian Institute of Health and Welfare (aihw.gov.au).

Step 2: Trends and patterns of service provision		
Analysis	**Sub-analysis**	**Data sources**
Trends in proportions and frequencies at DCJ Districts The key purpose of this analysis was to examine trends in proportions and frequencies at the DCJ District level and inform the Evaluation about regional variation in demand and service provision.	Constructing and assessing SHS intended outcomes The Evaluation drew insights from Step 1 analysis and reviewed trends and patterns of service provision at the DCJ District level. Using the provided mapping catalogue, the analysis identified the DCJ District in which the service was provided.[63] Measures of frequency distributions were estimated to evaluate the variation in selected client and service-related characteristics. Estimates in this analysis represented the average estimate or the total frequency where relevant by each DCJ District. In addition, the Evaluation examined variation in selected characteristics and outcomes of service provision by DCJ District for the selected cohorts of interest, as described in Step 1: Selected cohort analysis.	• NSW Homelessness Data • CHIMES • HOMES

[63] The mapping catalogue was provided as an additional document to inform the data analysis performed in this Evaluation. The catalogue maps the service provider organisation identifier with the respective Local Government Area and DCJ District, identifying the location of the service provider.

3.8 Economic Appraisal

The key objective of the economic appraisal was to address the question of efficiency and effectiveness of the SHS Program. The economic appraisal draws on the CBA framework outlined in NSW Treasury Guidelines for Cost-Benefit Analysis.[64] By comparing the estimated primary costs associated with delivery of the SHS Program and attributable monetary benefits, the economic appraisal represents an input to assessing the value for money delivered by the SHS Program. The value for money is expressed as the Benefit-Cost Ratio (BCR). [65]

The estimated value for money was also informed by several identified qualitative benefits. Such benefits are non-financial in nature or intangible, in that they do not lend themselves to being measured or valued in monetary terms, yet they are important to consider alongside the economic appraisal to ensure a holistic evaluation of wider and social benefits.

The economic appraisal compared estimated costs and benefits of the intervention scenario (services delivered through the SHS Program) against those of the incremental or Base Case scenario (a scenario in which clients do not receive SHS support) to attribute the impact of the SHS Program. For further detail regarding attribution of benefits, please refer to Section 3.9.

After initial consultations with the DCJ data team, it was identified that the NSW Homelessness Data only capture individuals who accessed and/or received homelessness support. The absence of data on individuals who accessed support without receiving a service suggests that the actual SHS population may be larger than observed in this economic appraisal. For this reason, the economic appraisal solely focused on evaluating the impact of the SHS Program for those who accessed and received SHS support compared to individuals who accessed and did not receive SHS support.

The Evaluation Team developed a synthetic base case. To a large extent, the base case status quo scenario was informed by recorded information on client requests for services (or client needs) and the service response to these needs. It was considered that the client need was “met” if the service was provided, or referred and provided. The benefits rely on the number of needs met and incorporate only clients who requested and received a service (met need). If the same client reported another need but the need was not met, the benefit related to that second need is not attributed to this client. No benefits are attributed in the economic analysis to clients who only received a referral to other providers.

For a selection of benefits, where the quantification does not rely on client needs (i.e., justice-related benefits), quantification of benefits relied on peer-reviewed evidence that compared the consequences of the support against the absence of relevant support. The inherent economic value or the impact of the SHS Program is then assumed as the effect of delivering SHS services compared to receiving no homelessness support services as identified by the synthetic base case scenario.

The development of the economic appraisal methodology was impacted by limited availability of outcomes data. Benefits to SHS clients were attributed based on the service they received and may only represent short-term outcomes. A more rigorous approach in attributing benefits to the client would be possible if short-/medium-/long-term outcomes could be observed throughout the evaluation period and beyond. These could include education outcomes, such as NAPLAN scores, healthcare outcomes, such as reported quality of life and future utilisation of healthcare services, and others.

In the absence of this longer-term data, the economic appraisal draws upon evidence from peer-reviewed research literature and publicly available reports. A more detailed methodology on costs and identified benefits is presented in the Economic Appraisal Frameworks described in Section 3.8.1 and 3.8.2. General assumptions of the Economic Appraisal are listed in Appendix 2.

[64] NSW Treasury. (2023). NSWE Government Guidelines to Cost Benefit Analysis. TPG23- 08.
[65] BCR is an indicator showing the relationship between the costs and benefits of the SHS Program. When the BCR is greater than 1, the economic appraisal concludes that the benefits of the program outweigh its costs.

3.8.1 Costs of the SHS Program

The costs of the SHS Program are estimated using the preliminary findings of the DCJ Unit Costing Project which considered costs over and above the DCJ funding amounts received by SHS service providers for the delivery of SHS programs.[66] Using the number of clients served through the SHS Program, the economic appraisal quantified the costs of delivering the following four types of SHS services:

- Short-term accommodation services;
- Medium-term accommodation services;
- Minor engagement services, defined as cases where the SHS support begins and ends on the same day; and
- Non-accommodation case management services, including all other SHS supports longer than one day.

The defined types of services are mutually exclusive categories except for short/medium-term accommodation. A client may have received multiple accommodation services, however this only applied to a small share of clients (<2%). To ensure the main costs of SHS were captured in the sensitivity analysis, the Evaluation considered that a client may have received one or two accommodation services. It is assumed that unit costs capture the costs of service provision as well as any additional costs, for example, for building management of crisis accommodation. Sunk costs such as capital investments are not considered in the economic appraisal.

Additional analysis was performed to inform the share of the costs that are subsidised by the SHS funding amounts. Funding figures were provided for FY 22/23 and it was assumed that service providers received the same funding in previous analysis years. The funding figures were adjusted for inflation and expressed in Net Present Value (NPV) terms.[67]

The central analysis was performed using the DCJ Unit Costing Project to represent the primary estimated costs.[68]

3.8.2 Benefits of the SHS Program

SHS benefits framework

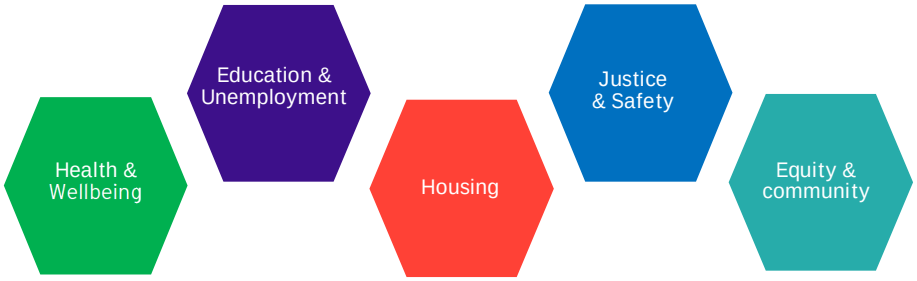
The provision of SHS delivers benefits to a wide range of cohorts and the broader community. The Evaluation Team developed a benefits framework that identifies relevant benefits assumed to be attributable to SHS. The framework draws on insights from the administrative data provided for the Evaluation (where feasible) and evidence from research literature and publicly available reports.

The benefits framework considered five benefit parent categories which deliver potential benefits to SHS clients, the government and the broader community.

[66] Due to the different timeframes of the SHS Evaluation and the Unit Costing Project undertaken by DCJ, unit costs were not final at the time of drafting this Report, and are utilised in the economic appraisal for the purposes of illustrating how the economic appraisal output varies when costs over and above the SHS funding amounts incurred by SHS service providers in the delivery of SHS programs are included.

[67] NPV is a financial metric that express all values in present values. For example, the benefits of the SHS Program were projected for five financial years beyond interaction with the SHS Program. All benefits that were projected into the future (particularly for clients who access SHS support at the end of the evaluation period) are expressed in present values. Present values are FY 22/23 values.

[68] Primary costs are considered as costs that relate to received funding amounts. There may be additional secondary costs such as cost of travel that were not included in this Economic Appraisal due to limited data available for the Evaluation.



Education & Employment

Benefits related to the SHS program's contribution to improved opportunities for continuing/ commencing education for future employment.

Justice & Safety

Benefits capturing the avoided costs to government as a result of reducing risk of engagement with the justice system through the SHS Program.

Health & Wellbeing

Benefits associated with SHS support to access health-related services as well as ensuring clients in need of accommodation due to homelessness or unsafe or unsuitable living conditions are safely housed in short/medium/long term accommodation as a result of SHS support.

Housing

Benefits associated with SHS support in accessing short/medium/long-term accommodation. This benefit parent category also considered any dis-benefits related to the provision of private rental assistance as an early prevention mechanisms aimed at sustaining private tenancies.

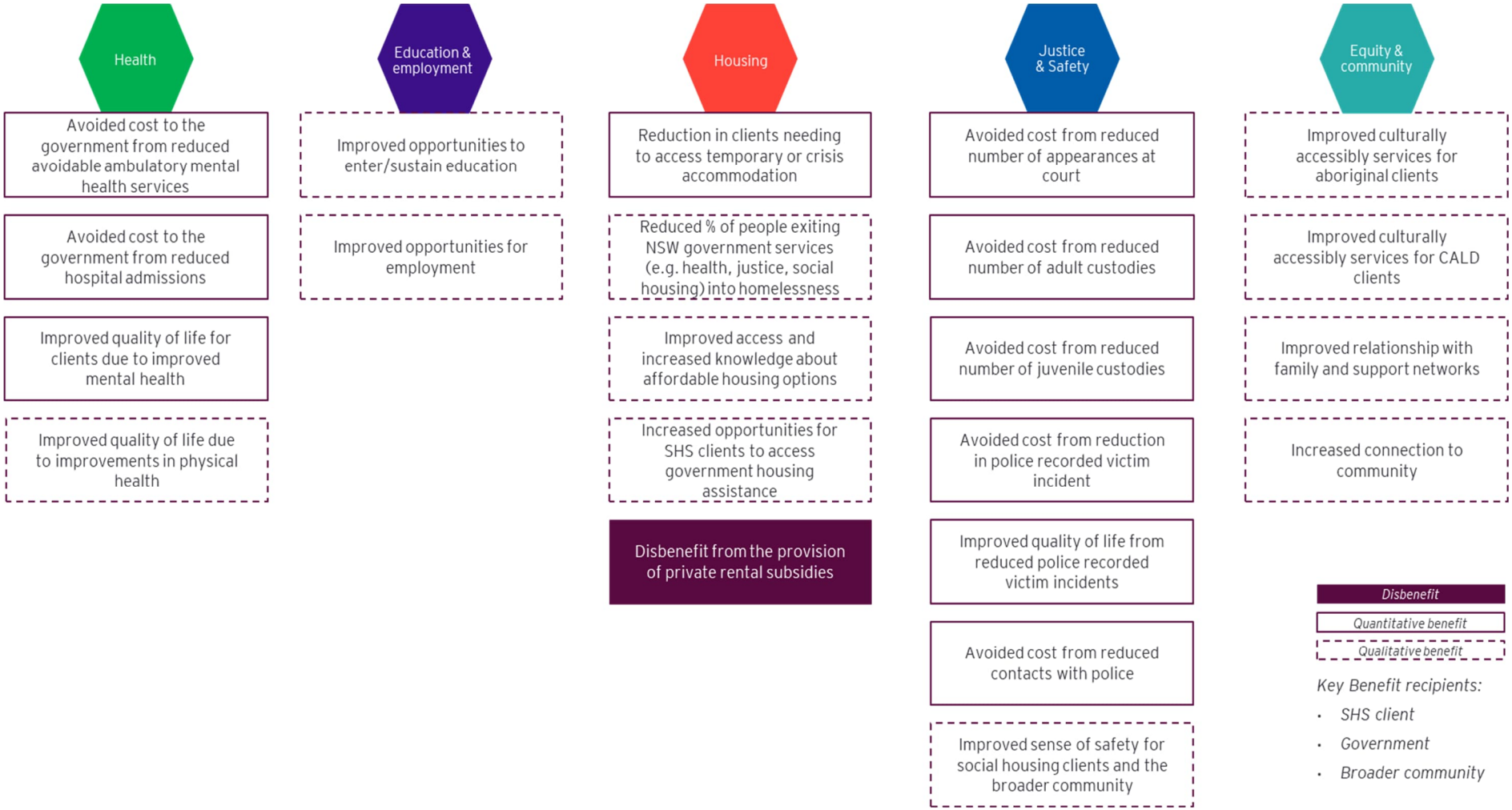
Equity & Community

Benefits capturing the benefits to the SHS client and the broader community, particularly through equitable, culturally diverse and client-centred services and empowerment of community.

Each benefit parent category included several benefits that were categorised as either quantitative or qualitative benefits. Quantitative benefits can be measured and monetised using the available data for the Evaluation on client volumes of the SHS Program and services provided to meet client needs or achieve anticipated outcomes. Qualitative benefits, by contrast, are those that are not generally expressed in measurable units and do not lend themselves to monetary valuation.

A range of such potential benefits were assessed qualitatively and informed by evidence-based research on the projected additional benefits of the SHS Program. These benefits often represent wider economic and social benefits which are important to consider when evaluating the potential value of investment in providing SHS services. Figure 3 presents the SHS benefit framework and lists all benefits considered under each benefit parent category.

Figure 3: Benefits Framework[69]



[69] Source: Developed by the Evaluation Team

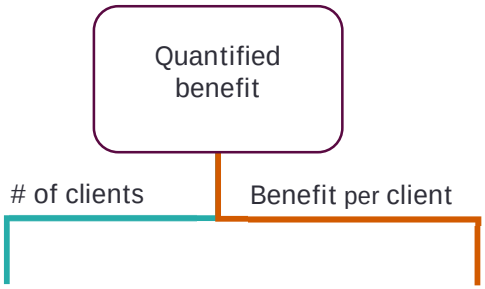
Quantitative benefits

Due to limited information on client outcomes, the quantification of monetised benefits largely relied on publicly available proxy value data of a comparable cohort or service. Additional proxy value data were provided by FACSIAR to support the justice and safety benefit parent category and inform the Evaluation regarding SHS client interactions with the justice system. Other proxy value data utilised in the economic appraisal stem from the DCJ Benefit Database, which includes several benefits and proxy values for the quantification of benefits of SHS and similar services provided by DCJ. Client volumes were drawn on from the NSW Homelessness Data provided by DCJ (based on the CIMS database and equivalent systems). The following data sources were used to inform the quantification of benefits:

- NSW Homelessness Data;
- HOMES data;
- Bureau of Crimes Statistics and Research (BOCSAR) proxy value data;
- DCJ Benefit Database (version June 2021); and
- Publicly available data sources including peer-reviewed literature and government reports.

The benefit quantification methodology was developed in line with available data to support the economic appraisal. Figure 4 presents the general quantification approach which relied on two key data inputs. The data inputs identified the relevant number of SHS clients to which the benefit can be attributed (in blue), and the estimated monetary benefit per client (in orange). The former was informed by client volumes observed in the administrative data and the latter was quantified using the DCJ Benefit Database or publicly available data sources.

Figure 4: Monetisation Approach



Detailed information on the quantification of each monetary benefit and data sources supporting the quantification approach are listed in Appendix 3. Table 7 describes the quantitative benefits of the SHS program in detail. Benefits are expressed in present values.

Table 7: Quantitative potential benefits of the SHS program

Benefit parent category	Potential benefit	Description
Health & Wellbeing	Improved quality of life due to improved mental health Avoided cost to government from reduced avoidable psychotherapy and counselling services	The SHS Program provides various services including assistance to access mental health-related services. The research evidence suggests that early access to mental health-related services contributes to reducing the severity of the condition.[70] Clients who are supported through counselling and psychotherapy are likely to avoid intervention by a specialist. This, in turn, may reduce the need for longer-term mental health care and lead to avoided costs of prolonged mental health related support. Benefits are attributed to clients who received a service related to assistance to access mental health-related services. The benefit associated with preventing the escalation of mental health conditions can be monetised based on the reduced need for longer-term mental healthcare to be provided by the government. For this group of clients, it is assumed that quality of life due to improved mental health would be improved for 65% of clients.[71] The improvement in quality of life can be monetised based on the quality of adjusted life years (QALY) equivalence for obsessive-compulsive disorder and panic disorders which are considered to be representative of the suite of mental health conditions affecting SHS clients, and that have a reasonable prospect of treatment.
Health & Wellbeing	Avoided cost to government from reduced hospital admissions	The SHS Program also provides assistance to access health-related supports, other than mental health-related services. People who are at risk of homelessness or are homeless often face barriers in accessing primary health and medical services.[72] This may be driven by limited knowledge about the importance of primary health support, by limited finances to cover the costs of healthcare, or by other priorities a person may have, such as accessing accommodation. Benefits are attributed to SHS clients who requested support in accessing primary health and medical services and received the requested support.

[70] Department of Health Victoria. (2021). Early Intervention in Mental illness. Retrieved from Early intervention in mental illness (health.vic.gov.au).

[71] Moritz, S., Rufer, M., Fricke, S., Karow, A., Morfeld, M., Jelinek, L. & Jacobsen, D. (2005). Quality of life in obsessive-compulsive disorder before and after treatment. Comprehensive Psychiatry 46(6): 453-459. doi: 10.1016/j.comppsych.2005.04.002.

[72] Davies, A. & Wood, L. (2018). Homeless healthcare: meeting the challenges of providing primary care. Medical Journal of Australia 209(5), 230-234. Retrieved from Homeless health care: meeting the challenges of providing primary care – the UWA Profiles and Research Repository.

Benefit parent category	Potential benefit	Description
		Based on evidence of potentially preventable hospitalisations published by the AIHW, access to primary care services has the potential to prevent a share of hospital admissions for a proportion of SHS clients who are supported in accessing primary healthcare.[73] A reduction in preventable hospital bed days represents an avoided cost to government from reduced hospital admissions.
Justice & Safety	Avoided cost from reduced contact with police Avoided cost from reduced number of appearances at court Avoided cost from reduced number of adult/juvenile custodies	Individuals who are homeless or at risk of homelessness are more likely to interact with the justice system.[74] The provision of SHS services is likely to decrease the likelihood of their interaction with the justice system at all stages. Interaction with the justice system imposes an associated cost to the government at each stage, including through initial contact with the police, court appearances or in custody. Preventing interactions with the justice system will generate avoided costs to the government.
Justice & Safety	Avoided cost from reduction in police recorded victim incidents Improved quality of life from reduced police recorded victim incidents	By reducing the likelihood of contact with the police, the provision of all SHS services is also likely to decrease the number of victim incidents (such as domestic violence).[75] The quantification of benefits relies on proxy value information on the % of police recorded victim incidents of similar individuals to the SHS cohort compared to the broader population. Police recorded victim incidents may impact victims through physical health (e.g., death, illness, injury and disability) and mental health factors (e.g. emotional and psychological trauma), and in turn improve the quality of life of potential victims.[76] Improvement in the victim's quality of life can be measured based on a proxy adjustment for Post-Traumatic Stress Disorder (PTSD) and soft tissue damage.[77]

[73] Australian Institute of Health and Welfare. (2020). Disparities in potentially preventable hospitalisations across Australia. Retrieved from Disparities in potentially preventable hospitalisations across Australia: Exploring the data, Introduction - Australian Institute of Health and Welfare (aihw.gov.au).
[74] Law and Justice Foundation of New South Wales. (2012). Legal Australia-wide survey: Legal need in Australia. Retrieved from Law and Justice Foundation - Download report (lawfoundation.net.au).
[75] Nilsson, S.F. et al. (2020). Homelessness and police-recorded crime victimisation: a nationwide, register based cohort study. The Lancet: Public Health 5(6), 333-341. Retrieved from Homelessness and police-recorded crime victimisation: a nationwide, register-based cohort study (thelancet.com).
[76] DCJ. (2022). The effects of domestic and family violence. Retrieved from The effects of domestic and family violence (nsw.gov.au).
[77] Family and Community Services Insights Analysis and Research (FACSIAR). (2021). DCJ Benefits Menu.

Benefit parent category	Potential benefit	Description
Housing	Reduction in clients needing to access temporary or crisis accommodation	The provision of medium- or long-term accommodation to SHS clients reduces the number of clients that may otherwise need temporary or crisis accommodation. The cost associated with providing temporary or crisis accommodation is significantly higher when compared to medium- or long-term accommodation. The difference in costs can be considered as a benefit to government.
Housing	Disbenefit from the provision of private rental subsidies	The provision of SHS services offers the opportunity to SHS clients to be supported in accessing private rental subsidies. The provision of such subsidies is considered a dis-benefit to the government and broader society and is considered in the Housing domain as a negative benefit.

3.9 Limitations

During the Evaluation, there were several key limitations which impacted data collection and analysis which are described below and should be considered in the interpretation of findings.

Selection bias in stakeholder engagement

Any selection of participants that is not undertaken using randomisation selection carries a risk of selection bias where selected participants may not be representative of the client cohort being identified. Instances of selection bias risk and occurrences of selection bias were observed throughout the Evaluation, particularly during the data collection phase. These are outlined below in relation to key stakeholder cohorts.

Selection bias: client interviews

Consultations with SHS clients were coordinated with the support of SHS service providers, who nominated clients that they were supporting at the time of the interview, or clients they had previously supported. It is plausible that the role of service providers in recruiting clients to participate may have resulted in positive bias with potential selection of clients with particularly positive experiences of engagement with SHS services and the Program more broadly. Positive bias in selection of clients to participate in the Evaluation may limit the validity of the qualitative evidence base for the process- and outcomes-based evaluation questions.

The Evaluation Team encouraged service providers to consider diversity of background, experience and views when selecting clients to participate in interviews to mitigate the potential impact of selection bias to the extent possible. Many service providers actively sought clients who could provide a range of perspectives regarding their interactions with the SHS Program.

Additionally, the Evaluation Team, in collaboration with DCJ and the Advisory Group, determined that conducting approximately 30 client interviews would be adequate for the purpose of the Evaluation to ensure representation of diverse SHS client cohorts and geographies, whilst also avoiding the risk of over-sampling. It is acknowledged that the client interview sample size represents a small proportion of the SHS client cohort and may not be representative of the broader SHS client group.

To address this, the Evaluation Team applied a targeted and iterative approach to recruiting clients to participate in interviews, ensuring the client group interviewed for the purpose of the Evaluation was representative of the SHS cohort to the greatest extent possible. Despite efforts to ensure representation of diverse client cohorts in client interviews, the Evaluation Team identified an over-representation of young people in client interviews, and an under-representation of older people aged 55 and over.

Selection bias: Focus group participants and Advisory Group members

Stakeholders that were selected to participate in workshops, focus groups and interviews were nominated by DCJ, with guidance from the Evaluation Team regarding balanced representation across geographies and staff roles and responsibilities. The Department was also responsible for selecting clients to participate in advisory bodies established to support the Evaluation, including the EWG and Advisory Group. The Department's role in nominating stakeholders to participate in the Evaluation inherently carries a risk of selection bias.

To limit this potential bias, the Evaluation Team suggested that Department representatives were not present in any data collection activities with focus group and workshop participants. The Evaluation Team also encouraged the selection of advisory body members representing a diverse range of services and geographies to ensure broadest representation of viewpoints.

Selection bias: Survey recipients

The Evaluation Team distributed the service provider survey to a sample of 80 SHS service providers that had elected to participate in the survey via response to an expression of interest issued by DCJ. 41 service providers (51%) responded to the survey. Several reminder communications were distributed to the sample of service providers who nominated to participate to garner the greatest number of survey responses. Based on the characteristics that were observed, there appeared to be adequate representation of responses across characteristics (i.e., DCJ District, role/position, etc.) within the service provider respondent organisation, however, there may have been unobserved characteristics in the survey respondents that were not captured by the survey which may contribute towards a bias in the results. The Evaluation Team observed low response rates for some survey questions with optional and/or dependent responses, with as few as five responses for some questions. It is noted that this sample size does not provide adequate representation of diverse respondent characteristics in survey responses, and there is a potential for bias to be present.

Qualitative insights from survey responses were explored in further depth in service provider workshops, with quantitative survey data and qualitative insights being blended where possible to reduce the potential impact of this limitation.

Challenges engaging stakeholders

The qualitative assessment was informed by focus groups, one-on-one interviews and small-group interviews with key stakeholder groups. The Evaluation Team was cognisant that consultation fatigue may have impacted upon the sector's participation in similar consultation activities to date, perhaps limiting the qualitative information collected during the Evaluation and preventing the Evaluation Team from gathering sufficient information to comprehensively address evaluation questions. Other sector consultations and ASES accreditation processes were cited by a number of stakeholders as reasons for being unable to participate in data collection for this Evaluation.

Likewise, challenges engaging with stakeholders due to reluctance to participate or limited availability may have also acted as a constraint to the representativeness of qualitative information collected. This was particularly evident with stakeholder groups including the NSW Police Force, Corrective Services and Community Housing Providers (CHPs). Limited engagement with these groups throughout the course of the Evaluation resulted in the perspectives of inter-agency stakeholders being insufficiently captured in the Evaluation.

To mitigate challenges engaging stakeholders, the Evaluation Team sought stakeholder availability prior to scheduling the consultation sessions to ensure maximum stakeholder availability during the consultations. Additionally, in some instances, the Evaluation Team scheduled a second consultation with specific stakeholder groups where participation in the first consultation was limited.

Representation of SHS cohort

The findings relevant to evaluation questions relating to access to services do not consider cases when an individual who was at risk of homelessness or experiencing homelessness accessed services and was not recorded in the administrative data (unrecorded and unassisted request).

Various rationales are likely to underpin this undercount of individuals presenting to SHS and not being recorded in the administrative system. Under-presentation may reflect perceived or actual poor access to service providers, alongside distrust of services or poor previous experiences of engagement with services.

Unassisted requests add to the undercount of individuals accessing SHS services. Unassisted requests refer to situations where an individual seeks help from an SHS agency but does not receive any immediate assistance. The data collected for reporting purposes were often restricted because it may not be appropriate for the agency to gather the same level of detailed information as they would for someone who becomes a client. Information required to create the SLK (the unique

identifier) was not collected for 47% of the unmet requests for service in FY 21–22.[78] This proportion of unassisted requests were not recorded in the administrative data and were not considered in the analysis.

Given that the unassisted cohort of people who are experiencing or at risk of homelessness do not appear in the data supporting this Evaluation, the data drawn upon may be overestimating outcomes relating to access to services. Likewise, whilst analysis is conducted to account for unmet needs of this cohort in the current Evaluation, this analysis may be misrepresentative and/or missing data may have implications for analysis of the needs of people experiencing homelessness and, therefore, the effectiveness of SHS's response to service these cohorts.

Noting the potential implications of this limitation, the Evaluation Team contextualised evaluation findings with relevant external literature and data to provide further context regarding potential issues of accessibility of the SHS Program. The Evaluation Team also consulted with StreetCare, who provided their own lived experience perspectives as to why a person experiencing or at risk of homelessness may not access SHS. These views have been incorporated into the findings where relevant.

Completeness of data

The Evaluation findings relied on the accuracy and completeness of administrative data which are recorded by a service provider in CIMS and/or equivalent systems. In some cases, the client may have provided inaccurate information or information may be recorded inconsistently due to human error. The Evaluation Team performed various data cleaning and check activities to ensure that the data were as complete and accurate as possible, however, a measurement error may occur in cases when the inaccuracy cannot be observed. Given this limitation, the results from the quantitative analysis should be interpreted with a degree of uncertainty. The measurement error is expected to be minor however it may disproportionately impact individuals or cohorts where the collection of information may be more challenging, i.e., children or clients suffering from severe mental health conditions or disability. Where the Evaluation Team was aware of known data issues, this was noted in the Report.

Benefit attribution

Developing a robust assessment of the benefits of SHS service provision relies on the availability of client outcome data. The Evaluation Team understood that the data currently available are largely focused on service provision rather than client outcomes. Whilst service provision may be influenced by client characteristics, it is difficult to identify whether any changes observed in client outcomes are as a direct result of services or may be driven by confounds which were not able to be controlled for statistically.

The impact of SHS services on client outcomes was estimated using proxy values from the Bureau of Crimes Statistics and Research (BOCSAR), the DCJ Benefits Database and broader research literature. This enabled the Evaluation Team to provide a high-level assessment of the benefits of SHS services.

Benefits were attributed only to clients to whom the services were provided, or their needs were met. The benefits were largely attributed based on two approaches:

- Benefits were attributed to the number of clients whose relevant needs were met at the end of SHS support with additional assumptions on the benefit attribution rate; and
- Benefits were attributed by identifying the share of SHS population at risk and the share of risk-averted as a result of SHS support (justice-related benefits).

[78] Australian Institute of Health and Welfare. (2021). Specialist homelessness services annual report 2021–22. Retrieved 07 July 2023, from Specialist homelessness services annual report 2021–22, Unmet demand for specialist homelessness services - Australian Institute of Health and Welfare (aihw.gov.au)

The first approach assumes that the relevant benefits are attributed only to clients whose needs were recorded as being met at the end of SHS support, and a 100% benefit was attributed to these clients. The Evaluation Team acknowledges that, in instances where the SHS Program acts as an intermediary in supporting SHS clients to access other services, i.e., mental health services, general practitioner, etc., some clients may have not received full benefits. Based on the data recording mechanisms, it is understood that, if the need for support in accessing other services was met (service provided, or referred and provided), the client received the required support as a result of SHS being the intermediary.

In the base case scenario, it is assumed that the SHS Program is not available and, hence, the client would not have accessed the required support from other services without the SHS intervention. The Evaluation Team acknowledges that this may overstate benefits in some cases, i.e., where some clients could have accessed other services and received a benefit in the absence of SHS support. However, individuals who are experiencing homelessness or are at risk of homelessness (i.e. the SHS population) may prioritise their housing needs over other needs such as health and social care; and the experience of homelessness may lead to further barriers to healthcare and deteriorate the client's health condition. For this reason, it is assumed that the SHS Program acting as the intermediary supported the client in accessing other services and the benefit from receiving those services is attributed to the SHS Program. The benefit attribution varies across years based on the benefit drop off profile to capture that the client's circumstances may have changed, and the benefit may last at a proportional rate.

There are various benefits of clients successfully accessing SHS services, however, the Evaluation Team acknowledges that due to limitations in the availability of data, there may be benefits that were higher than estimates, and were not captured and/or quantified in the report. Limited access to outcomes data also prevented the measurement of long-term client outcomes from being assessed in the quantitative analysis. Overall, due to this limitation, the economic analysis relies on proxy value data to measure potential benefits. Other findings related to client outcomes were supplemented with qualitative data, such as SHS client interview insights, as well as findings from the literature.

Estimating drop-off profiles

The lasting effect of benefits from SHS services may vary based on the quality-of-service provision and client specific characteristics. While a single instance of the provision of some services (such as information about housing services) may have a long-lasting benefit, other services (such as access to mental health practitioners) may require continued ongoing service provision for the benefit to be sustained. The research evidence to support the development of the benefit drop-off profiles was limited and may not fully capture the actual drop-off profile likely to occur in practice.

This analysis utilised a range of varying benefit drop-off profiles as a proxy to account for the diminishing profile of benefits from service provision.

Alignment with DCJ Unit Costing work

Due to misalignment of delivery timeframes, the Evaluation analysis and findings were well advanced at the time that the Evaluation Team was provided with the preliminary DCJ Unit Costing findings. Nevertheless, the Evaluation incorporates some analysis of services utilising the preferred DCJ Unit Costing definitions, and instead, presents analysis of service provision and response by investigating SHS clients' reported needs, representing 55 unique services.

4. Literature Review

4.1 Summary of findings

A literature review was undertaken to gain insights into key themes relating to homelessness and homelessness services in Australia. These themes included key drivers of homelessness, the challenges for addressing homelessness and best practice programs and services to support people experiencing homelessness.

4.2 Key drivers of homelessness

The experience of homelessness can be the result of many social, economic and health–related factors. The key drivers of homelessness in Australia identified by the Australian Housing and Urban Research Institute (AHURI) include, but are not limited to:

- Poverty;
- Family and domestic violence;
- Young people not having access to suitable accommodation;
- Impacts of colonisation and discrimination for Aboriginal and Torres Strait Islander Australians; and
- Lack of affordable suitable housing.[79]

4.3 Challenges addressing homelessness

4.3.1 Fragmented systems

The National Housing and Homelessness Agreement is the main funding agreement between the Council of Australian Governments (COAG), Commonwealth and the states and territories.[80] However, states and territories are ultimately responsible for managing homelessness programs, meaning that the NHHA is treated differently across jurisdictions outside of the traditional homelessness service system. This may create additional complexities for SHS providers as the policies and strategies together provide context for SHS. This has resulted in SHS service providers placing a greater emphasis on providing individual responses rather than addressing structural drivers of homelessness.[81]

4.3.2 Funding constraints

In NSW, SHS service providers are NGOs and are co-funded through the NHHA through equal funds from the Commonwealth and NSW DCJ to deliver services to those who are homeless or at risk of

[79] Spinney, A., Beer, A., MacKenzie, D., McNelis, S., Meltzer, A., Muir, K., Peters, A. & Valentine, K. (2020). Ending homelessness in Australia: A redesigned homelessness service system. Australian Housing and Urban Research Institute Limited Melbourne, Australia. Retrieved June 2022, from https://www.ahuri.edu.au/research/final-reports/347.

[80] Department of Social Services. (2021). National Housing and Homelessness Agreement. Retrieved 15 July 2022, from https://www.dss.gov.au/housing-support-programs-services-homelessness/national-housing-and-homelessness-agreement#:~:text=The%20National%20Housing%20and%20Homelessness%20Agreement%20%28NHHA%29%20commenced,million%20set%20aside%20for%20homelessness%20services%20in%202020-21.

[81] Spinney, A., Beer, A., MacKenzie, D., McNelis, S., Meltzer, A., Muir, K., Peters, A. and valentine, k. (2020) Ending homelessness in Australia: A redesigned homelessness service system, AHURI Final Report No. 347, Australian Housing and Urban Research Institute Limited, Melbourne, https://www.ahuri.edu.au/research/finalreports/347, doi: 10.18408/ahuri5119001.

homelessness.[82] SHS providers who receive NHHA funding are required to report data to the SHSC on clients who receive a service, in addition to unassisted requests. The uncertainties associated with reliance on government funding, the funding amount and contract term is perceived as a constraint for SHS providers in the delivery of services.[83] For example, service providers may rely on employment of fixed-term and casually contracted staff due to fixed term contracts with DCJ, contributing to workforce issues for providers.[84] Likewise, fixed funding has been cited to make it difficult for SHS providers to provide competitive salaries, retain high quality staff and provide training and professional development opportunities for staff.[85]

Research conducted by AHURI suggested that current levels of funding are below levels required to meet client demand, and that SHS providers support more clients than they are funded to.[86] The limits on funding duration and eligibility requirements were suggested to result in providers perceiving a degree of uncertainty and inability to plan and deliver long-term and consistent supports required to address homelessness.

4.3.3 Appropriate and affordable accommodation

While rental affordability improved during the COVID-19 pandemic in Sydney, Melbourne, Adelaide and the Australian Capital Territory (ACT), every capital city experienced a decline in rental affordability in 2022, with rents rising by at least 5% across all capital cities and dwelling sizes.[87] In Greater Sydney, for example, median weekly rent increased by 17% in the 12 months to March 2023.[88] This increase in median weekly rent has been attributed to the return of international tourism and students, placing constraint on domestic rental supply, particularly for singles, couples and small families.[89]

Likewise, in regional areas, natural disasters over recent years have affected existing rental stock and stock in development, and at the same time that regional areas have seen an influx of COVID-19 related regional migration.[90] Median weekly rent in regional NSW increased by 7% in the 12 months to March 2023, and affordability in regional NSW since the end of 2022 has declined with households spending just under 30% of their income on rent.[91] This is a stark increase as compared to mid-2020, where households reported spending just under 25% of their income on rent.[92]

Further exacerbating these challenges, Australia's public housing stock has fallen by 10% over the last decade.[93] While some stock has been transferred to community housing stock, which increased

[82] DCJ. (2021). Our homelessness programs. Retrieved 17 June 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/our-programs#:~:text=Specialist%20homelessness%20services%2C%20funded%20by%20DCJ%20and%20delivered,known%20to%20be%20most%20at%20risk%20of%20homelessness.

[83] Zaretzky, K. & Flatau, P. (2013). The cost of homelessness and the net benefit of homelessness programs: a national study, Australian Housing and Urban Research Institute. Retrieved 9 June 2023, from The cost of homelessness and the net benefit of homelessness programs: a national study (apo.org.au); Cortis, N. & Blaxland, M. (2017). Workforce issues in Specialist Homelessness Services. Social Policy Research Centre. Retrieved 9 June 2023, from 2021-06-Workforce_Issues_in_SHS_final_report.pdf (unsw.edu.au).

[84] Cortis, N. & Blaxland, M. (2017). Workforce issues in Specialist Homelessness Services. Social Policy Research Centre. Retrieved 9 June 2023, from 2021-06-Workforce_Issues_in_SHS_final_report.pdf (unsw.edu.au).

[85] Ibid.

[86] Flatau, P., Zaretzky, K., Valentine, K., McNelis, S., Spinney, A., Wood, L., MacKenzie, D. & Habibis, D. (2017). Inquiry into funding and delivery of programs to reduce homelessness. Australian Housing and Urban Research Institute Limited Melbourne, Australia. Retrieved 30 June 2022, from https://www.ahuri.edu.au/research/final-reports/279.

[87] SGS Economics and Planning. (2022). Rental affordability index – November 2022. Retrieved 9 June 2023, from Rental-Affordability-Index_Nov_2022_low-resolution.pdf (sgsep.com.au).

[88] DCJ. (2023). Rent and sales report – interactive dashboard. Retrieved 9 June 2023, from Rent and sales | Tableau Public.

[89] SGS Economics and Planning. (2022). Rental affordability index – November 2022. Retrieved 9 June 2023, from Rental-Affordability-Index_Nov_2022_low-resolution.pdf (sgsep.com.au).

[90] Ibid.

[91] DCJ. (2023). Rent and sales report – interactive dashboard. Retrieved 9 June 2023, from Rent and sales | Tableau Public; SGS Economics and Planning. (2022). Rental affordability index – November 2022. Retrieved 9 June 2023, from Rental-Affordability-Index_Nov_2022_low-resolution.pdf (sgsep.com.au).

[92] SGS Economics and Planning. (2022). Rental affordability index – November 2022. Retrieved 9 June 2023, from Rental-Affordability-Index_Nov_2022_low-resolution.pdf (sgsep.com.au).

[93] Australian Institute of Health and Welfare. (2022). Housing assistance in Australia. Retrieved 9 June 2023, from Housing assistance in Australia, Social housing dwellings - Australian Institute of Health and Welfare (aihw.gov.au).

to 108,519 dwellings in 2021, at the end of June 2021, AHURI estimated that there was a dwelling demand gap for social and community housing of over 216,000 in Australia.[94] This included over 200,000 applicants on waiting lists.[95] Despite Commonwealth, state and territory investments in social housing to boost social dwelling stock by just under 50,000 dwellings, there will still be a significant supply gap to meet demand.[96]

4.3.4 Collaboration between government and non-government agencies

It is vital for government and non-government agencies to work collaboratively in addressing the complexities of homelessness to provide integrated responses. People experiencing or at risk of homelessness often require additional support beyond the scope of SHS to obtain and sustain housing, including support from other interrelated services. Resolving homelessness requires adaptive and integrated responses to meet the needs of individuals experiencing homelessness.[97]

The NSW Government invested $177.5 million in the Together Home program in 2020 to support the Premier's Priority to halve street sleeping by 2025.[98] Together Home is an example of a program in which is seen as promoting proactive and ongoing collaboration amongst service providers and government bodies.

4.4 Best practice in addressing homelessness

The following section explores best practices in homelessness responses from a range of models from domestic and international literature.

4.4.1 Client-centred approaches

A client-centred approach places the person at the centre of a 'system', an ecosystem with many interconnected components, recognising homelessness services and interventions are part of a broader system for an individual.[99] Support and services must be capable of responding to the needs of the most vulnerable people at risk of or experiencing homelessness in a culturally safe and inclusive manner.[100] Applying a client centred framework, and moulding services to meet client needs rather than adopting a 'one-size-fits-all' approach, ensures the system is accessible and responsive to everyone accessing homelessness services.[101]

4.4.2 Housing First

The Housing First model prescribes safe and permanent housing as the first priority for people experiencing homelessness.[102] Once housing is secured, a multi-disciplinary team of support workers can address complex needs through services like drug and alcohol counselling or mental health

[94] Ibid; Australian Housing and Urban Research Institute. (2023). What is the difference between social housing and affordable housing and why do they matter. Retrieved 9 June 2023, from What is the difference between social housing and affordable housing - and why do they matter? | AHURI.
[95] Ibid.
[96] Collins, J. (Hon. MP). (2022). National Homelessness Conference 2022 [speech]. Retrieved 9 June 2023, from National Homelessness Conference 2022 | Department of Social Services Ministers (dss.gov.au).
[97] Ibid.
[98] DCJ. (2022). Together Home. Retrieved 8 August 2022, from Together Home | Family & Community Services (nsw.gov.au).
[99] Spinney, A., Beer, A., MacKenzie, D., McNelis, S., Meltzer, A., Muir, K., Peters, A. & Valentine, K. (2020) Ending homelessness in Australia: A redesigned homelessness service system, AHURI Final Report No. 347, Australian Housing and Urban Research Institute Limited, Melbourne. Retrieved from https://www.ahuri.edu.au/research/finalreports/347, doi: 10.18408/ahuri5119001.
[100] Ibid.
[101] Andrews, C. & R. McNair. (2020). LGBTIQ+ Inclusive Practice Guide for Homelessness and Housing Sectors in Australia. Melbourne: The University of Melbourne. Retrieved from LGBTQIHomelessness_GUIDE_Final-March2020.pdf (homelessnessnsw.org.au).
[102] Department of Housing and Public Works. (2018). Homelessness Program Guidelines, Specifications and Requirements, Queensland Government. Retrieved from Homelessness program guidelines, specifications and requirements (hpw.qld.gov.au); Ministry of the Environment, Action Plan for Preventing Homelessness in Finland 2016-2019. (2016). Retrieved 30 June 2022, from ACTIONPLAN_FOR_PREVENTING_HOMELESSNESS_IN_FINLAND_2016_-_2019_EN.pdf (asuntoensin.fi).

treatment.[103] However, an individual's engagement with these support services is not required for them to maintain accommodation and each individual is assisted in sustaining their housing as they work towards recovery and reintegration with the community at their own pace.[104]

4.4.3 Early intervention

Early intervention models prioritise targeting supports at points to help prevent people from experiencing homelessness. This may include people who are at risk of homelessness, supporting people to maintain tenancies and improving 'exit planning' for people leaving government services.[105] The Community of Schools and Services (COSS) model is emerging as an effective, evidence-based early intervention model for young people at risk of homelessness.[106] The COSS model screens all youth in the project area for vulnerability, allowing identification of young people who are at-risk before they reach a crisis point. It then works with all at-risk youth through secondary education until they are on a pathway to employment.

4.4.4 Coordinated systems

Homelessness is a complex, systemic problem requiring a coordinated, community-wide response to better utilise resources by aligning services, sharing information, managing overall performance and deploying resources in areas of greatest need to create the best outcomes.[107] Coordinated entry systems streamlines access and referral to services and housing so that all clients are treated, triaged and assisted.[108]

4.4.5 Data collection and assessment tools

Homelessness is a dynamic, person-specific problem that changes from night to night and from person to person, therefore relying on data that are collected at a single point in time is insufficient to help organisations respond quickly and effectively.[109] This understanding informed the 'By-Name List' (BNL), a data collection method developed to assist with prioritising people experiencing homelessness.[110] The tool records up to date personal information about people rough sleeping in the community, or at risk of, and tracks their movement in and out of homelessness, with the overarching goal of ending homelessness.[111]

The current BNL data capture point-in-time data of the inflow into homelessness through (a) those returned from housing and 'actively' homeless again, (b) newly identified sleeping rough homeless since the previous month, and (c) those who have returned from an 'inactive' state (where there is no record of their status) and are seeking housing again.[112] The BNL captures the stories of people experiencing homelessness and was designed as a case coordination tool to facilitate the sharing of key information across the sector, to prevent clients having to consistently re-tell their story. The

[103] Ibid.
[104] Ibid.
[105] DCJ. (2018). NSW Homelessness Strategy 2018-2023. Retrieved 9 June 2023, from Prevention and early intervention | Family & Community Services (nsw.gov.au).
[106] ACT Government Community Services, Review of Good Practice Models and Guiding Principles, retrieved 30 June 2022, from https://www.communityservices.act.gov.au/__data/assets/pdf_file/0009/1979622/Review-of-Good-Practice-Models-and-Guiding-Principles.pdf
[107] Gaetz, S., Dej, E., Richter, T. & Redman, M. (2016). The state of homelessness in Canada 2016. Canadian Observatory on Homelessness Press. Retrieved from The State of Homelessness in Canada 2016 | The Homeless Hub.
[108] Ibid.
[109] Maguire, J. (2018). How By-Name list helps communities end homelessness [blog]. Community Solutions. Retrieved 5 July 2022, from https://community.solutions/the-by-name-list-revolution/.
[110] Community Solutions. By-Name Data: A pillar of the Built for Zero methodology. Retrieved 5 July 2022, from https://community.solutions/quality-by-name-data/
[111] Community Solutions. By-Name Data: A pillar of the Built for Zero methodology. Retrieved 5 July 2022, from https://community.solutions/quality-by-name-data/
[112] Ibid.

tool better equips caseworkers with the information required to improve exits of people from street sleeping, ultimately, providing systems-level insights which can improve policy responses.[113]

4.4.6 Duration of need approach

A duration of need approach focuses on providing accommodation and/or support for as long as the client requires to obtain and maintain sustainable housing.[114] It provides services on a needs basis rather than an arbitrary time limit.

4.4.7 Preventing tenancy breakdowns and tenancy support

Preventing tenancy breakdowns involves strengthening partnerships with social housing and the private rental market to engage early with tenants experiencing tenancy issues with a view to prevent homelessness from occurring.[115]

Supported tenancy programs can include public housing tenancy support to prevent breakdowns of tenancies, as well as private rental assistance support. Such programs have been demonstrated to be effective in securing access to public housing and preventing tenancy breakdowns.[116]

[113] End Street Sleeping Collaboration. (2020). Annual Report: Financial Year 2019 - 2020. Retrieved 5 July 2022, from https://static1.squarespace.com/static/5b5fd0d7f2e6b141ab1f1f0f/t/6078da6b60a5d115197b9113/1618532999786/ESSC%2B2020%2BAnnual%2BReport+%281%29.pdf,

[114] 500 lives 500 homes. (2016). Housing First A roadmap to ending homelessness in Brisbane. Retrieved 3 August 2022, from https://www.500lives500homes.org.au/resource_files/500lives/20160808Housing-First-Roadmaplores.pdf.

[115] Homelessness Australia. (2017). A National Homelessness Strategy: why we need it Strengthening the service response to people who are homeless or at risk of homelessness. Homelessness Australia. Retrieved 2 August 2022, from https://sheltertas.org.au/wp-content/uploads/2017/05/HA-National-Homelessness-Strategy-position-paper_April-17.pdf.

[116] Australian Housing and Urban Research Institute (AHURI) (2021). What is a sustaining tenancies program? Retrieved 2 August 2022, from https://www.ahuri.edu.au/analysis/brief/what-sustaining-tenancies-program

5. Evaluation Findings

The evaluation questions were designed by the evaluators in consultation with the Department and examine process, outcomes and economic areas of SHS.

Most evaluation questions have been addressed through a combination of qualitative and quantitative analysis, allowing for a nuanced understanding of key outcomes, opportunities and challenges surrounding the SHS Program. Some evaluation questions lent themselves better than others to quantitative analysis (mostly process questions regarding accessibility and SHS client cohorts), and some questions have been addressed using solely insights from the stakeholder consultation and service provider survey responses (mostly process questions regarding process and approaches, networks and governance, and data collection mechanisms).

As outlined in Section 3.7.1 and further detailed in Appendix 1, the sample selection rules for the quantitative analysis were based on an SHS client's first observable interaction with SHS. The sample for the analysis throughout this section included approximately 272,577 unique clients over the evaluation period from FY 16/17 to FY 21/22.

In order to contextualise the findings presented under the evaluation themes and sub-questions below, an overview of the SHS Program, clients served and services provided, is detailed below.

5.1 SHS Overview

The SHS Program is the primary NSW Government response to homelessness.[117] Over the evaluation period (FY 16/17 to FY 21/22), the SHS Program supported 272,577 unique clients in NSW across 16 DCJ Districts. 62% of SHS clients accessed services at a service provider located in regional and rural DCJ Districts, and 38% accessed services in metro DCJ Districts.

Table 8: Number of unique clients by DCJ District over the evaluation period

Service Provider DCJ District	Number of unique clients
South Eastern Sydney	32,187
South Western Sydney	23,217
Hunter	22,572
Western NSW	21,417
Northern NSW	21,259
Western Sydney	20,206
Mid North Coast	19,772
Sydney	17,586
Illawarra Shoalhaven	17,192
New England	13,902
Murrumbidgee	13,731

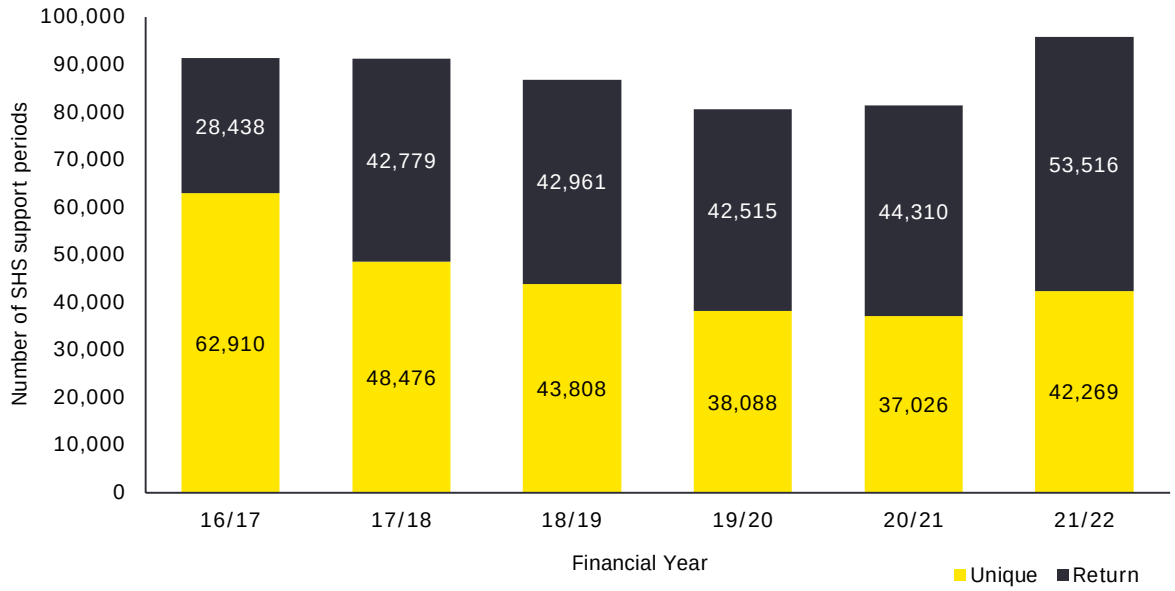
[117] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

Service Provider DCJ District	Number of unique clients
Southern NSW	12,697
Nepean Blue Mountains	12,321
Northern Sydney	11,159
Central Coast	10,445
Far West	2,913
Total	272,576[118]

Source: NSW Homelessness Data (CIMS and equivalent systems)

Figure 5 presents the trend in the number of SHS supports provided over the evaluation period.[119] The share of supports presented in yellow are the first client interactions with the SHS system and represent the number of unique clients presenting to SHS each year, which forms the basis of much of the analysis contained within this Report.[120] The share presented in black represents all return supports provided to these clients. The number of unique clients presenting to SHS trended downwards over the evaluation period until FY 20/21 then increased in FY 21/22, as did the total number of supports provided.

Figure 5: SHS support periods and unique clients by financial year (FY 16/17 – 21/22)



Source: NSW Homelessness Data (CIMS and equivalent systems)

[118] The SHS Program provided services to a total of unique 272,577 clients during the evaluation period (FY16/17-FY21/22). The DCJ District of the service provider was not reported for one client. NSW Homelessness Data (CIMS and equivalent systems).

[119] CIMS and equivalent systems consider the end of the support period when the support has been provided. Approximately 5% of clients commenced SHS support in the year prior to the end of the support period.

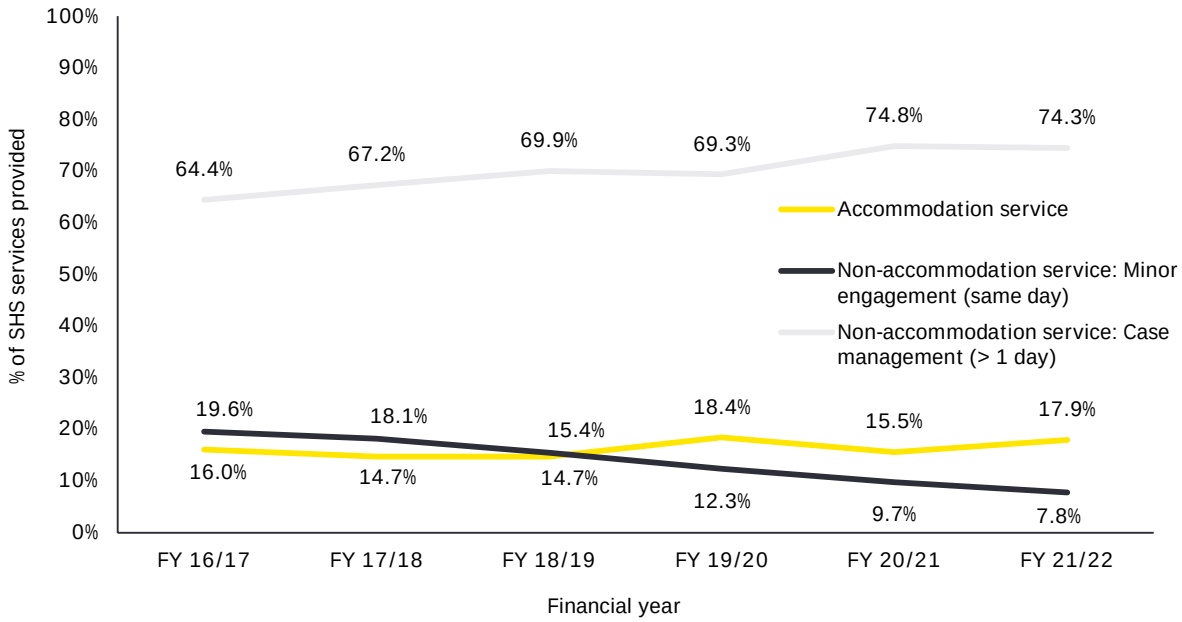
[120] The administrative data drawn on for this Evaluation record individuals who accessed SHS services. By virtue of this data capture mechanism, the SHS administrative dataset does not include individuals who accessed, but were not supported by, the SHS Program and hence were not recorded in the administrative data. The number of clients by financial year are not comparable with the AIHW SHS annual reports due to different counting rules. The AIHW reports the number of support periods and unique clients for each financial year. The data provided for the Evaluation captures six financial years, allowing the analysis to identify the number of clients that return within this period.

It is important to note that the first period in the analysis sample is FY 16/17, however it is possible that clients who received support in this period may have been supported by SHS prior to FY 16/17. Therefore, the identification of unique clients (indicated in yellow) in FY 16/17 was not informed by data collected prior to FY16/17 (as this was outside the evaluation period) and may misrepresent if the client is "unique" or returning; explaining why the number of clients reported in FY 16/17 is higher than the subsequent periods of analysis. For further information on this assumption, please refer to the Data Decision Register in Appendix 1.

The Program is supported by 102 NGOs[121] who deliver SHS services to support people experiencing homelessness, or at risk of homelessness, through early intervention, crisis, transitional and post-crisis support services.[122] These services are categorised into accommodation services, minor engagements (same day support), and case management (greater than one day of support), as defined by the Unit Costing Project.

Figure 6 presents the trends in types of SHS services provided in NSW by the SHS Program over the evaluation period.

Figure 6: Trends in type of SHS services provided FY 16/17 to FY 21/22[123]



Source: NSW Homelessness Data (CIMS and equivalent systems)

Case management support forms the majority of SHS services provided, and this type of service has been increasingly provided to SHS clients over the evaluation period. By contrast, minor engagements (same day support) have decreased. These trends in services provided could reflect the increasing complexity of client needs (refer to Section 5.2.2). DCJ has also identified changes in data recording processes and the maturity of data collections as potential influencing factors of this trend.

Within these broad categories of service, SHS caseworkers can identify up to 55 different needs for support for SHS clients throughout the course of SHS support. The number of clients expressing the

[121] 2021-2024 Provider and Service Count, provided by DCJ.
[122] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

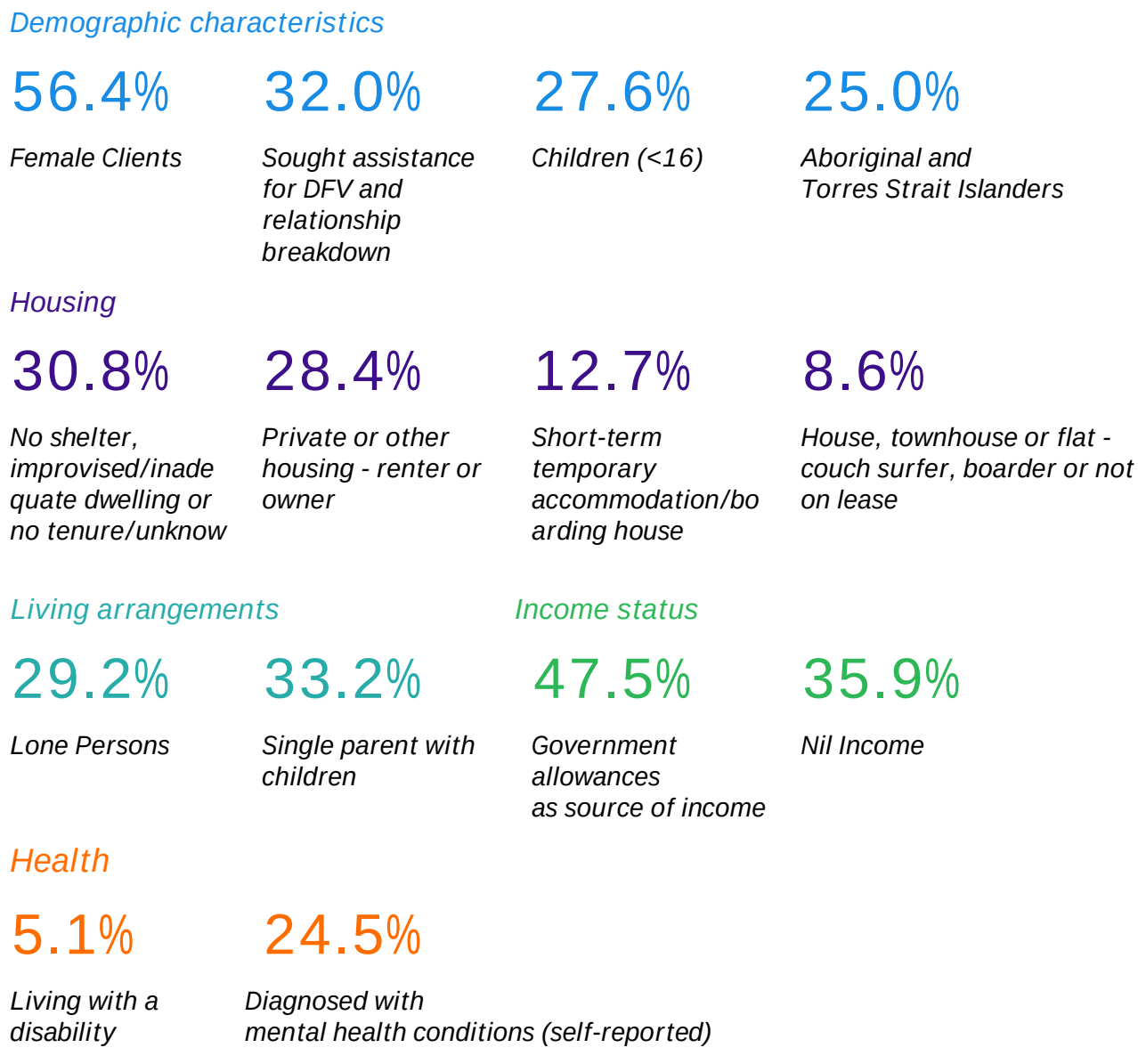
[123] A client may have received several accommodation services (<1% of clients). The share of accommodation services in this Figure presents the proportion of clients that have received at least one accommodation service. It is assumed that clients who were supported to access long-term accommodation also received case management support.

need for short-, medium- and long-term accommodation increased over the evaluation period (by 5.2%, 8.8% and 10.6% respectively), as have needs for assistance to access domestic and family violence services (increase of 7.2% over time) and mental health services (an increase of almost 4% over time).

Similarly, the increased volume of mental health support needs expressed by SHS clients as per the administrative data supports qualitative anecdotes of increasing presentations of clients with complex mental health needs over the evaluation period. SHS clients increasingly expressed a need for support with trauma (increase of almost 6%); access to psychological services (increase of almost 2%); access to health and medical services (increase of almost 3%); and access to specialist counselling services (increase of almost 2%). Further detailed analysis on client needs can be found in Section 5.2.2.

Analysis of the administrative data shows an increase in the proportion of clients self-reporting a diagnosed mental health condition, from just over 24% in FY 16/17 to almost 26% in FY 21/22. An overview of key demographic characteristics of SHS clients over the evaluation period can be found in Figure 7.

Figure 7: SHS current cohort (FY 16/17 – FY 21/22)



Source: NSW Homelessness Data (CIMS and equivalent systems)

Further detailed analysis on some of these cohorts can be found in Section 5.2.2.

The SHS Program met consistent levels of client need over time, demonstrating a degree of responsiveness from the sector, however rising demand for accommodation and support to access mental health services proved challenging for service providers. For detailed analysis on met and unmet demand, please refer to Section 5.2.2.

5.2 Process Evaluation

The following process evaluation questions were considered during the Evaluation:

- What are the pathways people take to access SHS? Are services accessible for the people who need them? What are the strengths and barriers for clients accessing SHS and what improvements can be made? How effective is Link2Home at connecting people to the services they need?

- What are the cohorts and characteristics of people who need SHS, including any emerging cohorts? Are existing services aligned with these needs? How capable is SHS of adapting to changing needs over time?

- Are people who need SHS receiving client-centred and integrated responses?[124] What are the strengths and barriers, both within SHS and in intersections with the broader service system to provide the services needed by clients? What improvements can be made?

- How effective are the networks and governance mechanisms in place, such as District Implementation Homelessness Groups (DHIGs) at working collaboratively to resolve implementation issues and consider practice principles and how they are applied when supporting clients?

- How effective are current data collection and reporting mechanisms? What improvements to data collection and reporting systems are needed to enable improved monitoring of the SHS Program?

Key evaluative findings related to each sub-evaluation question listed above are presented for each sub-question.

5.2.1 Accessibility of the SHS Program

What are the pathways people take to access SHS?

Key Findings

The key referral pathway into SHS was other mainstream service providers, forming 39% (≡12,409) of all formal referral sources in FY 21/22.

- Referrals from Domestic and Family Violence (DFV) services increased from 9% (≡2,410) in FY 19/20 (the first year for which these data were captured) to almost 17% (≡5,357) in FY 21/22. Service provider stakeholders expressed scope for refining the assessment and referral process for SHS clients, particularly between Link2Home and SHS service providers, to ensure

[124] A client-centred response is one which places a client at the centre of service delivery to ensure a high standard of customer service and the best outcomes are achieved for each client. An integrated response is one which brings together the participants in human services systems with the aim of achieving goals that cannot be achieved by those participants acting autonomously and separately.

Key Findings

clients experiencing or at risk of DFV and homelessness can access services in a timely and trauma-informed manner.

- Referrals from the justice and hospital systems made up 10.6% (≡3,373) of all mainstream referrals in FY 21/22, however service provider and inter-agency stakeholders reported particular challenges with these pathways, including incomplete and inefficient referrals and communication breakdowns, suggesting scope for improvement in collaboration and coordination to support the client accessibility. SHS service providers cited examples of challenges contacting Corrections Officers, for example, resulting in clients being released into homelessness, as well as capacity constraints in the health sector, resulting in clients being released from hospital without adequate supports.

- Just under 5% (≡1,547) of all mainstream service provider referrals were received from the mental health sector in FY 21/22, a figure which has reduced slightly over time from 5.5% (≡1,402) in FY 16/17. This may reflect capacity constraints within the mental health sector, which has experienced increasing demand in recent years and subdued workforce growth.[125]

- The second most common referral pathway into SHS in FY 21/22 was self-referrals, which constituted 25.5% (≡10,777) of all formal referral sources in that year, however self-referrals were found to decrease over the course of the evaluation period, from 30% (≡18,797) in FY 16/17.

Formal sources of referral to SHS

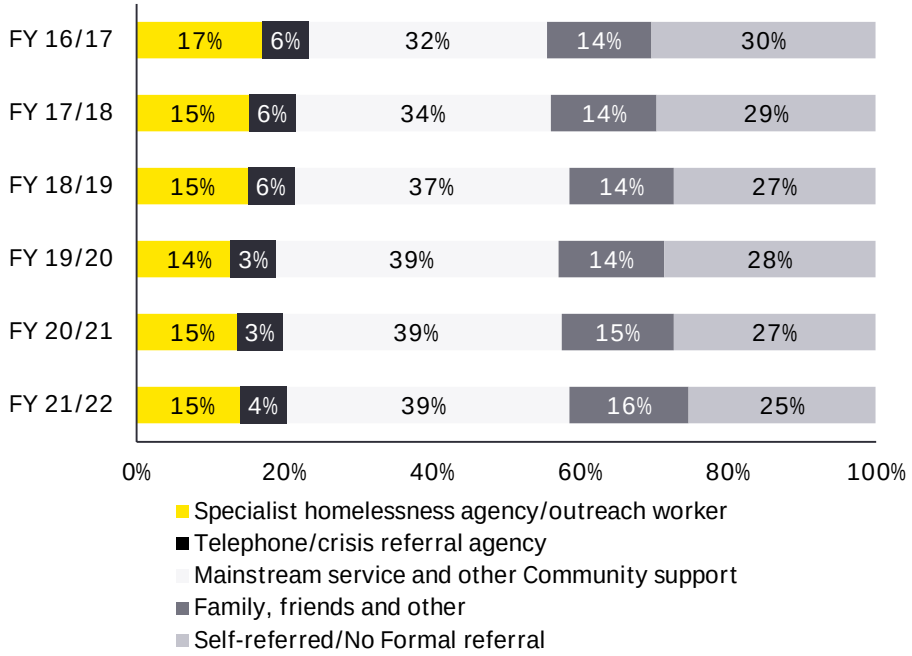
SHS clients interviewed reported accessing SHS support through a range of different means, including Link2Home, mental health services (such as Headspace), other SHS providers, DFV hotlines, word-of-mouth, parole and police officers, and Google, amongst other sources.

Figure 8 shows the proportion of formal sources of referral to SHS over the evaluation period, with the key sources being specialist homelessness agencies and/or outreach workers, telephone or crisis referral agencies, other mainstream services and community supports, family and friends, and self-referrals or no formal sources of referral.[126]

[125] Australian Institute of Health and Welfare. (n.d.). Mental health services activity monitoring: quarterly data. Retrieved from Mental health services activity monitoring - Mental health - AIHW; Ridoutt, L. (2021). Mental health workforce profile: community managed organisations report 2021. Human Capital Alliance. Retrieved from MHCC_WorkforceSurvey_2021.pdf.

[126] The formal sources of referral were categorised into five key categories. Mainstream services and community supports include the following referral response options: Centrelink or employment services; child protection agencies; family and child support agencies; hospitals; mental health services; disability support services; drug and alcohol services; aged care services; social housing (which includes Community Housing, Public Housing, State Owned and Managed Indigenous Housing and Indigenous Community Housing, as per the SHS Collection Manual); youth and juvenile justice correctional centres; adult correctional facilities; legal units; school and educational institutions; police; courts; immigration departments and refugee support services; family and domestic violence services (non-SHS); and other agencies. It should be noted that referral data from non-SHS DFV agencies have only been recorded since FY 19/20.

Figure 8: Formal sources of referral to SHS[127]



Source: NSW Homelessness Data (CIMS and equivalent systems)

During the evaluation period, the key referral pathways into SHS were other mainstream service providers, forming 39% of all formal referral sources in the most recent financial year, and self-referrals, which accounted for a quarter (25%) of all formal referral sources in the same year. The proportion of referrals from mainstream service providers increased by 7% during the evaluation period, whilst the proportion of self-referrals to SHS decreased by 5% during the same period.

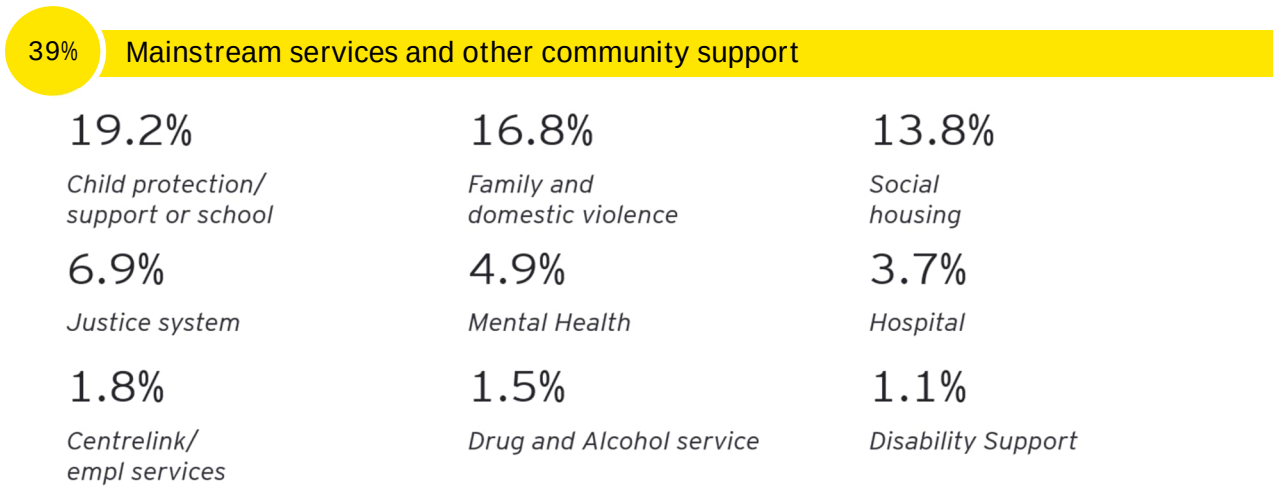
In contrast to the administrative data, many service providers shared that they had observed an increase in self-referrals. This observation from stakeholders varied depending on several factors, including location of services, the size of organisation, and whether the organisation had a visible presence or "shopfront" in the community. In more regional and rural areas, where services are more limited, self-referrals were reported by stakeholders to be common. This was reflected in the administrative data, whereby self-referrals or no formal sources of referrals represented 20% of all formal referral sources in metropolitan DCJ Districts, and 32% of all formal sources of referrals in regional and rural DCJ Districts across the evaluation period.

Referrals from mainstream services have increased over time, which appears to be largely driven by the addition of capturing formal referrals from non-SHS DFV services from FY 19/20 onwards. Whilst this data may have been captured previously and categorised differently (potentially under 'other agencies', which experienced a decrease of approximately 10% between FY 18/19 and FY 21/22), referrals from DFV services increased by 8% from FY 19/20 to FY 21/22.

Figure 9 presents a breakdown of the types of mainstream services and community supports referring to SHS in FY 21/22.

[127] Total cumulative proportions do not add up to 100% due to rounding.

Figure 9: Composition of mainstream services referring to SHS (FY 21/22)[128]



Source: NSW Homelessness Data (CIMS and equivalent systems)

Referrals from child protection services and schools

The number of children (aged <16 years) presenting to SHS increased substantially (by almost 10%) over the evaluation period, with every second child reported to have previously been issued with a Child Protection order and of those children, a significant majority (94%) were reported as at Risk of Significant Harm (ROSH) according to ChildStory data.[129] Referrals from child protection services and schools decreased over the same period by 7%.

Some stakeholders suggested that due to capacity constraints within the Department and OOHC policies, which aim to reduce the number of young people in OOHC[130], there has been increasing pressure on the education system to find the necessary support for young people at risk of homelessness, and on SHS services to support this cohort of clients.

Further highlighting the role of collaboration, service providers suggested a key role for school staff in supporting young people experiencing homelessness. For example, targeted youth service providers suggested that they were enabled to provide good outcomes for their clients when working collaboratively with stakeholders from the education system, emphasising the importance of service coordination in this context.

Referrals from family and domestic violence services

The proportion of SHS clients whose main reason for seeking assistance was due to DFV increased from 17.4% to 25.9% over the evaluation period, with DFV mainstream services referring increasing rates of clients to SHS over time, from 9.1% in FY 19/20 (the first year in which the data were collected) to 16.8% in FY 21/22. This trend is consistent with domestic violence-related assault

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[128] Figure 9 presents only the largest proportions of all referrals from mainstream services and other community supports, which accounts for a total of 69.7% of all mainstream services referrals. Mainstream services and other community supports excluded from the Figure 9 include aged care services, immigration department and refugee support services, and other agencies, and comprise 30.3% of all mainstream services referrals.

[129] The analysis drew upon ChildStory recorded historical Child Protection Orders and reflects the share of SHS clients (aged <16) who have ever been under a Child Protection Order and/or have been identified as at Risk of Significant Harm (ROSH). The statistic does not reflect the currently active Child Protection Orders. Based on the last reported information on Child Protection Orders, the most common reasons for Child Protection Orders are neglect, emotional, physical and sexual abuse (78%), at risk due to own behaviour (7%) and other (5%).

[130] Audit Office of New South Wales (2020). Their Futures Matter. Retrieved 13 June, 2023, from https://www.audit.nsw.gov.au/our-work/reports/their-futures-matter.

incidents recorded by the NSW Police Force, which rose 3% over five years to December 2022, noting the significantly higher growth in DFV-related SHS presentations over this period.[131]

It is likely that the proportion of referrals received from DFV agencies shown in Figure 9 does not reflect the true prevalence of SHS referrals related to DFV. Under-reporting of DFV is well-recognised and limits identification of the true rate of DFV-related SHS presentations, with many people experiencing violence reluctant to disclose this experience.[132] Alongside this under-reporting which limits the representative nature of the observed trends in DFV related presentations, anecdotal evidence from stakeholders highlighted that some women seeking support for DFV reasons were being advised by government services and agencies, including Centrelink and DCJ Housing, to refer themselves directly to SHS service providers, rather than through a DFV line or other DFV services, as there was a perception that *"they have a higher chance of a successful referral"* if self-referred.

Referrals from social housing providers

Social housing providers reported increasing referrals of their clients to SHS during the evaluation period, with referrals through this pathway increasing from approximately 10% in FY 16/17 to almost 14% in FY 21/22.[133] In focus groups, Community Housing Providers (CHPs) indicated that this may be due to a lack of exit pathways for existing tenants, whereby there is limited availability of permanent accommodation options for existing tenants at the end of their transitional housing period, and a reluctance from CHPs to transfer existing tenants to inappropriate housing lest that result in tenancy risk. This was perceived to result in limited ability to offer longer-term housing options to new clients.[134]

As of 30 June 2022, there were over 51,000 applicants listed on the NSW Housing Register, with over 6,500 priority applicants, and expected wait times for allocation of a suitable property exceeding 10 years in some suburbs for general applicants, with priority applicants with complex housing needs generally experiencing shorter wait times dependent upon an assessment of the urgency of their situation.[135] One CHP representative stated during consultations that, *"no homeless person will come into our office and leave without referrals to appropriate SHS and other services"*, representing the frequency of this SHS referral pathway. Consultations suggested that the increase in referrals from social housing providers to SHS over time is also reflective of social housing providers attempting to ensure that their clients are provided with additional wraparound supports in order to support tenancy sustainment.

Referrals from the justice and hospital systems

In the most recent financial year, over 1 in 10 mainstream service referrals originated from the justice system and hospital facilities. Service provider stakeholders reported experiencing frequent challenges with respect to the justice system and hospital referral pathways, including receiving referrals with minimal notice, incomplete details and/or after-hours referrals. Stakeholders shared their experiences of communication breakdowns with correctional services around the inmate's release date, resulting in inmates being released into homelessness. Lack of pre-release planning was found to be a potential risk for homelessness post-release, as well as a factor which might increase the likelihood of reoffending.[136] Further, stakeholders shared that capacity constraints in the health

[131] NSW Bureau of Crime Statistics and Research. (2018). Domestic & family violence in NSW, 2018-22. Retrieved from Microsoft PowerPoint - DV assault infographic - Police actions 2018-2022.pptx (nsw.gov.au).
[132] UNSW Australian Human Rights Institute. (2020). How frontline domestic and family violence workforce in Australia kept connected to their clients and each other through the pandemic. Retrieved from COVID DFV Report_V2.pdf (unsw.edu.au)
[133] Social housing" includes referrals from Community Housing, Public Housing, State Owned and Managed Indigenous Housing, and Indigenous Community Housing, as per the SHS Collection Manual.
[134] As per the SHS Program Specifications, accommodation in transitional housing should not extend beyond 18 months unless there is a clear time-limited exit strategy to more permanent accommodation and only a short bridging extension is required.
[135] DCJ. (2022). Expected waiting times. Retrieved from Expected waiting times | Family & Community Services (nsw.gov.au).
[136] Conroy, E. & Williams, M. (2017). Homelessness at transition: an evidence check rapid review, brokered by the Sax Institute for the NSW Family and Community Services, Sydney. Retrieved from Evidence check: homelessness at transition - November 2017 – full report (nsw.gov.au); Martin, C., Reeve, R., McCausland, R., Baldry., E., Burton, P., White, R. & Thomas, S. (2021). Exiting prison with complex support needs: the role of housing assistance, AHURI final report no. 361. Retrieved 7 September 2021, from https://www.ahuri.edu.au/research/final-reports/361.

sector has resulted in clients being released from the hospital without adequate supports, further increasing risk of homelessness.

Staff within Justice and Corrective Services reported facing issues of selection bias from SHS service providers when referring clients on bail. As described by one participant, *"providers are more likely to pick up a referral for a young person who had a fight with their parents, over a young person on bail",* and *"if I email a referral from a corrections email address, it feels like that alone blacklists the client".* Stakeholders suggested that improved relationships between service provider staff and staff at correctional and health facilities can support a stronger, more efficient referral pathway, highlighting that high staff turnover and inconsistency in these relationships can limit this and therefore impact the number and quality of referrals received.

Referrals from mental health services

In FY 21/22, clients referred by mainstream mental health services accounted for approximately 5% of mainstream referral sources, and 2% of all formal sources of referral in the same year. This may suggest limited awareness or an unwillingness of clients to access these services before seeking homelessness support. Referrals from mental health services as a proportion of all mainstream referral sources has reduced slightly, from 5.5% to 5.0% over the evaluation period. This may reflect capacity constraints within the mental health sector, which has experienced increasing demand in recent years and subdued workforce growth.[137] Further, this reduction may indicate a lack of awareness of SHS amongst mental health service providers, insufficient capacity of mental health service providers to facilitate effective referrals, or unclear referral pathways and/or channels of communication from mainstream mental health service providers to SHS.

During consultations, some service providers highlighted a lack of transparency in referrals from health and mental health services, with service providers reporting that the complexity of clients' mental health needs are often understated in referrals to increase the probability of achieving a successful referral.

SHS service providers reported that accepting clients with complex mental health needs on the basis of an inaccurate or incomplete referral can have a negative flow-on effect to other clients, as case managers may have to dedicate more time to the client with greater support needs, often to the detriment of the other clients within their caseload. Service providers also highlighted that acceptance of clients with complex mental health needs to services inadequately resourced to support these clients can pose a significant risk to the safety of other SHS clients and staff. Service providers felt that often SHS staff do not have the appropriate mental health training to support individuals with high mental health needs effectively.[138] Further analysis on the experience of service providers with managing clients with complex mental health conditions is provided in Section 5.2.3.

How accessible are services for the people who need them?

Key Findings

Service providers highlighted that one of the key barriers to access for SHS clients is limited resourcing within the sector relative to current levels of demand. A previous unpublished review procured by the Department in 2022 showed that the SHS Program served almost 9,000 more clients than budgeted in FY 20/21, resulting in services being 114% over-subscribed on average across the state.

[137] Australian Institute of Health and Welfare. (n.d.). Mental health services activity monitoring: quarterly data. Retrieved from Mental health services activity monitoring - Mental health - AIHW; Ridoutt, L. (2021). Mental health workforce profile: community managed organisations report 2021. Human Capital Alliance. Retrieved from MHCC_WorkforceSurvey_2021.pdf.

[138] The NSW SHS Program developed a Learning and Development Framework in consultation with service providers and Peak bodies. It includes face-to-face, online and in-house learning opportunities. Courses are fully subsidised by DCJ and although it is not clear whether these learning modules are compulsory, service providers are expected to ensure that they apply and maintain appropriate industry and professional standards relating to good practice in casework, as per the SHS Program Specifications. Learning modules include "Complex Needs in Homelessness", "Responding to mental health conditions", "Trauma and addictions", "Trauma informed practice (SHS)", "Impacts of trauma and loss and grief on adults", "Double whammy: co-occurring mental health and AOD disorders", and "Suicide and harm prevention", amongst others.

Key Findings

- SHS clients interviewed reported varying experiences in accessing SHS, particularly with respect to accommodation options. Some were able to obtain crisis or short-term accommodation soon after being referred, however many others reported needing to access TA or stay at a friend or relative's place of accommodation while they waited for SHS accommodation to become available. At the end of their SHS support period, many SHS clients interviewed shared that they were able to stay at the refuge beyond a three-month period, due to requiring longer-term support and reflective of limited suitable transitional or other longer-term accommodation options.

- Service provider stakeholders consulted for this Evaluation also discussed challenges in meeting demand, with many service providers reporting having long waitlists and needing to triage clients to provide support to those who are most vulnerable. Mainstream service providers and inter-agency representatives reported experiencing frequent delays with referrals and intakes which they attributed to high demand relative to service availability.

- Stakeholders suggested that service accessibility was inhibited by limited appropriate accommodation options, as evidenced by the proportion of met need for short-, medium- and long-term accommodation services in FY 21/22, which were 30.4% (≡5,100), 20.8% (≡2,354) and 1.7% (≡331) respectively.[139] Unmet demand analysis across a range of services is detailed further in Section 5.2.2.

Lack of capacity in the sector

One of the most frequently cited barriers to accessing SHS services was limited resourcing relative to current levels of demand. A previous unpublished review procured by the Department found that the SHS Program served almost 9,000 more clients than budgeted in FY 20/21, resulting in services being 114% over-subscribed on average across the state.[140] State-wide, it was found that the SHS Program was over-subscribed with average utilisation of services at 114%.[141]

Service providers highlighted the gravity of this challenge, with many reporting long waitlists and needing to triage clients in order to provide support to those who were most vulnerable. The implementation of innovative intake models as a means to manage capacity is further detailed on page 79.

Mainstream service providers and inter-agency representatives reported experiencing frequent delays with respect to referrals, and SHS intake teams being "overstretched", noting that not all SHS service providers have a dedicated person or team responsible for intake. DCJ Housing stakeholders also reported difficulties with successfully referring clients, due to service providers operating well over capacity, stating that they would refrain from completing a referral to SHS where they were aware of capacity issues, in an attempt to lessen the administrative burden on service providers and allow them to focus on the provision of client support.

Despite a lack of capacity, as evidenced by both administrative data and consultations with service providers, the majority of SHS clients interviewed reported that they accessed services fairly rapidly upon referral, often providing examples of flexible and responsive SHS intake practice. Additional analysis of SHS provision of client-centred approaches to service delivery is provided in Section 5.2.3.

Sector resourcing and capacity issues were reported to result in a prioritisation of the provision of resource-intensive crisis responses and supporting clients with complex needs, rather than a focus

[139] Long-term housing, as defined in the SHS Collection Manual (2019), includes public housing, private rental accommodation, community housing or owner-occupied housing provided or paid for by an SHS service provider.
[140] Met demand for the same services exceeded 31,000 service requests.
[141] This review commissioned by the Department was for internal use only and not released publicly.

on addressing the underlying drivers of homelessness, and providing early intervention and prevention supports. Some SHS clients interviewed also highlighted a perception that limited capacity at SHS providers may be resulting in prioritisation of clients with more complex needs at the expense of other clients.

"[Caseworker name] was good but she had so much stuff going on, it took her a long time to start working with me. She was spread too thin, it happened a lot that the workers would forget about the quieter kids" – SHS client

Resourcing and capacity issues were reported to be driven by lack of appropriate exit pathways, restricting the ability of SHS clients to exit services into safe and stable housing. The availability of exit pathways is largely influenced by the broader context in which SHS operates, with chronic shortages of affordable accommodation options being cited as a key contributor to return to services. The housing outcomes and contextual factors impacting housing affordability are explored in further detail in Section 5.3.1.

Limited appropriate SHS accommodation options

Figure 10 depicts the degree of met need amongst SHS clients for short-, medium-, and long-term accommodation services in FY 21/22.

Figure 10: SHS client accommodation needs met (FY 21/22)

Source: NSW Homelessness Data (CIMS and equivalent systems)

The short-, medium- and long-term accommodation needs of SHS clients are often unmet; almost a third (30.4%) of SHS clients had their short-term accommodation needs met in FY 21/22, just over 1 in 5 (20.8%) had their medium-term accommodation needs met in FY 21/22 and 1.7% of SHS clients had their long-term accommodation needs met in the same year.

Stakeholders attributed unmet demand to a variety of factors, including relatively low levels of accommodation availability generally, alongside perceived impacts of policy changes, including, but not limited to, the introduction of the 'No Wrong Door' approach and OOHC policy which aims to reduce children in OOHC, including the *Their Futures Matter* reform.[142] Stakeholders cited these policy changes as increasing pressure on the SHS sector to provide support to young people and adults referred to their services, irrespective of current capacity, despite this not being the intended purposes of the policies. According to AIHW data, the number of children in OOHC in NSW decreased by 12% between FY 17/18 and FY 21/22, however, the number of SHS clients decreased by 8.5% over the same period and there was no direct quantitative evidence to correlate these trends with policy reforms in OOHC and SHS.[143]

The availability of affordable housing options was cited consistently by stakeholders as a key driver of challenges in meeting SHS client need, with a range of challenges in transitioning clients from shorter-term supports being reported by stakeholders; namely, limited longer-term exit options resulting in SHS providers supporting their clients to stay in shorter-term refuge-type accommodation for periods greater than three months , which was perceived to be impacting contractual Key Performance Indicators (KPIs).

[142] Audit Office of New South Wales (2020). Their Futures Matter. Retrieved 13 June, 2023, from https://www.audit.nsw.gov.au/our-work/reports/their-futures-matter.

[143] AIHW (2023) Child protection Australia 2021-22. Retrieved from https://www.aihw.gov.au/reports/child-protection/child-protection-australia-2021-22/data

"As long as you do the right thing, they [the service provider] will extend your stay" – SHS client

Challenges in securing accommodation were highlighted in client interviews, including description of situations in which Link2Home could not link the client with any suitable medium-term accommodation options. In the case of one client interviewed, they were able to obtain medium-term accommodation in a different District, reflecting differential accommodation availability and intense demand in some geographic areas. Some clients interviewed were able to obtain crisis or short-term accommodation quite rapidly after referral, however many others reported needing to access TA or stay at a friend or relative's place to bridge the gap as they waited for SHS accommodation to become available.

"When I called [the service provider] the first time, they really wanted to help me, but they didn't have accommodation for us. The woman [from the service provider] knew I was staying at my friend's place, but she had other more urgent cases who had no accommodation whatsoever" - SHS client

Access to accommodation options for SHS clients appears to be further inhibited by the limited availability of appropriate accommodation options to meet the needs of specific cohorts, including single men or single fathers with children, and clients with complex mental health conditions and/or a history of violence, including those that have been 'blacklisted' from other services. A recent Ombudsman report found that service provider approaches to access, exclusion, eviction and withdrawal of services (essentially banning or blacklisting clients) was applied inconsistently, with each service provider having the ability to determine the degree of risk it is willing to accept with respect to clients with more complex needs.[144]

This may be resulting in certain cohorts of clients being "locked out" of the SHS system entirely, which is supported by consultative evidence gathered in the Evaluation, for example in regard to referrals from the justice system, as detailed on page 76. Additionally, service providers reported challenges providing suitable accommodation options to larger families of 6+ people and noted the specific challenges of housing larger families in shared-space accommodation, particularly those with teenage children.

"I had to call too many refuges to count before getting accepted, I received rejection after rejection due to my mental health issues. It was very stressful not knowing where I was going to go next." – SHS client

What are the strengths and barriers for clients accessing SHS and what improvements can be made?

Key Findings

Accessibility of services was found to be dependent on the quality of referrals made and service provider capacity to accept referrals, however service providers reported that client access is generally supported by efficient intake models and collaboration with other key stakeholders.

- Many service providers discussed the implementation of self-funded innovative intake models, complemented by fostering collaborative relationships with Community Housing Providers (CHPs) and inter-agency representatives to better meet SHS client needs for accommodation.
- Some SHS clients interviewed for this Evaluation reported challenges in accessing refuge-style accommodation immediately, resulting in uncertainty and safety concerns for some. Some clients also cited transportation as a key enabler of access to SHS; a minority of clients interviewed received transportation support from their SHS service provider to access accommodation and also broader supports during their SHS support period, such as medical appointments.

[144] NSW Ombudsman. (2022). Specialist homelessness services: helping people with high or complex needs. Retrieved from Specialist homelessness services: helping people with high or complex needs (nsw.gov.au).

Quality of referrals

The importance of the provision of accurate and comprehensive information when referring clients to services was a consistent theme emerging from consultations. Information sharing across the sector and in the broader service system was perceived to be a barrier to addressing homelessness and meeting the needs of clients by a range of SHS and inter-agency stakeholders, at the referral stage, in addition to when providing ongoing support to clients.

Service providers reported frequently receiving inappropriate referrals from Link2Home and inter-agency services. Limited availability of information and lack of transparency in referrals from Link2Home was often reported to result in inappropriate referrals to their services, transferring the onus to conduct a more comprehensive assessment and the responsibility to locate accommodation from Link2Home to the service provider.

Some smaller service providers noted that increased time spent processing and responding to referrals, particularly inappropriate referrals, directly correlates with decreased time spent providing support to clients. Qualitative evidence also suggests that inter-agency stakeholders would benefit from improved access to current information on the nature of supports provided by each SHS service, in addition to vacancies, to support with making appropriate and timely referrals to services.

Health stakeholders and SHS service providers mutually identified issues with the mental health referrals process to SHS services. One service provider also noted that withholding of information in referrals from mental health services and Child Protection has prevented SHS providers from conducting an accurate risk assessment prior to accepting a client.

Referral quality was also reported to negatively impact the ability of service providers to provide client-centred support, with inappropriate referrals being associated with clients being transferred from service-to-service and an inability to rapidly take in new clients, as well as delaying the provision of supports to existing clients. In group settings, including crisis accommodation services, the presence of clients that were inappropriately referred was reportedly triggering to other clients and placed their safety at risk.

For the most part, SHS clients interviewed for the Evaluation reported that they accessed SHS support almost immediately after referral, with limited waiting periods. The Evaluation Team recognises the influence of selection bias in the perspectives shared by interviewed SHS clients, which is further detailed in Section 3.9. Some clients indicated that crisis accommodation service providers were not able to provide immediate support i.e., on the day of referral, with clients being asked whether they had somewhere safe to stay for the period of time in which they expected a bed would become available, at times posing safety and wellbeing risks.

"I was able to find [accommodation at] a friend's house, but it would have been a really horrible situation if I didn't have anywhere to stay that weekend". – SHS client

Innovative intake models

To manage the volume of referrals received, service providers reported having implemented triage-based intake models to ensure people with the most acute needs are being provided with rapid responses. A number of service providers also noted the importance of hiring an experienced intake worker/s, with the skills to triage clients appropriately.

The observed triage approaches generally focused on enabling priority access for particular cohorts of people experiencing homelessness. For example, one service provider that had implemented such a model indicated that service priority is given to those with the most acute needs, including people experiencing DFV, people with complex mental health needs, people sleeping rough, and young people, whilst the remainder of people referred are provided with resources and asked to return to the service if there are any changes to their personal circumstances.

Despite the perceived effectiveness of these models to prioritise access to SHS resources to those most in need, such models were not implemented in all settings. Service providers reported relying on funding sources beyond those provided for SHS to hire intake workers. Smaller service providers suggested that whilst they felt their service would benefit from such intake roles, to employ intake workers would result in the transfer of resources away from case management.

Provision of transportation

Provision of transportation by service providers to SHS clients was commonly cited as enabling access to SHS support, particularly for those clients who needed to travel some distance from their initial location to receive accommodation, as well as clients with children and those fleeing situations of DFV with their belongings. One SHS client recounted the support she received from her service provider, who picked her and her children up and supported them all to transport their belongings to their new accommodation at the service provider's accommodation. Another SHS client suggested that his service provider significantly assisted him through the provision of financial support, such as fuel vouchers, to cover the costs of travelling between various services.

For those clients who lacked transportation options, access to SHS and TA was perceived to be noticeably more challenging.

"You can only take what you can carry with you. I got sent to [location], which is about 45 minutes away and I had no car" – SHS client

How effective is Link2Home at connecting people to the services they need?

Key Findings

The uptake in use of Link2Home as a coordinated entry point into SHS services was limited and varied significantly by region, with stakeholders highlighting that there was scope to streamline the assessment and referral process.

- In FY 21/22, 4% (≡1,639) of formal referrals into SHS services were from telephone or other crisis referral agencies, and of these, 38.5% (≡490) of clients were referred by Link2Home.[145]
- The service was found to be more commonly utilised in metropolitan or more populated regional areas, and frequently used to access TA.
- A perceived degree of mistrust and communication breakdowns between service providers and Link2Home was reported by stakeholders to create tension, duplication and inefficiency in the referral process, with many stakeholders involved in the referral process citing inconsistencies in and scope for refinement in the assessment and referral process.

Link2Home

Link2Home is a state-wide information and referral telephone service, which operates 24 hours a day, seven days a week.[146] From 9am to 10pm daily, Link2Home provides people who call the service with information, assessments and referrals to homelessness support and accommodation services across NSW.[147] Between 10pm and 9am, Link2Home provides information and assessment only and will refer people to emergency services if required.[148]

In FY 21/22, 4% of formal referrals into SHS services were from telephone or other crisis referral agencies, and of these, almost two in five (38.5%) clients were referred by the Link2Home service to

[145] The methodology for the linkage between the CIMS and equivalent systems and the Link2Home data collection is described in Section 3.7.2 and assumptions and additional linkage considerations listed in the Data Decision Register in Appendix 1.

[146] NSW Government Department of Communities & Justice (2023). Are you homeless? Retrieved from https://www.facs.nsw.gov.au/housing/help/ways/are-you-homeless

[147] Ibid.

[148] Ibid.

SHS, with the remainder being referred from other telephone and crisis referral agencies.[149] Referrals from Link2Home increased by more than 9% during the evaluation period, up to 38.5% of telephone and other crisis agency referrals in FY 21/22.

The uptake of Link2Home referrals varied across locations. Link2Home was reported to be more commonly used in metropolitan areas or more populated regional areas, which appeared to be driven, in large part, by the capacity of service providers to accept referrals. The administrative data also reflected this trend, with metropolitan DCJ Districts having a slightly higher proportion of telephone and crisis agency referrals (7%) compared to regional and rural DCJ districts (4%). Table 9 presents the breakdown of referrals by Link2Home compared to all other referrals. Of over 3,000 referrals made by Link2Home the majority of these referrals (62%) were accepted by SHS providers located in metropolitan areas.

Link2Home was commonly used to access Temporary Accommodation in the first instance, with the data suggesting that approximately every second person who accessed SHS through Link2Home also accessed TA; accordingly, in regional and remote locations where there was limited TA availability, uptake of Link2Home as a referral source was also reported to be more limited.

Table 9: Referrals to Link2Home by region

Referred by Link2Home	DCJ District where the service provider is located	
	Metro area	Regional or rural area
Yes	62%	38%
No	53%	47%

Source: NSW Homelessness Data (CIMS and equivalent systems)

Service providers expressed a level of inconsistency when engaging with Link2Home. From their perspective, Link2Home referrals did not always appear to involve a comprehensive assessment to identify individual needs and referral appropriateness thus impacting service provider capacity. Some service providers suggested that the appropriateness of the referral is driven by the skill and experience of the Link2Home staff member, stating that *"it takes a skilled interviewer from Link2Home to get the right information"*, yet also recognising that it is challenging for interviewers to pick up certain non-verbal cues and discern full client information over the phone.

The Link2Home assessment involves up to 36 questions asked of the caller in a conversational way to understand the purpose of the call, immediate needs of the caller and their eligibility to access Link2Home support. According to Link2Home staff, this assessment process can take anywhere between 20 to 40 minutes depending on the level of engagement from the client. Link2Home staff shared their belief that this assessment process would benefit from updating, as it has not changed since Link2Home was established.

"Often TA and Link2Home are not making referrals for clients. They are providing numbers to clients for inappropriate services. This results in the SHS provider having to respond with a NWD [No Wrong Door] response, impacting on time, capacity and also forcing clients to repeat their story." – SHS service provider

A review of Link2Home assessment questions is underway by Link2Home staff in collaboration with service providers, with the objective to exclude questions that capture only binary details and include more critical and immediate risk questions. Service providers reported being asked for their feedback

[149] Other telephone and crisis referral agencies may include organisations such as Lifeline and MensLine Australia, for example.

throughout this review process, with some sharing their views that Link2Home referrals are currently not trauma-informed and responsive to client needs.

Link2Home staff suggested that there can be duplication in the assessment and referral process, with clients having to respond to similar questions when they call Link2Home and again once they have been referred to the service provider. This highlights an opportunity for the implementation of a more streamlined information-sharing process to better support trauma-informed client experiences.

Some service providers expressed a degree of mistrust or scepticism related to the Link2Home service, perceiving that Link2Home staff do not comprehensively review information on the service offering or cohorts served by the service providers, nor their vacancies, before making a referral. Due to the 'No Wrong Door' approach, this was reported to increase pressure on service providers to find an alternative, more appropriate service for the client that has been referred to them through Link2Home. It should be noted that service providers are contractually obliged to regularly update the Vacancy Management System (VMS); where this is not the case, Link2Home staff report being required to follow up with service providers to confirm the currency of the data in the system.

From a Link2Home perspective on this issue, staff reported a potential need for greater training amongst SHS service providers who are tasked with accepting the Link2Home referral, stating that at times referrals are accepted without the requisite expertise or knowledge of vacancies to do so, and this can result in service providers sending referrals back to Link2Home. They also suggested that a dedicated intake person at the service provider would support a more efficient process, as well as service providers ensuring that the VMS is updated regularly, taking into account vacancies, services provided, and target cohorts.

From an SHS client perspective, feedback on Link2Home was mixed. Many SHS clients in metropolitan locations reported their first engagement with Link2Home and accessing TA as positive, largely due to the speed with which they were provided with accommodation. In contrast, individuals in regional and rural areas reported having less positive experiences with Link2Home, often due to limited availability of accommodation in their local area. Some indicated that they were requested to travel significant distances without a car, minimal public transport options and with children, in order to access TA or other SHS supports as referred by Link2Home.

It is understood from DCJ Housing staff that there is significant investment in both systems and staff time, in terms of training and resourcing, to facilitate referrals from Link2Home to SHS providers. However, the low rates of referral and inconsistent experiences with the Link2Home service suggest that, in addition to the current work being undertaken to refine the Link2Home assessment process, further investigation into the efficacy of this referral pathway may be required.

How does Temporary Accommodation feature in the pathways people take to access SHS?

Key Findings

Over the evaluation period, 20% of all SHS clients accessed TA at some point during their support period, however the availability of TA was reported to vary by region, impacting its role as a pathway into SHS in those regions.

- Limited accommodation and transportation options were reported to impact provision of TA, particularly in rural and remote areas of NSW, with some SHS service providers reporting having established partnerships with CHPs and local accommodation providers to support delivery of accommodation services.

- SHS client experiences were mixed with respect to TA support. Whilst many expressed an appreciation for the availability of the accommodation option and described the accommodation as of an adequate standard, many also reported experiencing uncertainty in

Key Findings

receiving TA support for longer than a few days, accommodation options being unsuitable or unsanitary, or even completely unavailable.

Temporary Accommodation (TA) is described, according to the SHS Program Requirements, as a "small number of nights of accommodation" funded by DCJ Housing and provided to a person if they can demonstrate that they have nowhere safe to stay for the night or are experiencing homelessness. TA may be provided in low-cost motels, caravan parks or other supported accommodation options. It is a condition of this support that clients are actively looking for other short- or long-term accommodation options. Eligible persons are entitled to 28 days of TA annually. In some instances, SHS providers assisted people to access TA by calling Link2Home or working with their local DCJ Housing office.

Similar to the analysis sample for SHS clients, the analysis sample for TA was based on the first observable interaction with TA. Analysis of the administrative data suggests that, over the evaluation period, 20% of SHS clients had accessed TA at some point during their SHS support period, for an average length of stay of 3.13 days.[150] Roughly half of SHS clients accessed TA before SHS support and the other half received TA at some point during or after their SHS support period. Over the evaluation period, the median time to access TA for clients who initially engaged with SHS was 7 days from when their SHS support period commenced. Approximately one in four people engaged with both TA and SHS on the same day, presenting some challenges in determining which service was accessed first.

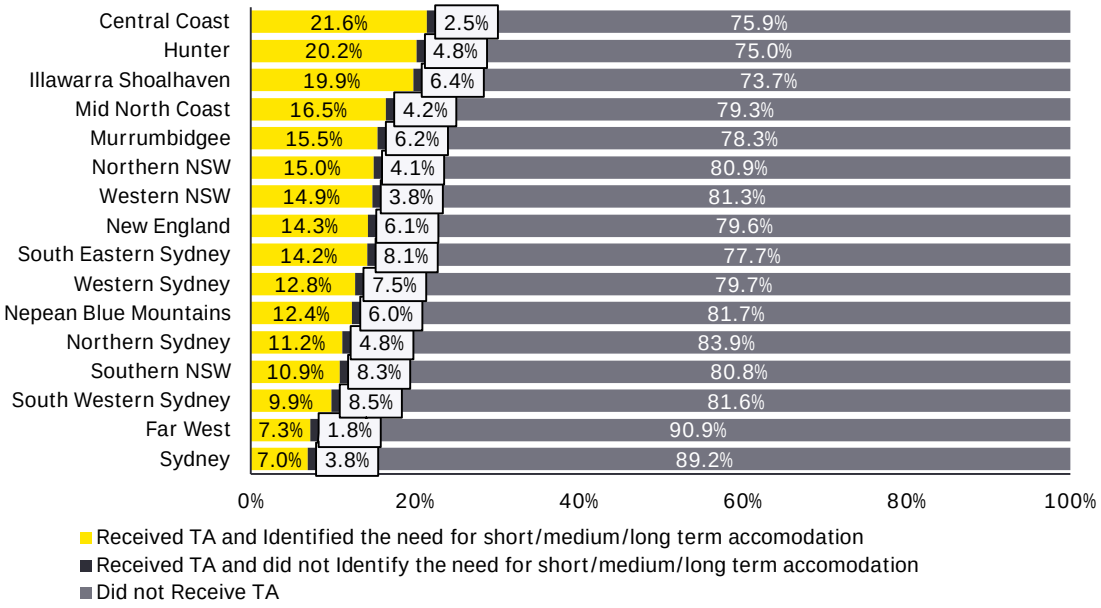
Almost 16% of SHS clients who had accessed TA did so for reasons related to DFV. Link2Home staff shared that although there is no formal prioritisation process in place in terms of linking clients who call Link2Home into supports, informally, they may prioritise DFV clients seeking TA support who have immediate safety concerns.

Figure 11 presents the percentage of clients who have received TA by DCJ District over the evaluation period.[151]

[150] Please note that the analysis only considers an SHS client's first interaction with TA, recognising that TA can be extended and that extensions may be recorded as a separate instance in the administrative data. The analysis sample of SHS clients' first interactions was linked with HOMES TA data using the unique client identifier SLK. Similar to the analysis sample of SHS clients, findings related to TA rely on the SHS client's first interaction with TA.

[151] In this instance, the DCJ District refers to the DCJ District in which the SHS client requested support with accommodation. It is possible that the SHS client received access to TA in a different DCJ District than that which accommodation support was initially requested.

Figure 11: Percentage of SHS clients that requested accommodation and received Temporary Accommodation by DCJ District FY 16/17 to FY 21/22



Source: NSW Homelessness Data (CIMS and equivalent systems)

There was significant variability in the proportion of clients who request an accommodation service and receive access to TA by DCJ District, with 9% of SHS clients receiving TA in the Far West District, and 26% of clients receiving TA in the Illawarra Shoalhaven District. Availability of TA and its role in pathways to SHS varied by geographic location. Service providers reported limited TA options in some rural and remote areas in the Western NSW and Far West DCJ Districts, and highlighted the barriers to accessing TA, primarily due to the limited provision of support to clients to travel to TA providers or between TA providers. The utilisation of TA in Far West NSW in Figure 11 is illustrative of these barriers.

Stakeholders also reported challenges accessing TA during holiday periods, particularly in regional and rural towns frequented by tourists, as motels that may typically accommodate TA clients can be completely occupied by tourists.

"Sometimes all hotels are booked out in Broken Hill and then you're having to look at TA in Adelaide." – SHS service provider

In areas with limited or no TA options, service providers shared that they have sought to establish relationships with local accommodation providers and work directly with them to provide TA support to people experiencing, or who are at risk of homelessness, rather than the accommodation providers working directly with DCJ under a formal TA contract. Service providers perceived that local accommodation providers may be more likely to work with SHS providers rather than DCJ, and highlighted the importance of establishing trust, achieved through prioritising ongoing communication, and supporting TA providers to address any issues with clients, or repair damage caused by clients.

SHS clients interviewed that accessed TA in their journey highlighted the uncertainties associated with relying on TA, including the requirement to pack their belongings and exit TA facilities in order to receive their next TA allocation. Clients with families staying in TA noted the disruption caused by staying in TA, particularly for families with school-aged children.

"I would send my sons to school, but wouldn't know where we were going that afternoon, or where we would sleep that night." – SHS client

Stakeholders highlighted the variance in the quality of TA options, with some accommodation options being described as of a high standard and meeting the immediate needs of clients, and other options unsanitary or inappropriate for the size of the family staying in the accommodation, impacting clients' sense of security and safety. Stakeholders also noted challenges in demonstrating that they met the eligibility requirements for accessing TA, specifically providing supporting evidence that the client was actively seeking private rentals, where real estate agents declined to validate this unless the client submitted a formal application for the property.

5.2.2 SHS current and emerging cohorts

Over the evaluation period a total of 272,577 unique clients accessed SHS. Further analysis of the total SHS cohort across the evaluation period has been conducted to analyse any cohorts and/or client characteristics which have increased or decreased over time. It should be noted that, for the purposes of this evaluation question, the term "emerging" should be understood as growing or increasing over time relative to other cohorts. From the analysis of administrative data, a number of client cohorts were identified to be growing over the evaluation period, however, there were no completely new cohorts identified.

What are the cohorts and characteristics of people who need SHS, including any emerging cohorts?

Key Findings

For the purposes of this sub-evaluation question, "emerging" should be understood as growing or increasing over time. The administrative data identified single fathers, clients experiencing family violence (both children and adults) and females seeking assistance for DFV and relationship breakdowns as growing cohorts over the evaluation period.

- Over half (56.4% ≡153,733) of SHS clients identified as female, over one third (33.24% ≡ 90,615) of SHS clients were single parents with children, and over a quarter (27.6% ≡ 75,231) were children under the age of 16. One quarter (25.01% ≡68,162) identified as Aboriginal and/or Torres Strait Islander. Almost a quarter (24.5% ≡66,781) self-reported having a mental health condition,[152] and 32% (≡87,225) of SHS clients sought assistance for DFV and relationship breakdown.[153]

- Female clients whose main reason for seeking assistance was DFV and relationship breakdown increased from approximately 18% (≡27,672) to 22% (≡33,821) over the evaluation period.

- Children aged 12-15 years were also more likely to seek support from SHS to access services for DFV and relationship breakdown, with 39% (≡7,726 of 19,811) of this cohort citing this as the main reason for presentation, compared with over 31% (≡78,357 of 252,766) for other SHS clients.[154] Presentations amongst this cohort for support to access services for DFV increased by 5% (≡41) over the evaluation period, highlighting the need to tailor early intervention supports for this vulnerable cohort.

[152] This variable refers to clients with a self-reported diagnosed mental health condition; hence the percentage of clients in this cohort may appear low when compared to AIHW counts, which uses additional criteria and was approximately 40% in FY 21/22.

[153] For the purposes of the analysis contained within this Report, the Domestic and Family Violence (DFV) and relationship breakdown category includes the following reported main reasons for assistance: Domestic and family violence (71%); Relationship/family breakdown (23%); Time out from family/other situation (4%); Sexual abuse (<1%); and Non-family violence (1%). A range of related reasons for seeking assistance are reported within DFV and relationship breakdown category to account for likely under-reporting of DFV.
Estimates indicate that only up to 40% of domestic violence incidents are reported: Morgan A & Chadwick H 2009. Key issues in domestic violence. Research in practice no. 7. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/rip/rip7

[154] Approximately 42% of children aged 12-15 presented unaccompanied. The main reason for seeking assistance for those children who were accompanied may reflect the circumstances of a parent or a guardian.

Key Findings

- Single fathers increased as a proportion of the total SHS population by approximately 2 percentage points (≡5,972 of 62,910 in FY 16/17 to 5,064 of 42,269 in FY 21/22). Over the evaluation period, two thirds of single parents who presented for support identified as single mothers (≡61,209) and one third as single fathers (≡28,937). Service providers reported experiencing challenges in accommodating parents with children, particularly larger families.

- Administrative data indicates an increase in the proportion of unique clients presenting with a self-reported diagnosed mental health condition from just over 24% (≡15,115) in FY 16/17 to almost 26% (≡10,982) in FY 21/22.[155] Service providers suggested that they are witnessing an increase in presenting clients who have mental health conditions, whether diagnosed or undiagnosed, which is presenting a challenge for them in the provision of support to access appropriate trauma-informed and clinical supports.

The administrative data identified single fathers, clients experiencing family violence (both children and adults), and all females seeking assistance for DFV and relationship breakdown as growing cohorts across the evaluation period.[156]

In terms of decreasing or "narrowing" cohorts over time, analysis of the administrative data identified clients from the cohorts listed below. Additional analysis on these cohorts can be found in Appendix 4.

- People living with a disability decreased from 6.2% (≡3,881) in FY 16/17 to 5.2% (≡2,209) in FY 21/22 of total clients accessing SHS;

- Young people aged 16-24 who had been sleeping rough in the last month before accessing SHS support decreased from 4.6% (≡2,874) in FY 16/17 to 3.5% (≡1,483) in FY 21/22 as a proportion of clients accessing SHS;

- Adults aged 25-44 years who had been sleeping rough in the last month before accessing SHS support decreased from 6.2% (≡3,869) in FY 16/17 to 5.0% (≡2,091) in FY 21/22 as a proportion of clients accessing SHS; and

- Young people aged 16-24 years decreased from 23.3% (≡14,685) in FY 16/17 to 20.3% (≡8,593) in FY 21/22 as a proportion of clients accessing SHS.

In addition, analysis has been conducted to explore trends in presentations of other key cohorts, including children aged 12-15 years (both male and female, accompanied and unaccompanied), Aboriginal and Torres Strait Islander clients, clients with increasingly complex needs, for example mental health conditions (as self-reported to SHS upon intake), clients born overseas, and people being locked out of the rental market.

[155] This variable refers to clients with a self-reported diagnosed mental health condition; hence the percentage of clients in this cohort may appear low when compared to AIHW counts, which uses additional criteria and was approximately 40% in FY 21/22.

[156] For the purposes of the analysis contained within this Report, the Domestic and Family Violence (DFV) and relationship breakdown category includes the following reported main reasons for assistance: Domestic and family violence (71%); Relationship/family breakdown (23%); Time out from family/other situation (4%); Sexual abuse (<1%); and Non-family violence (1%). A range of related reasons for seeking assistance are reported within the DFV and relationship breakdown category to account for likely under-reporting of DFV.
Estimates indicate that only up to 40% of domestic violence incidents are reported: Morgan A & Chadwick H 2009. Key issues in domestic violence. Research in practice no. 7. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/rip/rip7.

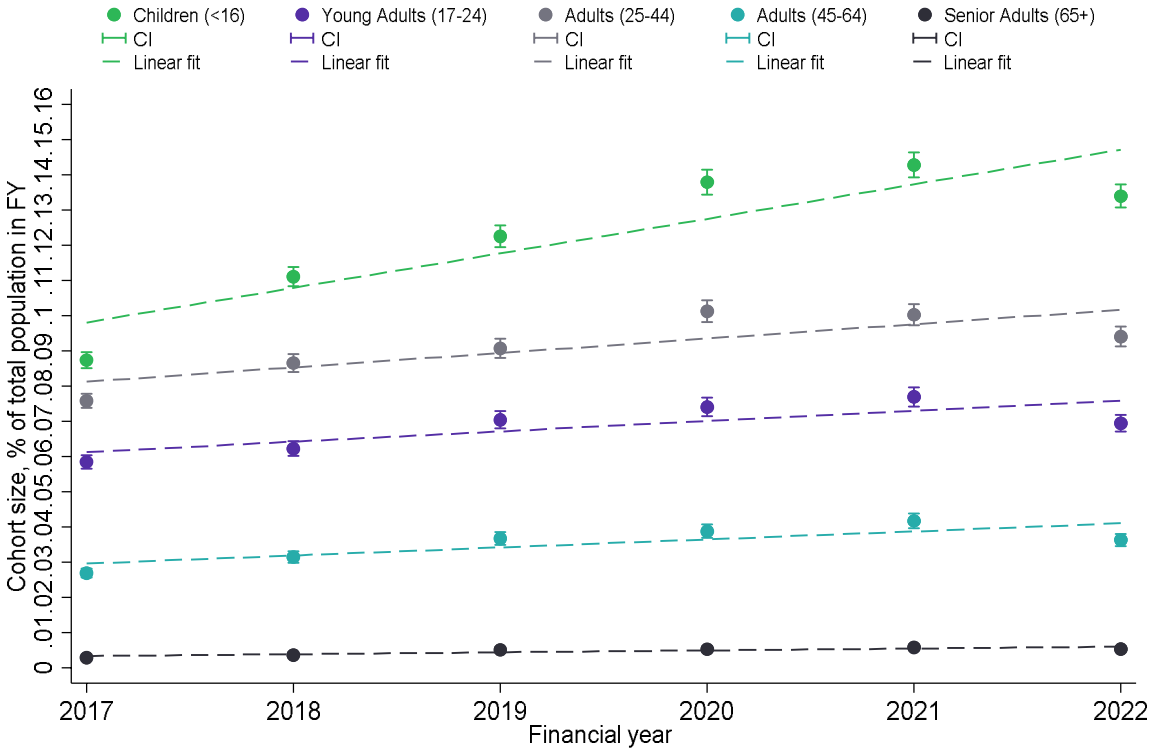
Emerging cohorts

Domestic and family violence

DFV is a key driver of risk of homelessness for women and children in Australia, with those who have experienced DFV making up 42% of SHS clients nationally in FY 21/22.[157] Accordingly, women and children affected by DFV are a national priority cohort in the NHHA.[158]

Figure 12 presents trends in SHS client presentations for clients whose main reason for seeking assistance was DFV and relationship breakdown by age group – children under the age of 16 years, young adults aged 16-24 years, adults aged 25-44 years and 45-64 years, and senior adults aged 65+ years. Trends amongst adults have only slightly increased over the evaluation period, however noticeable increases can be seen for children (green).

Figure 12: Trends in the main reason for seeking assistance for DFV and relationship breakdown by age groups



Source: NSW Homelessness Data (CIMS and equivalent systems)

Presentations for DFV and relationship breakdown amongst children under the age of 16 years increased by approximately 4% over the evaluation period.

[157] Australian Housing and Urban Research Institute. (2022). *Housing, homelessness and domestic violence*. Retrieved from https://www.ahuri.edu.au/analysis/brief/housing-homelessness-and-domestic-and-family-violence. It should be noted that the AIHW definitions of domestic violence and family violence differ slightly to the Domestic and Family Violence (DFV) and relationship breakdown category main reasons for seeking assistance used for the analysis contained within this Report, however this statistic is intended to provide context on the prevalence of DFV experiences in Australia. The AIHW definition of domestic violence is "A set of violent or intimidating behaviours usually perpetrated by current or former intimate partners, where a partner aims to exert power and control over the other, through fear. Domestic violence can include physical violence, sexual violence, emotional abuse and psychological abuse". The AIHW definition of family violence is "Violent or intimidating behaviours against a person, perpetrated by a family member including a current or previous spouse or domestic partner… It encompasses the broad range of extended family and kinship relationships in which violence may occur". Australian Institute of Health and Welfare. (2019). *Glossary*. Retrieved from https://www.aihw.gov.au/reports-data/behaviours-risk-factors/domestic-violence/glossary

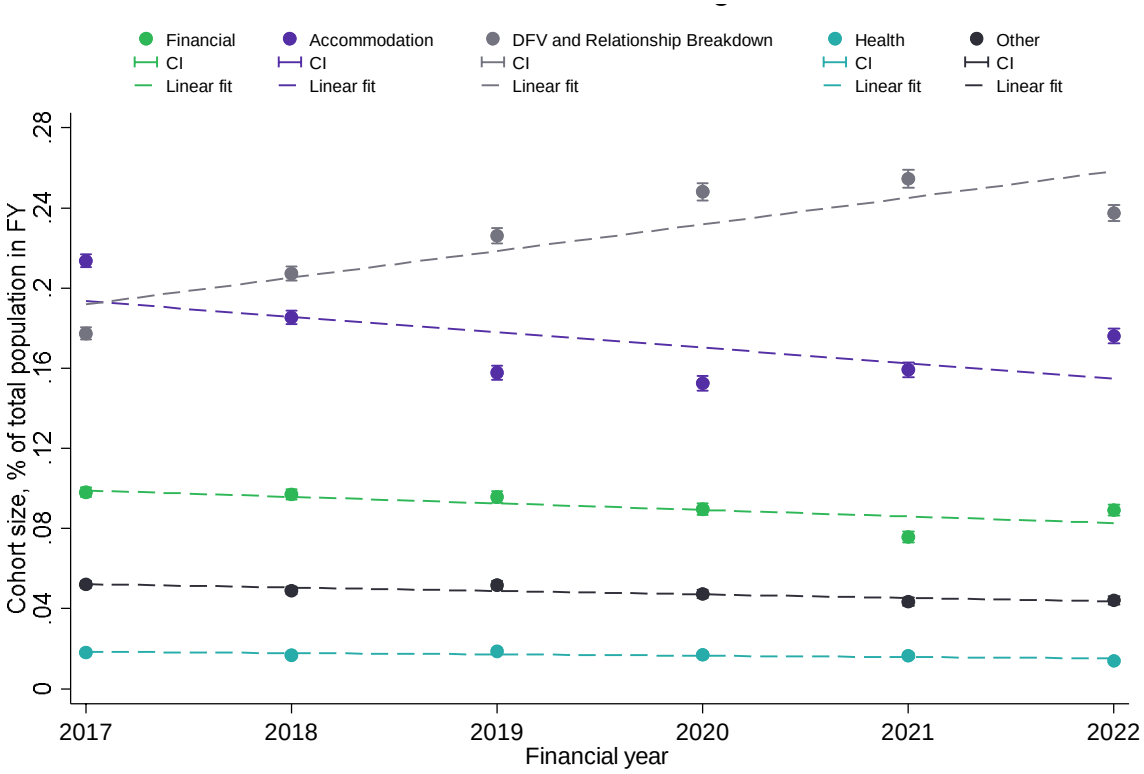
[158] Australian Institute of Health and Welfare. (2022). *Specialist Homelessness Services Annual Report 2021-22*. Retrieved from https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/clients-who-have-experienced-family-and-domestic-violence.

For adults aged 25-44 years, presentations for DFV and relationship breakdowns peaked at approximately 8% in FY 19/20, around the same period as COVID-19 lockdowns, however, there has since been a slight reduction in presentations over time. This peak was attributed by stakeholders to the prevalence of family violence and breakdowns associated with the COVID-19 pandemic and lockdowns. This trend is explored in further detail in 'Other key cohorts'.

While the proportion of adults aged 25-44 years seeking assistance for DFV increased over the evaluation period (from 23.0% to 34.5%), the proportion of adults aged 25-44 years accessing SHS services as a whole decreased over the evaluation period (from 32.8% to 27.3%). This explains why adults accessing DFV services as a proportion of the total population appears to have only slightly increased in Figure 12.

Upon analysis of reasons for SHS presentations by gender, Figure 13 shows that the main reason for females seeking assistance to access services for DFV and relationship breakdown (grey) increased over the period, while females seeking assistance for accommodation (purple) decreased.[159]

Figure 13: Main reasons for females seeking assistance



Source: NSW Homelessness Data (CIMS and equivalent systems)

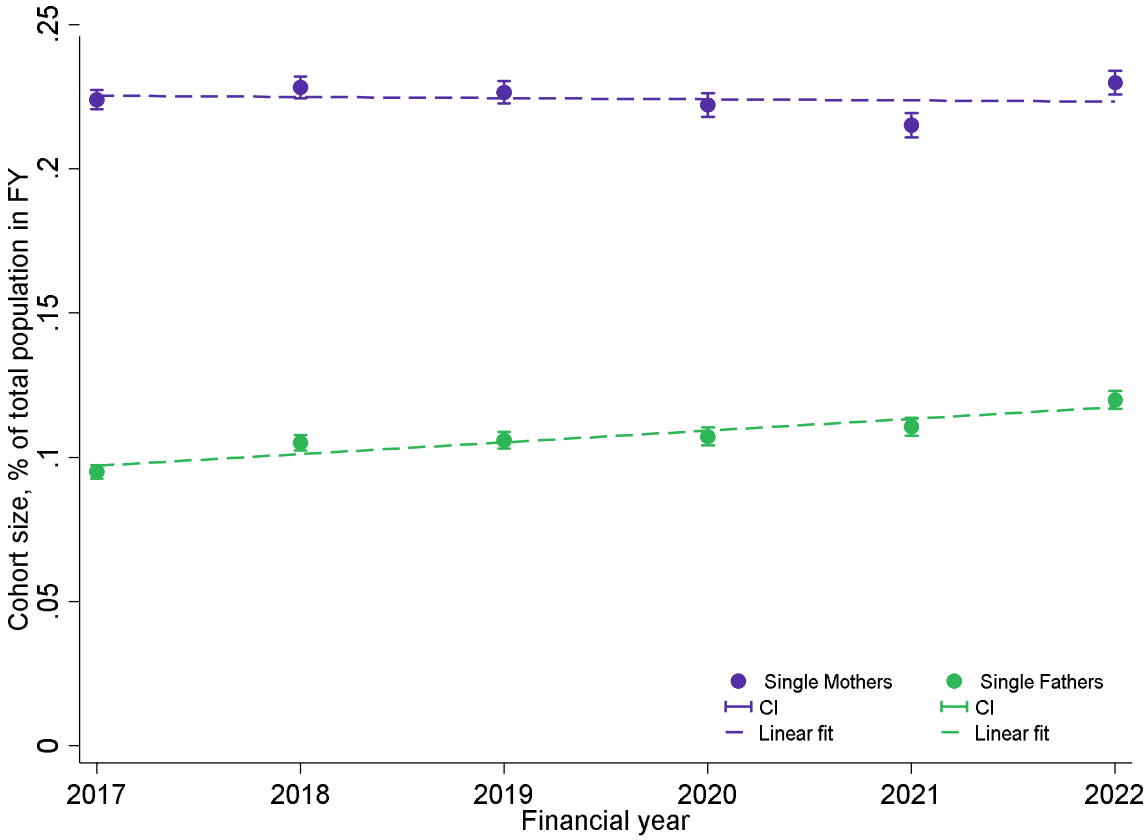
Presentations of women whose main reason for seeking assistance was for DFV and relationship breakdown increased by approximately 6% over the evaluation period, with presentations peaking in FY 19/20 and FY 20/21, a trend attributed to the COVID-19 pandemic and the associated trends in family breakdown and DFV by a number of stakeholders.

[159] For the purposes of the analysis contained within this Report, the Domestic and Family Violence (DFV) and relationship breakdown category includes the following reported main reasons for assistance: Domestic and family violence (71%); Relationship/family breakdown (23%); Time out from family/other situation (4%); Sexual abuse (<1%); and Non-family violence (1%). A range of related reasons for assistance are reported within the DFV and relationship breakdown category to account for likely under-reporting of DFV.
Estimates indicate that only up to 40% of domestic violence incidents are reported: Morgan A & Chadwick H 2009. Key issues in domestic violence. Research in practice no. 7. Canberra: Australian Institute of Criminology. https://www.aic.gov.au/publications/rip/rip7.

Single fathers

Figure 14 presents an increasing trend for single fathers (in green) as a proportion of the entire SHS cohort by each year. Presenting single mothers (in purple) are observed to be stationary as a proportion of the entire SHS cohort by each year. However, two thirds of single parents who presented for support identified as single mothers (≡61,209) and one third as single fathers (≡28,937) over the evaluation period.

Figure 14: Trends in single parents presenting to SHS



Source: NSW Homelessness Data (CIMS and equivalent systems)

Single fathers grew by approximately 2 percentage points of the total SHS population over the evaluation period, with every third single parent a single father. The main reasons for seeking assistance were reported as financial difficulties (1 in 10), housing crisis (1 in 4), and DFV and relationship breakdown (1 in 3). Service providers discussed the increasing presentations of single fathers in particular, given the limited service availability to accommodate them. Both SHS clients and service providers alike noted challenges in finding or providing accommodation to this growing cohort, as many refuges are targeted towards single mothers and children.

"There are no places for dads and children, and we are seeing more dads getting custody of their children. Dads can't take kids to the refuge." – SHS service provider

Nevertheless, the analysis highlights that two thirds of single parents who presented for support identified as single mothers, suggesting the continued need to ensure tailored SHS supports for single mothers and children.

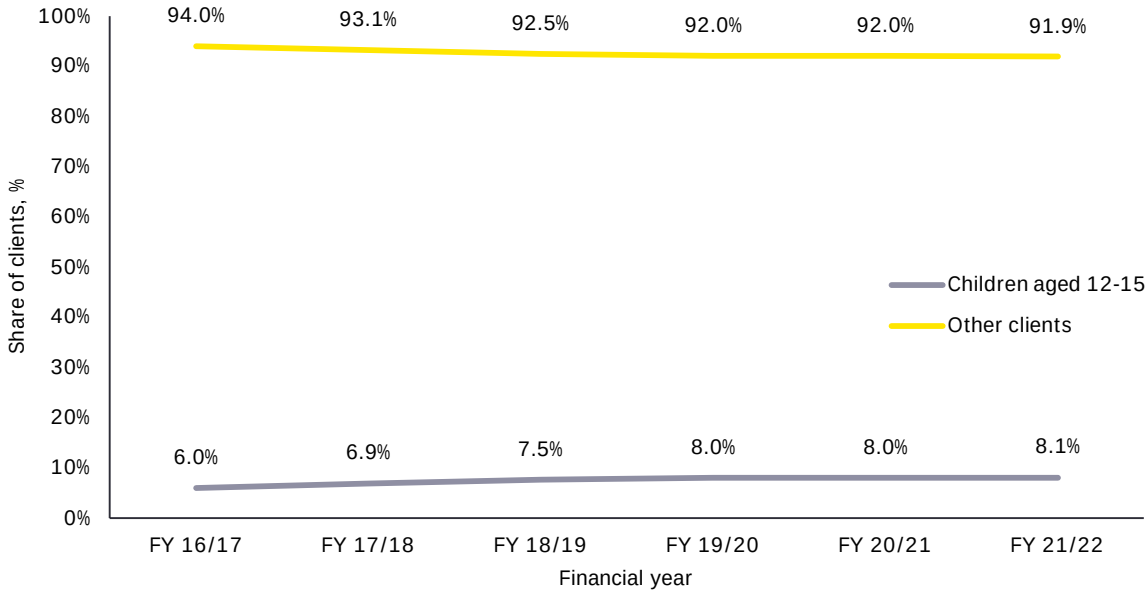
Service providers also highlighted the challenges of adequately housing and supporting larger families, including single parents with multiple children, particularly in instances where only shared space accommodation can be offered, and the need for greater longer-term accommodation options that are suitable for larger groups.

Other key cohorts

Children (12 – 15)

The administrative data demonstrate an increase in the number of children aged 12 to 15 years presenting to SHS over time, from 6% to 8% of the total client cohort. Figure 15 presents trends in children aged 12-15 years presenting to SHS relative to the broader SHS client cohort.

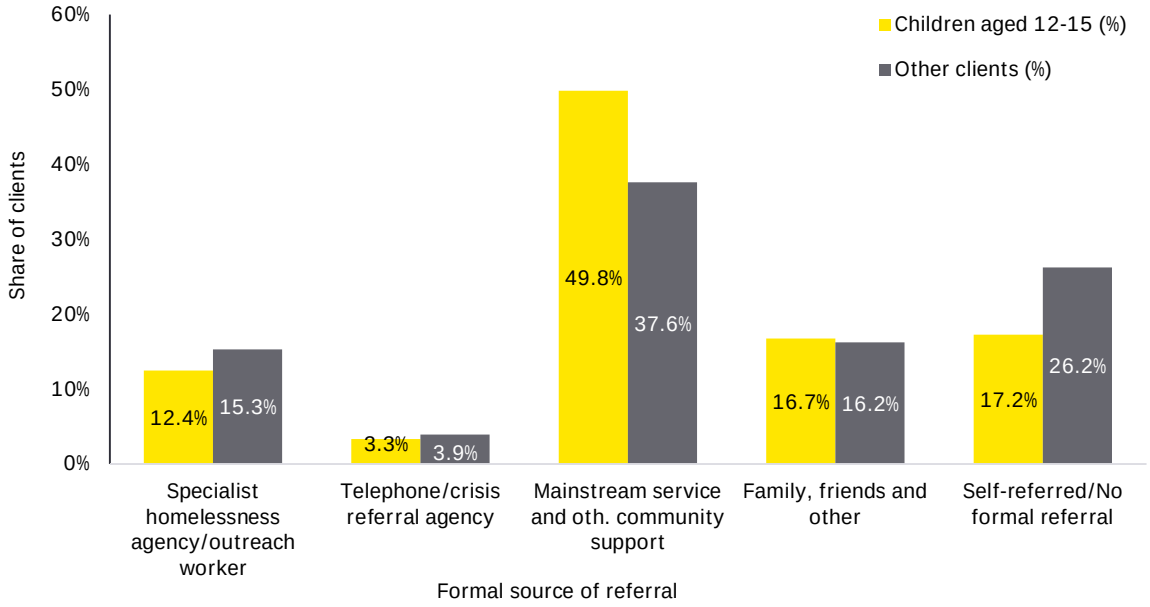
Figure 15: Share of children presenting to SHS services aged 12-15 years old by financial year



Source: NSW Homelessness Data (CIMS and equivalent systems)

The proportion of SHS clients aged 12-15 years varied somewhat by region, from 5% to 7%, with a larger proportion of this cohort present in the Northern Sydney, Sydney, South Western Sydney and the Hunter DCJ Districts. Administrative data indicate that children aged 12-15 years were much more likely than the general SHS population to access SHS through referrals from mainstream service providers and other community supports, which demonstrates the importance of an integrated and coordinated systems approach to support this vulnerable cohort. Figure 16 presents the formal sources of referral to the SHS program for children aged 12-15 years as compared to the general SHS population.

Figure 16: Formal source of referral to the SHS program (FY 21/22)[160]



Source: NSW Homelessness Data (CIMS and equivalent systems)

When reporting the main reason for seeking assistance, children aged 12-15 years were less likely to request support with accommodation (almost 24% as compared with 36% for all other SHS clients), however, were more likely to request support with DFV and relationship breakdown (over 39% as compared with over 31% for all other SHS clients). Children aged 12-15 years were also more likely to have their accommodation-related needs met than the general SHS population.[161]

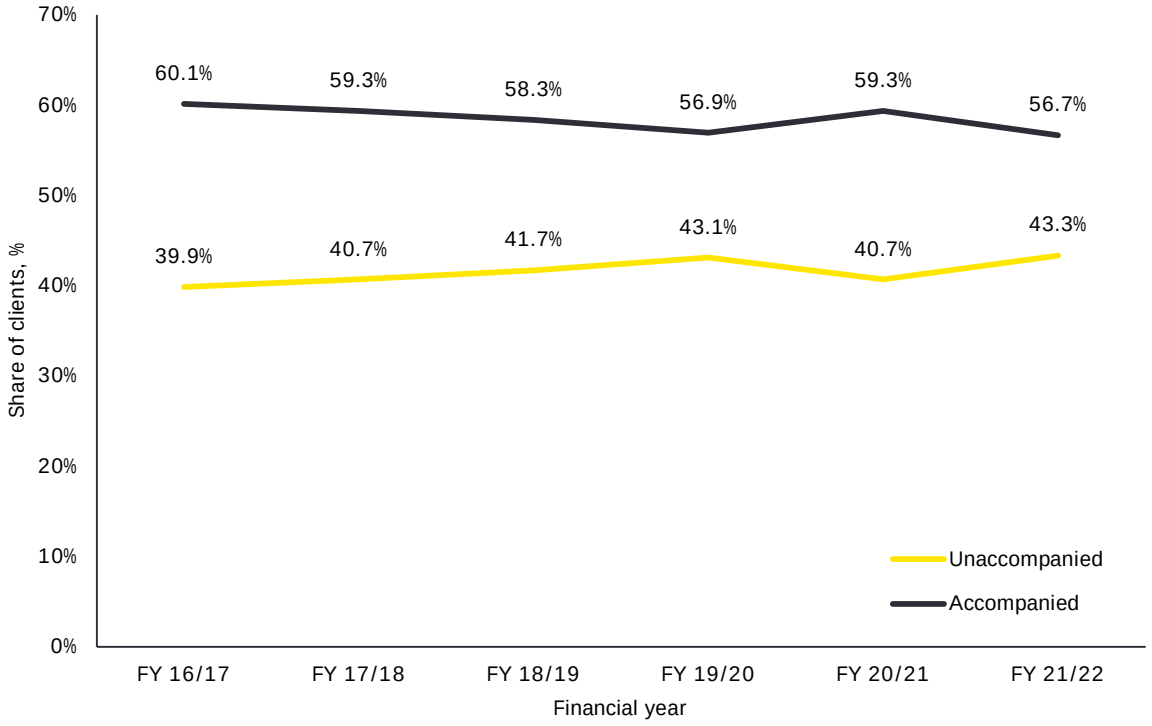
The increase in children presenting to SHS can be attributed to a number of factors, one being DFV and relationship breakdowns. Stakeholders cited challenges experienced by many families during the COVID-19 pandemic, which they perceived to have increased the number of family breakdowns.[162]

Stakeholders indicated that the GHSH reforms had impacted service provision for children, for example in stating that they felt *"children were lost as part of the reforms"* whilst also acknowledging that the Department was beginning to address this, with a sense that more attention and funding was required to fully respond to these needs.[163] In recognition of the impact of homelessness on this cohort, children and young people aged 15-24 years presenting alone are a national priority homelessness cohort in the NHHA. Sector Peaks such as YFoundations are advocating for the federal government and state governments to implement a dedicated National Child and Youth Homelessness and Housing Strategy that responds to the diversity and complexity of children and young people at risk of or experiencing homelessness, aligned to trends in child and youth presentations.

[160] Source of referral was not recorded for approximately 5% of SHS clients.
[161] Approximately 42% of children aged 12-15 presented unaccompanied. The main reason for seeking assistance for those children who are accompanied may reflect the circumstances of a parent or a guardian.
[162] A survey conducted of more than 10,000 adult women in Australia who had been in a relationship in the last 12 months found that approximately 45% of respondents had experienced partner violence for the first time during the pandemic; more than half had experienced sexual violence for the first time; and almost 57% had experienced emotionally abusive, harassing and controlling behaviours for the first time. Boxall, H. & Morgan, A. (2021). Intimate partner violence during the COVID-19 pandemic: A survey of women in Australia. Australian National Research Organisation for Women's Safety. Retrieved from apo-nid314517.pdf.
[163] It is worth noting that the total number of services for women and their children increased post reforms (as per the Going Home Staying Home Post-Implementation Review: Going Home Staying Home Post-Implementation Review | Family & Community Services (nsw.gov.au)), however these services may not support unaccompanied children.

One in every five children presented to SHS unaccompanied over the evaluation period.[164] Figure 17 demonstrates the increasing proportion of unaccompanied children presenting to SHS as a proportion of total children aged 12-15 years, rising from 40% in FY 16/17 to 43% in FY 21/22.

Figure 17: Unaccompanied and accompanied children aged 12-15 years presenting to SHS[165]



Source: NSW Homelessness Data (CIMS and equivalent systems)

Stakeholders also reported unaccompanied minors as a growing cohort and highlighted the challenges in providing services to those under the age of 16, who SHS are legislated to support by exception through the Homeless Youth Assistance Program (HYAP).[166] Specific policy considerations apply when a child under the age of 16 presents alone to an SHS provider, with some service providers receiving funding from HYAP to provide specialised services for this cohort.

Aboriginal and Torres Strait Islander clients

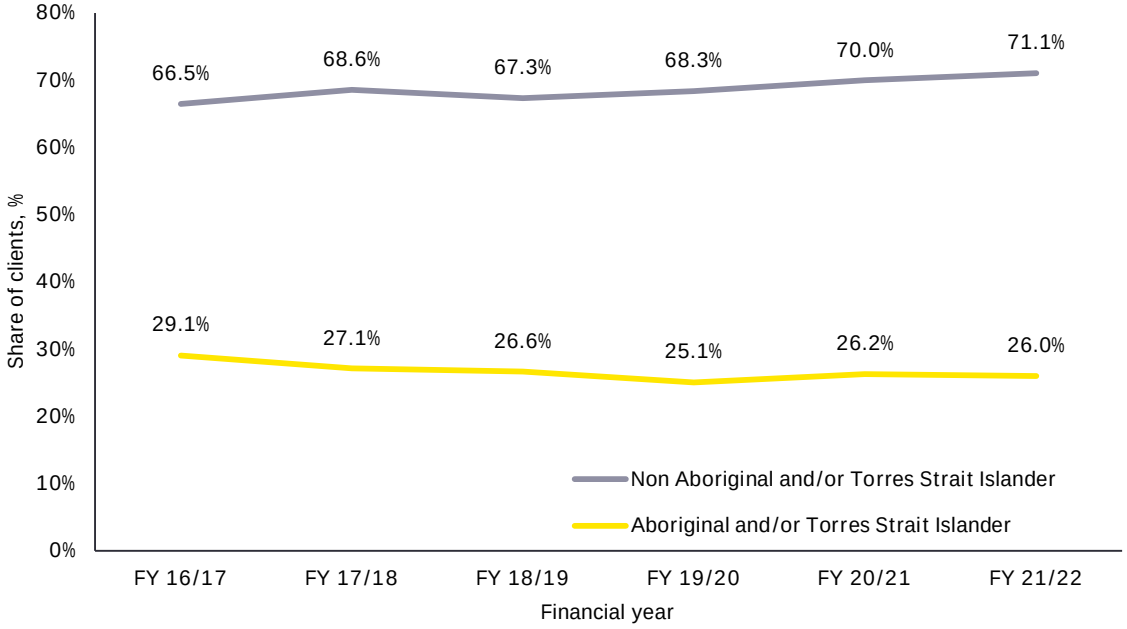
Aboriginal and Torres Strait Islander clients continued to be over-represented as SHS clients and in homelessness statistics over the evaluation period. Aboriginal and Torres Strait Islander people make up around 3% of the Australian population, yet they made up approximately 20% of the estimated number of people experiencing homelessness on Census night in 2021, up 6.4% since 2016. Additionally, Aboriginal and Torres Strait Islander people accounted for 28% of clients (an estimated 72,900 clients) assisted by SHS nationally in FY 21/22.[167]

[164] It should be noted that there are known errors in the use and interpretation of data on SHS clients under the age of 12 reported as "presenting alone".
[165] Age is not reported for approximately 1% of clients.
[166] SHS Program Requirements state that" Unaccompanied children under the age of 12 years are not eligible for support under the SHS Program". Children under the age of 12 are only able to access SHS services as accompanying children.
[167] ABS. (2022). Australia: Aboriginal and Torres Strait Islander population summary. Retrieved 23 May 2023, from Australia: Aboriginal and Torres Strait Islander population summary | Australian Bureau of Statistics (abs.gov.au); ABS. (2022). Estimating homelessness: census. Retrieved 23 May 2023, from Estimating Homelessness: Census, 2021 | Australian Bureau of Statistics (abs.gov.au); Australian Institute of Health and Welfare (2022) Specialist homelessness services annual report 2021–22. AIHW, Australian Government. Retrieved 4 July 2022, from https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/indigenous-clients

In interpretation of these trends, it is important to recognise that the ABS definition for homelessness had been developed for the general population of Australia and may not adequately capture homelessness among Aboriginal and Torres Strait Island people due to participation in the Census, those living remotely on Country and their kinship system.[168]

There was a slight reduction in observed presentations of Aboriginal and Torres Strait Islander clients to NSW SHS over the evaluation period (refer Figure 18). Whilst the share of Aboriginal and/or Torres Strait Islander clients appears to be decreasing over time, the total number of SHS support periods provided to Aboriginal and/or Torres Strait Islander clients has increased over time. The total support periods have increased from 30% in FY 16/17 to 35% in FY 21/22 and return support periods increased from 33% in FY 16/17 to 41% in FY 21/22. This suggests that Aboriginal and/or Torres Strait Islander clients often return to the SHS system for support.

Figure 18: Trends in share of Aboriginal and/or Torres Strait Islander clients[169]



Source: NSW Homelessness Data (CIMS and equivalent systems)

The proportion of Aboriginal and Torres Strait Islander clients varied significantly by region, with 5% of clients identifying as Aboriginal and Torres Strait Islander in the Northern Sydney DCJ District, and 58% of all clients identifying as Aboriginal and Torres Strait Islander in the Far West District. Overall, regional and rural DCJ Districts reported that 35% of clients identified as Aboriginal and Torres Strait Islander clients, whereas metropolitan DCJ Districts reported 15%.

The administrative data suggest that Aboriginal children aged 12-15 years present at higher rates to SHS than non-Aboriginal children; with Aboriginal children in this age bracket representing over a quarter (almost 27%) of Aboriginal SHS clients, compared to non-Aboriginal and Torres Strait Islander children aged 12-15 years representing almost one in five (18%) of total non-Aboriginal and Torres Strait Islander SHS clients.

Increasing complexity of client needs

Stakeholders perceived increasing presentations of people experiencing homelessness, or at risk of homelessness, with increasingly complex needs, including mental health issues and co-morbidities. It

[168] ABS. (2022). Housing Statistics for Aboriginal and Torres Strait Islander Peoples. Collation of housing and household characteristics statistics from ABS collections. Retrieved 30 June 2022, from https://www.abs.gov.au/statistics/people/aboriginal-and-torres-strait-islander-peoples/housing-statistics-aboriginal-and-torres-strait-islander-peoples/latest-release#content.

[169] Indigenous status is not reported for approximately 5% of clients.

is well established that people with mental health issues are particularly vulnerable to experiencing homelessness.[170] Environmental stress associated with experiences of housing instability or homelessness has been indicated to trigger, exacerbate or magnify mental health issues.[171] Symptoms of mental illnesses that increase psychological distress and impair decision-making in daily life can contribute to worse health outcomes, reduced support and experiences of financial hardship. In this way, people with mental health issues are especially susceptible to entering or maintaining homelessness.[172]

Administrative data indicates an increase in the proportion of unique clients presenting with a self-reported diagnosed mental health condition from just over 24% in FY 16/17 to almost 26% in FY 21/22.[173] Service providers suggested that they are also witnessing an increase in presenting clients who may have an undiagnosed mental health condition, of which they are not aware, and which, according to stakeholders, may result in those clients remaining in or cycling through the homelessness system.

Clients born overseas and non-Australian residents

There are a number of challenges associated with measuring homelessness amongst people from CALD backgrounds due to differing definitions of homelessness and data limitations, however, evidence suggests that factors including discrimination, social isolation, language barriers, visa status and limited knowledge of Australian social systems may contribute to obstacles faced by people of CALD backgrounds with regard to housing and homelessness.[174]

The findings of the analysis show that 1 in 5 SHS clients were born overseas and according to AIHW data from FY 21/22, after Australian Indigenous languages, the second most commonly spoken language at home for SHS clients in Australia was Arabic at almost 12% (of total clients excluding those whose main language spoken at home was English or not stated).[175] Clients from CALD backgrounds require a range of culturally appropriate and other specialised support options, including resources available in languages other than English, immigration and legal support services, and linkages into CALD networks or communities. Particularly in cases where large families have migrated together, stakeholders highlighted the provision of suitable accommodation as a key challenge.

Service providers also emphasised increased visibility of non-residents of Australia in people experiencing homelessness, or at risk of homelessness, which may relate to their ineligibility for services due to their visa status, and was reported to become more apparent during the COVID-19 pandemic. Stakeholders highlighted that the provision of crisis supports to this cohort is complex, as non-residents are not eligible for TA. The provision of ongoing support to non-residents was also cited to be particularly challenging due to limited exit pathways, as this cohort does not have access to longer-term housing options, such as social housing and rental products, nor income supports, such as Centrelink. Some SHS clients described receiving support from their service providers to

[170] Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S. & Davis, E. (2020). Trajectories: the interplay between mental health hand housing pathways: Final research report, Australian Housing and Urban Research Institute Limited and Mind Australia, Melbourne. Retrieved from Trajectories: the interplay between housing and mental health pathways–Executive Summary (ahuri.edu.au).

[171] Brackertz, N., Wilkinson, A., & Davison, J. (2018). Housing, homelessness and mental health: towards systems change, Australian Housing and Urban Research Institute Limited, Melbourne.

[172] Brackertz, N., Borrowman, L., Roggenbuck, C., Pollock, S. and Davis, E. (2020). Trajectories: the interplay between mental health hand housing pathways: Final research report, *Australian Housing and Urban Research Institute Limited and Mind Australia*, Melbourne. Retrieved from Housing, Homelessness and Mental Health: Towards Systems Change by Nicola Brackertz, Alex Wilkinson, Jim Davison :: SSRN.

173 This variable refers to clients with a self-reported diagnosed mental health condition; hence the percentage of clients in this cohort may appear low when compared to AIHW counts, which use additional criteria and were approximately 40% in FY 21/22.

[174] Ibid.

[175] Australian Institute of Health and Welfare. (2021). Specialist homelessness services annual report 2021–22. Retrieved 23 May 2023, from Specialist homelessness services annual report 2021–22, Data - Australian Institute of Health and Welfare (aihw.gov.au).

access external services to assist with visa applications, including the Refugee Advice and Casework Service and the Immigration Advice and Rights Centre.

"I had no job, no income supports, but they helped me to get a visa so I could work and let me stay there to save money for my bond amount." – SHS client

Clients excluded from the private rental market

A key emerging cohort identified by stakeholders was people being excluded from the private rental market due to housing unaffordability, particularly older people who have consistently maintained private leases and are now unable to afford private rentals. Administrative data highlight that nearly 1 in 5 SHS clients (18%) were in a private rental property at the time of presenting to SHS over the evaluation period. Furthermore, 40% of SHS clients reported in FY 21/22 their main reasons for seeking assistance as financial difficulties, housing affordability stress and/or the housing crisis. The proportion of clients citing financial difficulties and housing crisis as main reasons for presenting to SHS has decreased over time, with just over 11% citing financial difficulties in FY 16/17 to 8.5% in FY 21/22, and 30% citing housing crisis in FY 16/17 to just under 23% in FY 21/22. Nonetheless, the proportion of clients citing housing affordability stress has increased from 5.7% in FY 16/17 to 7.6% in FY 21/22.

The administrative data highlight that over the evaluation period, 37% of clients cited accommodation needs as their main reason for assistance in regional and rural DCJ Districts, compared with 29% in metropolitan DCJ Districts. Stakeholders noted their perception that housing affordability issues could be aggravated in regional areas. This trend is likely due to record net inflow of people relocating from metropolitan areas to regional areas when the COVID-19 pandemic began, with a 110% increase in net inflow to regional NSW between 2019 and 2020.[176] Conversion of existing rental properties into Airbnb's in regional areas has also been cited to contribute to this trend by reducing the supply of housing in these areas.[177]

Housing affordability issues impacting the sector are reflected in higher median rent in regional areas, for example, between 2019 and March 2023, median rents increased by 32.4% in regional NSW.[178] In December 2021, the residential vacancy rate in Sydney was 2.8%, whereas in certain regional and rural areas, such as Albury, Central West, and South Coast, vacancy rates were at 0.4% to 0.5%.[179] Vacancy rates have since rebalanced somewhat; as of April 2023, vacancy rates in Sydney were 1.3%, whereas in Albury, Central West and South Coast, they were 0.8%, 1.6% and 2.1% respectively.[180] Stakeholders also noted that the sector's ability to address housing affordability issues through a focus on provision of support to sustain tenancies is likely diminished due to limited capacity, resulting in a focus on crisis responses rather than early intervention and prevention.

"The unaffordability of the private market has increased, without the associated flow through of vacancies in SHS."– DCJ Housing

Stakeholders also reported a sub-cohort within this cohort of people unable to afford a private rental, being those that are not eligible for social housing due to total household income exceeding the income threshold, yet who are unable to afford private rentals due to increased private rental costs. Stakeholders were of the opinion that social housing eligibility thresholds have not been adequately re-aligned to consider cost of living increases such as increases in health, education and food costs seen over the past year.[181]

[176] ABS. (2021). Net migration to the regions highest on record. Retrieved 13 June 2023, from Net migration to the regions highest on record | Australian Bureau of Statistics (abs.gov.au).
[177] Ibid.
[178] DCJ. (2023). Rent and sales report – interactive dashboard. Retrieved 9 June 2023, from Rent and sales | Tableau Public; SGS Economics and Planning. (2022).
[179] Real Estate Institute of NSW (2023). Retrieved 13 June 2023, from Vacancy Rate Survey Results - REINSW
[180] Ibid.
[181] ABS. (2023). Selected living cost indexes, Australia. Retrieved 13 June 2023, from Selected Living Cost Indexes, Australia, March 2023 | Australian Bureau of Statistics (abs.gov.au).

While the current social housing income eligibility threshold for a single adult increased by 5.3% in July 2022 to $690 a week, the Consumer Price Index (CPI) in Australia increased by 7% in the 12 months between March 2022 and March 2023, indicating the adjusted social housing income eligibility threshold has not been adjusted sufficiently to offset cost of living increases.[182] Some stakeholders suggested that Centrelink systems are not conducive to timely achievement of case management goals for their clients, particularly for young people and women experiencing DFV who have to change payment types or access a benefit for the first time, stating that it was *"not uncommon for staff to spend an entire day at Centrelink."*

Are existing services aligned with these needs?

Key Findings

Administrative data indicate that the SHS Program did not meet client need across a range of service provision categories, which suggests that existing services are not aligned with demand and client support needs.

- SHS administrative data showed that 30.4% (≡5,100) of clients who reported a need for short-term accommodation had their needs met; almost 21% (≡2,354) of clients who reported a need for medium-term housing had their needs met; and 1.7% (≡331) of clients who reported a need for long-term housing had their needs met.

- Administrative data also suggest that existing services faced difficulties in facilitating clients' access to a range of requested mental health-related supports.[183] In FY 21/22, needs were met need for: 26% (≡587) and 27% (≡293) of SHS clients seeking support to access psychological and psychiatric services respectively; close to 36% (≡1,647) of clients seeking support to access mental health services; and just over 46% (≡383) of clients requesting connection into specialist counselling services.

- Analysis of the administrative data highlighted that the sector is not meeting need in supporting Aboriginal and Torres Strait Islander clients to access mental health services with 31.3% (≡1,593) of needs met over the evaluation period and 20.1% (≡84) of needs met for support for children aged 12-15 years to access psychiatric services.

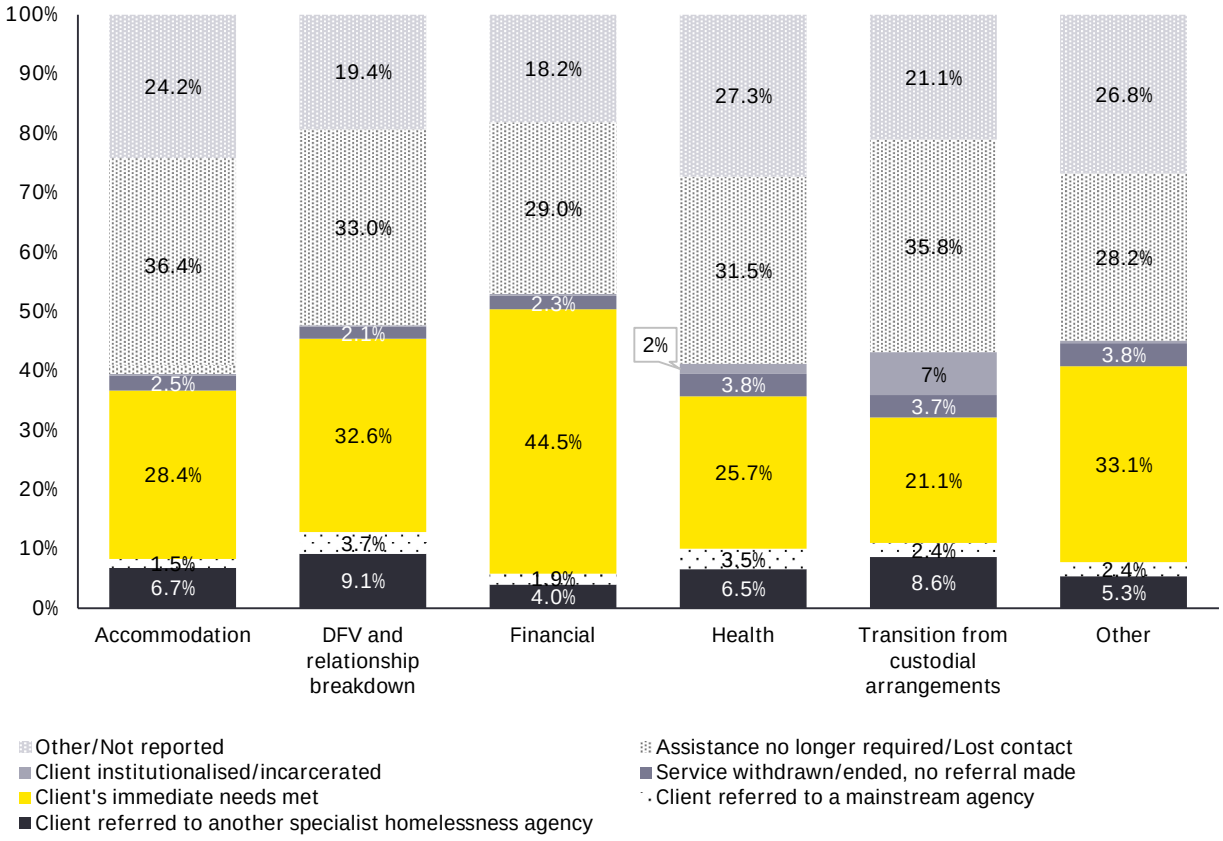
- Over 10,000 unique clients requested assistance to access domestic and family violence services in FY 21/22, equivalent to almost 24% of all unique SHS clients in that year. The sector's ability to meet these needs was comparatively strong, with just over 80% (≡8,136) of needs met.

For the purpose of this evaluation and the SHS Unit Costing exercise, SHS services are categorised into accommodation services (short-, medium- and long-term), same day minor engagements (non-accommodation) and case management services > 1 day (non-accommodation). Across these key service categories, clients can present for multiple needs. The main reasons for clients seeking assistance in FY 21/22 were categorised into accommodation (32.5%), DFV and relationship breakdown (32.0%), financial (17.0%), health (3.6%), transition from custodial arrangements (1.3%) and other (9.6%), which includes transition from foster or other care, disengagement from school, limited family/community support and other. Analysis on the proportion of clients who had their identified needs met is presented in Section 5.2. Figure 19 presents the reasons for ending a client's SHS support period by main reason for seeking assistance.

[182] DCJ. (2022). Social housing eligibility and allocations policy supplement. Retrieved 13 June 2023, from Eligibility for social housing – income - Social Housing Eligibility and Allocations Policy Supplement | Family & Community Services (nsw.gov.au); ABS. (2023). Selected living cost indexes, Australia. Retrieved 13 June 2023, from Selected Living Cost Indexes, Australia, March 2023 | Australian Bureau of Statistics (abs.gov.au).

[183] In the interpretation of met and unmet need analysis throughout the Report with respect to support from SHS to access mainstream services, it is worth noting that met need may be impacted by the capacity of mainstream service sectors to accept referrals from SHS and provide services to SHS clients. It may also be impacted by the closure of SHS support periods by SHS service providers prior to the SHS client being provided with a service from an external service provider.

Figure 19: Service end reason by main reason for seeking assistance (FY 21/22)[184]



Source: NSW Homelessness Data (CIMS and equivalent systems).

In FY 21/22, the proportion of clients' immediate needs met when exiting the service ranged from 21% for those who had transitioned from custodial arrangements, to 44% for those seeking financial support. This may suggest that services are not adequately meeting clients' needs.

Financial support

Almost half of clients whose main reason for seeking support in FY 21/22 was financial reasons (approximately 3,500 clients) were recorded as having their immediate needs met by SHS. Provision of financial support could be regarded as a lower-intensity service relative to accommodation, support to access services for DFV and relationship breakdown (which would likely require ongoing case management), and health services, which may explain why there is a higher proportion of needs being met by the SHS system for this category.[185]

Support for those transitioning from custody

By contrast, the lowest proportion of immediate needs met was for clients transitioning from custodial arrangements, with 21% of clients' immediate needs being met. Additionally, 7% of clients seeking support for this reason had their support period ended due to re-institutionalisation or reincarceration. It should be noted that this represents a proportionately small SHS cohort, with just over 1%, or 455 clients, citing assistance to transition from custody as their main reason for seeking support in FY 21/22.

Service provider stakeholders suggested that referrals received through corrections were often incomplete or inaccurate, creating challenges in ensuring adequate supports could be provided to

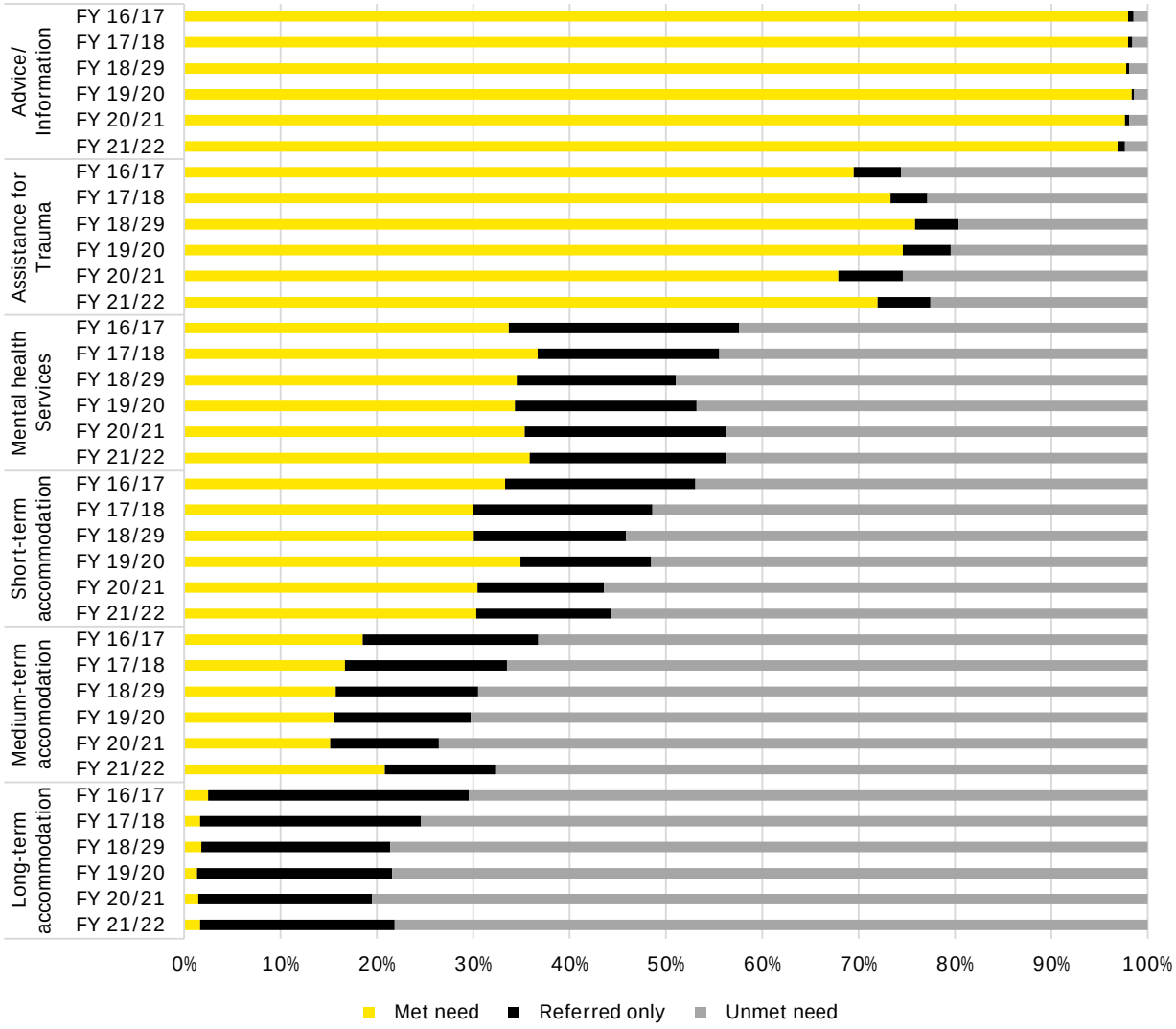
[184] Other assistance (as described in the text) made up (9.6%) and was excluded; 1.2% of clients did not report their main reason for assistance.

[185] Under the umbrella term of financial support, clients may have sought assistance for financial difficulties, housing affordability stress, employment difficulties, and/or problematic gambling.

them once accepted into the service. From the corrections perspective, the constraints of the corrections system inhibit staff from providing the level of detail required to support a more accurate and complete referral, as they receive limited notice of an inmate's release. Where possible, representatives from corrections shared that they try to continue case co-ordination and support beyond SHS referral acceptance to mitigate chances of clients being re-incarcerated, however inconsistent points of contact on both the corrections and SHS service provider side were highlighted as hindering effective communication.

Figure 20 presents unmet need according to a range of needs reported at the time of presenting to SHS. It should be noted that SHS caseworkers can identify up to 55 different needs for support for SHS clients throughout the course of SHS support.

Figure 20: Met and unmet needs over time by needs category



Source: NSW Homelessness Data (CIMS and equivalent systems)

A more detailed breakdown of unmet need according to some of these key needs for service is presented overleaf.

DFV and relationship breakdown support

Over 10,000 unique clients expressed the need for assistance with DFV services in FY 21/22, equivalent to almost 24% of all unique SHS clients that year. The sector's responsiveness to meet these needs was high, with just over 80% of needs met. Of those requesting assistance for domestic and family violence, over 97% requested victim support services.

61% of clients who expressed the need for support to access sexual assault services had their needs met. For family/relationship needs, almost 76% of clients' needs were met, whilst over 56% of clients' needs were met for requests for assistance with child contact and residential arrangements.[186]

Accommodation services

In FY 21/22, over 52,000 clients expressed a need for short, medium- and long-term accommodation from SHS providers (noting that clients are able to request support for more than one need, and hence total number of requests will be greater than total number of clients in any given financial year). It was recorded that over 30% of clients who reported a need for short-term accommodation had their needs met; almost 21% of clients who reported a need for medium-term housing had their needs met; and 1.7% of clients who reported a need for long-term housing had their needs met. This suggests a misalignment between existing SHS accommodation services with current demand and need for support.

The challenges associated with the provision of accommodation are discussed in Section 5.3.1 and include external factors such as availability of sufficient housing stock to meet demand, as well as inappropriate SHS accommodation options tied to long-term SHS contracts, which has hindered SHS providers in meeting these accommodation needs.

According to the administrative data, SHS providers were more likely to meet the needs of SHS clients requesting early intervention and prevention supports within the accommodation category, including support to sustain tenancies and prevent foreclosures, with just over 67% and approximately 59% of needs met respectively.

Mental health-related supports

Administrative data show that existing services frequently did not meet need across a range of requested mental health-related supports. In FY 21/22, met need for support to access psychological services was almost 26%; for support to access psychiatric services it was just over 27%; for support to access mental health services it was almost 36%; and for connections into specialist counselling services, it was just over 46%. Assistance for trauma and assistance with behavioural problems had significantly higher rates of met need, at almost 72% and just over 79% respectively.

As has been discussed with respect to referral pathways, SHS service providers and broader system stakeholders alike reported experiencing challenges in providing effective supports to people with complex needs. Service providers reported difficulties with coordination and collaboration to meet the needs of health inpatient clients, whereas some health services perceived SHS service providers to not consider health inpatient clients as urgent, as they are 'housed' in hospitals at the time of referral. In some instances, this was reported to result in increased pressure for inpatient clinicians to look for alternative accommodation.

Coupled with this, some service provider stakeholders perceived there to be a misalignment in the understanding of health services as to what SHS are contracted and able to provide for those with mental health conditions. In particular, one service provider highlighted that the term "supported accommodation" was commonly misunderstood by health services as being able to provide sufficient support to those in the midst of a mental health crisis, when in reality, this could just mean that the SHS accommodation is staffed around-the-clock.

[186] Family/relationship assistance is defined in the SHS Collection Manual (July 2019) as 'discussion sessions or support dealing with family and relationship problems or issues.'

Furthermore, service providers noted difficulties with emerging mental health clients, who may be limited in ability to self-manage, as they cannot be accommodated in communal living, refuge-style accommodation options due to a range of safety issues, for themselves, SHS staff, and other clients.

"We do see quite a few young people coming out of mental health facilities. A lot of young people are being exited from these services prematurely and on the other hand, when we have people that need mental support, getting them there has been noticeably more difficult since COVID." – SHS service provider

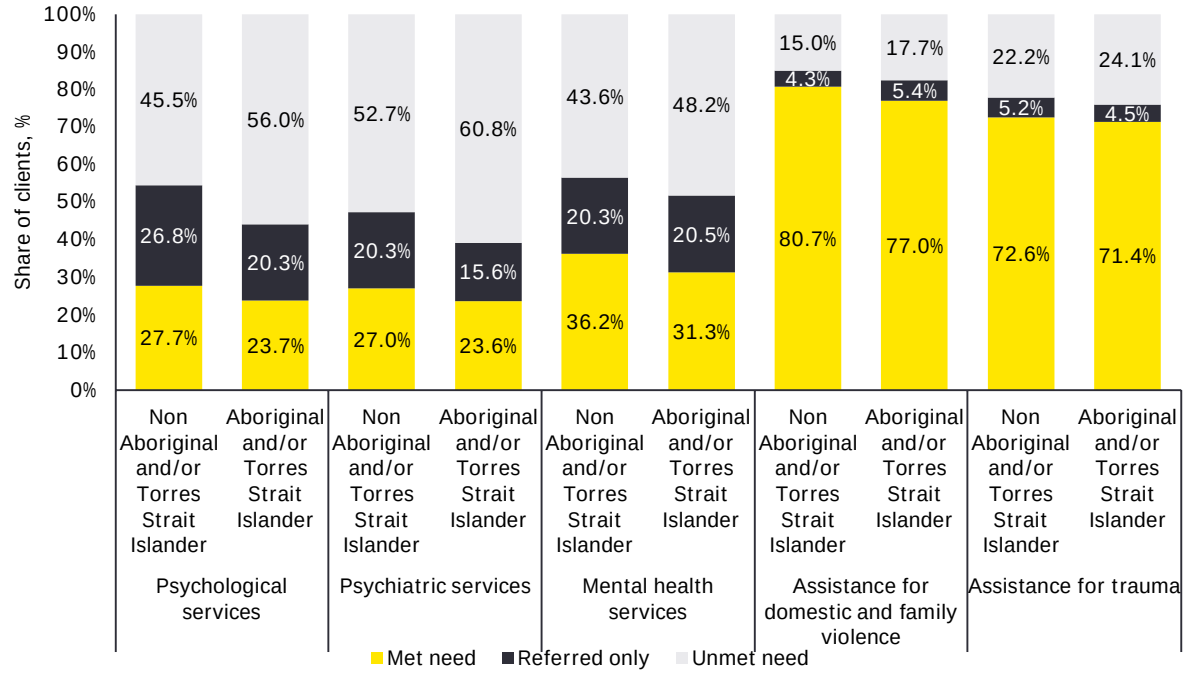
Evidence suggests that programs integrating housing and mental health supports were effective in generating government cost savings by improving consumer mental health and wellbeing, contributing to tenancy stability and social connectedness.[187]

Mental health-related supports for Aboriginal and Torres Strait Islanders

Stakeholders suggested there were minimal supports available for young Aboriginal men, particularly those exiting correctional facilities, stating this was concerning given the high suicide rate of Aboriginal men. AIHW data from 2021 found that suicide rates are more than twice as high amongst young Aboriginal people compared to non-Aboriginal and Torres Strait Islander Australians.[188]

With respect to support to access mental-health and trauma-related supports, the administrative data show that the proportion of needs met for Aboriginal and Torres Strait Islander clients was lower than that of non-Aboriginal and Torres Strait Islander SHS clients. Figure 21 shows a comparison of met and unmet needs for non-Aboriginal and Torres Strait Islander clients and Aboriginal and Torres Strait Islander clients over the entire evaluation period.

Figure 21: Trauma and mental health-related needs: The comparison of met/unmet needs[189]



Source: NSW Homelessness Data (CIMS and equivalent systems)

[187] Australian Housing and Urban Research Institute (2018). Housing, Homelessness and mental health: towards systems change. Retrieved 30 June 2022, from Housing, homelessness and mental health: towards systems change (mentalhealthcommission.gov.au).

[188] Australian Institute of Health and Welfare. (n.d.). Suicide & self harm monitoring. Retrieved from Suicide & Indigenous Australians - Australian Institute of Health and Welfare (aihw.gov.au).

[189] Indigenous status is not reported for about 5% of clients.

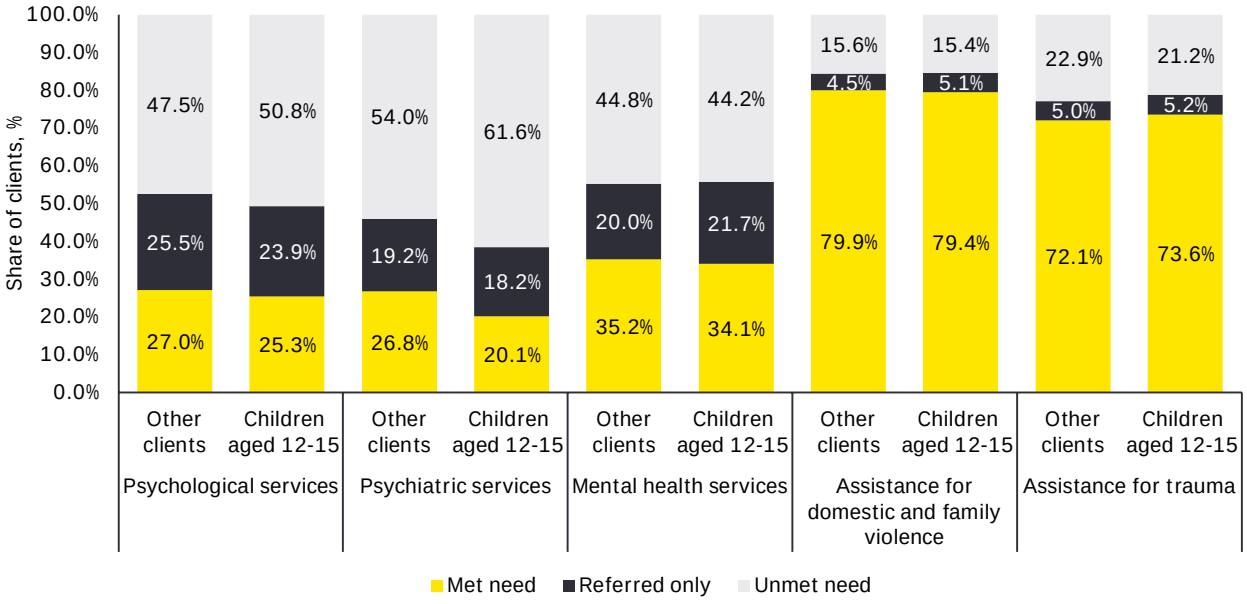
The degree of met need for support to access mental health services varied by region, from 20% in the Hunter District to 47% in the Far West District. It should be noted that across all needs listed in Figure 20, a smaller proportion of Aboriginal and Torres Strait Islander clients requested support with these needs than their non-Aboriginal and Torres Strait Islander counterparts, which may suggest limited knowledge of these services or willingness to request support, rather than less need.

Service providers generally supported the need for Aboriginal-focused service delivery, however some cautioned against rapid transfer of services from non-Aboriginal organisations to Aboriginal Community Controlled Organisations (ACCOs) encouraging a partnership approach in order to build capacity within the ACCO sector. Stakeholders also noted resourcing constraints within the ACCO sector, impacting its ability to address client needs without external support. Further analysis of Aboriginal-led service delivery is provided in Section 5.2.3 and of culturally appropriate supports in 5.3.1.

Mental health-related supports for children

Figure 22 presents the proportion of met and unmet needs for children aged 12-15 years as compared to other SHS clients across a range of mental health and DFV related needs over the evaluation period.

Figure 22: Comparison of met/unmet needs by age group of interest[190]



Source: NSW Homelessness Data (CIMS and equivalent systems)

With the exception of assistance for trauma, the proportion of met need across the range of needs was lower for children aged 12-15 years as compared to other SHS clients, with the difference most notable for support to access psychiatric services with just over 20% of need met for children aged 12-15 years as compared with almost 27% for other clients. Across all needs categories in Figure 22, a greater percentage of children aged 12-15 years also reported the need as compared to other SHS clients, which highlights the complexity of needs of this cohort.

Other child-specific supports achieved greater degrees of met need for children aged 12-15 over the evaluation period. Almost 83% of clients who requested a school liaison had their needs met; over

[190] Age is not reported for about 1% of clients. A client may have identified one or more needs.

58% for child protection services; with a lower share of met needs met for child-specific counselling services (30%).

How capable is SHS (the Program and services) of adapting to changing needs over time?

Key Findings

The SHS Program's ability to meet client need across remained consistent over the evaluation period, even where demand increased, as in the case of assistance for trauma, support to access mental health services and short-term accommodation. This demonstrates a degree of responsiveness from the SHS sector, however it must be noted that met need across many categories, particularly accommodation and mental health-related needs, remained low to moderate.

- Service providers have consistently met approximately 30% (≡5,100) of clients' short-term and 21% (≡2,354) of client's medium-term accommodation needs, however have not met growing demand for long-term accommodation, meeting 1.7% (≡331) of these needs in FY 21/22, likely impacted by contextual factors such as lack of exit pathways due to housing unaffordability.

The SHS Program's ability to meet client need across key reported needs, as outlined in Figure 20, remained consistent over the evaluation period, even where, in the case of assistance for trauma, mental health needs and short-term accommodation, demand increased.

The need for advice and information in SHS services remained consistent since FY 16/17 with about 80% of SHS clients requesting this support, and the large majority (approximately 97%) of this need was also consistently met over time. This could be considered a lower intensity service, as it is defined as the provision of advice or information related to the client's identified needs, and may include information about other services where the client is responsible for following up the information.

Assistance for trauma is defined as "assistance for clients who have experienced or witnessed an event that threatened their life or safety, or that of others around them".[191] This definition excludes sexual assault and DFV, and this support need may be considered a higher intensity need than requests for advice and information. In comparison to requests for advice and information, requests for assistance for trauma also increased over the evaluation period, from 11% to 17% of SHS clients over the evaluation period, however, Figure 20 shows that SHS services have consistently met this need over time, meeting on average more than 72% of this need and referring 5%, with a decrease in FY 20/21 where 68% of needs were met and 7% were referred. SHS services were also consistent in meeting the growing need for support to access mental health services, albeit at a lower rate than assistance for trauma, at around 35% of needs met, and 18% of needs referred.

With regard to accommodation supports, the need for short-term accommodation increased, from 35% to 40% of SHS clients over the evaluation timeframe, yet SHS services have remained consistent in meeting need at about 30% of needs met. The need for long-term accommodation increased more significantly, from 37% to 48% of SHS clients over the evaluation period and SHS services met a small proportion (1.7%) of these needs, with met need decreasing over time, and referrals to other services also decreasing from 27% in FY 16/17 to 20% in FY 21/22. These trends reflect some of the broader contextual factors impacting the sector such as lack of exit pathways due to housing unaffordability. This is explored in further detail in Section 5.3.1.

The consistency in service delivery across key categories of need demonstrated a degree of responsiveness from the SHS sector, however it must be noted that unmet need across these categories, particularly accommodation and mental health needs, remained low. The ability of the sector to adapt and respond flexibly is evident through this consistency, however, this may not be sustainable should demand continue to increase. A number of perceived barriers to service delivery,

[191] SHS Collection Manual (July 2019), retrieved from https://www.aihw.gov.au/getmedia/47792815-cce2-4ebd-858c-68f7c639ff0a/shs-collection-manual-2019.pdf.aspx

including workforce challenges such as recruitment and retention, identified by stakeholders in consultations are presented in the following section.

5.2.3 Processes and approaches in SHS provided response

Are people who need SHS receiving client-centred and integrated responses?

Key Findings

Evidence to assess the extent to which SHS clients received client-centred and integrated responses varied considerably, with qualitative evidence from SHS client interviews suggesting that supports received were adaptive and integrated, whilst qualitative evidence from service providers and other inter-agency representatives suggested that significant barriers to delivering client-centred and integrated responses existed (refer to key findings under the next evaluation sub-question).

- Clients interviewed reported the responsiveness of service providers to individual needs and their ability to connect clients into support services beyond those requested to meet the holistic needs of clients and their families (noting the positive bias present in this evidence as discussed in Section 3.9).
- Analysis of quantitative evidence shows that during the evaluation period, more than 1 in 5 clients (21%) withdrew their request for assistance and service providers lost contact with almost 14% of clients, suggesting client dissatisfaction with services or an inability to engage with supports.

An assessment of whether SHS clients received client-centred and integrated responses can be completed with reference to the proportion of client needs met by SHS service providers. For the purpose of answering this evaluation sub-question, only clients who reported having their needs met were considered to have received a client-centred, integrated response.[192]

Analysis of quantitative evidence relating to client needs met by SHS service providers shows that during the period FY 16/17 to FY 21/22, more than 1 in 5 clients (21%) withdrew their request for assistance, almost 14% of service providers lost contact with clients and 4% of clients did not present to an arranged meeting or support, which may suggest client dissatisfaction with services however this may also be reflective of an inability to continue engaging with supports for a variety of reasons, including, but not limited to, the client moving away from services and the client receiving the required supports from another service provider.

Adaptability and responsiveness of SHS providers to client needs

Feedback from SHS client interviews indicates that clients largely received integrated and holistic responses to their identified needs. SHS clients also highlighted the responsiveness of service providers to their individual needs, connecting clients into support services beyond those they had requested in order to meet their holistic needs, such as support to access immigration services, support with enrolling their children in local schools after escaping DFV relationships, and providing financial support for specialist medical appointments. Service providers reported that provision of an effective response to clients is underpinned by building trust with clients through the adaptation of their approach based on the individual needs of the client.

"Everything they did was beyond my expectation. They have always pre-empted my need for support." – SHS client

Targeted youth service providers suggested that improved client outcomes were generally achieved when working in collaboration with schools, family and community services and DCJ Housing. In contrast, a number of service providers supporting people with complex needs noted that limited

[192] The Evaluation Team acknowledges that an SHS client may still have received a client-centred and integrated response from SHS despite not having their met needs formally recorded in the administrative data.

collaboration and challenges with information sharing between SHS providers and integrated services impacted their ability to meet the holistic needs of clients. Service providers cited experiencing significant challenges collaborating with health services, specifically mental health services, and attributed these challenges in-part to the fact that some DCJ Districts cover multiple local health districts, and the difficulties for the homelessness sector which is already at capacity, to manage relationships across health districts and services. This finding is consistent with service provider responses to the survey, where 100% of respondents (n=6) cited difficulties supporting clients to access health services.

Further discussion on the provision of client-centred approaches is provided on page106.

Trauma-informed service provision

Providing trauma-informed supports is integral to client-centred service provision, as per the SHS Program Specifications. Incorporating trauma-informed approaches in the context of allocation of Temporary Accommodation and housing was deemed to be a challenge, noting the scarce availability of accommodation options. Stakeholders reported instances of allocation of Temporary Accommodation not being trauma-informed, and in some cases suggested these contributed to the re-traumatisation of SHS clients. Highlighting this issue, an SHS client interviewed for the purpose of the Evaluation reported being allocated to Temporary Accommodation by Link2Home at the location she experienced DFV in the past, despite informing the Link2Home allocations representative of her experience and requesting an alternative TA allocation.

Noting limited accessibility of housing options, stakeholders recommended the implementation of service-delivery frameworks that are more responsive to the needs of clients with a history of trauma. Where possible, improved access to a diverse range of Temporary Accommodation and housing options was recommended by stakeholders, in addition to ensuring SHS clients and TA users with a history of trauma have access to safe and stable accommodation.

Support timeframes

Provision of support over an extended time period was reported to contribute to an improved ability to meet the needs of clients and improved client outcomes. Many SHS clients interviewed recounted being enabled to stay in refuges for periods of greater than three months.

The three-month case management timeframe was frequently referenced by service providers during consultations despite there no longer being guidance from DCJ on a standard timeframe. It is noted that service providers seeking to adhere to a three-month timeframe may be driven by contractual client targets, however, frequent references to the three-month case management timeframe suggests there is scope for DCJ to strengthen dissemination of information regarding case management timeframes. Several service providers and DCJ stakeholders reported that strictly adhering to a case management timeframe of three months posed a barrier to providing client-centred and integrated supports, due to clients requiring support beyond this timeframe to address their complex needs and build the tools required to sustain a tenancy.

Several stakeholders suggested that the provision of effective support to clients was hindered by the current SHS framework being built on the 'No Wrong Door' approach. This approach was perceived to exacerbate the capacity and resourcing issues faced by service providers at times, with a number of poorly targeted referrals and for some stakeholders, a perceived "shift from a focus on quality of supports, to quantity of supports".

"They don't just dump you onto a new service after 6 months." – SHS client

Contractual obligations

Contractual obligations were perceived by service providers to impact their ability to provide client-centred approaches at times, particularly with regard to the administration of client surveys, including the Personal Wellbeing Index (PWI) survey.

The PWI is a survey administered by service providers as part of the SHS outcomes measurement process as required by the Department. The PWI is designed to measure subjective wellbeing at multiple points in a client's service journey, including at the beginning of the support period, and at the end, to understand how client experiences change over time. Service providers reported feeling ethically vexed issuing the PWI survey, as they did not perceive the survey to be culturally appropriate. Despite this, stakeholders recognised that the Department is currently working to ensure that the PWI is culturally appropriate for Aboriginal and Torres Strait Islander clients. Service providers also reported feeling conflicted about issuing the survey to clients at intake in crisis. Service provider feedback indicated that uncertainty about how and when to administer the PWI survey existed amongst service providers, suggesting there are opportunities for additional training on how to administer the PWI to support with strengthening the robustness of SHS client outcomes data and ensure client voice is captured in outcomes data.

Additionally, stakeholders reported that service providers are needing to be increasingly flexible in their service offering to meet client needs, however minimal flexibility in contracting arrangements may result in contracts not accurately reflecting the services provided.

"The guidelines [SHS program specifications] have not kept up with what the service is actually doing. If service providers are seeing something changing [with respect to the needs of various cohorts], we need to be able to be flexible to amend the contract to reflect this." – DCJ C&P stakeholder

Inter-agency referral process

Service providers noted the impact of inappropriate referrals in reducing their ability to provide client-centred approaches. Further detail on the extent to which inappropriate referrals impact the provision of client-centred responses is provided in Section 5.2.1.

Aboriginal-led service provision

Prioritisation of service delivery by ACCOs to Aboriginal clients was highlighted as a focus area by a range of stakeholders, to ensure the SHS program is more representative of the cohorts it services, and to support self-determination of Aboriginal and Torres Strait Islander peoples. Stakeholders reported that the capacity of ACCOs to service Aboriginal clients was limited by perceived disproportionate access to resources by non-Aboriginal and Torres Strait Islander SHS providers relative to Aboriginal service providers. Stakeholders noted that increased provision of resources to ACCOs would be required to ensure the needs of Aboriginal clients are met, including the allocation of newly allocated Aboriginal Housing stocks to the Aboriginal homelessness sector.

What are the strengths and barriers, both within SHS and in intersections with the broader service system to provide the services needed by clients?

Key Findings

Strategic partnerships (refer to Section 5.2.4) and co-location or provision of allied services on-site at SHS accommodation was found to enable delivery of holistic and integrated responses, whilst workforce challenges, sector competition, limited capacity and resourcing relative to demand were reported to create ongoing challenges for the sector.

- Service providers and DCJ stakeholders highlighted significant challenges providing case management support for periods less than three months, due to clients requiring support beyond this timeframe to address their complex needs. Many SHS clients interviewed reported being enabled to remain in refuges for longer than a three-month period, indicating some providers are working flexibly to deliver client-centred support, despite capacity and resourcing challenges.

- Lack of transparency and minimal flexibility in current contracting arrangements were also cited as impediments to collaboration and delivery of client-centred responses to clients. Several SHS service providers consulted with for this Evaluation suggested that additional clarity as to how contractual requirements vary across providers and geographies would be

Key Findings

beneficial to improve understanding of roles and responsibilities across the sector and increase collaboration, whereas it was suggested that increased flexibility in contracting would allow providers to determine the most optimal way to deliver client outcomes within their funding agreements.

- Many stakeholders suggested that SHS staff frequently operate beyond capacity, and at times are not trained appropriately to support clients with increasingly complex needs and manage risk of burnout, leading to high turnover and associated workforce challenges.

Service system strengths

Key strengths for providing services needed by clients largely relate to the ability of services to provide client-centred and integrated supports, in addition to establishing effective collaboration mechanisms and partnerships. The analysis of strengths relating to provision of client-centred and integrated supports is supported by qualitative evidence from SHS client interviews. In noting these findings, the Evaluation Team recognises the influence of stakeholder bias in the cohort of SHS clients interviewed for the Evaluation, and the large proportion of clients that received or are receiving crisis supports from SHS service providers.

Provision of client-centred supports

Qualitative evidence suggests service providers are working flexibly and promptly to ensure the needs of clients are met. Clients who were interviewed for the purpose of the Evaluation reported being accommodated in SHS crisis refuges almost immediately upon referral to the service.

Client perspectives on the flexibility and adaptability of SHS services are supported by findings from service provider consultations, where service providers noted the expansive variety of supports offered to clients, including arranging transport for clients to and from services and the purchase of furniture and whitegoods to establish a tenancy. Service providers emphasised the importance of brokerage funding as a flexible means to provide supports or services which are tailored to individual client needs.

Service provider stakeholders in leadership positions attributed the ability of service providers to deliver client-centric support to the skill of case managers in tailoring and adapting their approach to engaging with clients based on the client's personal preference, and their ability to build trusting relationships with clients. Qualitative evidence from client interviews suggests that SHS clients are generally content with the services received from service providers and reflect positively on their interactions with staff.

Provision of integrated supports

Clients interviewed also reported receiving integrated supports and referrals to a variety of external services, including immigration lawyers and health specialists, to an extent which exceeded their expectations.

Co-location of allied services or provision of allied services on-site at SHS accommodation was reported to be instrumental in ensuring service providers could deliver holistic and integrated responses to clients, in addition to contributing to improved collaboration between services. Qualitative evidence suggests that the ability of service providers to provide integrated services was significantly influenced by the size of the SHS service provider and its associated resources, its reputation and the extent of its establishment within the sector. Larger service providers reported providing DFV services, disability services, counselling, and therapeutic supports, in addition to a comprehensive mental health portfolio, to ensure the holistic needs of clients are met.

Coordinated approaches and partnerships

The implementation of coordinated and place-based approaches to service delivery was reported to improve engagement with services and support with the development of exit pathways for SHS clients

into transitional housing. The strengths of coordinated approaches and partnerships in ensuring the delivery of client-centred approaches is further explored in Section 5.2.4.

Service system barriers

The key barriers to providing the services needed by clients were consistent across consultative evidence and service provider survey responses, with resourcing and capacity issues emerging as a prominent theme across both data collection methods. The analysis below highlights the key barriers reported to impact service delivery and their underlying drivers. Survey responses regarding barriers to service delivery are available in Appendix 5.

Sector resourcing and capacity issues

Resourcing constraints were identified by almost 80% (*n*=11) of service provider survey respondents as a key barrier to service delivery. Sector resourcing and capacity issues were reported to result in a prioritisation of provision of resource-intensive crisis responses and supporting clients with complex needs, rather than a focus on addressing the underlying drivers of homelessness and providing early intervention and prevention supports. Comprehensive findings relating to sector resourcing and capacity issues are provided in Section 5.2.1.

Information sharing

The importance of the provision of accurate and comprehensive information when referring clients to services was a consistent theme emerging from consultations. Information sharing across the sector and in the broader service system was perceived to be a barrier to addressing homelessness and meeting the needs of clients by a range of SHS and inter-agency stakeholders, at the referral stage, in addition to when providing ongoing support to clients.

Key findings relating to barriers that information sharing pose to providing client-centred and integrated supports are further detailed in Section 5.2.1.

Sector workforce challenges

Whilst not an identified barrier in survey responses from service providers, feedback from service providers suggests managing the SHS workforce is a key barrier to service delivery. Service providers reported significant challenges recruiting and retaining staff and attributed these issues to ongoing sector capacity issues and the associated burnout of staff. Provision of supports outside of what service providers are contracted to provide due to the complex needs of clients was perceived to result in the 'over-extension' of existing funding and resources.

The management of workforce issues and staff burnout by SHS service providers is reportedly rendered difficult due to increasing complexity of client needs, with 26% of people presenting to SHS services in FY 21/22 having a self-reported mental health condition and requiring resource-intensive responses. Furthermore, consultative evidence suggests that the proportion of SHS clients with mental health conditions is significantly understated, as clients are often undiagnosed or do not recognise their mental health condition.

Service providers noted that additional training opportunities, including specialised mental health training, are required to support the management of clients with increasingly complex needs. One service provider noted that they had *"clients released from hospital at lunch time, [that are] back in hospital at 9pm the same night"*, attributing the inability of staff to address the complex needs of clients to the lack of resources and training provided to SHS staff, and highlighting the stress such scenarios place on SHS staff.

Service providers also cited workforce challenges within the broader service system as key challenges to service delivery, including challenges with workforce retention amongst CHPs. Low staff retention amongst CHPs was reported to negatively impact the effectiveness of collaboration between SHS and CHPs, as well as referrals for SHS clients into CHPs. Additionally, regional service providers reported high turnover of DCJ C&P staff, and the allocation of new C&P staff from outside

of the local area as barriers to service delivery, as newly allocated staff are perceived to lack an understanding of the local context and challenges experienced by service providers on a local scale.

Competition between service providers

Stakeholder responses to interview questions regarding the nature of collaboration highlighted that competition between some service providers acts as a barrier to collaboration. This finding was reinforced by service provider survey findings, where 50% (*n*=7) of respondents identified difficulties collaborating with other service providers as a barrier to service delivery. Competition between service providers was largely attributed to limited sector resources, the competitive nature of contractual requirements and the need to meet KPIs.

"There has been a definite shift from when the competitive tendering process was initiated. It becomes a numbers game, so there are issues of 'ownership' around some clients" – SHS service provider.

Some service providers noted the inherent tension between SHS service providers in rural areas and the lack of transparency in contracting arrangements. Competition between service providers was reported to be most evident in rural areas which are serviced by limited numbers of providers, and service providers highlighted the ongoing challenges establishing a shared understanding of the roles and responsibilities of each provider in the respective area.

Nonetheless, participation in governance forums and networks, including DHIGs, was reported to minimise competition and encourage the implementation of strategic and collaborative responses to addressing homelessness. Analysis on the effectiveness of governance forums and networks in supporting collaboration is further detailed in Section 5.2.4.

What improvements can be made?

Key Findings

Resourcing that is better aligned with service demand was frequently cited by service providers as a potential enabler to support meeting demand in referrals and client needs and may improve the sector's ability to deliver client-centred and integrated supports, including supporting the identification of appropriate exit options.

- Staff training for data capture and monitoring was also raised by service providers as an enabler of more efficient service delivery.

Increased funding was the most frequently cited need by SHS service provider respondents to support them to meet the needs of clients and achieve improved outcomes, with 100% (*n*=14) of survey respondents identifying this as a need, followed by training. This is consistent with insights derived from stakeholder consultations, whereby service providers shared that current resourcing levels present a barrier for SHS and its delivery staff in effective service provision. Stakeholders suggested that increased funding may allow SHS providers to better meet the increased demand in referrals and client needs, including identifying appropriate exit options.

Provision of additional training was identified by 86% (*n*=12) of survey respondents as a key improvement to enable the SHS Program to achieve better outcomes. One stakeholder shared that they felt SHS staff are *"beyond capacity and are not trained appropriately to manage burnout whilst also addressing and supporting clients with increasingly complex needs"*. It was reported by service provider stakeholders that challenges with the labour market have increased difficulty in hiring and retaining staff, and due to capacity constraints, providers frequently struggle to balance providing staff training in addition to supporting their clients. Additional training in terms of data capture, monitoring and reporting was also cited by service providers as likely to support staff to deliver better outcomes.

Although not ranked highly as a survey response, with 36% (*n*=5) of service provider survey responses identifying this as an area for improvement, flexibility in contracting was raised consistently in consultations as an area that would enable service providers to deliver more tailored,

client-centred services to their clients. Due to increasingly complex client needs, predominantly around mental health-related support requirements, clients reportedly often require prolonged support in order to support progress and the achievement of outcomes. Many service providers reported allowing clients to stay in refuges for periods greater than three months, citing limited exit options and their commitment to ensure positive outcomes for their clients.

Based on consultative evidence, there appears to be broad recognition in the sector that there needs to be a greater focus on homelessness prevention, early intervention and a focus on client outcomes *"to understand and respond to the cause of homelessness rather than treating the symptoms."*

"There needs to be greater awareness of the role of SHS and SHS' need to be resourced adequately to have capacity for engagement in communities of practice to enhance ongoing mechanisms for referral pathways and collaboration within a multidisciplinary approach to enhance integrated service delivery. "– SHS service provider

5.2.4 Effectiveness of the networks and governance mechanisms

How effective are the networks and governance mechanisms in place, such as District Homelessness Implementation Groups, at working collaboratively to resolve implementation issues and consider practice principles and how they are applied when supporting clients?

Key Findings

Opinions on effective collaboration across the service system varied widely by geography and service and cohort types, with many stakeholders citing that they faced the greatest challenges in collaborating with the health and mental health sectors, leading to receipt of inappropriate referrals which may impact existing clients.

- Opinions on the effectiveness of higher-level more strategic forums, such as DHIGs, also varied widely, often impacted by the size of the relevant District, with larger DCJ Districts comprising multiple Local Government Areas (LGAs) and therefore potentially multiple similar meetings. Many stakeholders suggested that increased clarity regarding the purpose of and appropriate level of attendance at these forums would support the achievement of more productive service coordination.

- Tailored, place-based, collaboratively designed approaches to meeting client needs were highlighted by stakeholders as supporting collaboration to resolve implementation issues to support clients, whereas limited time and capacity was the most commonly cited challenge impeding sector collaboration, followed by limited knowledge sharing and integration between SHS and mainstream service providers.

Service system collaboration

The SHS Evaluation Service Provider Survey results indicate that roughly half of service provider respondents (*n*=21) found the SHS collaboration forums for service delivery either effective or very effective. 87% (*n*=36) of service provider survey respondents also indicated that they felt able to collaborate effectively with mainstream service providers.

Survey responses to a question on the major barriers to collaboration with mainstream services were consistent with consultative evidence, with 100% (n=5) of service providers identifying time and capacity constraints as a key barrier to effective collaboration (refer to Appendix 5). Consistent with the analysis on barriers to accessing services and barriers to service provision in Section 5.2.1 and Section 5.2.3 respectively, communication, lack of shared knowledge and inability to share information were consistently identified as barriers to collaboration.

In consultations with sector stakeholders, opinions on effective collaboration across the service system varied widely, with efficient collaboration mechanisms varying by geography. One factor which was raised as impacting the effectiveness of collaborative forums, such as District

Homelessness Implementation Groups (DHIGs), is the relevant size of each District. In those DCJ Districts which comprise multiple LGAs and Local Health Districts, stakeholders were reported to be attending multiple similar meetings, leading to potential duplication and reduced productivity. There was also common feedback regarding lack of clarity around the purposes of key forums and the person from each organisation best placed to attend, with stakeholders suggesting that guidance to ensure that the appropriate individuals attend the relevant meetings would result in enhanced productivity, reduced duplication and administrative burden.

"We have a strong relationship with the local DCJ office. We're here and willing to work with anyone to resolve or prevent homelessness." – Community Housing Provider

A range of stakeholders spoke to the importance of fostering inter-service collaboration and establishing partnerships as key to addressing the needs of SHS clients. Tailored, place-based approaches designed with the stakeholders involved in order to meet a need or fill a gap were generally perceived by stakeholders to be the most optimal approaches. Examples of such approaches varied widely, with some taking place at a more strategic, program level, and others at the level of resolution of client supports. At the strategic level, one stakeholder shared that, in regard to attendance at DHIGs, *"going at a high level helps us avoid issues of competition over tenders"*. At a more localised client level, examples of approaches which stakeholders considered to be effective include the following:

- An assertive outreach pilot project working with rough sleepers in Tweed Heads, using a collaborative approach between local SHS providers, DCJ and NSW Health, to facilitate access to wraparound supports and support the creation of exit pathways;
- Network meetings between DCJ Housing and SHS service providers for "facilitated movements" i.e. to prioritise movement of SHS clients out of refuges and into longer-term accommodation options to free up capacity at refuges;
- A DHIG "sub-group" on the Central Coast which established a Rough Sleeper Protocol to support rough sleepers being moved on from parks by local councils;
- Strategic partnerships between SHS service providers and CHPs, managed under an approach of shared geography, common client cohorts and reciprocal referral arrangements, to support with fostering of exit pathways for SHS clients into transitional housing; and
- Targeted youth services working in collaboration with schools, housing and DCJ on a case-by-case basis to support with the achievement of improved outcomes for youth, particularly due to the complexity of providing SHS services to this cohort.

Qualitative evidence suggests there was consensus amongst providers that the localised approaches focused on client needs tend to be effective and promote greater collaboration amongst relevant agencies, which in turn, supports more efficient referrals, whereas many providers seemed to view larger forums, such as DHIGs, as a *"tick box exercise"*. Local knowledge sharing between inter-agency stakeholders and service providers through regular meetings ensuring that all stakeholders were aware of their respective roles, responsibilities, services provided and capacity was also deemed to be critical for effective collaboration.

"When it's [the meeting] about individual clients, it's a different story." – SHS service provider

Several service providers highlighted their views that the homelessness Peak bodies were effective in disseminating relevant information to SHS providers, however with respect to providers sharing their input into SHS program design and delivery improvements, there was a belief that this should be driven through local governance forums, rather than centrally through the Peaks.

The End Street Sleeping Collaboration (ESSC) methodology and use of the By-Name-List (BNL) was identified by stakeholders to have been an effective means of promoting collaboration across the

homelessness service system, with key strengths identified as enabling real-time information sharing, establishment of local governance mechanisms, supporting the provision of person-centred approaches, and ensuring clients are not having to continually re-tell their stories. A case study of the ESSC methodology and implementation of the ESSC in a local community in the Southern NSW DCJ District is provided below, with key strengths of this methodology and the potential for its expansion explored further in Section 6, Key Findings and Recommendations.[193]

Case Study: End Street Sleeping Collaboration

The ESSC's objective is to support communities to end street sleeping by establishing local collaborations and implementing a coordinated, person-centred approach. To support this objective, the ESSC has implemented the BNL data collection and case coordination tool to allow stakeholders across the service system to share real-time information on the journeys of people street sleeping. As of July 2023, there were approximately 3,500 individuals on the BNL across NSW with 1,000 stakeholders trained and more than 60 organisations using the BNL to collaborate.

The local ESSC collaboration in the Southern NSW DCJ District was reported to have been successful in establishing a shared vision; that homelessness, if experienced in the local area, is rare, brief and non-reoccurring. The specific ESSC goals identified by this local community included: to develop a united response to homelessness; to understand the local homelessness context; to respond to needs flexibly and innovatively; to improve local systems; and to achieve functional zero where the number of people housed is greater than the number of people who enter into homelessness.

This Southern NSW collaboration was reported to be effective in promoting engagement, with the collaboration involving 12 organisations committed to working together to achieve the aforementioned goals, including three SHS service providers, two housing providers, six inter-agency representatives (mental health, AOD and hospital social worker), the local DCJ Housing office and the local council. As of July 2023, this collaboration had 69 people on the BNL, with 36 active clients experiencing street sleeping.

To support achievement of their goals and foster information-sharing, this collaboration has established:

- A leadership group to oversee implementation, ongoing collaboration performance and lead system change; and
- A case coordination group to ensure each client has a sustainable pathway to exit homelessness and identify system gaps and barriers that are preventing people accessing services, supports and accommodation.

"No one service has the complete picture of homelessness, so to come together as 'one-team' we are able to develop a holistic understanding, share expertise and work together on local solutions. The energy derived from the collaborative effort is exactly what the homelessness sector needs right now as workloads continue to increase, and the improved communication through the BNL is helping create efficiencies – more time can be spent supporting people rather than chasing information."- SHS service provider

Collaboration with the health sector

According to survey respondents, service providers faced the greatest challenges in collaborating effectively with the health, disability, aged care and mental health sectors, with 100% of survey respondents (n=5) indicating they encountered difficulties facilitating access to health, disability and

[193] This case study has been developed based on information provided directly by ESSC representatives and has not been validated by external stakeholders or publicly available literature.

aged care services, and 80% of respondents (*n*=4) indicating difficulties supporting clients to access mental health services. Refer to Appendix 5 for complete survey results.

This survey result was also corroborated through consultative evidence. Stakeholders highlighted that given the size of the healthcare sector it can be difficult for SHS providers to manage relationships with multiple health services, particularly in larger and more geographically disparate DCJ Districts which may cover numerous local health districts.

There are exceptions to this perception, with examples provided in consultations whereby DCJ staff, service providers and local health providers were reported to have implemented effective mechanisms of collaboration, however this appears to vary greatly depending on DCJ District. Some examples of effective network and governance mechanisms in certain DCJ Districts that were highlighted in consultations include the Local Collaborative Housing and Mental Health Service (CHAMHS) Committees in some locations, and the Local Implementation and Coordinating Committee (LIACC) in certain DCJ Districts, whereby stakeholders come together to hold case-based discussions.

5.2.5 Data collection

How effective are current data collection and reporting mechanisms?

Key Findings

The key SHS data collection and reporting mechanism, the Client Information Management System (CIMS), was perceived by some stakeholders to be best suited and easiest to use for case management, however its limitation in reporting functionality and flexibility were noted, with opportunities for refinement.

- Although there is an expectation that SHS providers are progressively transitioning towards collecting greater client outcomes data and service providers expressed a desire to be able to better track the client's journey, they also generally perceived there was limited ability to do so through the current data collection tools.

- There were some examples cited in consultations of tools currently being used to collect and track client outcomes, including the Housing Occupancy Management and Engagement System (HOMES) data system (to track referrals), a "TA register" allowing providers to capture referral pathways and outcomes, the PWI and Client Outcomes Survey (COS) tools, and the Vulnerability Index – Service Prioritisation Decision Assistance Tool (VI-SPDAT) tool as part of involvement with the End Street Sleeping Collaboration (ESSC)), however the overall effectiveness of these tools was reported to be constrained by limited integration ability and reporting features.

Data collection and reporting include the responses of 92% of survey respondents (*n*=38). Survey results highlight that roughly three quarters of service provider respondents (*n=31)* found the SHS data collection and reporting mechanisms either very effective or effective. Almost 85% (*n*=32) indicated they used CIMS for data collection and reporting.[194]

Service provider survey results highlight the key perceived strength of SHS data collection and reporting mechanisms are their simple interfaces and functionality, with 34% (*n*=13) of respondents identifying this as the primary strength of current data collection and reporting mechanisms. However, in consultations, stakeholders indicated that CIMS is best suited and easiest to use for case management, whilst noting that the reporting functionality of CIMS is often limited; service providers described CIMS reporting functions as "restrictive" and "manual" with minimal ability for users to manipulate the data variables to produce a report for different purposes and audiences.

DCJ stakeholders also reported that CIMS may not always meet the needs of C&P staff, as CIMS data cannot be shared in real-time, and furthermore indicated that often the service provider data are not

[194] Approximately 11% of respondents (*n*=4) used MA Connect or Hende for data collection and reporting, with the remaining respondents selecting "other" (*n*=2).

shared in a "digestible" format, so if the DCJ Districts do not have a dedicated data analyst, they may be unable to interpret the data received.

One of the Department's three key program expectations that SHS service providers are expected to progressively achieve during the current contractual term is "progress towards collecting data for effective identifying, measuring and driving on client outcomes". Related to this, two new tools to measure a client's wellbeing and goal progression have been implemented by DCJ in the current contractual period; namely, the PWI and COS. Enhancements have also been made to CIMS by the Department to allow increased outcomes data capture, with reporting eventually intended to be streamlined and automated across all outcomes data capture tools.

Stakeholders discussed that, across different data systems, there was limited ability to be able to capture and track client outcomes, despite the intended progression towards this, with examples shared where service providers had implemented mechanisms to capture greater outcomes-related data. According to some service providers, the HOMES data system has some capacity to track referrals which can support analysis of changes in demand for different services, however this tracking functionality is not reported to be widely operational or utilised.

On the basis of consultation, it also appeared that many DCJ Districts had developed bespoke "TA registers", whereby client data, such as referral pathway and outcomes, were captured in a spreadsheet. Stakeholders suggested that limited analysis is currently conducted using this data. Some service providers are also collecting outcomes data on rough sleepers using the VI-SPDAT as part of their involvement with the ESSC.

As discussed earlier in the Report, stakeholders have shared their ethical concerns regarding use of the PWI and COS tools due to the timing of administration and cultural appropriateness of the surveys. It is noted that DCJ recognises that there may be occasions where surveys are not completed due to "concerns for client safety, a provider's assessment of client cognitive impairment that would affect survey comprehension or a lack of appropriate opportunity", and that providers should always practice wisdom and a duty of care to their individual clients.[195] Stakeholders also expressed that the point-in-time data captured in the PWI can compromise the accuracy of this outcomes data, but noted the importance of this mechanism in capturing client voice in outcomes data.

What improvements to data collection and reporting systems are needed to enable improved monitoring of the SHS Program?

Key Findings

Lack of time and capacity to adequately meet reporting obligations and limited training on how to use reporting systems appear to be the main challenges with the current SHS data reporting mechanisms, reflected in both survey and consultation findings, suggesting that improvements, including automation, dashboard reporting features and increased training opportunities may be required.

- Stakeholders also expressed desire for a streamlined, performance-based data collection and monitoring system linked to key agreed outcomes. The Data Exchange (DEX) tool used by the Targeted Earlier Intervention (TEI) program was highlighted as an exemplar of such a system.

Lack of time and capacity to adequately meet reporting obligations and limited training on how to use reporting systems were the key challenges identified by service provider survey respondents in meeting reporting obligations, with almost 2 in 5 (n = 27) service providers identifying these barriers as the primary challenges. This was also raised by stakeholders in consultations, who highlighted that the provision of training around reporting functionality of the data systems would be beneficial. It is noted that training was intended to be provided by the Department as part of its expectation that

[195] DCJ. (2021). SHS Outcomes Framework Guide June 2021. Retrieved from SHS Outcomes Framework Guide | Family & Community Services (nsw.gov.au).

service providers would make progress toward collecting greater client outcomes data, and additionally there is CIMS introductory training for new SHS staff and CIMS reporting training for SHS managers available through the SHS Learning and Development Framework. A consistent recommendation from stakeholders was the development of a reporting dashboard, to enable improved monitoring of performance and client outcomes, in addition to supporting service providers to adhere to reporting obligations.

Stakeholders suggested there was an opportunity to develop a data collection and monitoring system that is performance-based, data driven and linked to key agreed outcomes for both SHS service providers and other key contractors. Improved functionality and reporting were also recommended by stakeholders to support with workforce performance management, for example, by linking key workers or client list selections with PWI scores as a means to support individual caseworker performance targets. In addition, service providers highlighted a strong desire to be able to track and report on client journeys, with a supporting data collection and monitoring system that enables such monitoring, yet also maintains some degree of flexibility for service providers due to the diversity of services provided. Multiple service provider stakeholders referenced the current SHS Program Logic, stating that the sector would benefit from an updated program logic in order to reflect the current environment, and that personalised program logics for each service provider may support flexibility in tracking outcomes.

"We want to view the client's trajectory. We want to be able to track employment, income and see how effective the service has been and its economic value". – Community Housing Provider

The DEX tool used by TEI program providers was highlighted as an example of a tool which could support the provision of up-to-date information on SHS client outcomes through the ability to run automated CIMS reports. There is a minimum dataset that all TEI service providers must report against, captured as mandatory reporting requirements in the Data Exchange (DEX).[196] This ensures that sufficient information is captured to support continuous improvement of the TEI program over time.[197]

5.3 Outcomes Evaluation

The following outcomes evaluation questions were considered during the Evaluation:

- Is SHS achieving the intended outcomes?
- To what extent do outcomes vary across cohorts and locations?

5.3.1 SHS intended outcomes

The SHS Program's primary objective is to ensure people who are experiencing homelessness, or who are at risk of homelessness, are supported to achieve safe and stable housing in the community.[198]

Other key objectives[199] of the Program include:

- SHS clients are identified and supported to remain safely in their existing housing, or to secure stable housing which is affordable for the person;

[196] DCJ. (2023). TEI Data Collection and Reporting Guide. Retrieved from TEI Data Collection and Reporting Guide | Family & Community Services (nsw.gov.au).

[197] Ibid.DCJ. (2023). TEI Data Collection and Reporting Guide. Retrieved from TEI Data Collection and Reporting Guide | Family & Community Services (nsw.gov.au).

[198] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[199] Ibid.

- SHS clients are provided with safe and secure accommodation and supported to access stable housing which is affordable for the person;
- SHS clients are re-housed after experiencing homelessness and are supported across the broader service system to stay housed;
- SHS clients are supported to access mainstream and specialist services; and
- SHS clients are supported to connect with community and family.

In addition to the Program's objectives, as defined by the SHS Program Specifications, the SHS Program has a range of short-, medium- and long-term intended outcomes as included in the SHS Program Logic. These outcomes span three domains: Housing, Safety and Wellbeing.

As outlined in the Methodology and Limitations sections earlier in this report, the Evaluation Team had access to limited outcomes-related data for the purpose of this Evaluation. Hence, findings below draw on some analysis of the administrative data, however, predominantly focus on qualitative findings from SHS client interviews and other relevant stakeholder consultations.

Is SHS achieving the intended outcomes?

Key Findings

Although the degree of met need across SHS accommodation services remained low relative to demand, linkage of SHS data with social housing data suggests achievement of some of the intended SHS program outcomes related to housing.

- Almost 14% (≡37,321) of SHS clients accessed community housing during the evaluation period. Over 28% (≡10,596) of these clients were successfully housed in community housing while being supported by SHS, with the vast majority (82% % ≡ 8,689) of this cohort able to be housed in a community housing property within six months. Clients who accessed a community housing property before their SHS support ended were more commonly single parents, compared to lone persons and Aboriginal and/or Torres Strait Islander clients, who were identified as more commonly accessing community housing after their SHS support ended.
- Over 12% (≡33,765) of SHS clients accessed public housing during the evaluation period and over 1 in 5 (≡6,955) of those clients were successfully housed in public housing after having first accessed SHS.[200] Aboriginal and Torres Strait Islander clients more commonly required SHS support, while being housed in a property and more commonly sought SHS support after their tenancy ended when compared to other SHS client cohorts.

Other SHS outcomes, linked to the Program Logic, were more challenging to analyse due to data limitations present for this Evaluation (detailed in Section 3.9). However, some outcomes related to the Safety and Wellbeing domains were observed with the limited client outcomes data available, coupled with insights from SHS client interviews.

- In the Safety domain, assistance for DFV and relationship breakdown was frequently associated with repeated presentations to SHS, with over 7 out of 10 return clients (≡22,955 of 33,384) returning the same year and for the same reason.
- In the Wellbeing domain, SHS clients interviewed reported an improved sense of confidence, independence and connection to family, friends and community as a result of their support from SHS. The administrative data also indicated that nearly 9 out of 10 students in primary

[200] Community housing and public housing are social housing properties. Public housing is managed by DCJ and Aboriginal Housing Office while community housing properties are managed by not-for-profit, non-government registered community housing organisations.

Key Findings

(≡22,964 of 25,695) and secondary schools (≡23,685 of 26,939) were able to successfully continue their studies throughout their SHS support periods.

Another indicator to assess achievement of outcomes may be return to services.[201] Whilst the majority of SHS clients did not return for support, more than 1 in 3 clients (≡102,656) re-presented to SHS over the evaluation period. Of those who re-presented to SHS in the same year, 60.3% (≡25,494) re-presented with the same service need most. Clients returning in the same year most often sought housing and support to access services for DFV and relationship breakdown needs.

In addition to the data limitations in responding to this question, it is also important to consider external factors which may impact the SHS Program's ability to achieve outcomes. Service providers are impacted in their ability to meet client needs by barriers or factors outside of their control, including, but not limited to, limited resourcing relative to client need and demand, limited housing stock to support exit pathways and low vacancy rates, and limited availability of other services with which to link clients in the local area. Service providers particularly highlighted achievement of housing outcomes, or objectives as outlined in the SHS Program Specifications, as *"unachievable in many cases"* due to such external factors as housing stock availability and affordability, as outlined in the report.

"If measuring outcomes on housing, sometimes it can feel like we're not doing much at all as the reality is that houses are not available" – SHS service provider

Housing outcomes

Shortages in and barriers to accessing accommodation was a common discussion theme amongst all stakeholders. During the consultation process, service providers highlighted the limited capacity and availability of accommodation options. Restrictions in both long- and short-term accommodation, such as refuges or temporary housing, to support clients in crisis situations were highlighted consistently by stakeholders.

Meeting client needs was reported to be difficult due to limited housing stock affecting the availability of government subsidised accommodation and was also reported to reduce the stock of affordable housing options in private rental markets. Chronic shortages of affordable accommodation choices were raised as an issue preventing service providers from adequately supporting their clients, perceived by SHS stakeholders as causing people to cycle in and out of the SHS system. These challenges were reflected in the administrative data; assistance with accommodation was frequently associated with repeated presentation, with nearly 8 out of 10 return clients returning the same year continuing to seek these supports.

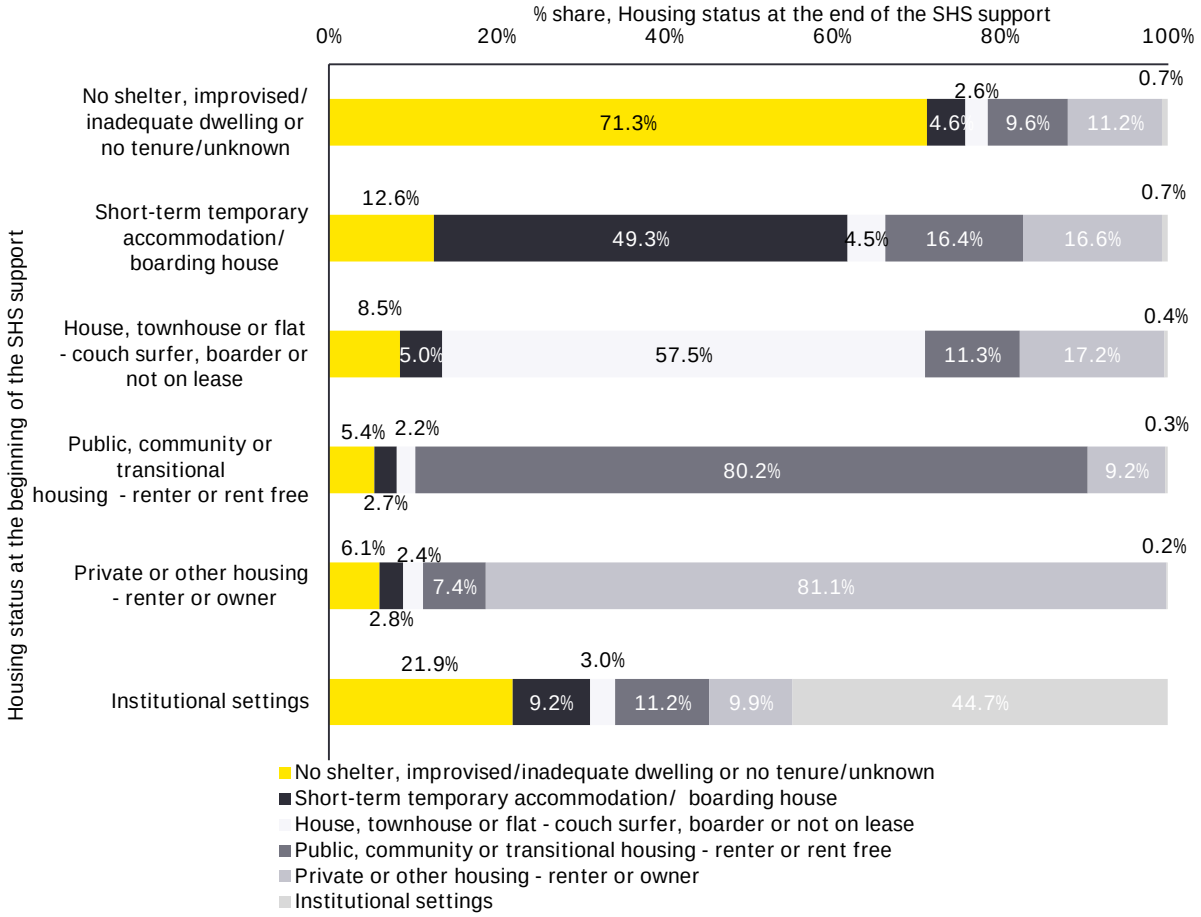
"[Service provider] had 3 of us attend a course which was a teleconference with people from housing, real estate, everyone in the know about how to get a rental. Ironically, following their advice, I got the next application which was my 45th rental application." – SHS client

Limited achievement of housing outcomes was also reflected in the analysis of administrative data. Figure 23 presents the change in SHS client's housing status as reported at the time of presenting to

[201] It is important to consider that returning to SHS is not necessarily a negative outcome, particularly if it is for a different reason than the initial reason for support; it could be an indication of the provision of trauma-informed support and the client's trust in the system. Similarly, a client may choose not to return to SHS, even if they still have support needs, as they may have had a negative experience with the service provided.

SHS and then at the end of their SHS support period.[202] This analysis represents the short-term outcomes of the SHS support.

Figure 23: Change in client housing status at the end of the SHS support period[203]



Source: NSW Homelessness Data (CIMS and equivalent systems)

The majority of clients remained in the same type of accommodation pre- and post- SHS support, including those that were in improvised dwellings. For those who were accommodated in an institutional facility at the beginning of their SHS support, almost 45% remained in, or returned to, an institutional facility at the end of their SHS support period.

[202] Housing status was defined using the information on tenure and occupancy reported at the beginning and end of the SHS support period. The category 'No shelter or improvised/inadequate dwelling or unknown' includes 'Renter or Rent-free-caravan park', 'No tenure', 'Don't know'; the category 'Short-term temporary accommodation/boarding house' includes ' Renter or rent-free boarding house' and 'Renter or rent-free – emergency accommodation'; the category ' House-townhouse or flat-couch surfer' includes 'Renter or rent-free-private housing/public/community/transitional housing' with the condition that occupancy status was reported as 'Lease in place-not on lease', 'Couch surfer' and 'Boarder'; the category 'Public, community or transitional housing – renter or rent free' includes 'Renter or rent-free-public/community/transitional housing' with the condition that occupancy status was reported as 'Leased tenure-on lease', 'living with relative fee free', 'Other', ' Occupancy not reported' and tenure reported as 'Other rent free'. The category 'Private or other housing – renter or owner' includes 'Renter or rent free-private housing', 'Other renter', 'Life tenure scheme', 'Owner shared equity or rent/buy scheme', Owner-being purchased/with mortgage', 'Owner-fully owned' with occupancy status reported as 'Leased tenure-on lease', 'living with relative fee free', 'Other', ' Occupancy not reported'. The category 'Institutional setting' includes individuals who reported their dwelling as 'hospital', 'psychiatric hospital or unit', 'Disability support', 'Rehabilitation', 'Adult correctional facility', 'Youth detention centre', 'Boarding school/residential college', 'Aged care facility', or 'Immigration detention centre' with the condition that tenure was reported as 'No shelter or improvised/inadequate dwelling or unknown' as defined above.

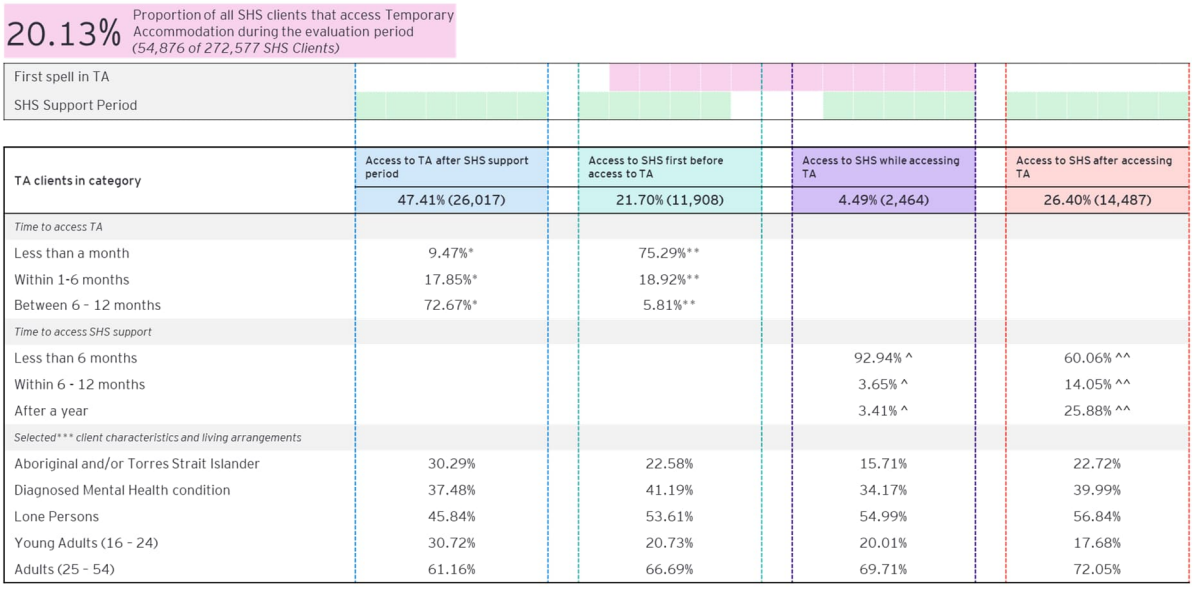
[203] The length of SHS support varies significantly. Due to waiting times to access accommodation, it is unlikely that SHS clients with short support period(s) will be directed towards and provided access to a different type of dwelling between the start and end of their support period. This may skew the data towards clients recording the same type of dwelling before and after the SHS support period.

For those who were already in short-term temporary accommodation at the time of accessing SHS support, almost half (49.3%) remained in that (or other) temporary accommodation. For all other housing status categories, between 2.7% and 9.2% of clients accessed short-term accommodation within or after their SHS support period.

Acknowledging that some housing outcomes may be achieved after the end of the SHS support period due to increased waiting times to access housing, additional analysis was performed to understand SHS client access to TA, community and public housing.[204] Linking CIMS and equivalent systems data with other administrative data enabled the development of SHS client journeys in accessing different type of housing before, during and after SHS support. This analysis provides a broader picture of medium- and long-term housing outcomes of SHS clients.

Figure 24 presents the SHS client journey in accessing TA. The SHS client journey was divided into four time periods detailing the time when the client accessed SHS support. As noted in the figure, the clients may have accessed TA after first accessing SHS support (the blue and teal categories) or they may have received SHS support after first receiving TA (the purple and red categories).

Figure 24: Breakdown of SHS client journey with Temporary Accommodation



TA clients in category	Access to TA after SHS support period	Access to SHS first before access to TA	Access to SHS while accessing TA	Access to SHS after accessing TA
	47.41% (26,017)	21.70% (11,908)	4.49% (2,464)	26.40% (14,487)
Time to access TA				
Less than a month	9.47%*	75.29%**		
Within 1-6 months	17.85%*	18.92%**		
Between 6 - 12 months	72.67%*	5.81%**		
Time to access SHS support				
Less than 6 months			92.94% ^	60.06% ^^
Within 6 - 12 months			3.65% ^	14.05% ^^
After a year			3.41% ^	25.88% ^^
*Selected*** client characteristics and living arrangements*				
Aboriginal and/or Torres Strait Islander	30.29%	22.58%	15.71%	22.72%
Diagnosed Mental Health condition	37.48%	41.19%	34.17%	39.99%
Lone Persons	45.84%	53.61%	54.99%	56.84%
Young Adults (16 - 24)	30.72%	20.73%	20.01%	17.68%
Adults (25 - 54)	61.16%	66.69%	69.71%	72.05%

* Comparing the end of SHS period with the beginning of the TA period
** Comparing the beginning of SHS with the beginning of the TA period
^ Comparing the beginning of the TA period with the beginning of the SHS period
^^ Comparing the end of the TA period with the beginning of the SHS period
*** The table presents only selected characteristics to demonstrate the key differences between each category. Other and not reported categories had small differences. Characteristics cannot be summed up and presents the share of clients with selected characteristics compared to other clients.

Source: NSW Homelessness Data (CIMS and equivalent systems) and HOMES

Over 1 in 5 SHS clients (20.1%) accessed TA during the evaluation period overall throughout those time periods listed. Nearly 50% (47.4%) of clients accessed TA after first accessing SHS support (the blue category) and the majority (72.7%) received access after at least six months. Compared to other categories, many of these clients were young adults aged 16-24 years (30.7%). A smaller proportion of clients (21.7%) received access to TA while concurrently receiving support from SHS (the teal category), with the majority of these clients being housed in TA within a month of their SHS support (75.3%). Over 30% (the purple and red categories above) of clients who received TA at some point in their SHS journey engaged with SHS after first accessing TA, suggesting that TA was a pathway into SHS, with almost 93% (92.9%) of clients receiving SHS support within 1 to 6 months of accessing TA. The analysis showed that, on average, TA as a pathway into SHS was less common for Aboriginal

[204] Community housing and public housing are social housing properties. Public housing is managed by DCJ and Aboriginal Housing Office while community housing properties are managed by not-for-profit, non-government registered community housing organisations.

and/or Torres Strait Islander clients and young adults aged 16-24 years and more common for lone persons and adults aged 25-54 years.

A SHS client journey was also developed for clients accessing social housing properties to understand their medium- to long-term housing outcomes. Social housing, as recorded in the HOMES and CHIMES data collections, can be either public housing properties managed by DCJ and the Aboriginal Housing Office, or community housing properties managed by not-for-profit and non-government registered community housing organisations. Whilst access to both social housing options are based on similar criteria, community housing properties that are not managed by state government bodies are often of a smaller scale and may offer options for clients to participate in community life and hence foster their independence and integration into society.[205]

In total, 1 in 4 SHS clients were housed in social housing properties over the evaluation period, with about 2 % of all SHS clients having accessed both public and community housing over the evaluation period (i.e., due to transfers between properties). Further analysis was performed to develop the SHS client journeys with community housing (presented in Figure 25) and with public housing (presented in Figure 26). Similarly, as with TA properties, the SHS client journey was divided into a timeline regarding their timing in accessing SHS support.

Figure 25: Breakdown of SHS client journey with community housing[206]

13.65% Proportion of all SHS clients that access Community Housing during the evaluation period *(37,231 of 272,577 SHS Clients)*

Community Housing Period

SHS Support Period

Community House clients in category	Access to Community housing post-SHS support period	Access to Community housing after first accessing SHS	Access to SHS after first accessing Community housing	Access to SHS post accessing Community housing
	44.40% (16,529)	28.46% (10,596)	20.87% (7,771)	6.27% (2,335)
Time to access Community Housing				
Less than a month	6.44%*	29.31%**		
Within 1-6 months	20.29%*	51.44%**		
Between 6 - 12 months	73.26%*	19.24%**		
Time to access SHS support				
Less than 6 months			9.56% ^	22.66% ^^
Within 6 - 12 months			9.21% ^	19.10% ^^
After a year			81.23% ^	58.24% ^^
*Selected*** client characteristics and living arrangements*				
Aboriginal and/or Torres Strait Islander	32.11%	27.54%	35.03%	47.71%
Lone Persons	33.49%	29.28%	30.00%	28.39%
Single Parents	33.47%	36.93%	38.12%	37.73%
Young Adults (16 - 25)	25.34%	23.53%	23.09%	21.28%

* Comparing the end of SHS period with the beginning of the CHIMES period
** Comparing the beginning of SHS with the beginning of the CHIMES period
^ Comparing the beginning of the CHIMES period with the beginning of the SHS period
^^ Comparing the end of the CHIMES period with the beginning of the SHS period
*** The table presents only selected characteristics to demonstrate the key differences between each category. Other and not reported categories had small differences. Characteristics cannot be summed up and presents the share of clients with selected characteristics compared to other clients.

Source: NSW Homelessness Data (CIMS and equivalent systems) and CHIMES

As shown in Figure 25 , almost 14% (13.6%) of SHS clients accessed community housing during the evaluation period. A larger share of clients accessed community housing after first engaging with SHS (the blue and teal categories) compared to those who sought SHS support while being housed or after being housed in a community housing property (the purple and red categories). Over 44% (44.4%) of SHS clients successfully accessed community housing after their SHS support period (the blue category). Approximately 1 in 4 of these clients (26.7%) were housed in community housing within six months, and the rest of this cohort were required to wait more than six months until their application had been processed and they could access an available community housing property.

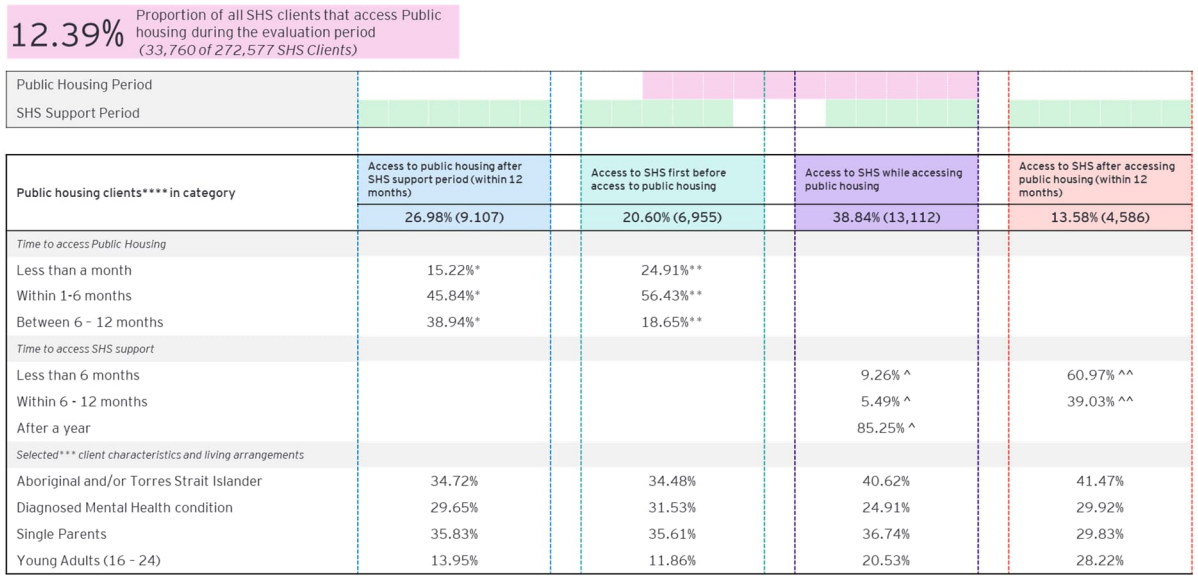
[205] Inner Sydney Voice. Regional Social Development Council. (n.d.) Community vs Public Housing. Retrieved on 23 August, 2023 from https://innersydneyvoice.org.au/our-resources/resources-waterloo-community-capacity-building-project/social-housing-types/.
[206] Analysis of SHS client housing journeys combines all transfers between properties assuming one ongoing tenancy and does not consider SHS support to transfer between accommodation.

Over a quarter (28.4%) of clients were housed in community housing while being supported by SHS (the teal category) and for most of them (82%), they were able to be housed in a community housing property within six months. Clients who accessed a community housing property before their SHS support ended (the teal category) were more commonly single parents, compared to lone persons and Aboriginal and/or Torres Strait Islander clients, who were identified as more commonly accessing community housing after their SHS support ended (the blue category).

The CHIMES data collection records information about a client's exit from their community housing property, offering the opportunity to identify positive and negative terminations of tenancy agreements. A positive exit describes the tenancy end with a positive outcome, i.e., a transition to a stable and independent housing arrangement, while a negative exit denotes a negative tenancy end, i.e., a breach of the tenancy agreement.[207] Of all clients who accessed a community housing property over the evaluation period (14% of all SHS clients), approximately 32% of clients exited their tenancy and 67% continue to reside in the property, as observed over the evaluation period. Of those who exited their tenancy, most clients (25%) exited due to other reasons such as the tenant initiated the exit or they experienced changes to long-term care living arrangements, and 4% experienced a negative exit.[208] A small share of clients (4%) successfully transitioned to stable and independent housing arrangements as observed over the evaluation period. From those clients who have been supported to access community housing property (the blue and the teal categories), 4 % transitioned to stable and independent housing arrangements and less than 3% experienced a negative exit.

The SHS client journey in accessing public housing properties is presented in Figure 26. Whilst a similar share of SHS clients accessed public housing properties over the evaluation period (in total 12.4% compared to 13.6% accessing community housing), less than half of these clients accessed public housing as a result of SHS support, compared to over 70% accessing community housing. This may suggest that access to properties managed by DCJ and the Aboriginal Housing Office may receive a higher share of applications, reducing the number of clients who are successful in accessing the property.

Figure 26: Breakdown of SHS client journey with public housing[209]



Public housing clients**** in category	Access to public housing after SHS support period (within 12 months)	Access to SHS first before access to public housing	Access to SHS while accessing public housing	Access to SHS after accessing public housing (within 12 months)
	26.98% (9,107)	20.60% (6,955)	38.84% (13,112)	13.58% (4,586)
Time to access Public Housing				
Less than a month	15.22%*	24.91%**		
Within 1-6 months	45.84%*	56.43%**		
Between 6 - 12 months	38.94%*	18.65%**		
Time to access SHS support				
Less than 6 months			9.26% ^	60.97% ^^
Within 6 - 12 months			5.49% ^	39.03% ^^
After a year			85.25% ^	
*Selected*** client characteristics and living arrangements*				
Aboriginal and/or Torres Strait Islander	34.72%	34.48%	40.62%	41.47%
Diagnosed Mental Health condition	29.65%	31.53%	24.91%	29.92%
Single Parents	35.83%	35.61%	36.74%	29.83%
Young Adults (16 - 24)	13.95%	11.86%	20.53%	28.22%

* Comparing the end of SHS period with the beginning of the PH period

[207] The exit from a community housing property was defined using the information recorded by variables *terminationreason* and *wherenexthoused* available in the CHIMES data collection. A positive exit is defined if the exit is tenant-initiated (request notice or short notice) and was housed in an affordable/social housing property, private rental or ownership. A negative exit includes any type of breaches of tenancy agreement.

[208] Other exits included tenant initiated exits, changes to long-term care living arrangements, and cases when clients are deceased or were institutionalised. This excludes all transfers between properties labeled as transfer, relocation or mutual change.

[209] Analysis of SHS client housing journeys combines all transfers between properties assuming one ongoing tenancy and does not consider SHS support to transfer between accommodation.

** Comparing the beginning of SHS with the beginning of the PH period
^ Comparing the beginning of the PH period with the beginning of the SHS period
^^ Comparing the end of the PH period with the beginning of the SHS period
*** The table presents only selected characteristics to demonstrate the key differences between each category. Other and not reported categories had small differences. Characteristics cannot be summed up and presents the share of clients with selected characteristics compared to other clients.
****The analysis of SHS client journey combines all transfers between properties assuming one ongoing tenancy and does not consider SHS support to transfer between accommodation.

Source: NSW Homelessness Data (CIMS and equivalent systems) and HOMES

Some 27% of clients accessed public housing after their SHS support ended (the blue category) and about 21% (20.6%) of clients had their application processed and received public housing while being supported by SHS (the teal category). For those clients who received public housing whilst being supported by SHS, the time taken to access housing was, on average, shorter compared to prospective community housing tenants, with the majority (81.3%) accessing public housing within six months. Based on the described SHS client journey accessing public housing, a large share of clients (38% compared to 21% of community housing tenants) required SHS support while being housed (the purple category) and 14% (compared to 6% of community housing tenants) engaged with SHS within 12 months after their tenancy ended (the red category). Notably, Aboriginal and Torres Strait Islander clients more commonly required SHS support while being housed in a property and more commonly sought SHS support after their tenancy ended compared to other SHS client cohorts.

As for community housing tenants, the analysis explored SHS client positive and negative exits from public housing properties. Of all clients housed in a public housing property during the evaluation period, 73% of clients continue to maintain their tenancy and the remainder initiated an exit. Approximately 16.9% exited public housing due to other reasons, 5% had a negative exit and about 4.8% successfully transitioned to stable and independent housing arrangements, as observed over the evaluation period.[210]

Increased proportions of SHS clients accessing government housing assistance is also an intended outcome of the SHS program as per the SHS program logic and SHS Program Specifications.[211] Early prevention strategies, including the provision of prevention payments (commonly referred to as private rental assistance), can be provided to SHS clients to overcome housing affordability challenges and enter or sustain a tenancy in the private rental market. About 11.5% of SHS clients received one or more prevention payments over the evaluation period, with an average total payment of $1,068, directed towards rental assistance or assistance with bond payments. Of this group, approximately 25% received one prevention payment, 42% received two prevention payments, and 33% received three or more payments. The type (and average amount) of available prevention payments were:[212]

Single payments:	Ongoing payments
• BRK bond loan ($1,020.45) • Bond Assistance ($481.43) • Advanced Rent ($490.02) • Tenancy Guarantee ($488.39)	• Rental Choice assistance ($478.1) • Rental Assistance ($496.43)

According to the administrative data, there was a slight increase in the proportion of SHS clients supported to receive welfare payments and employment support over the evaluation period, from

[210] Other exits included tenant initiated exits, changes to long-term care living arrangements, and cases when clients are deceased or were institutionalised. This excludes all transfers between properties labeled as transfer, relocation or mutual change.

[211] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

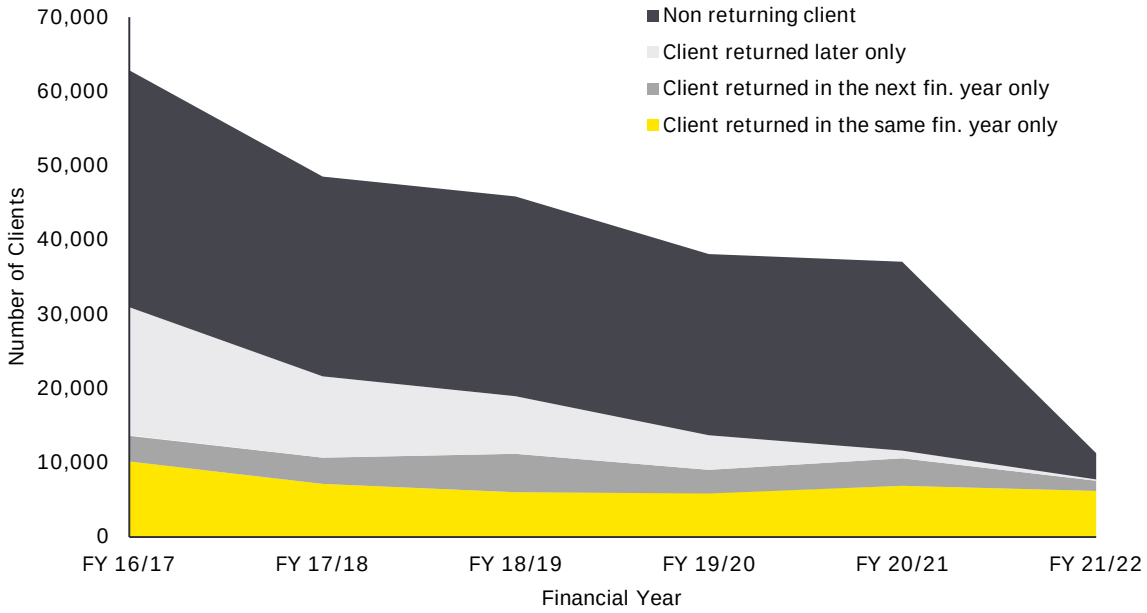
[212] Advanced Rent, Rental Choice Assistance, Tenancy Guarantee, Bond Assistance and Private Rental Assistance are assumed to be funded by DCJ: Eligibility for private rental assistance | Family & Community Services (nsw.gov.au).

1.8% in FY 16/17 to 2.5% in FY 21/22, however for almost 93% of SHS clients whose income status was reported, their income status had not changed at the end of their SHS support period.

Return to services

Figure 27 demonstrates the trend of clients returning to SHS services over time.[213] The majority of SHS clients did not return for support (as shown in black), which may suggest the achievement of the intended program outcomes.[214] More than 1 in 3 clients re-presented to services. Returning clients most commonly re-presented in the same financial year (41.2%) (as shown in yellow) or sought support beyond the next financial year after originally seeking support (40.9%) (as shown in grey). 17.9% of returning clients returned in the financial year immediately following their original request for support (as shown in blue). This may indicate that SHS services were able to successfully meet the short-term needs of clients, as the client only needed to re-enter SHS services after more than one financial year.

Figure 27: SHS clients return to service of SHS clients[215]



Source: NSW Homelessness Data (CIMS and equivalent systems)

Of the clients who returned to SHS in the same financial year as originally presenting, 60.3% of clients returned for the same reason of seeking assistance, which could suggest that clients may not have achieved the intended outcome of the support. When clients returned the following financial year for support, just less than half (48%) returned for the same reason, and just over half (52%) returned for a different reason, which may suggest a slight improvement in achievement of outcomes over time. However, when clients returned to SHS at some point after this i.e., beyond the next financial year,

[213] The analysis was performed for the evaluation period FY 16/17 – FY 21/22. A portion of clients whose first contact with the SHS Program appeared to be during the evaluation period may be returning clients who accessed the SHS Program prior to FY 16/17. This information is not observed in the analysis and for this reason the return to services may be slightly under-estimated, particularly for clients in earlier years of the evaluation period. Similarly, clients who accessed SHS services at the end of the evaluation period may appear as non-returning clients, because they return after FY 21/22, a time period which was not observed in this Evaluation. Hence, this will lead to over-reporting of the rates of non-returning, particularly for clients accessing SHS support at the end of the evaluation period.

[214] The journey beyond the SHS support period for non returning clients over the evaluation period is unobserved in the dataset. In some instances, SHS clients may experience dissatisfaction with the quality of services if their needs are not being met based on their preferences and may choose not to return to SHS.

[215] For the purposes of this analysis, the reported main reasons for assistance were categorised into six key categories: financial support, accommodation, DFV and relationship breakdown, health-related, other, or not reported. If the client reported the category 'other' or 'not reported' as the main reason for assistance during their first contact with the system, any category reported in later contacts is considered as a different main reason for assistance. The truncation of the analysis data did not allow observation of client engagement before FY 16/17. For this reason, some clients recorded in the first analysis year may have returned. Similarly, the analysis does not observe activity after FY 21/22, driving the return rate down in the later financial years of the analysis.

the results reverted to similar return statistics as clients returning in the same financial year; 59.6% returning for the same reason and 40.4% returning for a different reason.

Repeat presentations for the same reason were most frequently associated with housing and DFV and relationship breakdown needs (discussed below). In contrast, in cases when clients returned for a different reason, re-presentation was often associated with requests for financial assistance and other support, such as advice, information and legal support.

Although returning to service may be one potential indicator of achievement of client outcomes, it is important to note that it may not be a negative outcome if clients are re-presenting to SHS, particularly if it is for a different reason than the initial reason for support, as this could be an indication of the provision of trauma-informed support and the client's trust in the system. Similarly, a client may choose not to return to SHS, even if they still have support needs, as they may have had a negative experience with the service provided.

"I'm only now starting to dip my toes into the world. Although I'm getting on my feet now, if they were to leave, I would go back into a void" – SHS client

Safety

Assistance for DFV and relationship breakdown was frequently associated with repeated presentations, with nearly 7 out of 10 return clients returning the same year and for the same reason.

Stakeholders shared that funding requirements may have impacted the Program's ability to deliver outcomes, particularly with respect to youth and DFV clients. According to stakeholders, the Program focuses on housing-related outputs, particularly in the short-term, whereas, in their opinion, the Program needs to have a longer-term view on early intervention and prevention, to minimise the need for clients to access services in the future.

Many SHS clients interviewed received support due to family breakdowns or domestic violence and reported experiencing an immediate improved sense of safety upon arrival at the various SHS refuges, particularly due to the onsite staff and security measures such as cameras and pin code security systems.

"I feel safe in here and my case worker is making sure everything is safe" – SHS client

Stakeholders also expressed challenges in measuring outcomes related to safety and wellbeing, particularly for DFV clients. Although service providers recognised the benefits of tracking and measuring outcomes, they expressed some ethical discomfort with administering the PWI and COS surveys to clients in a heightened emotional state, such as those who have recently left a DFV situation.

"My opinion on PWI is that it is very tough on clients in crisis. They don't want you asking them how they are feeling – they have been through severe DV, they're worried about whether their children are going to eat." – SHS service provider

Wellbeing

During interviews, clients frequently highlighted the effectiveness of their SHS provider and caseworker in supporting them in achieving wellbeing outcomes. One of the key themes among clients was the receipt of support in accessing mental health services. Such support to engage in counselling and psychological services was reported to provide a foundation for an increase in the client's confidence to overcome other challenges related to housing, education and/or employment.

"They advised me to get counselling which I resisted at the beginning as I thought I was doing well, but I'm glad I made the decision to go to counselling and since I started going I've never stopped. I'm still with the same counsellor 4 years later. To be honest it changed my perspective completely, it made me mentally so strong, now I can face anything without fear." – SHS client

SHS clients interviewed also relayed an improved sense of confidence, independence and connection to family, friends and community as a result of their support from SHS. Similar findings were reflected in the SHS service provider survey data, whereby service providers reported SHS clients successfully achieving outcomes in health, economic and client empowerment, education and training domains.

Based on administrative data, most SHS clients who are students at primary, secondary or tertiary education facilities continued to study despite the challenges prompting them to seek support from SHS. Nearly 9 out of 10 students in primary and secondary schools successfully continued their studies. The highest dropout rates were found for students in vocational (1 in 5) and in university education (1 in 10). Despite some clients leaving education and training, approx. 2,400 clients of relevant age commenced studying at primary school and about 400 clients entered secondary schooling.

During interviews, clients shared how service provider support enabled their ongoing access to education. Some clients interviewed had successfully completed Certificate 1 and Certificate 2, acquired a diploma or commenced studying at university after engaging in SHS supports. Service providers also highlighted the success in achieving outcomes related to education and training. Less favourable outcomes were suggested for employment, with more than 9 out 10 clients of working age reporting that their income status had not changed since accessing SHS, with the majority of clients continuing to be supported by government pensions and allowances, according to the data.

One of the short-term outcomes under the Wellbeing domain in the SHS Program Logic is a reduced proportion of clients with closed SHS support periods due to disengagement from service. Over the evaluation period, 38.5% of clients disengaged from the service, of which in 54.6% of cases the client no longer requested assistance, in 35.8% of cases the service provider lost contact with the client, and in 9.6% of cases the client did not present.[216] The proportion of support periods that ended due to disengagement from service reduced over time, from 40.0% in FY 16/17 to 33.3% in FY 21/22, and the proportion of support periods that ended due to lost contact with the client also reduced over the evaluation period, from 14.3% to 12.9%.[217]

To what extent do outcomes vary across cohorts and locations?

Key Findings

Variation in outcomes was observed across a range of key cohorts. Analysis was conducted for children aged 12-15 years, young adults aged 16-24 years and Aboriginal and Torres Strait Islander clients, across the domains of housing, safety (DFV and relationship breakdown), and wellbeing (education and cultural accessibility), with trends also observed across DCJ Districts.

- For all three examined cohorts of interest, the majority of clients remained in the same type of accommodation from the beginning to the end of their SHS support period, whether that be an improvised or inadequate dwelling, an institutional setting, or some other form of more stable housing.

- A higher share of children aged 12-15 who were staying in short-term temporary accommodation at the beginning of their SHS support transitioned to more stable housing by the end of their SHS support as compared to the total SHS cohort (39% (≡630) compared to 33% (≡11,426) respectively).[218] Children aged 12-15 were also more likely to be living in public, community or transitional housing upon presentation to SHS than the total SHS cohort (26% (≡5,224) compared to 17% (≡48,106) respectively).

[216] Disengagement with the client is defined using the information recorded at the end of the service and including the following categories: client no longer requested assistance, client did not turn up, lost contact with client.
[217] It must be noted that the proportion of support periods ending for unknown reasons (recorded as "Don't know" in the CIMS and equivalent systems) increased from 1.3% in FY16/17 to 16.7% in FY21/22. This disproportionate increase could be driven by the data entry error and may impact the interpretation of trends and patterns of the recorded service end reasons.
[218] More stable housing is considered to be 'public, community or transitional housing - renter or rent free' or 'private or other housing – renter or owner.'

Key Findings

- Sustained housing during the SHS support period for young adults aged 16-24 years varied considerably across DCJ Districts, from 10.4% (≡298) in Northern Sydney to 23.2% (≡692) in Murrumbidgee, with low rates of sustained housing outcomes compared to the total SHS cohort (24% (≡65,476)) consistent with stakeholder sentiment of the challenges in provision of suitable accommodation for young adults.[219]

- Sustained housing outcomes were also varied for Aboriginal and Torres Strait Islander clients across DCJ Districts, with the largest share of Aboriginal and Torres Strait Islander clients sustaining housing in Western Sydney (30% (≡1,412)) and the lowest in Northern Sydney (11.7% (≡67)), demonstrating notable cohort differences compared to the total SHS cohort (24% (≡65,476)).

- The overall rates of re-presentation to SHS varied between the three cohorts selected for the detailed cohort analysis. The lowest rates of return to services amongst these cohorts were observed for children aged 12-15 (35.0% (≡6,932) of all children re-presented), followed by young people aged 16-24 (42.0% (≡25,259)) and the highest rate of re-presentation was observed for Aboriginal and Torres Strait Islander clients (47.3% (≡34,731)), all compared to 37.7% (≡10,656) of the total SHS cohort.

- Of the three cohorts, children aged 12-15 more commonly presented to SHS seeking support with DFV and relationship breakdown as their main reason for seeking assistance (39.6% (≡7,797) of the cohort) compared to young people aged 16-24, 30.7% (=18,371) or Aboriginal and Torres Strait Islanders 27.2% (=19,967).

- The majority of children aged 12-15 were able to remain in schooling throughout their SHS support period, from 65% (≡86) in Murrumbidgee to 92% (≡761) in Far West NSW.

- The SHS Program met almost 84% (≡4,632) of needs requested by Aboriginal and Torres Strait Islander clients for culturally specific services, and almost 81% (≡2,913) of needs for assistance to connect culturally, which demonstrates strength in culturally appropriate service provision across the Program.

Housing outcomes

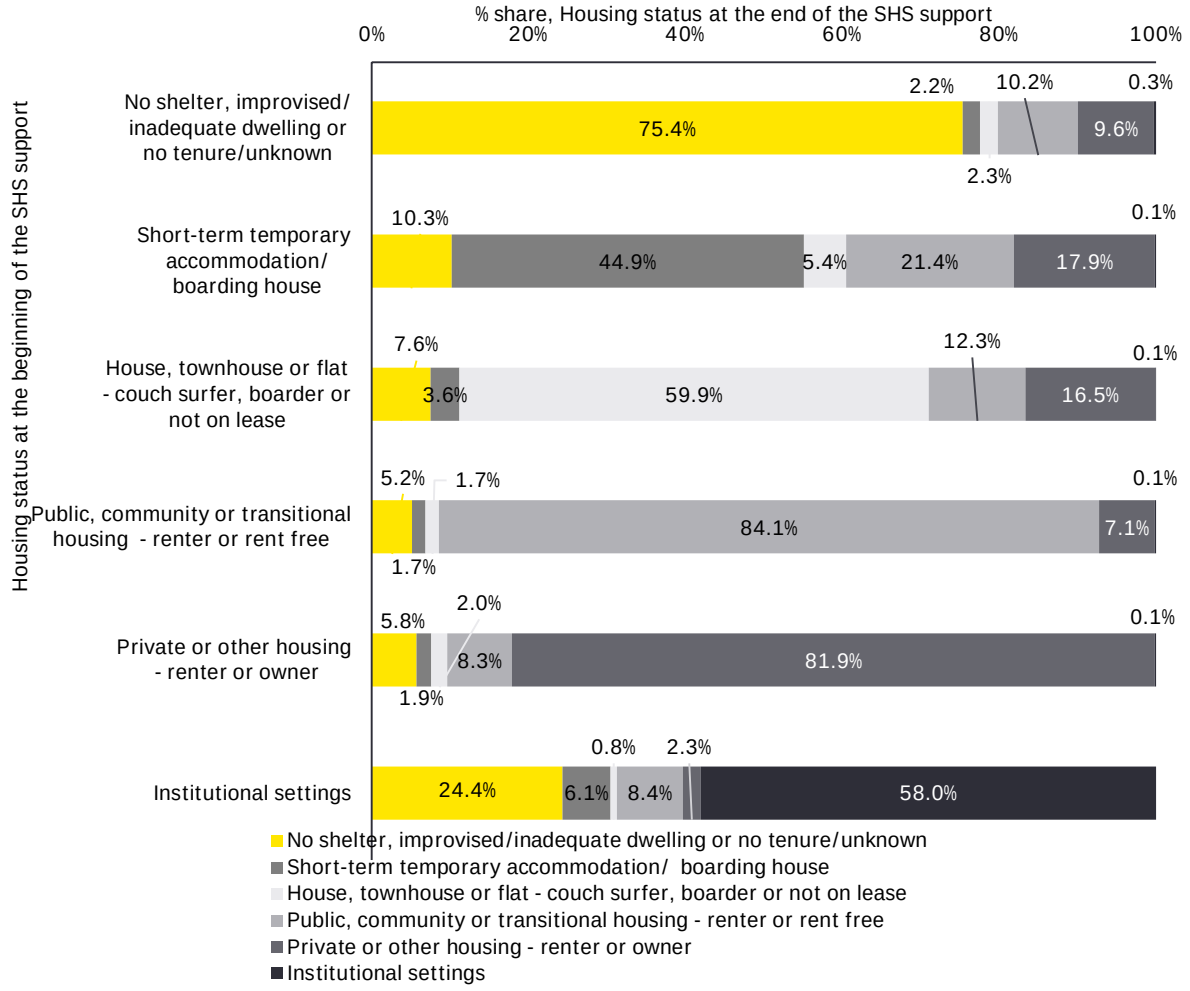
To inform analysis of the extent to which housing outcomes vary across cohorts, a cohort analysis was conducted to identify changes in housing status for specific SHS cohorts, as previously presented in Figure 23 for the entire SHS cohort. The change in housing outcomes presented herein estimates the share of clients that remained in the same housing or changed their housing status at the end of their SHS support compared to the beginning of their SHS support for children aged 12-15, young adults aged 16-24 years, and all Aboriginal and Torres Strait Islander clients.

Figure 28 presents the housing status for all children (accompanied and unaccompanied) aged 12-15 years at the beginning and end of their SHS support period.[220]

[219] It is considered that the client 'sustained housing' if the client reported being housed as a renter or owner in private, public, community or transitional housing at the beginning and end of their SHS support.

[220] Out of 19,811 children aged 12-15 years, approximately 42% were unaccompanied. It is expected that for children who are accompanied, their housing status may reflect that of their parents/legal guardians. Whilst the Evaluation observed a small share of unaccompanied children aged 12-15 being housed in public, community, transitional or private housing as renters, it is assumed that this may have been caused by data entry error and further analysis of sustained housing outcomes, as defined in this analysis, was not considered for this cohort in the Evaluation.

Figure 28: Change in client housing status for children aged 12-15 (in total 19,811 clients)



Source: NSW Homelessness Data (CIMS and equivalent systems)

Similar to the total SHS cohort as outlined in Figure 23, the majority of children aged 12-15 years remained in the same type of housing at the end of their SHS support period as compared to their housing at the beginning of their SHS support period. Approximately 75% of children remained in improved/inadequate dwellings and about 20% of those who were previously in inadequate dwellings transitioned to more stable housing.[221] A higher share of children aged 12-15 who were staying in short-term temporary accommodation at the beginning of their SHS support transitioned to more stable housing by the end of their SHS support as compared to the total SHS cohort (39% compared to 33%), suggesting that children aged 12-15 years may have had improved access to short-term housing options as compared to the total SHS cohort.

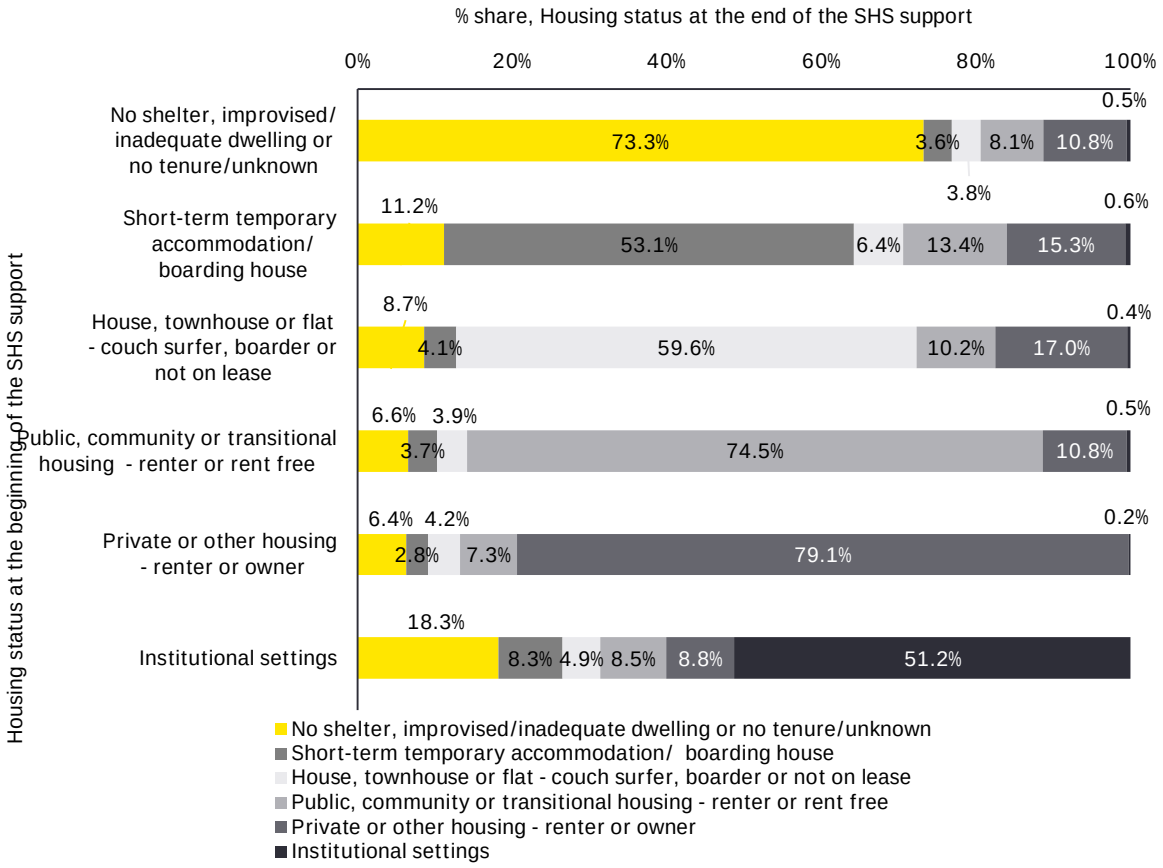
Compared to the total SHS cohort, children 12-15 years presenting to SHS were more commonly living in public, community or transitional housing (26% compared to 17%) and less commonly in institutional settings (0.7% compared to 1.9%). 58% of children aged 12-15 years who were housed in an institutional setting at the beginning of their SHS support remained in or returned to the institutional setting after SHS support and 10.7% transitioned to more stable housing. In contrast, about 45 % of the total SHS cohort who were housed in an institutional setting remained in or returned to the same housing arrangements, and more than 21% transitioned to more stable housing. This may suggest that SHS providers face greater challenges in supporting children in institutional

[221] Based on the definition of housing status presented in Figure 28, more stable housing is considered to be 'public, community or transitional housing - renter or rent free' or 'private or other housing – renter or owner'.

settings to access stable housing than adults, as they may require additional wraparound supports and targeted trauma-informed care.

The patterns of change in children's housing status are similar for young people aged 16-24 years. Figure 28 and Figure 29 present the housing status for young people aged 16-24 years at the beginning and end of their SHS support period.

Figure 29: Change in client housing status at the end of SHS support for young people aged 16-24 (in total 59,821 clients)

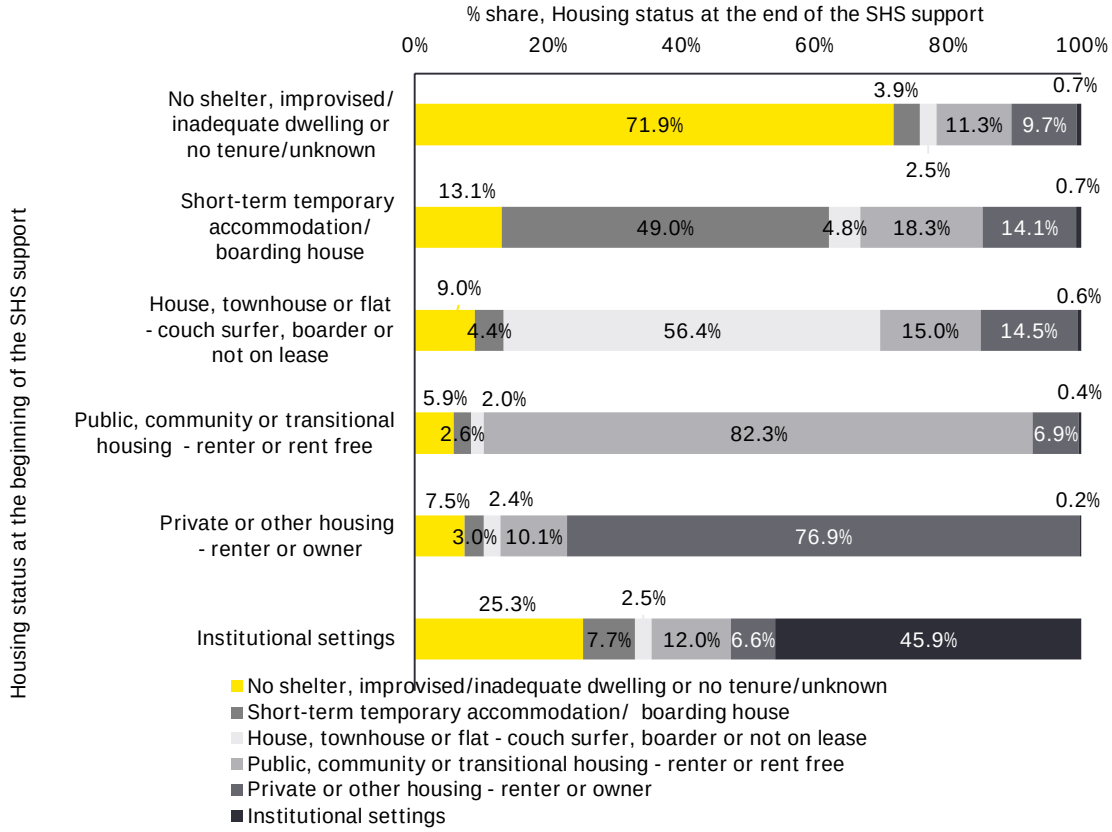


Source: NSW Homelessness Data (CIMS and equivalent systems)

The majority of these clients remained in the same housing arrangement at the end of their SHS support period as at the beginning of their SHS support period. Compared to the total SHS cohort, a larger share of young people aged 16-24 stayed in a house, townhouse or flat as a couch surfer or boarder at the beginning of the SHS support (14% compared to 7% respectively). Most of these clients continued to stay in this type of housing arrangement (almost 60%) and about 27% transitioned to more stable housing. A slightly lower share of young people transitioned to more stable housing after being housed in an institutional setting (17%) compared to the total SHS cohort (45%), albeit the share of clients living in an institutional setting at the beginning of their SHS support was similar (about 2%)

A similar pattern of results was observed for Aboriginal and Torres Strait Islander clients with the majority of clients continuing to remain in the same housing arrangement at the end of their SHS support period as at the start of their SHS support period.

Figure 30: Change in client housing status at the end of SHS support for Aboriginal and Torres Strait Islanders (in total 73,376 clients)



Source: NSW Homelessness Data (CIMS and equivalent systems)

In contrast to the SHS total cohort, a larger share of Aboriginal and Torres Strait Islander clients transitioned to public, community or transitional housing from couch surfer/boarder housing arrangements (15% compared to 11% respectively), yet a smaller share of these clients transitioned to private housing arrangements as a renter or owner (14.5% compared to 16.6% respectively). Similar trends are noted for Aboriginal and Torres Strait Islander clients who were housed in private or other housing as a renter or owner at the beginning of the support with a smaller share of these clients remaining in the same housing arrangement compared to the total SHS cohort (almost 77% compared to just over 81% respectively) and a larger share transitioning to public, community or transitional housing (10% compared to 7% respectively).

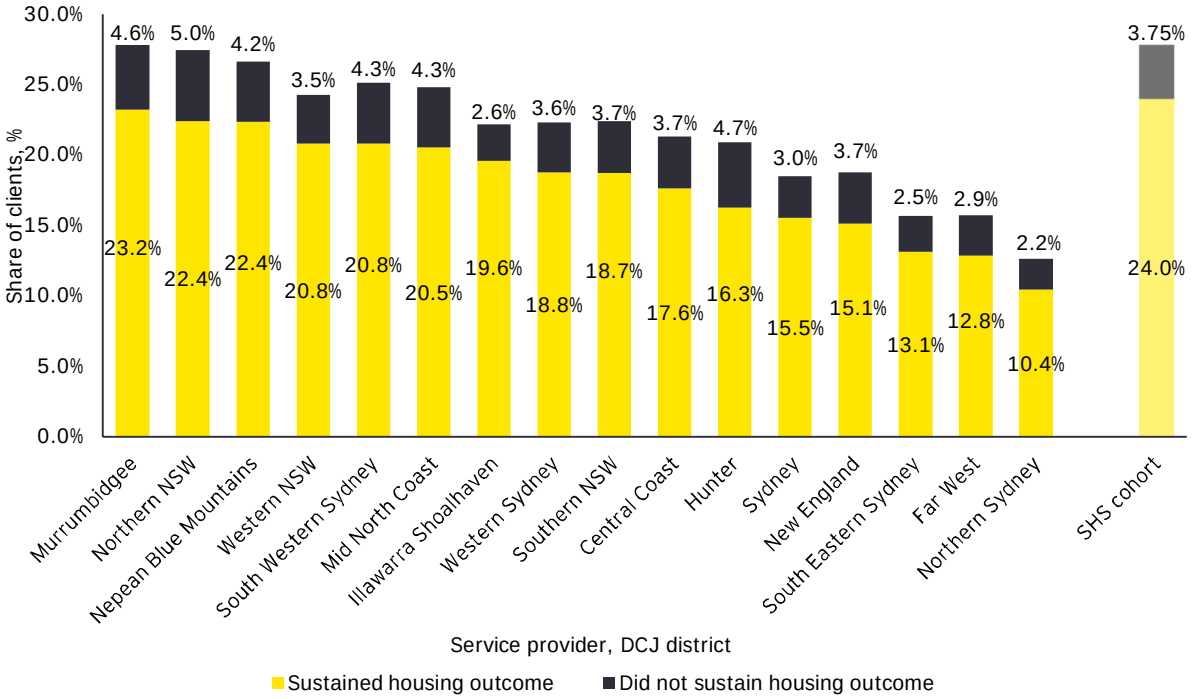
To support analysis of change in client's housing status, a comparative DCJ District analysis was performed to investigate the share of SHS clients that sustained stable housing arrangements at the end of SHS support compared to the beginning of SHS support. It is considered that the client 'sustained housing' if the client reported being housed as a renter or owner in private, public, community or transitional housing at the beginning and end of their SHS support period.[222] The analysis of sustained housing outcomes was conducted for Aboriginal and Torres Strait Islander clients and young adults aged 16-24 years.[223]

[222] Note that the analysis excludes those SHS clients who reported living in any of the listed accommodation options as "rent-free".

[223] Children aged 12-15 can present to SHS as accompanied or unaccompanied children. It is expected that for those who are accompanied, the sustained housing outcome would reflect the outcome for their parents/legal guardians. Whilst the Evaluation observed a small share of unaccompanied children aged 12-15 being housed in public, community, transitional or private housing as renters, it is assumed that this may have been caused by data entry error and further analysis of sustained housing outcomes, as defined in this analysis, was not considered for this cohort in the Evaluation.

Figure 31 presents the proportion of young people aged 16-24 years who sustained their housing during their SHS support period by DCJ District. The remaining clients in this cohort not reported in this figure reported being housed in other housing arrangements (i.e., they were not reported as renters or owners in private, public, community or transitional housing) at the beginning of their SHS support period.

Figure 31: Proportion of young people (16-24 years) who sustained housing during their SHS support period by DCJ District



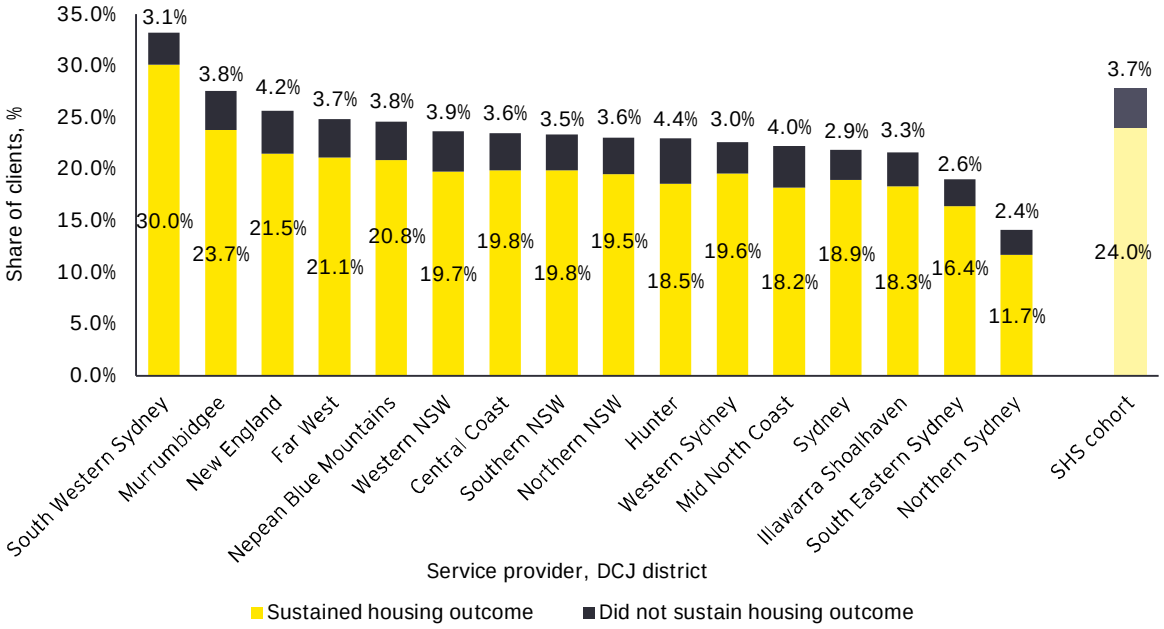
Source: NSW Homelessness Data (CIMS and equivalent systems)

Achievement of sustained housing outcomes during the SHS support period for young people aged 16-24 years varied considerably across DCJ Districts, from 10.4% in Northern Sydney to 23.2% in Murrumbidgee. Rates of sustained housing outcomes achieved for this cohort were lower compared to the total SHS cohort (24%), consistent with evidence from stakeholders regarding the challenges of providing suitable accommodation to young adults (please refer to Appendix 4). The limited achievement of outcomes in this domain for young people may also emphasise the importance of early intervention and preventative measures, as well as the provision of wraparound support to best enable sustainment of housing.

Figure 32 presents the proportion of Aboriginal and Torres Strait Islander SHS clients who achieved a sustained housing outcome at the end of their SHS support period by DCJ District.[224] The remaining clients in this cohort not reported in this figure reported being housed in other housing arrangements (i.e., they were not reported as renters or owners in private, public, community or transitional housing) at the beginning of their SHS support period.

[224] The shares presented in Figure 32 represent the share of clients who sustained a housing outcome during their SHS support. The remaining clients within the cohort reported being housed in a different type of dwelling at the beginning of SHS support. The sample included only clients who identified as Aboriginal and/or Torres Strait Islanders.

Figure 32: Proportion of Aboriginal clients who sustained housing during their SHS support period by DCJ District



Source: NSW Homelessness Data (CIMS and equivalent systems)

On average, across DCJ Districts, about 20.1% of Aboriginal and Torres Strait Islander clients achieved a sustained housing outcome at the end of their SHS support period, and about 3.6% did not sustain their housing at the end of their SHS support period. The number of Aboriginal and Torres Strait Islander clients who sustained their housing during SHS support varied across DCJ Districts, with the largest share of Aboriginal and Torres Strait Islander clients sustaining housing in South Western Sydney (30.0%) and the lowest in Northern Sydney (11.7%), demonstrating notable cohort differences compared to the total SHS cohort (24%). The highest share of Aboriginal and Torres Strait Islander clients that did not sustain their housing was found in the Hunter (4.4%) and New England (4.2%) DCJ Districts.

Safety

The overall rates of re-presentation to SHS varied between the three cohorts selected for the detailed cohort analysis. The lowest rates of return to services amongst these cohorts were observed for children aged 12-15 (35.0% of all children re-presented), followed by young people aged 16-24 (42.0%) and the highest rate of re-presentation was observed for Aboriginal and Torres Strait Islander clients (47.3%), all compared to 37.7% of the total SHS cohort. Of those who re-presented to SHS after their first interactions, more than 1 in 2 clients from these three cohorts re-presented for the same main reason for seeking support.[225]

Analysis of re-presentation to SHS for reasons of DFV and relationship breakdown was conducted for young adults aged 16-24 years, children aged 12-15 years and Aboriginal and Torres Strait Islander clients across DCJ Districts to observe any trends in cohorts seeking repeat support for this reason. The analysis considered clients who first presented to SHS with DFV and relationship breakdown as their main reason for seeking assistance and were observed to return for the same reason during the evaluation period.[226]

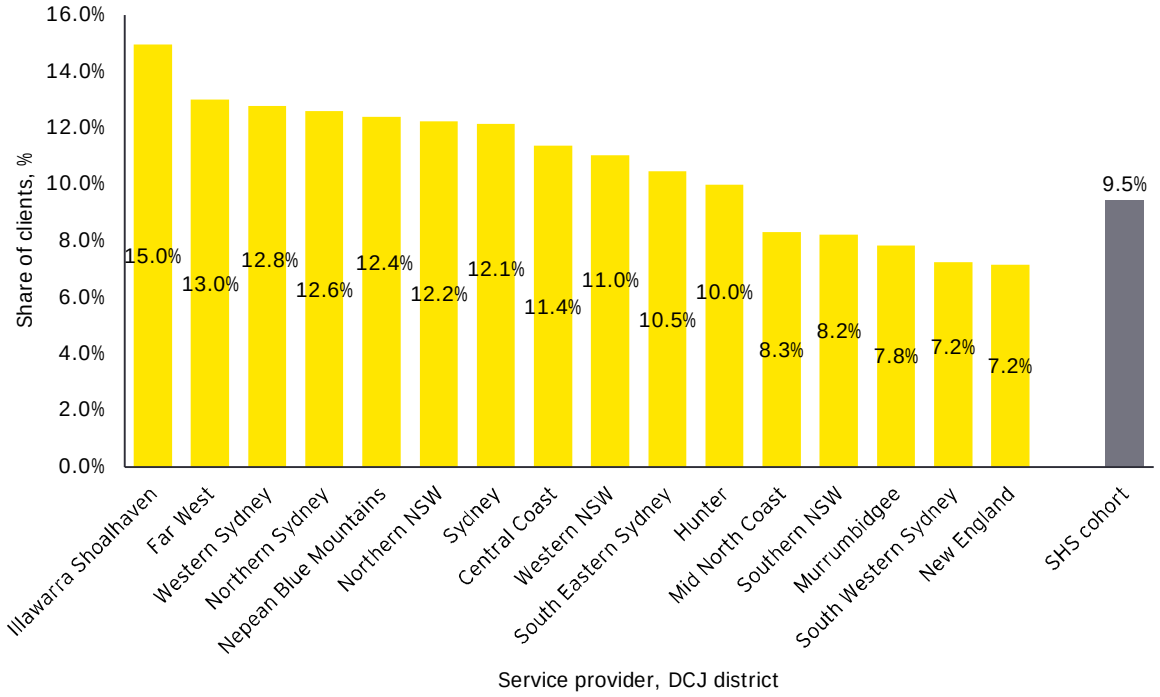
[225] Of all children aged 12-15 who re-presented to SHS after their first interaction, 54.2% re-presented for the same reason. The equivalent statistics for young people aged 16-24 and Aboriginal and Torres Strait Islander clients are 54.5% and 56.8% respectively.

[226] It is possible that clients may have returned for the same reason after the end of the evaluation period, however this was not observed for this Evaluation.

The figures below provide a comparative overview across cohorts and DCJ Districts and present the shares of young adults (Figure 33), children (Figure 34) and Aboriginal and Torres Strait Islander clients (Figure 35) who reported that their main reason for seeking SHS support was DFV and relationship breakdown in their first SHS support period and they subsequently re-represented to SHS for the same reason. The rest of the clients not reported in these Figures either did not return to SHS or presented to SHS for other reasons.

Of 59,820 clients who were young people aged 16-24, about 31% reported DFV and relationship breakdown as their main reason for seeking assistance during the evaluation period. In total, more than 1 in 10 of these clients (11%) returned to SHS later seeking support for the same reason, which is slightly higher than the proportion of SHS clients overall who return for this same reason (9.5%). As presented in Figure 33, the share of young people who returned to SHS for DFV and relationship breakdown varied considerably across DCJ Districts.

Figure 33: Young people (16-24 years): returned to SHS for support with DFV and relationship breakdown

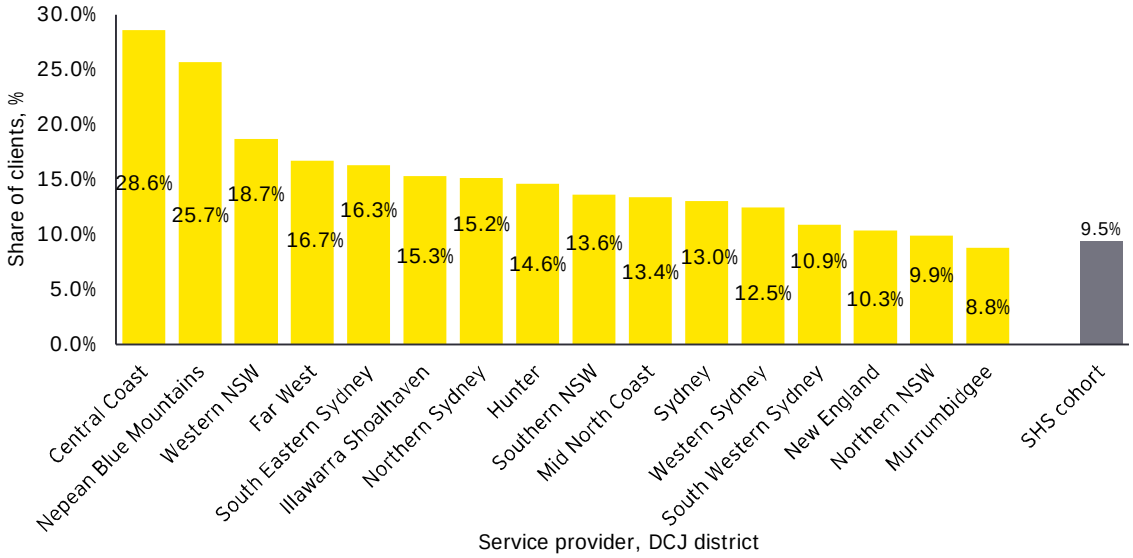


Source: NSW Homelessness Data (CIMS and equivalent systems)

The highest share of returning SHS clients seeking support for DFV and relationship breakdown was found in Illawarra Shoalhaven (15%) and the lowest share in the South Western Sydney and New England (7.2%) DCJ Districts. The majority of DCJ Districts, including metropolitan areas such as Sydney, had higher rates of re-presentation to SHS for this support reason as compared to the total SHS cohort (9.5%). Only in the Mid North Coast, Southern NSW, Murrumbidgee, South Western Sydney and New England DCJ Districts was the share of returning young clients lower compared to the total SHS cohort.

Figure 34 presents the variation in re-representation to SHS related to DFV and relationship breakdowns for children aged 12-15 years across DCJ Districts.

Figure 34: Children (aged 12-15 years): returned to SHS for support with DFV and relationship breakdown



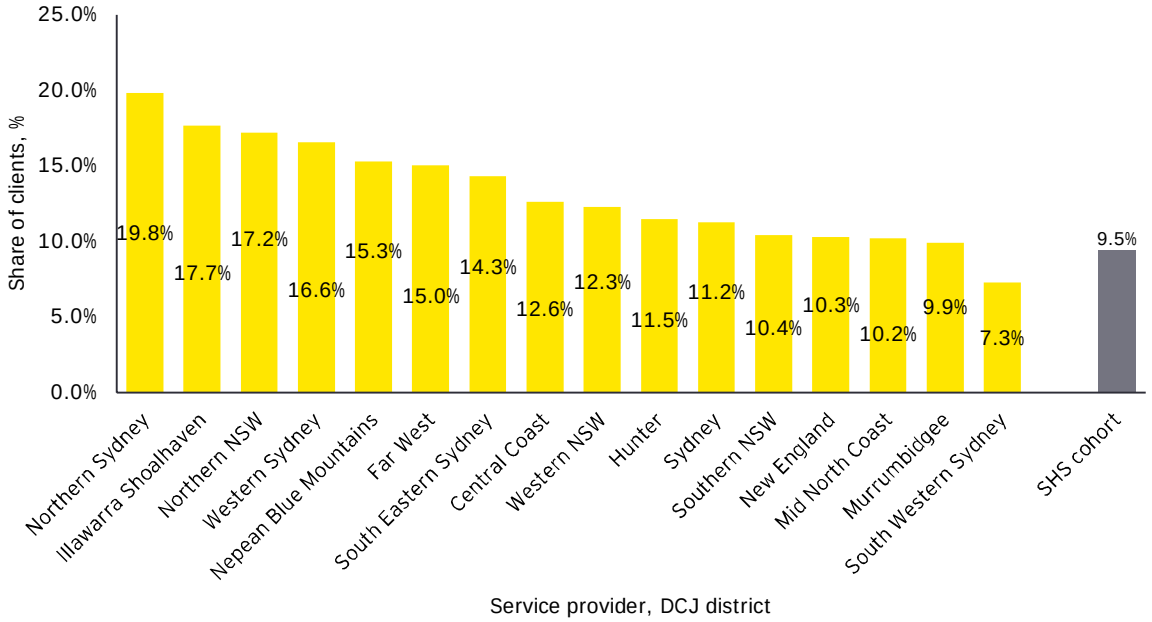
Source: NSW Homelessness Data (CIMS and equivalent systems)

Compared to the cohort of young people aged 16-24 years, a higher share of children aged 12-15 years presented to SHS seeking support with DFV and relationship breakdown as the main reason for seeking assistance (39.6% compared to 30.1%). On average, 15% of those children aged 12-15 years returned to SHS for the same reason.

Substantial variation in the share of returning children is observed across DCJ Districts, and in all except one DCJ District (Murrumbidgee), the share of children returning to SHS for support with DFV and relationship breakdown was higher than the total SHS cohort. The most notable differences appeared in the Central Coast (28.6%) and Nepean Blue Mountains (25.7%) DCJ Districts, where more than every fourth child aged 12-15 years returned to SHS seeking support for DFV and relationship breakdown. This could suggest that this cohort may need additional support in those DCJ Districts in order to meet their needs and prevent their return to SHS seeking support for the same reason.

Figure 35 presents the variation in re-representation to SHS related to DFV and relationship breakdowns for Aboriginal and Torres Strait Islander clients across DCJ Districts.

Figure 35: Aboriginal clients: return to SHS for support with DFV and relationship breakdown



Source: NSW Homelessness Data (CIMS and equivalent systems)

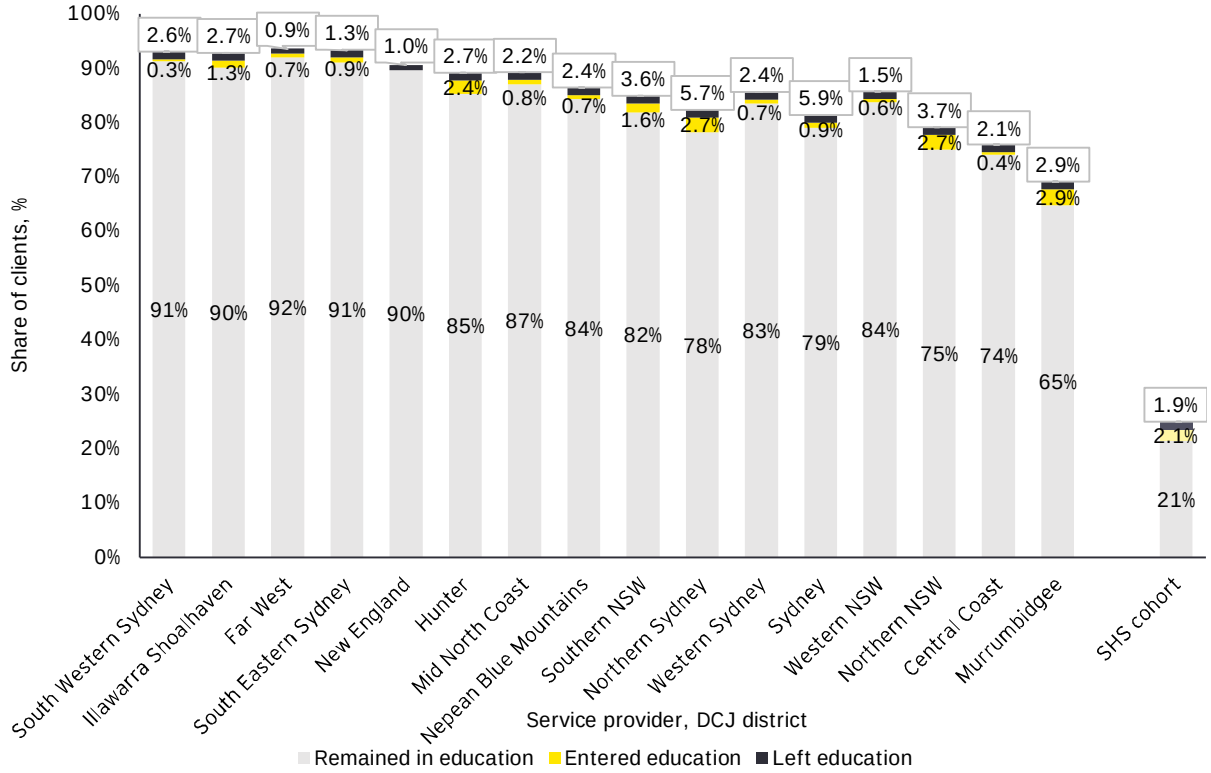
Compared to other cohorts, Aboriginal and Torres Strait Islander clients sought support for DFV and relationship breakdown less often (27.2% compared to 39.6% and 30.7% for children aged 12-15 years and young people aged 16-24 years, respectively). Of those, about 13% returned to SHS seeking the same support (Figure 35). The rate of return varied across DCJ Districts with the highest return observed for Northern Sydney (19.8%). Similar to children aged 12-15 years, in all DCJ Districts except for one (South Western Sydney), the share of returning Aboriginal and Torres Strait Islander clients for support with DFV and relationship breakdown was higher compared to the total SHS cohort.

Wellbeing

Analysis of education outcomes was conducted for children aged 12-15 years, young adults aged 16-24 years and Aboriginal and Torres Strait Islander clients across DCJ Districts to observe any changes in student status from the beginning to the end of the client's SHS support period. The analysis considered various types of educational settings, including school, vocational training and university studies. For children aged 12-15 years, it is assumed that they would not have discontinued their studies, and hence, the percentage of children who reported not being a student at the end of their SHS support period was also investigated.

Analysis of variation in education outcomes across DCJ Districts for children aged 12-15 years demonstrated larger differences in educational status. Figure 36 presents the proportion of children aged 12-15 years who remained in education, commenced or ended schooling during their SHS support period by DCJ District.

Figure 36: Children (12-15 years): Entered, remained in, or ended education during SHS support by DCJ District



Source: NSW Homelessness Data (CIMS and equivalent systems)

Figure 36 demonstrates some variation in education status across DCJ Districts, with notable differences between DCJ Districts in supporting children aged 12-15 years to remain in education. With the highest share of this cohort supported to remain in education located in the Far West, South Western Sydney, South Eastern Sydney, New England and Illawarra Shoalhaven DCJ Districts (more than 90%), the share of children who remained in education was found to be the lowest for the Northern NSW, Central Coast and Murrumbidgee DCJ Districts (75% or less). The analysis shows some variation in both the proportion of children entering schooling during their SHS support period and proportion of children leaving education. The highest share of children aged 12-15 leaving school are noted in the Northern Sydney and Sydney DCJ Districts, at 5.7% and 5.9% respectively.[227]

Compared to the total SHS cohort, a slightly higher share of young adults aged 16-24 years commenced some form of educational pursuit at the end of their SHS support compared to the beginning (2.7% compared to 2.1% respectively), with little regional variation observed. Given the age of this cohort, it could be reasonably expected that a higher proportion of clients may have commenced education, such as vocational training or university studies, than what can be observed from the administrative data; the low rates of commencement of educational pursuits may be an indication of the challenges service providers face in providing other supports to this cohort, and/or that this cohort of young people may have greater support needs in other areas of their lives which are a greater priority. On the other hand, many young people were supported to remain in their education throughout their SHS support period, with approximately 29.4% of young people aged 16-24 continuing their education, which was observed to be higher than for the total SHS cohort (21.2%).

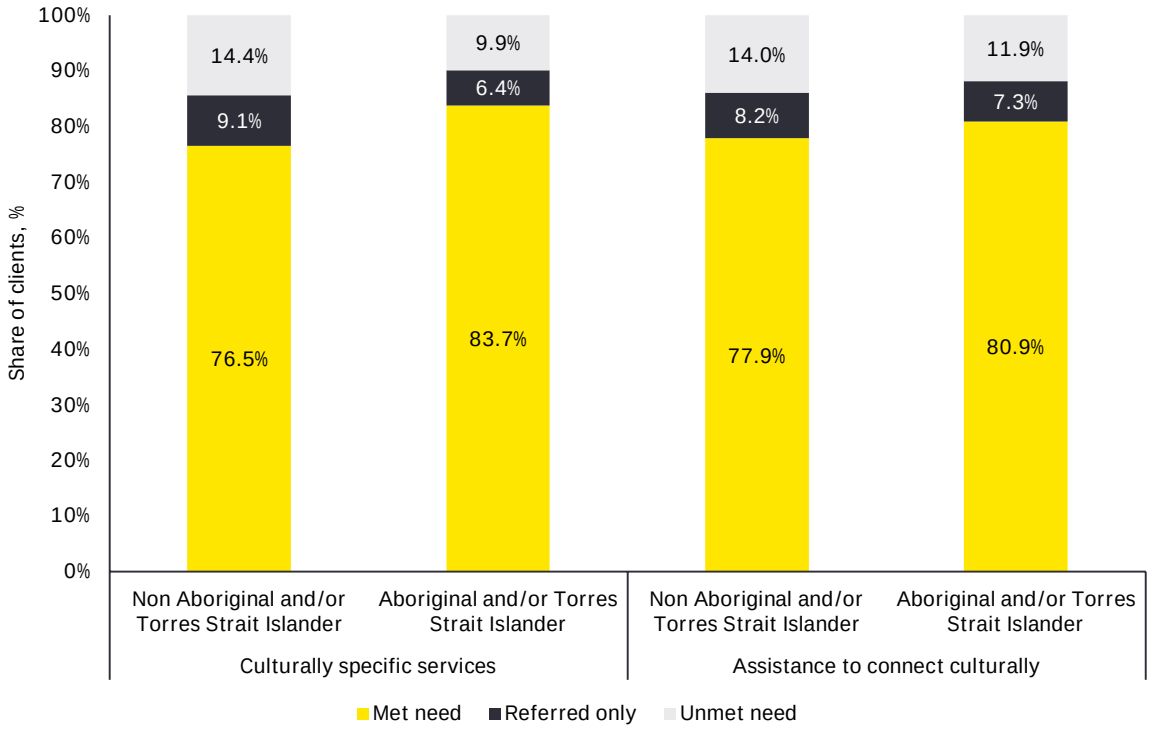
For Aboriginal and Torres Strait Islander clients, 2.1% of this cohort commenced some form of education between the beginning and end of their SHS support period and about 21.1% of these

[227] Figure 36 includes the relevant statistics for the total SHS cohort for comparative reasons. Due to varying characteristics, the overall SHS cohort is not considered a suitable comparator for children aged 12 -15 years and has been included for reference only.

clients retained their student status during their SHS support. The observed changes in student status for Aboriginal and Torres Strait Islander clients were found to be similar to non-Aboriginal clients (2.2% commenced education and 21.2% remained studying). Little regional variation in entering or leaving education was observed for Aboriginal and Torres Strait Islander clients in the administrative data.

One of the outcomes sought by SHS is that Aboriginal clients report experiencing culturally accessible services, as per the SHS program logic and SHS Program Specifications.[228] Figure 37 shows the proportion of met and unmet need and referrals to other services for non-Aboriginal and Torres Strait Islander and Aboriginal and Torres Strait Islander clients across two key relevant requested needs: culturally specific services and assistance to connect culturally.

Figure 37: Met and unmet need for culturally specific services for non-Aboriginal and Torres Strait Islander and Aboriginal and Torres Strait Islander clients FY 16/17 to FY 21/22[229]



Source: NSW Homelessness Data (CIMS and equivalent systems)

Figure 37 shows that the SHS Program met almost 84% of needs requested by Aboriginal and Torres Strait Islander clients for culturally specific services, and almost 81% of needs for assistance to connect culturally, which demonstrates strength in culturally appropriate service provision across the Program.

Several SHS clients identifying as Aboriginal and Torres Strait Islander were interviewed as part of this Evaluation and noted receiving supports such as assistance to obtain formal identification papers recognising the client as Aboriginal and Torres Strait Islander, as well as opportunities to connect with community. One client has become an Aboriginal social worker since accessing SHS support, as *"it inspired [her] to help others the way [she] was helped."*

[228] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[229] Indigenous status was not reported for approximately 5% of clients.

5.4 Economic Appraisal

The following economic evaluation questions were considered during the Evaluation:

- To what extent is SHS delivering value for money?
- What are the economic benefits of SHS?
- What are the costs associated with SHS?

Key Findings

- The economic appraisal estimates the total benefits of the SHS Program at $1,106.5m and a BCR of 1.02. This suggests that the potential benefits of the SHS Program marginally outweigh its costs. The result reflects a lack of outcomes data in combination with the low proportion of met need and high proportion of clients re-presenting for the same service.
- This is not an unexpected result given modelling assumptions and that SHS tends to address more immediate and acute needs of clients which means modelling a longer than 5-year benefit horizon is difficult to justify for many clients, particularly the 22% who return to SHS seeking the same service.
- The total estimated value of modelled benefits in present value terms is $1,106.5m comprising Health benefits ($449.8m), Justice and Safety benefits ($692.4m) and Housing benefits that represent a disbenefit of $35.7m through the provision of private rental assistance.
- The SHS Program provided services to SHS clients between FY 16/17 and FY 21/22 at a total primary cost of $1,086.4m or approximately $4,000 per client in present value terms.
- The funding provided by DCJ captures approximately 93% of primary SHS costs based on the findings of the Unit Costing Project. This suggests that service providers subsidise the SHS Program using other funding sources to levels in the order of 7% above the total funded amount.

5.4.1 Estimated SHS costs

The primary costs of the SHS Program were estimated by the Evaluation Team to be $1,086.4m over a six-year period from FY 16/17 to FY 21/22 as outlined in Figure 38.

The estimation of costs was informed by the number of services provided over the evaluation period and the preliminary findings of the Unit Costing Project which estimate the average cost for each service.[230] Based on the Unit Costing definitions established by the Department, the SHS Program costs comprise four cost categories, two of which are related to the provision of accommodation services: short- (3%) and medium-term (23%) accommodation; and other minor engagement (1%) and non-accommodation case management services (73%).

The estimated SHS costs capture DCJ funding in addition to any other additional DCJ, Land and Housing Cooperation or other funding sources which service providers may use to subsidise the cost

[230] Due to the timelines of the SHS Evaluation and the Unit Costing Project undertaken by DCJ, unit costs were not final at the time of finalising the SHS Evaluation Report, and are utilised in the economic appraisal for the purposes of demonstrating how the economic appraisal output varies when an estimate of "total" costs (SHS funding and funds from others sources) is included.

of delivering SHS. Based on the DCJ funding figures, approximately 93% of the total estimated primary costs of the SHS Program are funded by DCJ.[231]

Figure 38: Estimated SHS primary costs[232]

Broader primary costs* (informed by the DCJ Unit Costing Project)	
The provision of short-term accommodation services	$ 31.4m
The provision of medium-term accommodation services	$ 248.0m
The provision of non-accommodation case management	$ 796.6m
The provision of minor engagements	$ 10.3m
Broader primary costs of the SHS Program	$ 1,086.4m

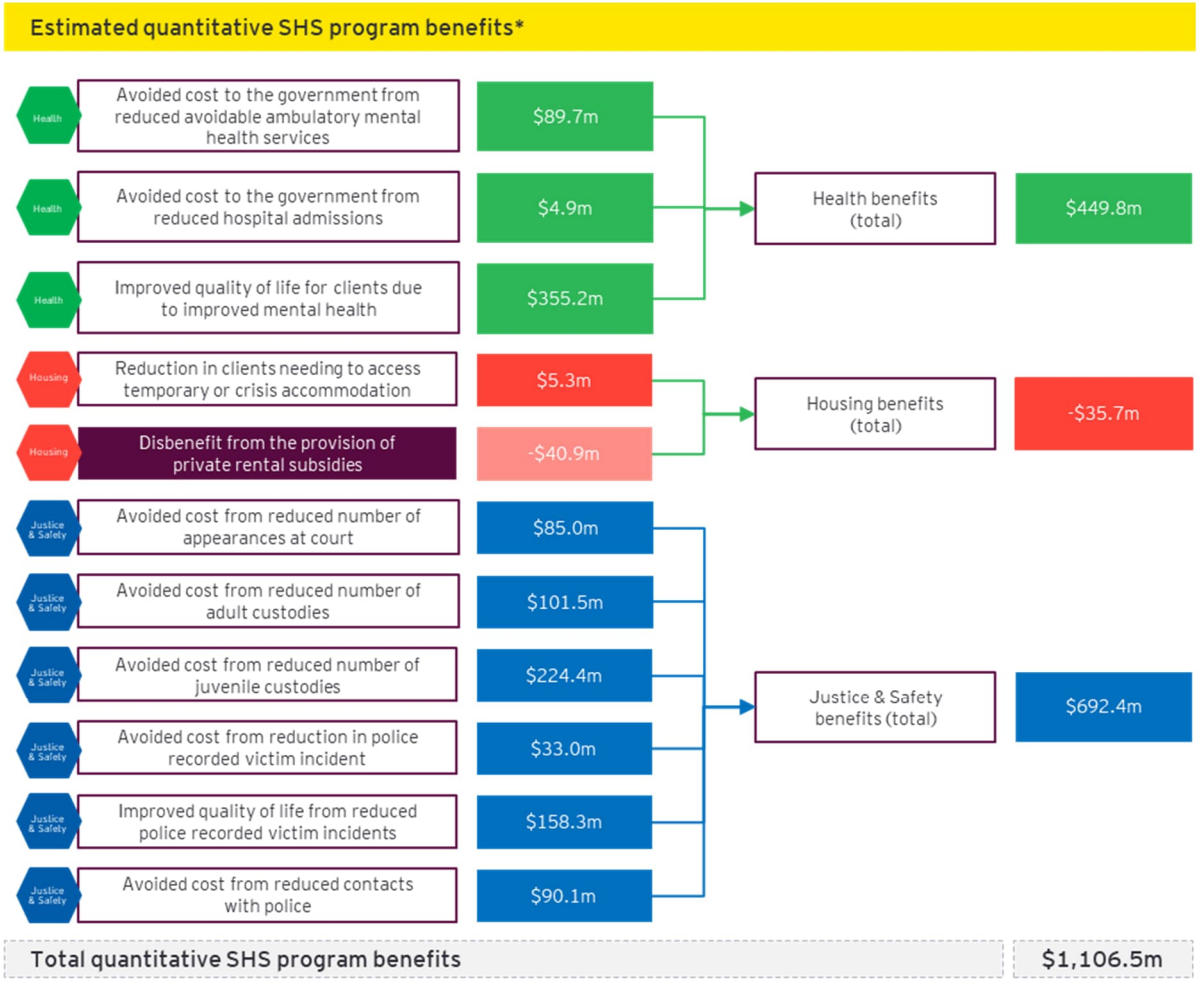
*Primary costs incurred during FY16/17-21/22 period are considered. All figures are expressed in FY22/23 AUD values. Total values may not sum up due to rounding.

5.4.2 Estimated SHS benefits

The estimated value of potential benefits realised through the SHS Program amounted to $1,106.5m over a period of six years from FY 16/17 to FY 21/22. The largest estimated value of benefits was realised through the Justice & Safety domain with approximately $692.4m in benefits, and the second most significant estimated value of benefits was attributed to the Health domain with approximately $449.8m. A disbenefit was observed in the Housing domain driven by the provision of private rental subsidies. Figure 39 presents an overview of the monetised estimated benefits under each category.

[231] The estimated SHS costs do not consider sunk costs, such as capital investment into building housing options for SHS clients or other capital investments required to carry out services. The Evaluation was not informed by the methodology of the Unit Costing Project and assumes that the unit costs may not capture initial capital investments, however, may capture the costs of building management.
[232] Source: Unit Cost analysis conducted by DCJ

Figure 39: Estimated SHS benefits



Drop-off profile varies by the return status of clients. 15% Benefit drop-off profile assumed. All benefits inflated/discounted to FY 22/23 AUD values. Benefits are projected to 5 years since the begin of the SHS support period. Total values may not sum up due to rounding.

A number of qualitative benefits support the results on the estimated monetised benefits. These have been qualitatively assessed in Section 5.4.5.

5.4.3 Findings of the economic appraisal

Figure 40 presents the findings of the economic appraisal. With the total primary costs of the SHS Program estimated to be $1,086.4m and the estimated total value of potential benefits quantified as $1,106,5m, the economic appraisal produces a BCR result of 1.02, indicating that the potential benefits of the SHS Program marginally outweigh its primary costs.

Figure 40: Economic appraisal findings

Primary costs of the SHS program	$ 1,016.5m
Quantitative SHS program benefits	$ 1,086.4m
Benefit Cost Ratio	1.02

All values of the Economic Appraisal are expressed in NPV values (FY 22/23)

5.4.4 Sensitivity analysis and checks

Sensitivity analysis: discount rates

The economic appraisal was adjusted to vary the central discount rate and inform the impact on NPV and BCR. As outlined in the list of general assumptions of the Economic Appraisal listed in Appendix 2, the potential quantified benefits were projected for a five-year period after provision of SHS services and represent future expected benefits for clients who received services in FY16/17 - FY21/22. In line with the NSW Treasury Guidelines 2023, two additional discount rates were considered: a lower bound of 3%, and an upper bound of 10%.

Based on the findings of the sensitivity analysis as shown in Figure 41, adjustment to the lower bound yields an increase of quantified estimated benefits of the SHS Program to $1,109.9m and the average BCR estimate remains unchanged. When the discount rate is increased to the upper bound, the quantified estimated benefits reduce to $1,099.0m and the BCR to 1.01. The findings of the sensitivity analysis suggest that the BCR estimate is relatively stable despite the adjustment to the discount rate.

Figure 41: Sensitivity analysis: impact of discount rates

Discount Rate	Lower bound discount rate, 3%	Central discount rate, 5%	Upper bound discount rate, 10%
Primary costs of the SHS program	$ 1,086.4m	$ 1,086.4m	$ 1,086.4m
Quantitative SHS program benefits	$ 1,109.9m	$ 1,016.5m	$ 1,099.0m
BCR	1.02	1.02	1.01

All values of the Economic Appraisal are expressed in NPV values (FY 22/23)

All values of the Economic Appraisal are expressed in NPV values (FY 22/23).

Sensitivity check: SHS benefits

The economic appraisal acknowledges that three benefits attributed to the SHS Program capture approximately two thirds of the potential identified benefits:

- Improved quality of life for clients due to improved mental health (32% of total SHS benefits);
- Avoided costs from reduced number of juvenile custodies (20% of total SHS benefits); and
- Improved quality of life from reduced police recorded victim incidents (14% of total SHS benefits).

The findings of the economic appraisal may be sensitive to changes in the following assumptions which informed the estimation of these benefits. The assumptions have been informed by research findings and publicly available data and reports.[233]

- % of clients where mental health services improved client's quality of life (assumed 65% - confidence rating medium).
- Likely % of SHS clients who are at risk of custody without service provision (assumed 9.7% - confidence rating medium).
- Likely % of clients who would develop PTSD or have an injury as a result of an incident (assumed 35% - confidence rating low).

5.4.5 Qualitative Benefits

Health benefits

Improved quality of life due to improvements in physical health

The World Health Organisation (WHO) identifies physical health, including pain and discomfort levels, energy and fatigue, as one aspect contributing to people's quality of life.[234] However, physical health issues can also result from a person experiencing homelessness, significantly decreasing the quality of life experienced by people experiencing homelessness.[235] Consequently, through the provision of accommodation and specialised health or medical services, physical health of SHS clients and quality of life may be improved. For example, in one Canadian study measuring Lehman's 20-item Quality of Life Interview scores (which include health indicators) amongst participants experiencing homelessness, those who were randomly allocated housing and other assistance scored their total quality of life 33.1% higher after 12 months of housing support.[236]

Accommodation provides adequate living space, safety and privacy for clients to address their health needs, including being able to have adequate rest and sleep, undergo treatment and recovery or to safely adhere to medication requirements.[237] Support in accessing health or medical services also helps to reduce barriers that people experiencing homelessness often face in order to access necessary healthcare, especially in terms of appointment costs.[238] Likewise, emergency departments are often highly utilised by people experiencing homelessness as a first, and often only, point of healthcare.[239]

However, more efficient use of healthcare systems has been associated with better housing outcomes for people experiencing homelessness. For example, people experiencing homelessness receiving housing and support from the Collaborative Initiative to Help End Chronic Homelessness presentation to emergency departments dropped from 39% in the 90 days prior to receiving support

[233] The economic appraisal investigated publicly available data and information and relied on evidence that best described the conditions and environment of the SHS Program, however in some instances the evidence was limited and the economic appraisal relied on international evidence including varying cohorts and social systems. For this reason, benefits of the SHS Program may be either overestimated or under-estimated depending on the assumption.
[234] World Health Organisation. (2012). The World Health Organization Quality of Life (WHOQOL). Retrieved 23 May 2023, from WHOQOL - Measuring Quality of Life| The World Health Organization.
[235] Australian Institute of Health and Welfare. (2021). Health of people experiencing homelessness. Retrieved 23 May 2023, from Health of people experiencing homelessness - Australian Institute of Health and Welfare (aihw.gov.au).
[236] Powell, G., Adair, C., Streiner, D., Mayo, N. & Latimer, E. (2017). Quality of Life Research 26, 1853-1864. DOI: 10.1007/s11136-017-1522-8.
[237] National Health Care for the Homeless Council. (2019). Homelessness & health: What's the connection? Retrieved 23 May 2023, homelessness-and-health.pdf (nhchc.org); Public Health Degrees. (2022). Understanding homelessness as a public health issue. Retrieved 23 May 2023, from Understanding Homelessness as a Public Health Issue (publichealthdegrees.org).
[238] Australian Institute of Health and Welfare. (2021). Health of people experiencing homelessness. Retrieved 23 May 2023, from Health of people experiencing homelessness - Australian Institute of Health and Welfare (aihw.gov.au).
[239] Johnson, E., Borgia, M., Rose, J. & O'Toole, T. (2017). No wrong door: can clinical care facilitate veteran engagement in housing services? Psychological Services 14(2), 167-173. Retrieved from https://doi.org/10.1037/ser0000124.

to 25% in the 90 days prior at the end of support.[240] This was in contrast to a similar comparison group of people experiencing homelessness that did not receive support which experienced an increase from 38% reporting to the emergency department in the 90 days prior to 41%.[241] In another study of inpatients experiencing homelessness in a Chicago hospital, for every 100 adults experiencing homelessness who received post-hospital case and housing support, the expected benefits over the next year would be 49 fewer hospitalisations, 270 fewer hospital days and 116 fewer emergency department visits.[242]

Education and employment benefits

Improved opportunities to enter/sustain education

Housing instability can disrupt a person's ability to enter and sustain education, especially for children and young people.[243] Lower educational attainment has also been linked to greater risk of homelessness.[244] In contrast, better housing affordability is often associated with better academic achievement and school engagement for children, where children have a permanent base from which parents can enrol them in school and they can complete educational requirements.[245] Further, with decreased housing stress, it has been found that parents have more money available to spend on children's education.[246] According to Heckman's model of early education investment, by increasing years of schooling, both the person and their community benefit from increased success in school, higher education and career progression, including an increase in expected future income.[247] In Australia, the private return on investment of an additional year of education is estimated to be 8.3%, meaning an 8.3% increase in the value of lifetime earnings of the individual to the net present value of costs of education.[248]

Further, early intervention strategies have been found to provide opportunities for people experiencing or at risk of homelessness to enter or sustain education.[249] For example, the Kids Under Cover program provided youth-specific studio apartments and education scholarships to keep young people engaged in education and connected to their family and community.[250] After receiving the scholarship, 96% of participants were planning to finalise 2022 studies, up from 54% prior to receiving the scholarship.[251] Likewise, a case study in Geelong, Victoria, attributed a 40% decrease in adolescents entering the SHS system to secondary school students using the COSS model to reduce disengagement from education and early school leaving.[252]

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[240] Moore, D. & Rosenheck, R. (2017). Comprehensive services delivery and emergency department use among chronically homeless adults. Psychological Services 14(2), 184-192. Retrieved from https://doi.org/10.1037/ser0000111.
[241] Ibid.
[242] Sadowski, L., Kee, R. & VanderWeele, T. (2009). Effect of housing and case management program on emergency department visits and hospitlisations among chronically ill homeless adults. Journal of the American Medical Association 301(17), 1771-1778. doi:10.1001/jama.2009.561.
[243] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021–22. Retrieved 24 May 2023, Australia's children, Homelessness - Australian Institute of Health and Welfare (aihw.gov.au).
[244] Australian Institute of Health and Welfare. (2022). Homelessness and homelessness services. Retrieved 24 May 2023, Homelessness and homelessness services - Australian Institute of Health and Welfare (aihw.gov.au).
[245] Clair, A. (2018). Housing: an under-explored influence on children's well-being and becoming. Child Indicators Research 12(2):609–626. Retrieved 24 May 2023; Launch Housing. (2019). Employment and education. Retrieved 24 May 2023, from Employment and Education (launchhousing.org.au).
[246] Robinson, E. & Adams, R. (2008). Housing stress and the mental health and wellbeing of families. Australian Family Relationships Clearinghouse briefing no. 12. Melbourne: Australian Institute of Family Studies. Retrieved 24 May 2023.
[247] Heckman. (n.d.) Invest in early childhood development: Reduce deficits, strengthen the economy. Retrieved 14 June 2023, from page 2_2 (heckmanequation.org); Psacharopoulos, G. & Patronos, H. (2018). Returns to investment in education: a decennial review of the global literature. World Bank Group Education Global Practice. Retrieved 14 June 2023, from World Bank Document.
[248] Ibid.
[249] Australian Institute of Family Studies. (2020). Early intervention strategies to prevent youth homelessness. Retrieved 24 May 2023, from Early intervention strategies to prevent youth homelessness | Australian Institute of Family Studies (aifs.gov.au).
[250] Ibid.
[251] Kids Under Cover. (2022). Annual report. Retrieved 24 May 2023, from KUC-Annual-Report-2022.pdf.
[252] MacKenzie, D. (2018). The Geelong Project: interim report 2016-2017. Retrieved 24 May 2023, from TGP_Interim_Report_FINAL_e-PRINT.indd (apo.org.au).

SHS data also indicate that increasing support for people experiencing homelessness can have a positive effect on education outcomes. Of clients who reported their student status at the beginning of support, 3.2% changed their student status from not being a student to some form of education at the end of support. Of those who reported their student status at the beginning of support and were participating in primary education, 89.4% had continued their studies at the end of support and 3.0% had advanced to secondary school. On the other hand, of those who reported their student status as being a secondary student at the beginning of support, 87.9% were continuing their studies at the end of support while 1.4% had advanced to vocational studies at the end of support. About 2% (=3,429) of SHS clients who did not report student status at the beginning of SHS support entered pre-school, primary or secondary education and 1 % (=1,630) entered university.

Improved opportunities for employment

People experiencing homelessness often face a number of barriers to opportunities for employment, including having health issues, low levels of education and/or training, a lack of social support and integration, lack of support for affordable childcare, difficulty finding information about job opportunities and difficulties presenting for interviews.[253] Both housing and non-housing support from SHS aims to assist clients to become self-reliant and independent, improve health and wellbeing outcomes and to re-establish positive social connections and thus employment participation.[254] For example, a 2013 survey-based study of clients of specified SHS prevention and assistance programs in several states in Australia found that only 8.6% of case managed respondents were employed at the point of the baseline survey, however this nearly doubled to 15.5% at the point of the follow-up survey (12 months later).[255] The proportion classified to be in the labour force also increased from 48.3% to 60.3% between surveys.[256]

Data on SHS client incomes suggest that of those with nil income at the beginning of SHS support, 1.5% were receiving employment income at the end of support while 4.7% were receiving government pensions. However, of clients who received their income from government pensions at the beginning of SHS support, 95.6% remained on government pensions at the end of SHS support. It is likely that outcomes, such as employment and education, as a result of homelessness support take time to materialise and may not be captured in outcome studies that often consider 24-month periods or less to measure differences in outcomes.[257] Thus, knowledge about the longer-term employment trajectories of people who receive homeless support is limited.

Housing benefits

Reduced percentage of people exiting NSW government services (e.g., health, justice, social housing) into homelessness

Initiatives to support people exiting NSW government services transition into employment and housing may reduce the amount of people who become homeless upon exit. For example, those with a history of homelessness while in out-of-home care who were part of the Premiers' Youth Initiative (PYI) were 182% less likely to become homeless after the age of 18 than those who did not receive PYI and did not have a prior SHS history.[258] Likewise, the Sustaining Young People's Tenancies pilot between 2016 and 2017 saw 30 out of 31 young people at risk of homelessness in social housing

[253] Swami, N. (2018). The effect of homelessness on employment entry and exits: Evidence from the journeys home survey. Retrieved 24 May 2023, from Microsoft Word - WP 32'17.docx (unimelb.edu.au).
[254] Zaretzky, K. & Flatau, P. (2013). The cost of homelessness and the net benefit of homelessness programs: a national study. The Australian Housing and Urban Research Institute. Retrieved 24 May 2023.
[255] Ibid.
[256] Ibid.
[257] Aubry, T. (2020). Analysis of Housing First as a practical and policy relevant intervention: the current state of knowledge and future directions for research. European Journal of Homelessness 14(1), 13-26. Retrieved from EJH_14_1-A1-Web[2].pdf (feantsa.org); Kertesz, S. & Johnson, G. (2017). Housing First: lessons from the United States and challenges for Australia. Australian Homelessness-Research and Policy Insights 50, 220-228. Retrieved from https://doi.org/10.1111/1467-8462.12217.
[258] Centre for Evidence and Implementation – Monash University. (2020). Evaluation of the Premier's Youth Initiative. Retrieved 29 May 2023, from Premier's Youth Initiative | Family & Community Services (nsw.gov.au).

exited into secure and sustainable housing as a result of the program.[259] The program helped clients improve confidence in sustaining tenancies independently, increase knowledge about housing processes and increase their ability to meet requirements such as inspections and housing reviews.[260]

Likewise, there may be an opportunity for SHS services to provide support to reduce the number of people exiting hospitals to homelessness. This is particularly relevant given that homelessness is a consistent predictive factor for re-presentations to hospitals.[261]

Services such as these have also been found to have non-housing outcomes such as increased self-esteem, improved ability to navigate systems, better life skills, enhanced social connectivity, greater access to material needs and better mental and physical health, all aspects that may reduce the proportion of people exiting NSW government services into homelessness.[262] The Royal Perth Hospital Homeless Team is an example of a collaborative model between health and homeless services providers where doctors, nurses and case workers in the hospital connect people to accommodation, housing, primary care and other community supports as part of patient discharge planning.[263] Of the 72% of patients experiencing homelessness presenting to the Homeless Team, 32.8% of episodes of care resulted in discharge back to rough sleeping.[264]

Similarly, more than half of Australian prison discharges are expected to be homeless upon release, indicating a need for homelessness support services upon release.[265] The 12-month Debt and Tenancy Legal Help for Prisoners Project pilot demonstrated how this could be achieved with 25 Victorian prisoners being released into their homes rather than to homelessness after being provided with legal representation to avoid eviction.[266] Further, the physical presence of the project in Victorian prisons increased prisoners' access to legal assistance regarding housing.[267]

Improved access and increased knowledge about affordable housing options and government housing assistance

Assisting people experiencing or at risk of homelessness in accessing and navigating government systems is a form of direct support provided by SHS providers.[268] 211,300 SHS clients presented with a need for advice and information in FY 21/22, of which almost all had this provided directly by SHS providers.[269] SHS agencies provide access to affordable housing options and can assist clients in increasing their knowledge around affordable housing options.[270] For example, temporary and transitional accommodation can provide short-term relief from housing stress, allowing clients

[259] Australian Housing and Urban Research Institute. (2018). Evaluation of the Sustaining Young People's Tenancies Initiative. Retrieved 29 May 2023, from Evaluation of the Sustaining Young People's Tenancies Initiative (brisyouth.org).
[260] Ibid.
[261] Currie, J., Stafford, A., Hutton, J. & Wood, L. (2023). Optimising access to healthcare for patients experiencing homelessness in hospital emergency departments. International Journal of Environmental Research and Public Health 20. Retrieved from https://doi.org/10.3390/ijerph20032424.
[262] Ibid.
[263] Tuvey, J. & Wood, I. (2021). Reducing hospital discharges back into homelessness. Parity 34(10), 76-78. Retrieved from Reducing hospital discharges back into homelessness (nd.edu.au).
[264] Ibid.
[265] Australian Institute of Health and Welfare (2018). The health of Australia's prisoners 2018. Retrieved from https://www.aihw.gov.au/reports/prisoners/health-australia-prisoners-2018/summary
[266] Justice Connect Homeless Law. (2016). Debt and tenancy legal help for prisoners: twelve month project report. Retrieved 14 June 2023, from Homeless-Law-Prison-Project-Twelve-Month-Report.pdf (justiceconnect.org.au).
[267] Ibid.
[268] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications
[269] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021–22. Retrieved 29 May 2023, from Specialist homelessness services annual report 2021–22, Clients, services and outcomes - Australian Institute of Health and Welfare (aihw.gov.au).
[270] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

greater resource flexibility to explore longer-term affordable housing options.[271] SHS data show, for example, that there was an increase in the proportion of clients living in private or other housing from 38% at the beginning of support to 42% at the end of support in 2022.[272] Likewise, a 1992 study of an after-shelter case management program found that the proportion of families that were placed in permanent housing (subsidised housing or rental units paid for by the resident) increased from 40% to 67% once the program was in place.[273]

SHS agencies provide opportunities for clients to access government housing mainly through intermediate support and referrals.[274] For example, direct support from SHS providers includes providing assistance in completing housing application forms, assistance in obtaining identification documents, referrals to legal support and services, brokerage or resources in financial literacy.[275] Providers also work indirectly through building relationships with real estate agents to facilitate rapid rehousing of clients in crisis or the early notification of affordable housing availability.[276]

Justice and safety benefits

Improved sense of safety for social housing clients and the broader community

SHS providers play a role in improving the sense of safety of social housing clients through the provision of both housing assistance and other forms of support. For example, Mission Australia found that after seeking help from their services, more than half of people reported improvements in their safety.[277] Likewise, respondents to a study of homelessness programs in Australia reported increases in their feelings of safety after receiving support, with 86% of single women feeling safer.[278] Housing also provides clients greater safety from criminal behaviour, which benefits both social housing clients and the broader community in which they live.[279]

Equity and community benefits

Improved culturally accessible services for Aboriginal clients

Aboriginal and Torres Strait Islander peoples are over-represented in the Australian homeless population, making up around 28% of SHS clients in FY 21/22.[280] This is due to complex interrelated factors including the lasting impacts of colonisation, higher rates of exposure to family violence, substance disorders and unemployment, low education and poor health.[281] Aboriginal and Torres

[271] Australian Institute of Health and Welfare. (2022). Housing assistance in Australia. Retrieved 26 May 2023, from Housing assistance in Australia, Housing assistance - Australian Institute of Health and Welfare (aihw.gov.au).
[272] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021–22. Retrieved 24 May 2023, from Specialist homelessness services annual report 2021–22, Clients, services and outcomes - Australian Institute of Health and Welfare (aihw.gov.au).
[273] Helvie, C. & Alexy, B. (1992). Using after-shelter case management to improve outcomes for families with children. Public Health Reports 107, 585–88.
[274] Australian Institute of Health and Welfare. (2022). Housing assistance in Australia. Retrieved 29 May 2023, from Housing assistance in Australia, Housing assistance - Australian Institute of Health and Welfare (aihw.gov.au).
[275] DCJ. (2021). Specialist Homelessness Services Program Specifications. Retrieved 14 June 2023, from Specialist Homelessness Services - Program Specifications | Family & Community Services (nsw.gov.au).
[276] Ibid.
[277] Mission Australia. (2023). A safe place to call home: Mission Australia's homelessness and stable housing impact report 2023. Retrieved 29 May 2023, from A Safe Place to Call Home- Homelessness Impact Snapshot 2023 (1).pdf.
[278] Zaretzky K. & Flatau, P. (2013). The cost of homelessness and the net benefit of homelessness programs: a national study. Retrieved May 29 2023.
[279] Believe Housing Australia. (2022). A win-win: How having a home benefits people and economies. Retrieved 30 May 2023, from How housing benefits people and economies | Believe Housing Australia.
[280] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021–22. Retrieved 29 May 2023, from Specialist homelessness services annual report 2021–22, Indigenous clients - Australian Institute of Health and Welfare (aihw.gov.au).
[281] Australian Institute of Health and Welfare. (2019). Aboriginal and Torres Strait Islander people: a focus report on housing and homelessness. Retrieved 14 June 2023, from Aboriginal and Torres Strait Islander people: a focus report on housing and homelessness (full publication; 27Mar2019edition) (AIHW).

Strait Islander peoples are also three times as likely to live in overcrowded conditions compared to non-Aboriginal and Torres Strait Islander Australians, adding further strains on housing.[282]

SHS agencies specifically targeting homelessness among Aboriginal and Torres Strait Islander peoples aim to provide clients with access to culturally appropriate services and ensure equity for SHS clients with different cultural backgrounds. This is especially relevant considering the bi-directional relationship between housing and health outcomes for Aboriginal and Torres Strait Islander people.[283] Furthermore, connection to Country is a fundamental part of the culture and identity of many Aboriginal and Torres Strait Islander people and disconnection from Country can also be considered a form of homelessness.[284] For example, an ABS paper on Aboriginal and Torres Strait Islander perspectives on homelessness found that the importance of family and connectedness to feelings of home were emphasised in discussions with Aboriginal people[285]; thus, emphasising the importance of the provision of specific and culturally accessible SHS support for Aboriginal clients that is considerate of Aboriginal and Torres Strait Islander peoples' cultural needs.

Improved culturally accessible services for CALD clients

Language, discrimination, issues around settlement and immigration, pre-migration history of trauma, lack of family and community support, fear of authority and/or lack of understanding about service systems can all be barriers for CALD clients seeking homelessness support.[286] This represents a 'double disadvantage' where people from CALD backgrounds are more likely to face homelessness and also more likely to face barriers accessing help.[287] This was especially evident during the COVID-19 pandemic where industries such as meat processing, aged care and hospitality, all industries usually comprised of a high proportion of CALD workers, were most impacted by lockdowns.[288] CALD communities reported that they had limited information about and access to services regarding COVID-19 isolation, loss of income supports and immigration restrictions despite their increased need for them.[289] Furthermore, temporary CALD migrants with temporary visa statuses were often first to experience job loss while also being excluded from government benefits such as JobKeeper and JobSeeker.[290] The importance of culturally appropriate and accessible services for CALD SHS clients is evident from the learnings of the pandemic. These may involve improving access for CALD clients to online services, increasing the number of multicultural SHS workers and further advocacy of CALD support to governments.

Improved relationship with family and support networks

Attaining housing or homelessness support can provide people with a secure and stable foundation from which to reconnect or restore broken relationships, improving client's relationships with both their family and support networks.[291] Several studies have found that after entering housing and

[282] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021–22. Retrieved 29 May 2023, from Specialist homelessness services annual report 2021–22, Indigenous clients - Australian Institute of Health and Welfare (aihw.gov.au).

[283] Australian Institute of Health and Welfare. (2022). Indigenous mental health, housing and homelessness. Retrieved 29 May 2023, from Housing & homelessness - AIHW Indigenous MHSPC.

[284] Australian Bureau of Statistics. (2014). Aboriginal and Torres Strait Islander Peoples Perspective on Homelessness. Retrieved 30 May 2023, from 4736.0 - Information Paper: Aboriginal and Torres Strait Islander Peoples Perspectives on Homelessness, 2014 (abs.gov.au).

[285] Ibid.

[286] 1800 Respect. (n.d.). Supporting people from CALD, migrant and refugee experiences of violence. Retrieved 30 May 2023, from Supporting people from CALD, migrant and refugee experiences of violence | 1800RESPECT.

[287] Centre for Social Impact – The University of Western Australia. (2019). Homelessness in culturally and linguistically diverse populations in Western Australia. Retrieved 30 May 2023, from Homelessness in Culturally and Linguistically Diverse Populations in Western Australia (uwa.edu.au).

[288] Weng, E., Mansouri, F. & Vergani, M. (2021). The impact of the COVID-19 pandemic on delivery of services to CALD communities in Australia. ADI Policy Briefing Papers 2(2). Retrieved from The impact of the COVID-19 pandemic on delivery of services to CALD communities in Australia (apo.org.au).

[289] Ibid.

[290] Ibid.

[291] Henwood, B., Stefancic, A., Petering, R., Schreiber, S., Abrams, C. & Padgett, D. (2015). Social relationships of dually diagnosed homeless adults following enrolment in housing first or traditional treatment services. *Journal of the Society for Social Work and Research 6*(3), 385-406, retrieved 30 May 2023, from https://www.journals.uchicago.edu/doi/10.1086/682583.

support services, positive outcomes related to social ties were reported.[292] For example, one study found a twofold average increase in contact with non-family 12 months after placement in housing.[293] Other studies have found that attaining housing and housing support may help individuals rebuild familial relationships. For example, a United States study found that almost half of study participants reported increases in the number of family members in their network after moving into secure housing.[294]

Increased connection to community

Helping clients improve their connection to community is an important role that homelessness services may play. For example, of respondents to an Australia-wide follow up survey 12 months after receiving homelessness support, 53% of single men and 59% of single women reported feeling a better sense of community.[295] Housing programs, in particular, typically may help clients to feel an increased sense of community. For example, in the 2021 Australian National Housing Survey, 82% of social housing tenants felt they were part of the local community.[296] Services that support clients outside of housing may also foster connection to community by connecting clients with social and support networks, especially for First Nations and CALD clients.

[292] Cummings, C., Lei, Q., Hochberg, L., Hones, V. & Brown, M. (2022). Social support and networks among people experiencing chronic homelessness: a systematic review. *American Journal of Orthopsychiatry 92*(3), 349-363, retrieved 30 May 2023, doi: 10.1037/ort0000616.

[293] Henwood, B., Matejkowski, J., Stefancic, A. & Lukens, J. (2014). Quality of life after housing first for adults with serious mental illness who have experienced chronic homelessness. *Psychiatry Research 220*(1-2), 549-555, retrieved 30 May 2023.

[294] Henwood, B., Stefancic, A., Petering, R., Schreiber, S., Abrams, C. & Padgett, D. (2015). Social relationships of dually diagnosed homeless adults following enrolment in housing first or traditional treatment services. *Journal of the Society for Social Work and Research 6*(3), 385-406, retrieved 30 May 2023, from https://www.journals.uchicago.edu/doi/10.1086/682583.

[295] Zaretzky, K. & Flatau, P. (2013). The cost of homelessness and the net benefit of homelessness programs: a national study, retrieved 30 May 2023.

[296] Australian Institute of Health and Welfare. (2022). National social housing survey 2021. Retrieved 30 May 2023, from National Social Housing Survey 2021, What are the benefits of living in social housing? - Australian Institute of Health and Welfare (aihw.gov.au).

6. Key Findings and Recommendations

6.1 Findings

Analysis of available quantitative and qualitative data suggests that the SHS Program is achieving its intended Program outcomes in the short-term to some extent. Short-term accommodation services have consistently maintained the highest degree of met need across the evaluation period, at approximately 30%, as compared to medium- and long-term accommodation, and many clients achieved successful housing outcomes in community and public housing after first accessing SHS support (28% and over 20% of SHS clients who accessed community and public housing during the evaluation period respectively).

However, more than 1 in 3 SHS clients returned to the Program for repeat support, and of these clients, 60.3% returned in the same financial year for the same reason, suggesting the Program was not able to meet their needs and achieve the intended outcomes in the short-term. Repeat presentations for the same reason were most frequently associated with housing, and DFV and relationship breakdown needs.

A lack of data on medium- to longer-term outcomes for SHS clients with regard to access to broader housing, homelessness and the community services system is a considerable limitation of the economic analysis of the SHS Program. This factor, combined with low rates of met need and high rates of repeat presentations for the same service, results in a marginal benefit cost ratio (BCR) of 1.02 for the central case.

It should be noted that there was some qualitative evidence to suggest that SHS clients are receiving a client-centred and an integrated response to their support needs. However, the extent to which this qualitative evidence can be substantiated with quantitative evidence is limited by the lack of outcomes data and is also negatively impacted by levels of service demand in the sector which exceed sector capacity.

Aligned with the key objectives of the SHS Program and the findings contained within this Report, a suite of recommendations for the Department's consideration are provided below across many of the key evaluation themes.

6.2 Accessibility

Implement a more coordinated and integrated systems approach

There are a range of actions that may be considered by the Department to facilitate accessibility of the SHS Program across the state and refine the referral process to enable more efficient and appropriate referrals and delivery of subsequent supports.

Stakeholders observed that significant DCJ time and resources are invested into facilitation of Link2Home. Low rates of referrals from Link2Home and reported experiences of inappropriate referrals suggest that there may be scope for improvement in these processes and review of Link2Home's role as a referral pathway into SHS. It is understood that Link2Home staff are currently conducting a review of the intake assessment questions and have consulted with SHS providers throughout this process, with the aim to focus on more critical and immediate at-risk questions. This is a promising development, as it is understood that the Link2Home assessment has not been updated since it was first implemented. Streamlining the Link2Home assessment process may also provide an opportunity for more effective information-sharing to service providers, which may support with establishment of a trauma-informed referral process, minimising the number of times clients are required to re-tell their stories.

1. *It is recommended that the implementation of the refined Link2Home assessment process is closely monitored by the Department with regard to its efficacy, alongside Link2Home's function as a centralised intake process.*

It was also reported that there may be duplication in the assessment and referral process, with clients having to respond to similar questions when they call Link2Home and again once they have been referred to the service provider. All service providers are required to commence a Common Assessment for a person they provide support to, which is conducted during early engagement with a client and is recorded in CIMS or an equivalent system. According to the Department, he Common Assessment is intended to ensure that there is a minimum, standardised approach across the SHS Program for people seeking assistance from service providers. It is understood that a client's Common Assessment information can move from one service provider to another through the CIMS tool, provided client consent has been shared, aligned with the No Wrong Door approach. It is not clear from the evaluation, however, the degree to which client assessment information is shared between Link2Home and service providers, or the degree to which the current Link2Home assessment process (nor the refined process currently under development) aligns with the Common Assessment.

2. *It is recommended that the Link2Home assessment is refined, by the Department in partnership with service providers, to align closely with the SHS Common Assessment tool, and that Link2Home assessments are able to be shared in full with service providers to enhance the referral process. Digital enhancements to facilitate automatic upload of the Link2Home assessment into CIMS could also be considered.*

SHS service providers highlighted challenges with the efficacy of current intake models. Both SHS providers and Link2Home representatives alike recognised the potential value of a dedicated intake FTE in-house to support the broader intake function for formal and informal referrals, including Link2Home referrals. It was suggested that the role should have intimate familiarity with vacancies at the service, as well as the capacity and skills of the service to support this potential new client effectively.

Recognising that hiring a dedicated intake staff member is beyond the financial realms of many service providers without additional funding, the referral process between Link2Home (and other referral pathways) and SHS providers may be better supported through ensuring that service providers are updating vacancy data in VMS daily, in addition to reviewing the scope of services offered as per VMS on a quarterly basis, to ensure the currency of VMS data and potentially improve the efficiency of the referral process.

3. *It is recommended that compliance with the contractual requirement to record and maintain VMS listings is prioritised by service providers and closely monitored by DCJ Commissioning and Planning representatives to ensure more current vacancy data and further support the referral process.*

Recognising that capacity constraints may pose a significant barrier to service providers making the required daily updates to the VMS, exploration of mechanisms by the Department to reduce the administrative burden of updating the VMS on service providers is recommended to support with the streamlining of this process. Some service providers stated that they feel as if Link2Home staff do not sufficiently consult the services provided or cohorts served by the service providers before making a referral, which can result in additional burden on the service provider, if the referral is accepted, to find a more appropriate solution for the client due to the No Wrong Door approach. It is understood that some degree of this relevant information, i.e., types of services provided and target cohorts, is supposed to be available through VMS, as uploaded by the service provider, however many service providers shared that the system is not intuitive, which may inhibit real-time updates. Regular training on VMS and the reporting functionality provided by DCJ may support with reducing the administrative burden of making the updates.

4. *It is recommended that the VMS be reviewed by the Department in partnership with service providers to optimise user interface, and additional training is introduced by the Department to support uptake of more consistent and standardised approaches to assessing vacancies and referrals.*

Additionally, there were many challenges raised by stakeholders regarding collaboration and information sharing between mainstream and SHS service providers. Many SHS service providers noted particular challenges with mainstream providers not comprehending their funded services and/or target cohorts. This finding suggests that greater visibility of existing services could support accessibility and a more holistic understanding of the service system. A centralised platform or database may further support the identification of relevant client services and expedite referral processes. Such a platform or database could provide clear explanations or definitions of services provided (as per funding and contracting arrangements) to avoid or minimise any potential confusion or misunderstanding in the referral process.

5. *It is recommended that DCJ consider mechanisms for mainstream providers and other referrers to access information with regard to SHS services, which could coincide with additional effort in awareness raising, and could involve a technology solution, such as a portal for mainstream services to access additional information.*

Complementing this, a standardised triaging template or framework for service providers may further support them with acceptance of referrals in instances where demand outweighs capacity. Some service providers reported having developed their own innovative intake models to manage demand and ensure they were delivering services to those deemed most at risk. Developing a framework may further support service providers who are struggling with demand to prioritise their focus on those clients with the most acute needs.

6. *It is recommended that DCJ, in close consultation with service providers and the sector, develop a standardised prioritisation framework(s) to further support greater consistency in prioritising clients where demand for services outweighs capacity, and to support efficiencies in the client assessment and intake process.*

6.3 Client cohorts and needs

Prioritise investment in key areas of need and demand

Across short-, medium- and long-term accommodation needs, unmet need for SHS clients remains consistently high. Stakeholders reported particular challenges in providing appropriate accommodation options to youth clients aged 16-24, suggesting that additional refuges, and supported accommodation options could be prioritised. Provision of suitable accommodation for single parents with children and larger family groups was also identified as a focus area due to current challenges meeting their housing needs. In a previous Department commissioned review of SHS (unpublished) a key theme identified was the mismatch between available accommodation and support services and client cohorts presenting, ultimately contributing to capacity and utilisation issues. This mismatch was found to be driven by misalignment in contracting and funding arrangements with changing client demographics and needs over time.

7. *It is recommended that investment into SHS accommodation services is prioritised by the Department and based on evidence related to unmet need and client characteristics, with consideration of provision of greater flexibility within contractual arrangements to enable service providers to account for changing client needs over time.*

For more specific detail regarding contractual arrangements, please refer to the recommendations under Section 6.4. In the provision of shorter-term accommodation, the SHS Program also falls short of meeting demand based on the evaluation findings. As a key type of support provided by the

Program[297], meeting greater demand in the provision of this type of service should be further prioritised. In addition to limited accommodation options driving low rates of met need, other contextual factors, including geographic location, were also identified to be contributing to this and may need to be considered, such as lack of transport options to help clients travel from their current location to TA or other services.

8. *It is recommended that a review of supply and demand factors pertaining to the utilisation of the TA scheme is undertaken by the Department to identify and understand key drivers, particularly in areas of low utilisation, and develop recommendations for investment prioritisation, including in pathways to stable accommodation options.*

Low demand by SHS clients for TA support in rural locations was attributed to the absence of TA providers in some rural areas. Service providers reported establishing local partnerships with local external accommodation services to temporarily accommodate people experiencing homelessness. The effectiveness of these local partnerships was attributed by stakeholders to ongoing communication between SHS services and external accommodation providers, and SHS services supporting informal TA providers to address any issues with guests, including repairing damage.

9. *It is recommended that the Department review alternative models to provision of TA in rural areas, including consideration of the expansion of the brokerage component of SHS funding to further support rural SHS service providers to partner with local external accommodation providers to temporarily accommodate people experiencing homelessness.*

People exiting institutions and care into homelessness are a national priority homeless cohort identified in the NHHA with the proportion of people exiting correctional, health and mental health facilities into homelessness identified as a key challenge for the sector.[298] Research from the AIHW released in 2019 shows that more than half of people preparing to leave prison expected to be homeless, however, in FY 21/22 referrals from youth and adult correctional facilities represented 2.6% of referrals from mainstream services into SHS.[299] In 2020, approximately one third of young people leaving OOHC experienced homelessness at some stage within their first year after leaving care.[300] Anecdotal evidence from inter-agency stakeholders in this Evaluation also highlighted a perception of bias amongst SHS service providers in accepting referrals through these pathways.

Addressing exits from institutional facilities into homelessness may be further supported by improved collaboration between SHS services and inter-agency services. Information sharing between SHS and other relevant sector agencies was reported to be a key barrier to ensuring the housing needs of this cohort are met, with SHS service providers citing referrals are often received with minimal notice, incomplete details and/or after hours. Improved communication between agencies and SHS may further support efficiency of the referral process, and potentially enable clients to be referred to appropriate services that are adequately resourced to meet their individual needs (and adhere to court-ordered conditions where applicable).

10. *It is recommended that collaboration between agencies, such as Corrective Services and NSW Health, and SHS is strengthened by the Department through the implementation of a standardised pre-release screening process to identify people exiting institutional facilities*

[297] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[298] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021-22. Canberra: AIHW. Retrieved from https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/clients-leaving-care.

[299] Australian Institute of Health and Welfare. (2019). The health of Australia's prisoners 2018. Canberra: AIHW.

[300] Australian Institute of Health and Welfare. (2022). Specialist homelessness services annual report 2021-22. Canberra: AIHW. Retrieved from https://www.aihw.gov.au/reports/homelessness-services/specialist-homelessness-services-annual-report/contents/clients-leaving-care

and care who are at risk of homelessness and support SHS services to engage with these clients with sufficient notice and information prior to exit.

Evidence suggests that programs integrating housing and mental health supports are more effective in generating government cost savings by improving consumer mental health and wellbeing, contributing to tenancy stability and social connectedness. The SHS Program's primary objectives relate to supporting clients to achieve safe and stable housing[301], however, as the evidence demonstrates, part of ensuring housing stability is also the provision of wraparound supports. According to the Housing First principle, housing should be provided first, without pre-condition, followed by a series of holistic wraparound supports.[302] The provision of Housing First, particularly for clients with a mental health condition and/or other complex needs, may be challenging for the SHS sector given the resource-intensive nature of providing wraparound supports.

In some instances, service providers reported that the co-location of allied services or provision of allied services on-site at SHS accommodation was instrumental in delivering an integrated and holistic response to clients. Clients also reported that access to counselling services was significantly facilitated when there was a counsellor in-house and/or the service provider's organisation had an established connection to a mainstream service provider. With a low rate of referrals through the mental health and health service provider pathways, coupled with evidence suggesting success of co-location and strategic partnerships, it is suggested that increased coordination amongst relevant stakeholders may prove beneficial to the provision of a client-centred, integrated response.

11. *It is recommended that SHS providers and mainstream health and mental health service providers in their DCJ Districts form strategic partnerships to further improve referrals and provision of supports to clients with complex needs, which could include multi-disciplinary co-location models.*

In addition, service provider staff reported feeling ill-equipped to manage and support clients with increasingly complex needs. There are a range of relevant mental-health and trauma-informed support training modules available to SHS service provider staff through the SHS Learning and Development (L&D) Framework.[303] Whilst not a substitute for formal, clinical training, completing these training modules may enable staff to better support these clients, as well as manage capacity.

12. *It is recommended that the SHS mental health training curriculum is reviewed by the Department to ensure relevance and is provided on an ongoing basis to enable continuous improvement, with consideration of mandating training under the SHS program specifications.*

6.4 Client centricity and integration

Increase flexibility and opportunity to innovate for service providers

It was recognised throughout the Evaluation that SHS service providers are working flexibly to provide client-centred support. This was evident from the feedback received in SHS client interviews, as well as examples from providers themselves of some of the innovative models they have

[301] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

[302] Department of Housing and Public Works. (2018). Homelessness Program Guidelines, Specifications and Requirements, Queensland Government. Retrieved from Homelessness program guidelines, specifications and requirements (hpw.qld.gov.au); Ministry of the Environment, Action Plan for Preventing Homelessness in Finland 2016-2019. (2016). Retrieved 30 June 2022, from ACTIONPLAN_FOR_PREVENTING_HOMELESSNESS_IN_FINLAND_2016_-_2019_EN.pdf (asuntoensin.fi).

[303] Homelessness NSW (2019). SHS Learning & Development Framework, accessed at https://rise.articulate.com/share/np2f_lNqV4EC4zFoE-VrTRyLFTSLYnO_#/

implemented to ensure they are providing the best possible support to the greatest number of clients within their current funding envelope and contracting arrangement.

It was evident from the consultations that each DCJ District had distinct and individualised needs and requirements. To meet these needs and requirements more effectively, a greater degree of flexibility may be required for service providers to design their services and properties to meet changing client demographics. Current contractual arrangements with minimum client target numbers and links to accommodation types may not be reflective of current need, demand nor actual services delivered by providers, and may actually be hindering the delivery of improved client outcomes. Recognising that the sector is transitioning towards a greater focus on client outcomes, service providers could be supported with this transition by being given increased flexibility and discretion to use their funds, including brokerage funding, to better enable client-centric outcomes. This may require adequate accountability mechanisms, which may include service specifications that place parameters on the degree of flexibility, performance monitoring and compliance activities.

Many service providers expressed a desire to conduct greater assertive outreach and early intervention activities, however, were limited in their ability to do so by resourcing constraints. According to stakeholders, this has resulted in the SHS Program having a focus on crisis responses rather than early intervention and prevention, despite the intention that the SHS Program is delivered through a combination of early intervention, crisis, transitional and post-crisis support services.[304] Increased flexibility in funding and contracting, in this respect, may allow service providers to determine the best approach to service delivery based on an "on the ground" and more real-time understanding of client needs and demand in their respective DCJ Districts. This may include some additional flexibility to assess the ongoing support needs of clients where supports are required to sustain a tenancy.

13. *It is recommended that the Department revise contractual arrangements with SHS service providers to include additional flexibility in service delivery and increase the proportion of brokerage funding to be used at the service provider's discretion to further enable more client-centric outcomes, which would require ongoing monitoring and reporting according to the transition towards outcomes-based commissioning.*

Provision of client-centred and culturally appropriate supports for Aboriginal SHS clients requires continued investment in the capacity building of Aboriginal specialist services, to ensure services are representative of the clients they serve. Stakeholders highlighted the critical role of ACCOs in providing place-based, locally led and culturally safe services to Aboriginal people experiencing homelessness or at risk of homelessness. Stakeholders noted the potential for the strengthening of the sector through the implementation of policy changes and funding strategies to improve coordination between Aboriginal housing, homelessness and other mainstream services.

Additionally, integral to building the capacity of ACCOs is the establishment of genuine strategic partnerships with ACCOs, to support the development of the cultural competence of non-Aboriginal and Torres Strait Islander SHS service providers.

14. *It is recommended that the Department continue to prioritise building the capacity of ACCOs to deliver SHS services, in addition to building cultural safety and capability in non-Aboriginal organisations, to ensure clients continue to be provided with culturally appropriate and client-centred support.*

Challenges meeting a standard three-month case management timeframe were consistently cited by SHS service providers during consultations, which were perceived to hinder service providers from delivering client-centred supports. Whilst previous iterations of the SHS Program Specifications stipulated a standard case management timeframe of three months, the June 2021 program

[304] New South Wales (NSW) Government (2021), Specialist Homelessness Services Program specifications and protocols. Retrieved 26 July 2022, from https://www.facs.nsw.gov.au/providers/homelessness-services/resources/program-specifications-and-protocols/chapters/shs-program-specifications

specifications outline that the intensity and duration of support and accommodation setting in which the support will be delivered should be individually tailored to ensure a person-centred approach.

Inconsistencies in understanding of case management timeframes amongst service providers suggests opportunities to further increase awareness of the removal of case management timeframes from the SHS Program Specifications. Awareness raising initiatives should recognise the impact of contractual client targets on case management timeframes, and outline best practices in managing client targets with provision of client-centred approaches.

15. *It is recommended that the Department undertake awareness raising initiatives to ensure further clarity amongst service providers of the removal of standard case management timeframes, in addition to best practices in balancing non-time-limited case management with meeting contractual targets.*

6.5 Networks and governance

Clarify the purpose and streamline the number of collaborative forums

Place-based networks and governance forums, including DHIGs, are reported to be an effective means of promoting collaboration between SHS services, inter-agencies and other non-government organisations, supporting with the dissemination of information and strengthening of service models. Notwithstanding, qualitative evidence suggests there are opportunities to further refine the number and purpose of governance forums and network meetings to ensure efficient allocation of resources and ensure participation in such forums does not detract from the ability of services to deliver supports. This was particularly notable for DCJ Districts covering large geographic areas, where area managers reported being requested to participate in up to three DHIGs to ensure coverage of their geographical area.

This refinement process may be further supported by clarifying the specific purpose of governance forums and the objectives of each meeting, as there was a perception amongst DHIG participants that the purpose of the meetings was primarily to meet the Department's overarching objectives and KPIs. Ensuring the audience at governance forums and network meetings is aligned to their purpose was suggested to aid in developing an action focus, avoid competition over tenders and minimise time consumed by administrative matters. For example, ensuring a delineation of the audience for governance forums with the purpose of strategic planning with the audience for case management forums was recommended.

16. *It is recommended that the Department conduct a comprehensive review to identify the specific purpose of forums and work with key stakeholders to determine the most appropriate audience for each forum to foster a collaborative environment in meetings and facilitate maximum productivity.*

The advantages of implementing coordinated, place-based approaches were consistently highlighted by stakeholders, with service providers noting the benefits of such approaches in harnessing the specific resources, experiences and opportunities of local communities.

As a component of the abovementioned recommendation regarding streamlining collaborative forums, it is recommended that the Department consider leveraging the ESSC's methodology of implementing place-based approaches supported by local action plans, clearly defined governance structures and meeting purpose, and a focus on the short- and long-term goals of clients and barriers.

To enable the effective establishment and governance of such forums, it is recommended that the implementation and integration of components of the ESSC's methodology be led by internal DCJ stakeholders, specifically local DCJ Commissioning and Planning and DCJ Housing representatives, with strategic guidance from DCJ Homelessness Program Management and ESSC members.

17. It is recommended that the Department conduct a review of the implementation of place-based approaches in local communities, including LIACCs, considering how elements of the ESSC's coordinated and place-based methodology can be further leveraged.

6.6 Data collection and reporting

Integrate systems and processes to enable capacity to track outcomes

The SHS Program currently has sufficient ability to record output-related data through CIMS and equivalent systems, however, more opportunities exist to better link existing data systems, as well as refine outcomes-related data collection mechanisms in order to better understand the client's journey through the homelessness system and tailor services accordingly. Improved availability of client outcomes data may enable more accurate attribution of benefits to the SHS Program, which could support a more robust outcomes evaluation in future.

Service providers consulted with as part of this Evaluation, for the most part, were eager to collect and report on greater client outcomes data. However, given capacity constraints in the sector, it is important that the burden of data collection does not come at the expense of spending time with clients and achieving said outcomes, and service providers already appear to experience challenges with the current level of required data collection, monitoring and reporting.

To enable collection, monitoring and reporting of outcomes data, a few strategies are suggested for consideration. Firstly, there may be opportunities to integrate existing SHS and DCJ datasets to further increase the effectiveness of monitoring client journeys through the system. It is understood that the CIMS, VMS and Link2Home datasets are already integrated. Further integration of these datasets may facilitate more effective sharing of client data and support a greater understanding of pathways in the service system.

18. It is recommended that the Department undertake a review to understand the data needs of various stakeholder groups, and consider the potential integration of CIMS, VMS and Link2Home with other DCJ datasets including the CHIMES portal and the DEX to better track client journeys through the service system.

SHS service providers identified challenges with monitoring client journeys in the service system after being exited from services and reported this to be a barrier to accurately assessing client outcomes. Monitoring client journeys was perceived to be exacerbated by challenges contacting and communicating with clients after exiting services.

Establishing an understanding of longer-term client journeys in the service system and ongoing achievement of client-level and housing outcomes may be enabled through the development and implementation of a framework, based on the SHS Program Logic, to track ongoing client outcomes. Implementation of an outcomes tracking pilot with a sample of SHS client participants is recommended to inform longer-term monitoring of client outcomes and may lead to more accurate benefits attribution and robust future evaluations. The pilot could run for a period of approximately 12 months, with collection of client outcomes data at regular intervals throughout that time. Implementation of this pilot in the short-term, in addition to linkage of CIMS, VMS and Link2Home with other DCJ datasets in the medium-long term may support with developing more fulsome outcomes data.

Engaging with SHS clients at fixed intervals after exiting services may support with improved tracking of client outcomes, and maintaining some degree of contact with these services may increase the likelihood that clients proactively engage with services if they become at risk of homelessness in future. Upon completion of the pilot period, an assessment of the data collected and the data collection process should be conducted to determine whether this approach was beneficial in supporting greater outcomes data collection.

19. *It is recommended that the Department, in collaboration with SHS service providers, design and implement a pilot to engage with a sample of SHS clients at fixed intervals after exiting services to better understand ongoing achievement of client outcomes.*

Further, it is understood that enhancements have, or are supposed to have, been made to the CIMS and equivalent systems to enable increased capturing of outcomes data, with the aim for all reporting to eventually be automated. Expediting this automation ability may support service providers to transition towards the collection of greater outcomes-related data as per the requirements expected of them as they approach the next recontracting period.

20. *It is recommended that automation of outcomes data collected through mechanisms such as the PWI and COS surveys is prioritised by the Department to support service providers.*

Reporting was also cited to be an administrative burden for service providers, who shared that a lack of time and capacity can create a barrier for them in meeting their reporting obligations. Furthermore, the reporting mechanisms do not appear to be fit-for-purpose, for service providers and government stakeholders alike. Some service providers suggested that a reporting dashboard would be helpful for reporting purposes, and may also assist with reducing the time required to adhere to reporting obligations. Ensuring that reporting functions have some ability to be tailored to the relevant audience and purpose may also support this aim.

21. *It is recommended that reporting functions are updated by the Department in collaboration with service providers for ease-of-use, such as a dashboard or downloadable templates.*

Limited training on how to use reporting systems appears to be the main challenges with the current SHS data reporting mechanisms according to survey respondents. Data system training was also regularly raised as a potential solution. Although some training has been provided to service providers in the past on data system usage, and there is online training content available for staff at any time, staff turnover creates inconsistency and breaks the cycle of knowledge transfer regarding data. Furthermore, feedback from stakeholders suggests that there may be limited uptake of the online learning content.

22. *It is recommended that a regular compulsory SHS data training calendar be implemented by service providers for new starters and as a refresher course for current staff, and that greater effort be placed on promotion of available online training options to staff.*

As a component of refining data collection, monitoring and reporting, it is recommended the Department explore opportunities to expand the implementation of real-time data collection tools, such as the BNL developed by the ESSC to facilitate information sharing between key stakeholders and across the sector. Improved information sharing was reported to reduce the number of times clients were required to re-tell their stories, which was perceived to be a barrier preventing clients from accessing services.

As part of any implementation of similar tools, it is critical that client consent is provided, and access to view and edit such information sharing tools is restricted to a core group of stakeholders, with provisions for additional access to be granted to additional stakeholders including external services where appropriate.

23. *It is recommended that the Department explore opportunities to leverage existing data collection tools and consider the development of new tools to facilitate improved information sharing across the sector to best meet the needs of clients.*

Appendix 1. Data Decision Register

Table 10: Data Decision Register

No.	Title	Data-related decision	Status
1	Master data	For this Evaluation, the master data including all SHS clients are generated using files named "`year' Support Period by Month.csv".	Reviewed and confirmed by the DCJ data team.
2	Analysis data	Analysis data are defined as the key data used for the Evaluation. These data were generated using the master data excluding any duplicative entries, incorrectly specified identifications and outliers. The analysis data contain all unique clients and their interactions with the SHS system following their first entry. The analysis data cover the period FY 2016/17 - 2021/22. The financial year identified the fin year of the support period last reported/end. The data are uniquely identified using variables: *SLK, spell* and *episode*. For more information on the excluded observations, see item 8 below.	Reviewed and confirmed by the DCJ data team.
3	Analysis data identifier	The analysis data rely on the *SLK* identifier for SHS clients. For financial years 18/19 and 20/21, the DCJ data team recommended on 1 February 2023 that the *SLK* identifier be replaced by the SLK *alphacode* identifier.	Reviewed and confirmed by the DCJ data team.
4	Analysis period	The period FY 16/17 - 21/22 is considered in the analysis and the base year is FY 16/17. The analysis period is defined by financial years that identified the fin year of the support period last reported/finished. This means that a few clients may have commenced their support prior to the analysis period, but ended their support during the analysis period. All such clients are considered in the analysis as new unique clients in FY 16/17.	Reviewed and confirmed by the DCJ data team.
5	Truncation/ returning clients	The analysis does not observe client interaction with the SHS system after FY 21/22 (these clients are considered non-returning clients). The analysis does not observe if the clients reported in FY 16/17 are returning clients.	Reviewed and confirmed by the DCJ data team.
6	Client spell	To follow SHS clients over time, spells and episodes were generated to uniquely identify SHS clients. Spells were generated using variables: *SLK, date_support_period_commenced* and *assistance_request_date* and a spell represents one continuous support period. The SHS client can have two or more spells in their interactions with the SHS system and these are considered as returns to the SHS system. About 96% of clients interacted with the system less than five times throughout the analysis period. Approximately 0.04% of SHS clients are considered very frequent clients with 10 or more interactions with the SHS system throughout the analysis period. Only the first spell is considered in the analysis; additional spells are generally not considered except in the case of counting return clients.	Reviewed and confirmed by the DCJ data team.
7	Client episode	To follow SHS clients over time, spells and episodes were generated to uniquely identify SHS clients. Episodes identify additional interactions with the SHS system during the support period. Only 0.5% of clients have episode "2". These cases include cases when the support period is finished and the client commenced another support period on the same day or the day after. In addition, it includes cases with matching *date_support_period_commenced*, but varying *date_support_period_finished* and *collection_period_identifier*. Episodes are generally not considered in the analysis, except in the case of counting return clients.	
8	Excluded observations (duplicative drop)	After appending all datafiles (all financial years), we found the total number of observations was 1,836,965. Out of these, 1,309,866 observations were excluded from the analysis, leaving a total of 272,577 unique clients (527,099 observations included client interactions with the SHS system at and after the first entry). The observations were excluded in the following five steps.	Reviewed and confirmed by the DCJ data team.
		Exclusion 1) The datafile reporting fin. year FY 18/19 included 819 observations with incorrectly specified *SLK* (SLK = 99999999999). These observations were excluded from the analysis data.	Reviewed and confirmed by the DCJ data team.
		Exclusion 2.1) The previous data structure reported client interaction with SHS by reporting period and for this reason, a number of observations were duplicated in datafiles. These duplicative observations were identified using variables *SLK, date_support_period_commenced, organisation_id*	Reviewed and confirmed by the DCJ data team.

No.	Title	Data-related decision	Status
		and *collection_period_identifier*. The last reported entry was kept in the analysis data. Total no. of obs excluded: 1,298,789	
		Exclusion 2.2) Same identification process as in 2.1). A few data entries included duplicative *collection_period_identifier* and could not be uniquely identified. The last reported entry was kept in the analysis data. Total no. of obs excluded: 3,859	Reviewed and confirmed by the DCJ data team.
		Exclusion 3) A number of clients engaged with two or more service providers at the same time. The entry with the longest support period is considered in the analysis. In the cases when the length of the support was equal, the last entry was selected based on *collection_period_identified*. Total no. of obs excluded: 5,763 (identified longest support period), 630 (length of support equal).	Reviewed and confirmed by the DCJ data team.
		Exclusion 4) A few outlier cases that do not fall into any abovementioned rules were excluded from the analysis. Total no. of obs excluded: 6.	Reviewed and confirmed by the DCJ data team.
9	Linkage to Link2Home data	Linkage to Link2Home (L2H) dataset: Approx. 39,000 unique clients (as identified by *clientrefno*) are available in the L2H dataset, of which all were linked with an *SLK* identifier using the file '*Link2Home SLK List for EY.xslx*'. The linkage to the NSW Homelessness Data was performed using the *SLK* identifier and year and month of accessing the Link2Home service. To increase the linkage rate, year and month was adjusted to account for cases when the client approached Link2Home at the end of the month and commenced SHS support next month. Using this linkage approach, the linkage rate was approximately 76%, with 24% of Link2Home clients identified without a respective SHS support.	Reviewed and confirmed by the DCJ data team.
10	Categoric Variables	Interpretation of *diagnosed_mental_health* variable. Definitions of categories: • 99 - Don't Know – The information is not known or the client has refused to provide the information • 0 - Not Applicable – There is no consent for information to be provided to the AIHW, or the question was not asked of a child under 15. The categories 'Don't know' or 'Not Applicable' or missing values will be treated as missing in this analysis. We will present descriptive statistics, including reporting missing values where relevant. We will not explore client behaviours for reporting or not reporting information; this will not affect the analysis results. For other variables, we will refer to the SHS Collection Manual 2019 which outlines how service providers should code responses. Interpretation supported by SHS Collection Manual 2019.	Reviewed and confirmed by the DCJ data team.
11	Dates	The definition of the date "31dec9000" and "31dec2000" in HOMES data indicate an ongoing tenancy. Such dates are found in the HOMES Tenancies file (variable tenancyenddate) and Tenants file (tenancyenddate f). The former file included a few "31dec2000" dates, while the proportion of such entries in the latter file was about 10%. Provided the file was exported without errors, we will assume both of these entries are active/ongoing tenancies and correct them locally.	Reviewed and confirmed by the DCJ data team.
12	HOMES	The analysis data (described in item 2 above) has been linked with the following datasets. We have identified that: • Approx. 14% of SHS clients in the analysis data accessed community housing support • Approx. 20% of SHS clients in the analysis data accessed temporary accommodation • Approx. 12 % of SHS clients in the analysis data accessed public housing support • Approx. 11% of SHS clients in the analysis data received prevention payment assistance We note that a client may have had one or more tenancies, and one or more prevention payments.	Reviewed and confirmed by the DCJ data team.
13	HOMES	DCJ confirmed that there was likely no ETA provided during the reporting period.	Reviewed and confirmed by the DCJ data team.
14	CIMS	Mental health will be reported based on the number of mental health cases SHS clients self-report as diagnosed. A disclaimer will be added to communicate that this is likely an under-representation of the total number of SHS clients that live with a mental health condition, as many clients would not have access to, or the opportunity to access (mental) health support – inhibiting their ability to diagnose their condition.	Reviewed and confirmed by the DCJ data team.
15	CIMS	Upon DCJ's request - categorisation of the met and unmet need variables in CIMS has been updated to collect information across all reported periods within a support period identified in CIMS and equivalent systems – as opposed to only reporting based on the last reported period.	Reviewed and confirmed by the DCJ data team.

No.	Title	Data-related decision	Status
16	CIMS	It was noted that the client's Indigenous status may be inconsistently reported across different support periods and reporting periods (the service provider reports client information every month). It is assumed that the client identifies as Aboriginal or/and Torres Strait Islander client if Indigenous status was reported in any of the reporting periods. If no information was ever recorded – the variable will be considered not reported across all periods.	Reviewed and confirmed by the DCJ data team.
17	L2H	At times when a client is redirected multiple times, the initial source of referral is not recorded. There are many instances where L2H indicates that they have referred a client, however this client is not found in the NSW Homelessness Data, or the NSW Homelessness Data indicates that this client is referred from a mainstream service provider. In these instances, the NSW Homelessness Data is considered as the source of truth.	Reviewed and confirmed by the DCJ data team.
18	CIMS	DCJ confirmed that, of the 102 service providers, four of them do not use CIMS and their reporting systems may be slightly different. Two of these providers are St Vincent de Paul and Mission Australia. Of the 95,000 support periods in FY 21/22, 22% were provided by the four service providers that do not use CIMS. DCJ confirmed that the findings using the provided administrative data (CIMS and equivalent systems) capture consistent information for the majority of users.	Reviewed and confirmed by the DCJ data team.
19	CIMS	The DCJ team confirmed that SHS rules indicate that services should not be provided to unaccompanied children under the age of 12 years. The DCJ team confirmed that anyone presenting under the age of 12 can be considered an administrative error, as the parent and child may have been incorrectly linked.	Reviewed and confirmed by the DCJ data team.
20	CIMS	DCJ indicated that there are a couple of ways in which the child and youth cohort can be split. Two main groupings of interest were identified; 12 – 15 year-old persons to be defined as children and 16 – 24 year-old persons to be defined as youth.	Reviewed and confirmed by the DCJ data team.
21	HOMES	In the HOMES public housing data, the *SLK* identifier is treated as a unique identifier. In cases when one *SLK* has multiple different *clientrefno*, it is assumed that this is the same person identified by the *SLK* identifier.	Reviewed and confirmed by the DCJ data team.
22	HOMES - Transfers	DCJ has advised that transfers in the HOMES public housing data are identified using *tenancytrmnreason* and include the following options: • Mutual Exchange • Mutual Exchange of Property • Re-sign – ended by NCAT • Re-sign – Household Breakdown • Re-sign – Joint/ Name Change/ Exp Tenure • Re-sign – Property/ Management Transfer • Rehoused • Transfer – At Risk/ Harassment • Transfer – Medical/Mobility/ Disability • Transfer – Other tenant needs • Transfer – Under/over occupance • HNSW Relocation – Expired Headlease, Portfolio Management, Tenancy Management • Uninhabitable (EG: Fire/Storm/Etc) • Uninhabitable (Fire/Storm/etc) EY has implemented the following rules to adjust the identification of transfers: • In cases when the next tenancy appears within more than six months, and the *tenancytrmnreason* variable identifies this tenancy as a transfer, this is not treated as a transfer. • If the *tenancytrmnreason* identifies a transfer from tenancy 1 and the next tenancy (tenancy 2) starts before tenancy 1 ends, it is assumed that tenancy 2 starts when tenancy 1 ended. EY observed cases when the difference between the tenancy 2 start date and the tenancy 1 end date is more than 2 years.	Reviewed and confirmed by the DCJ data team.

No.	Title	Data-related decision	Status
		When *tenancytrmnreason* was specified as NA, and the end date of tenancy 1 was within seven days of the start of tenancy 2 (including cases when tenancy 2 started before tenancy 1 ended), it is assumed that this is a transfer.	
23	HOMES	DCJ provided the following definition to identify positive and negative exits from social housing, where the remaining were categorised as other: Positive Exits: Tenancy termination reasons are: PROV_EXIT, TENEXIT_RN, TENEXIT_SN and/or Next housed are: AFFORD_HSG, PRIV_REN, PRIV_OWN. Negative exits: Tenancy termination reasons are: BRCH_ABAN, BRCH_EVICT, BRCH_NCAT. All other exits from social housing are defined as 'Other' (neither positive, nor negative).	Reviewed and confirmed by the DCJ data team.
24	The definition of the type of SHS services	The following definition has been adopted to define the types of SHS services: 1. Accommodation services - if the client identified a need for accommodation services listed below, it is assumed that an accommodation service was provided. If the client required any other services in addition to accommodation services, it is assumed that the key service provided was the accommodation service. • The need for short-term accommodation was met (provided or referred and provided) • The need for medium-term accommodation was met (provided or referred and provided) 2. Non-accommodation services – if the client did not identify the need for any accommodation service, it is assumed that the client received a non-accommodation service(s). The following categories of non-accommodation services were identified based on the begin and end dates of SHS support. • Minor engagement (support begins and ends on the same day) • Non-accommodation case management (SHS support > 1 day) *Additional assumptions:* • Type of SHS service is defined using the recorded information on client needs and service response and begin/end dates of the support period. All information is recorded in the CIMS and equivalent systems dataset. • Clients whose need for long-term accommodation was met are considered as receiving non-accommodation case management. • A small share of clients (<2%) received both accommodation services and are considered as receiving both services.	Reviewed and confirmed by the DCJ data team.

25	Economic analysis – data source	The economic analysis will rely on the following data sources:
		• Cost Data - The economic analysis will rely on DCJ funding data from FY 21/22. It will be assumed that service providers received the same funding amount in previous analysis years. The HOMES private rental subsidies data will inform about additional rental payment subsidies SHS clients received. The sensitivity analysis will compare the cost of services informed by the DCJ Unit Costing Project with the aggregate DCJ funding estimate to test the implications on the final results.
		Note: The economic analysis data source was subsequently revised to be the preliminary DCJ Unit Costing findings upon receipt of feedback from FACSIAR between delivery of the draft and final SHS Evaluation Report.
		• Benefits Data: The economic analysis will employ the administrative data provided for the Evaluation where possible (CIMS and equivalent systems, HOMES, CHIMES). Noting that outcomes data are limited in the administrative data, the quantification of benefits will largely rely on publicly available proxy value data of a comparable cohort and rely on the following sources:
		  • BOCSAR proxy value data
		  • DCJ Benefit database
		  • Publicly available data sources such as: (AIHW, AHURI, government reports, peer-reviewed literature)
			Reviewed and confirmed by the DCJ data team.

26	Economic analysis – overarching assumptions	Analysis period: Costs incurred and benefits delivered by the SHS Program during the SHS Evaluation analysis period in FY 16/17-21/22 will be considered. The final date of the SHS evaluation period is 30 June 2022. Benefits will be projected up to five years following the provision of SHS services. Benefits inflating: All costs and benefits from before 30 June 2022 will be inflated using the observed inflation rate (CPI as at June each year) to reflect the net present value (NPV).	Reviewed and confirmed by the DCJ data team.

No.	Title	Data-related decision	Status
		Benefits discounting: All costs and benefits from after 30 June 2022 will be discounted using a hyperbolic discount rate of 5% as per the NSW Government guidance.	

Appendix 2. Assumptions for Economic Appraisal

Table 11: Key assumptions for economic appraisal

Input	#	Source	Rationale	Confidence rating
Overarching Assumptions				
Discount Rate	5%	NSW Treasury (2023 Feb). NSW Government Guidelines to Cost Benefit Analyses. TPG23- 08	The Economic Appraisal was developed with reference to NSW Treasury Evaluation Guidelines.	High
Benefit Drop off Profile – general	Year 1 – 100% Year 2 – 50% Year 3 – 25% Year 4 – 12.5% Year 5 – 6.3%	DCJ assumption based on other internal DCJ Evaluations		-
Benefit Drop off Profile – general assumption – justice domain	Year 1 – 100% Year 2 – 73.0% Year 3 – 43.5%	Kerman, N., Sylvestre, J., Aubry, T. et al. The effects of housing stability on service use among homeless adults with mental illness in a randomized controlled trial of housing	Based an evaluation of a Housing First program in Canada. The evaluation compares outcomes across a number of service systems, including justice services between recipients of Housing First program services and standard homelessness services. The estimates rely on the comparator group (standard homelessness services) and consider individuals with sustained housing instability. Individuals with housing instability will be most similar in their characteristics to SHS clients.	Medium

Input	#	Source	Rationale	Confidence rating
	Year 4 – 24.9% Year 5 – 6.9%	first. BMC Health Serv Res 18, 190 (2018).	The benefit drop-off profile is applied on all justice outcomes except for adult and youth custody and court appearances. Please refer to input 'Distribution of court appearance of custody over the 5 years' on page 170.	
Benefit Drop off Profile – general assumption – health domain	General benefit drop off profile assumed.	Baxter A.J., et al. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: systematic review and meta-analysis of randomised controlled trials. J Epidemiol Community Health.73(5):379-387. Morton, M.H. et al (2020). Interventions for youth homelessness: A systematic review of effectiveness studies. Children and Youth Services Review 116.	Based on meta-analysis of randomised control trials focusing on the 'Housing First' program, evidence on the long-term health impact of housing and other support services is lacking. This evidence is also supported by meta-analysis that focused on the youth cohort. For the evaluations that focused on impact on health and mental health, the evidence about long-term impacts is limited. For this reason, the general assumption of benefit drop-off profile is assumed. The benefit drop-off profile is applied on all health-related benefits.	Low
Benefit Drop off Profile – general	Year 1 – 100%	Various sources. Please refer to the next page.	The benefit drop-off profile has been estimated based on the available research evidence to sustain housing after participation in a Housing First program. Whilst Housing First programs focus on different priorities of	Medium

Input	#	Source	Rationale	Confidence rating
assumption – housing domain	Year 2 – 82% Year 3 – 80% Year 4 – 76% Year 5 – 68%		service provision, the cohort receiving such services are most comparable to the SHS cohort receiving access to medium-term housing described in this benefit. The approach taken to quantify this benefit profile is described on the following page. The benefit drop-off profile is applied on the benefit 'Reduction in clients needing to access Temporary or Crisis accommodation' and attributed to clients whose need for long-term accommodation was met and quantified the avoided costs from multiple requests for temporary or crisis accommodation as a result.	
Proportion of SHS clients that did not return for the same reason	78.2%	Administrative Data	Administrative data were provided by the Department for the Evaluation and are considered the source of truth to determine the cohort of SHS clients.	High
Definition on the client's needs being met	-	Specialist Homelessness Services Collection manual (Version: 12 June 2019)	The definition of the client needs being met aligns with the provision of service response. The CIMS and equivalent systems record needs identified and the response described as: provided, referred and provided, referred only, or not provided. Benefits are attributed based on the service being provided or referred and provided. It is considered that if only a referral is arranged, the client need was not met.	High

Table 12: Benefit drop off profile for housing benefit parent category

Description	Year 1 (baseline)	Year 2	Year 3	Year 4	Year 5
Indicator: Estimate numbers of days in prison within 3 months* and based on individuals receiving standard homelessness care compared to Housing First program services*	Assumed that clients whose need for medium-term accommodation was met are housed, 100%. (Baseline 4.19 days in prison/3months)	5.32 days in prison/3months	6.89 days in prison/3months	8.17 days in prison/3months**	9.64 days in prison/3months**
% change in estimate compare to baseline year or previous year		27.0% increase in days in prison compared to baseline (4.19 days in prison)	29.5% additional increase in days in prison compared to Year 2 (5.32 days in prison)	18.5% additional increase in days in prison compared to Year 3	18.5% additional increase in days in prison compared to Year 4
Impact on benefit drop off		Benefit drops to 73.0% compared to baseline	Additional benefit drop-off 29.5%	Additional benefit drop-off 18.5%	Additional benefit drop-off 18.0%
Benefit drop off profile	100%	73.0%	43.5%	24.9%	6.9%

*Evidence based on the estimate for standard care sustained housing instability. Source: Kerman, N., Sylvestre, J., Aubry, T. et al. The effects of housing stability on service use among homeless adults with mental illness in a randomized controlled trial of housing first. BMC Health Serv Res 18, 190 (2018).

** No evidence is available on average number of days in prison within 3 months at 36/48 months. A linear projection was applied based on baseline year, Year 2, Year 3 (and Year 4 for 48 months).

Table 13: Benefit drop off profile for justice benefit parent category

Average	Year 1	Year 2	Year 3	Year 4	Year 5
	Assumed that clients whose need for medium-term accommodation was met are housed, 100%.	Sustaining tenancy at 12 months	Sustaining tenancy at 24 months	Sustaining tenancy at 36 months	Sustaining tenancy at 48 months
		90% housing retention Evidence from the Way2Home program in Australia. Source: Padgett, D. et al. (2015) Housing First: ending homelessness, transforming systems, and changing lives, Oxford University Press, USA.	85% housing retention Evidence from the Un Chez Soi d'Abord program in France: Source: Aubry, T. (2020) 'Analysis of Housing First as a practical and policy relevant intervention: the current state of knowledge and future directions for research', European Journal of Homelessness 14 (1):13-26.	No evidence is available on sustaining tenancy at 36 months. A linear projection applied based on Year 1 and Year 2.	68% housing retention Evidence from the Secondary study program in the U.S. Source: Tsemberis, S. (2010) Housing First: Ending homelessness, promoting recovery and reducing cost, in: Ellen, I. and O'Flaherty, B. (2010) (eds) 'How to House the Homeless' New York, Russell Sage Foundation.
		82% housing retention Evidence from the Platform 70 program in Australia. Source: Whittaker, E. et al. (2015) 'A place to call home: study protocol for a longitudinal, mixed methods evaluation of two housing first adaptations in Sydney, Australia', BMC Public Health 15 (1): 1-9.	84% housing retention Evidence from the Secondary study program in the U.S. Tsemberis, S. (1999) 'From streets to homes: an innovative approach to supported housing for homeless adults with psychiatric disabilities', Journal of Community Psychology 27 (2: 225-241.		

		74% housing retention Evidence from the Common Ground Sydney program in Australia Source: Whittaker, E. et al. (2015) 'A place to call home: study protocol for a longitudinal, mixed methods evaluation of two housing first adaptations in Sydney, Australia', BMC Public Health 15 (1): 1-9.	74% housing retention Evidence from the At Home/Chez Soi programs in Canada Source: Aubry, T. et al. (2016) 'A multiple-city RCT of housing first with assertive community treatment for homeless Canadians with serious mental illness', Psychiatric Services 67 (3): 275-281.		
			76% housing retention Evidence from the HF program in Ottawa, Canada Source: Cherner, R.A. et al. (2017) 'Housing first for adults with problematic substance use', Journal of Dual Diagnosis 13 (3):219-229.		
	100%	82.0%	79.8%	77.5%	68.0%

Table 14: Health domain benefits: list of assumptions and sources

Input	#	Source	Rationale	Confidence rating
Number of SHS clients who expressed need for support with mental health-related challenges and their need was met at the end of SHS support	-	Yearly estimates from the NSW Homelessness Data (CIMS and equivalent systems)	Administrative data were provided by the Department for the Evaluation and are considered the source of truth to determine the cohort receiving the benefit(s). SHS clients who expressed the following needs represent the most likely group of clients who would benefit from psychotherapy and counselling service: • Need for assistance with trauma, • Need for mental health services, • Need for assistance with behavioural problems It is considered that the client need was met if the services were provided or the support or assistance from a qualified practitioner was provided and recorded in CIMS and equivalent systems (see the definition on client's needs being met in Section 3.7.2).	High
Cost to the government per counselling and psychotherapy service	$91	NSW Health South Easter Sydney Local Health District, 2021. NSW Patient fee. Retrieved fromhttps://www.seslhd.health.nsw.gov.au/sites/default/files/groups/Executive_Services/Service_Agreement/NSW%20Patient%20Fee%20-	The cost of counselling and psychotherapy services refer to a cost for an outpatient service provided not at a public hospital. The cost indicator is based on the NSW South Eastern Sydney Local Health district agreed patient fees.	Medium

Input	#	Source	Rationale	Confidence rating
		%20Category.PDF, accessed on 26 May 2023.		
Number of services based on the Medicare mental health treatment plan	10	Services Australia (n.d.). Mental Health care and Medicare. Retrieved from https://www.servicesaustralia.gov.au/mental-health-care-and-medicare?context=60092, accessed on 6 Jun 2023.	It is assumed that a person living with a mental health condition would receive a Mental Health Treatment Plan, allowing claims of up to 10 sessions with a mental health professional each calendar year.	Medium
% of clients where mental health services (psychotherapy and counselling) improved the client's quality of life	65%	Moritz S. et al (2005). Quality of life in obsessive-compulsive disorder before and after treatment. BMJ Open 11:e040061. FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 31.	Relying on the DCJ Benefits Menu, obsessive-compulsive disorder and panic disorders are considered as representative of the suite of mental health conditions afflicting SHS clients with a reasonable prospect of treatment. The research evidence suggests that the efficacy of psychotherapy and medication would improve quality of life between 50 to 80%. The average between the two estimates is assumed.	Medium
Quality of Adjusted Life Year (QALY)	$59,874	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 31.	The current value of the QALY reported in the DCJ Benefits Menu relies on the Global Burden of Disease Study and considers obsessive-compulsive disorder and panic disorders as representative of the suite of mental health conditions afflicting SHS clients with a reasonable prospect of treatment. The current value has been inflated to represent AUD values in FY 22/23.	High

Input	#	Source	Rationale	Confidence rating
		WHO (2004). Global Burden of Disease 2004 Update		
QALY equivalence weight for mental health	0.07	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 31.	From the DCJ Benefits Menu, two mental health conditions - obsessive-compulsive disorder and panic disorders - are considered representative of the suite of mental health conditions afflicting SHS clients with a reasonable prospect of treatment.	Medium
Number of SHS clients who expressed need for health and/or medical services and their need was met at the end of support	-	Yearly estimates from the NSW Homelessness Data Specialist Homelessness Services Collection manual (Version: 12 June 2019)	Administrative data were provided by the Department for the Evaluation and are considered to be the source of truth to determine the cohort of SHS clients receiving benefit(s). It is considered that the client need was met if services were provided. (See the definition on the client's needs being met in Section 3.7.2). The response includes assessment of the client's health and medical needs and any treatment provided.	High
Cost to government per hospital admission	$4,990	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 27.	The cost to government is defined in the DCJ Benefits Menu as one unit of hospital service for an acute patient. The current value of the cost has been inflated to represent AUD values in FY 22/23.	High
% of clients where access to primary care potentially prevented hospital admissions	6.6%	Australian Institute of Health and Welfare, (2020), Disparities in potentially preventable hospitalisations across Australia 2012 – 2013 to 2017 – 2018	Based on an AIHW study on potentially preventable hospitalisations, a share of acute hospitalisations can be prevented through early access to primary care services. This number accounts for the proportion of potentially preventable hospital bed days through early provision of healthcare.	Medium

Table 15: Justice and Safety domain benefits: list of assumptions and sources

Input	#	Source	Rationale	Confidence rating
Likely % of SHS clients who would appear at court without service provision	32.1%	Law and Justice Foundation of New South Wales, (2012), Legal needs in Australia, LCFNSW. Page 64.	This assumption relies on a survey conducted in NSW to determine the number of people experiencing homelessness that had accessed court recently. The homelessness population consider all individuals who are currently homeless and do not receive homelessness support.	Medium
% of SHS clients who still appeared in court	22.7%	Bureau of Crime Statistics and Research, (2022), LinDA: People in Custody and SHS client interactions data BOCSAR.	BOCSAR proxy value data, including the number of SHS clients with at least one court appearance in each financial year, were provided by DCJ. The average across all years is assumed.	High
Cost per court appearance	$929	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 71.	The cost relies on the cost per finalisation of a magistrates' court prosecution. The current value of the cost has been inflated to represent AUD values in FY 22/23. The cost per court appearance does not include the cost for the office of the director of public prosecution and for police officers required to attend the court.	Medium
Average number of court appearances per client	3.60	Bureau of Crime Statistics and Research, (2022), LinDA: People in Custody and SHS client interactions data BOCSAR.	The average number of court appearances per client per year has been provided by DCJ in the BOCSAR proxy value data.	High

Input	#	Source	Rationale	Confidence rating
Distribution of court appearance and custody events over 5 years	Evenly Distributed	BOCSAR proxy value data provide the number of SHS clients that could've committed a crime or experience a custody event at any point over the course of the evaluation period. Because it is unknown in which year the event takes place, the analysis assumes that the event will be avoided sometime within the 5-year period. The benefits are then equally distributed over 5 years and no benefit drop off is applied.		
Likely % of SHS clients who are at risk of custody without service provision	9.7%	NSW Network Patient Health survey. Justice Health ^ Forensic Mental Health Network. Page 13;	This assumption relies on a survey conducted in NSW and determines the % of individuals who were homeless prior to incarceration.	Medium
% of SHS clients who still appeared in custody	7.9%	Bureau of Crime Statistics and Research, (2022), LinDA: People in Custody and SHS client interactions data BOCSAR.	BOCSAR proxy value data, including the number of SHS clients with at least one custody event in each financial year, were provided by DCJ. The average across all years is assumed.	High
% of custody episodes in non-juvenile facilities	80.7%	Bureau of Crime Statistics and Research, (2022), LinDA: People in Custody and SHS client interactions data BOCSAR.	The share of custody episodes in non-juvenile facilities was provided by DCJ as part of the BOCSAR proxy value data.	High
Cost of adult custody per day	$173	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 77. (Avoided Adult Custody – open).	The BOCSAR proxy value data provided additional information on the % of clients by a principal offence. Based on this, it is assumed that the majority of SHS clients are at risk of custody at an open facility due to less serious offences being more common amongst the SHS population. The current value of the cost has been inflated to represent AUD values in FY 22/23.	High

Input	#	Source	Rationale	Confidence rating
Cost of Juvenile custody per day	$1,598	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 74 (Avoided youth custody stay)	The Benefits Menu was provided by FACSIAR as an additional database to support the Evaluation. The current value of the cost has been inflated to represent AUD values in FY 22/23.	High
Average number of days in custody	147 days	Bureau of Crime Statistics and Research, (2022), LinDA: People in Custody and SHS client interactions data BOCSAR.	BOCSAR proxy value data were provided by DCJ.	High
% of SHS clients that would likely experience a victim incident without service provision	23%	NSW DCJ Pathways to Homelessness report, 2021 Dec. Table 16, Page 31.	This assumption reflects the likely share of police recorded victim incidents by individuals 12 months prior to accessing homelessness services and relies on the social housing population. People accessing social housing are most likely to use homelessness services to access housing and it is assumed that this population is most similar to the SHS client cohort in their demographic characteristics and service use.	Medium
% of SHS clients that would likely experience a victim incident with service provision	9%	NSW DCJ Pathways to Homelessness report, 2021 Dec. Table 15, Page 30.	This is an assumed comparator group and represents the share of police-recorded victim incidents for the general NSW population.	Medium
Average number of police recorded	1.1	NSW DCJ Pathways to Homelessness report, 2021 Dec. Table 19, Page 41.	This assumption relies on the difference between those at risk (3.5) and the full population (0.21) and is divided by three to reflect the average number of police recorded victim incidents per year.	Low

Input	#	Source	Rationale	Confidence rating
victim incidents per client				
Cost per police recorded victim incident	$358	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 59 (Avoided call out to a client's residence or community)	This number relies on police cost per incident including labour cost of police service for an hour of time from two officers. The current value of the cost has been inflated to represent AUD values in FY 22/23.	Medium
Likely % of clients who would develop PTSD or have an injury as a result of the incident	0.35	DCJ assumption	This assumption applies additional weight on the number of clients who would benefit from improvements in quality of life as a result of avoiding a police-recorded victim incident.	Low
QALY equivalence weight for PTSD and injury	0.09	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 63.	This assumption relies on the quality of life reduced for an individual due to DV, based on the adjustment for PTSD and soft tissue damage.	Medium
Likely % of SHS clients that would be in contact with the police with service provision	32%	Kouyoumdjian F.G. et al, (2019). Interactions between Police and Persons Who Experience Homelessness and Mental Illness in Toronto, Canada: Findings from a Prospective Study. Can J	The share reflects the odds ratio for the association between housing status and police interaction based on the Canadian setting. It is assumed that the SHS population will be either homeless or partially housed (staying with friends and family or at temporary housing). For this reason, the average between the odds ratios for police interaction for those not housed (33.2) and partly housed (30.8) is assumed.	Low

Input	#	Source	Rationale	Confidence rating
		Psychiatry. 64(10):718-725. Table 3.		
Likely % of SHS clients that would be in contact with the police without service provision	25.2%	Kouyoumdjian F.G. et al, (2019). Interactions between Police and Persons Who Experience Homelessness and Mental Illness in Toronto, Canada: Findings from a Prospective Study. Can J Psychiatry. 64(10):718-725. Table 3.	The share reflects the odds ratio for the association between housing status and police interaction based on the Canadian setting. This represents a comparator group for the risk of police interaction for those who are housed (25.2).	Low
Average number of police interactions	6.0	Kouyoumdjian F.G. et al, (2019). Interactions between Police and Persons Who Experience Homelessness and Mental Illness in Toronto, Canada: Findings from a Prospective Study. Can J Psychiatry. 64(10):718-725. Table 2.	The estimate represents the average number of police interactions per year. The average is assumed between Study year 1 (6.3) and year 2 (5.8).	
Cost per contact with the police	$358	FACSIAR (June 2021). DCJ Benefits Menu. The financial value of client outcomes. Page 59 (Avoided call out to a client's residence or community)	This number relies on police cost per incident including labour cost of police service for an hour of time from two officers. The current value of the cost has been inflated to represent AUD values in FY 22/23.	Medium

Table 16: Housing domain benefits: list of assumptions and sources

Input	#	Source	Rationale	Confidence rating
Number of clients who identified the need for long-term accommodation and their need was met		Yearly estimates from the NSW Homelessness Data	Administrative data were provided for the Evaluation and are considered the source of truth to determine the cohort of SHS clients receiving the benefit(s). The group receiving the benefit are considered individuals whose need for long-term accommodation was met at the end of the SHS support (See the definition on the client's needs being met in Section 3.7.2.)	High
Number of people per unit	2	DCJ assumption	It is assumed that two people occupy one unit of housing.	Medium
Cost of short-term accommodation per unit per day	$322	DCJ Preliminary Unit Costing Data	The cost of short-term accommodation is based on the preliminary estimates of the DJ Unit Costing Project and represents the cost for small to medium refuges (weighted average) service. The cost is measured on an annual basis for a refuge with 6.7 units on average. The cost estimate used in the analysis was divided by 6.7 and divided by 365 days to reflect one unit cost per day.	Medium
Cost of social housing per day	$63	DCJ Draft Unit Costing Data	The cost of social housing per day is based on the preliminary estimates of the DCJ Unit Costing Project and represents the cost for transitional housing services as a proxy for other housing options than short-term accommodation. The cost is measured on an annual basis. The cost estimate used in the analysis was divided by 365 days to reflect the cost per day.	Medium

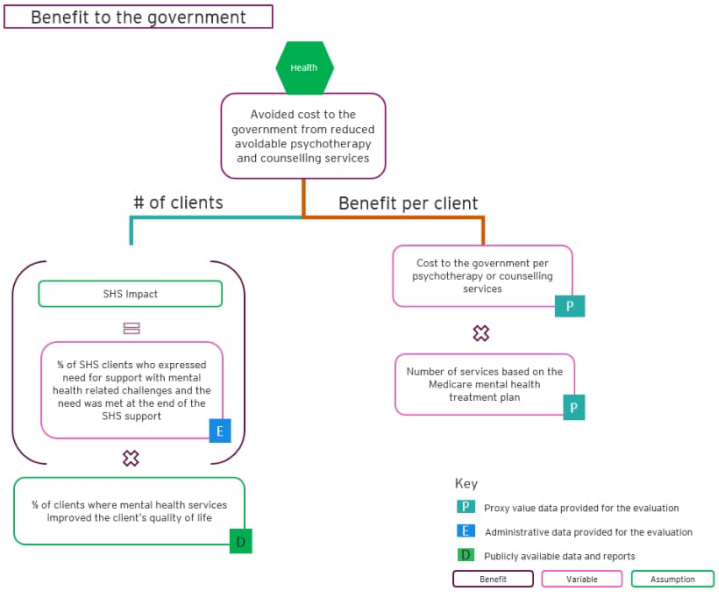
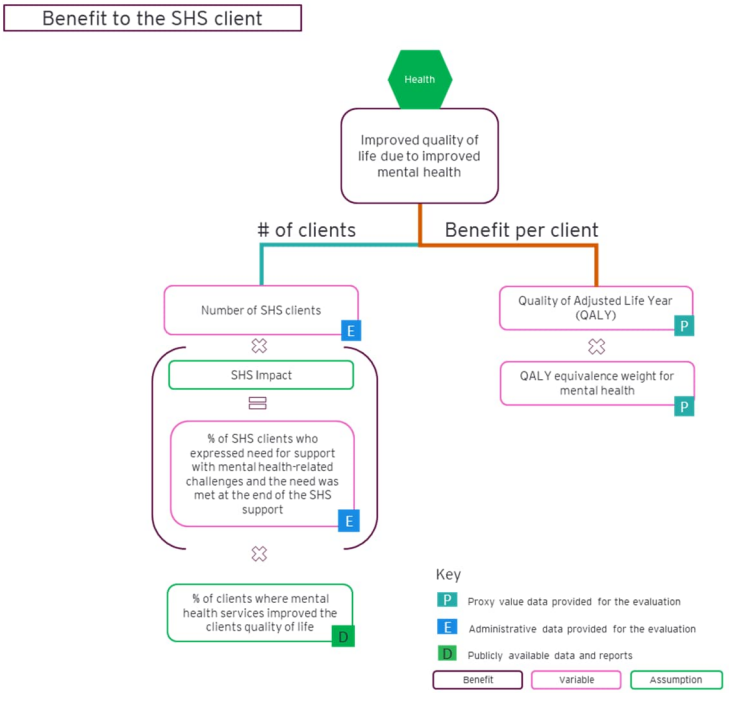
Input	#	Source	Rationale	Confidence rating
Average length of stay in TA/CA	3.13 days	HOMES TA	HOMES temporary housing data provided for the Evaluation were used to determine the average length of stay in temporary/crisis accommodation.	High
Average length of stay in transitional housing	270 days	Women Housing Company (n.d.). Transitional Housing Factsheet. Retrieved from here, accessed on 9 June, 2023.Retrieved from here, accessed on 9 June, 2023. Bridge Housing (n.d.) Transitional Housing Factsheet. Retrieved from here, accessed on 9 June, 2023.Retrieved from here, accessed on 9 June, 2023.	The tenures in transitional housing are offered for 3 months at a time and up to 18 months. A median tenure is assumed. The assumption is used in calculating the total costs of service provision based on the DCJ Unit Costing Project preliminary findings.	
Advanced Rent (AR), Rental Choice Assistance (RCA), Tenancy Guarantee (TG), and Bond Assistance (BA) are funded by the NSW government		DCJ administrative data	It is assumed the following private rental subsidies are funded by the NSW government: Advanced Rent, Rental Choice Assistance, Tenancy Guarantee and Bond Assistance the Private Rental Assistance.	Medium
Number of clients accessing AR, RCA, TG and BA		Yearly estimates from the HOMES Data linked with SHS Data; variable pra_type	The number of clients receiving a private rental subsidy has been estimated using HOMES data, which were provided for the Evaluation.	High

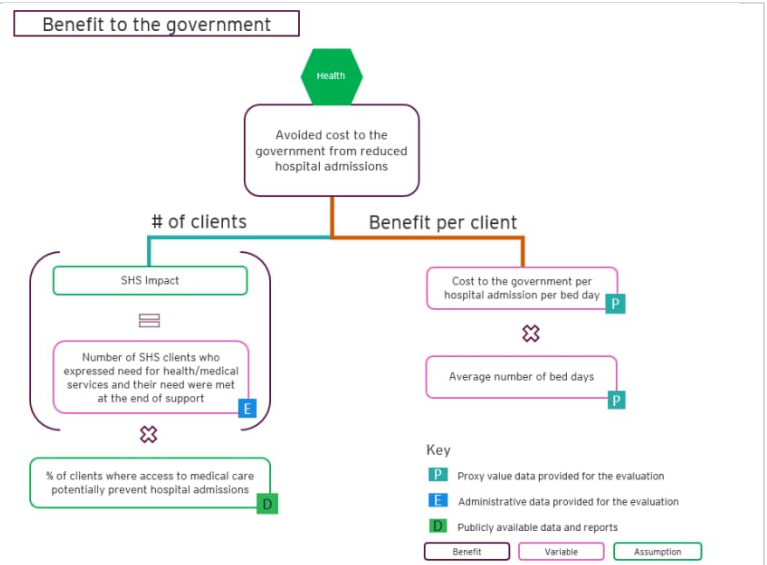
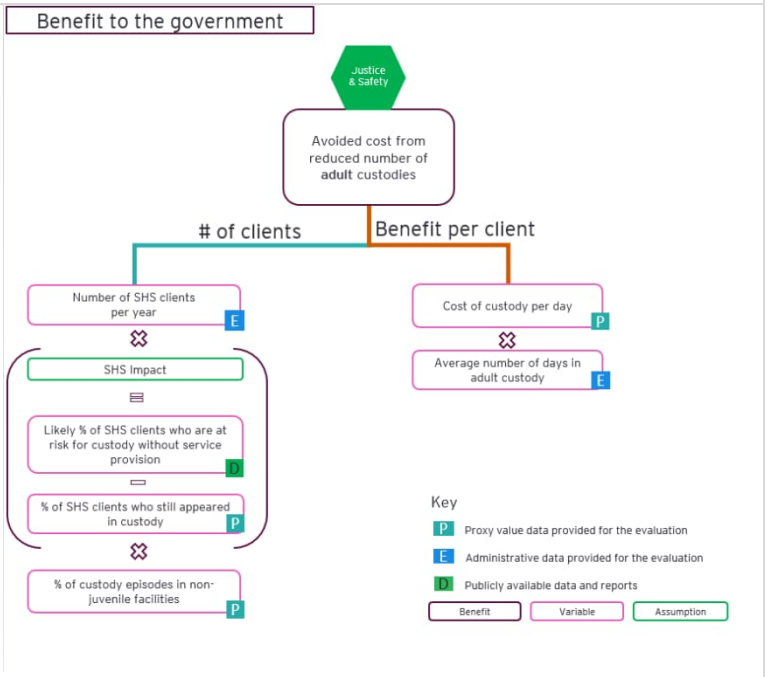
Input	#	Source	Rationale	Confidence rating
Average annual cost of Advanced Rent	$490	Yearly estimates from HOMES Data linked with SHS Data, variable: pra_amount and pra_type.	After linkage of the HOMES data with the NSW Homelessness Data, the relevant sample of individuals was determined. The average subsidy 'Advanced Rent' received by an individual is assumed. Note, that the median value was $460.	High
Average annual cost of Tenancy Guarantee	$488		After linkage of the HOMES data with the NSW Homelessness Data, the relevant sample of individuals was determined. The average subsidy 'Tenancy Guarantee' received by an individual is assumed. Note, that the median value was $500.	High
Average annual cost of Rent Choice Assistance	$478		After linkage of the HOMES data with the NSW Homelessness Data, the relevant sample of individuals was determined. The average subsidy 'Rent Choice Assistance' received by an individual is assumed. Note, that the median value was $478.	High
Average annual cost of Bond Assistance	$481		After linkage of the HOMES data with the NSW Homelessness Data, the relevant sample of individuals was determined. The average subsidy 'Bond Assistance' received by an individual is assumed. Note, that the median value was $481.	High

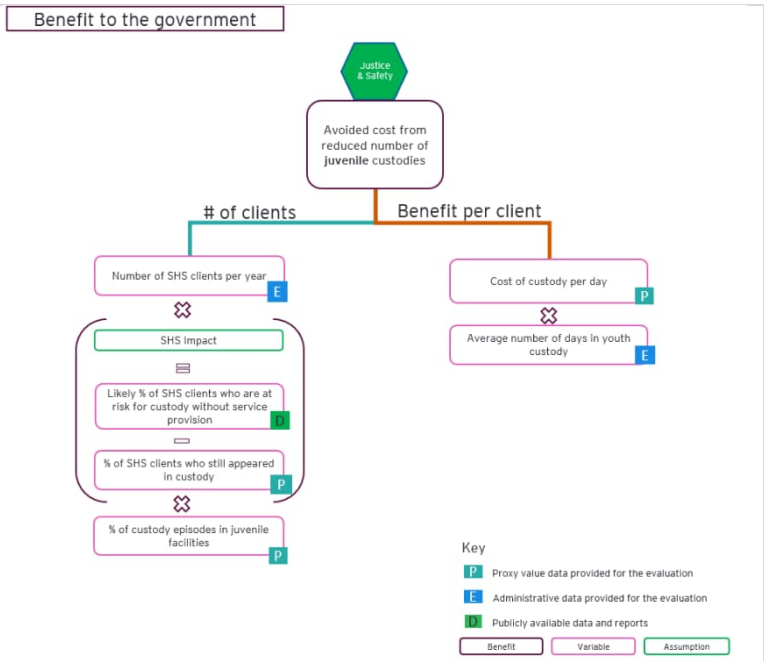
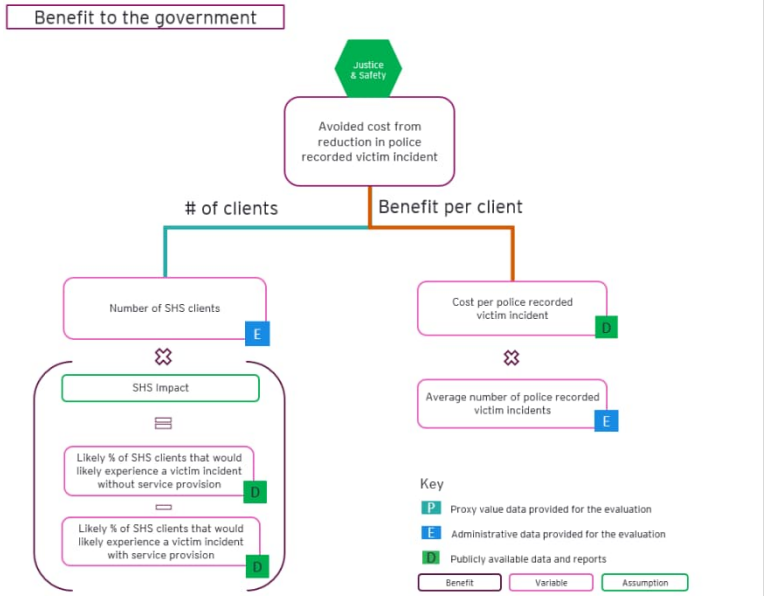
Appendix 3. Monetisation Approaches

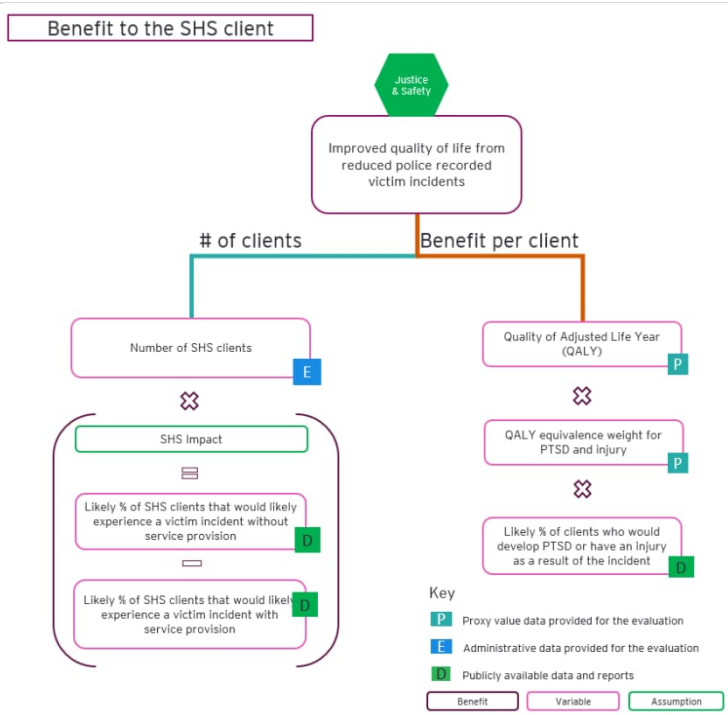
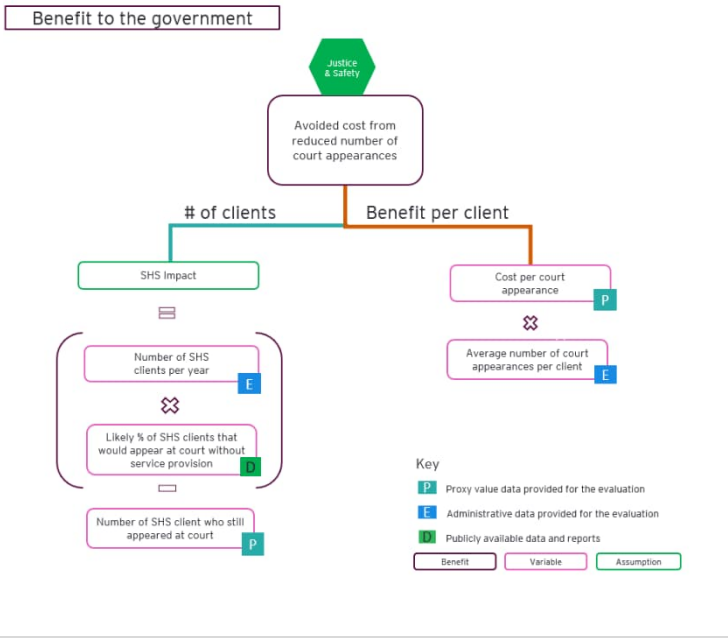
Table 17 outlines the detailed monetisation approach to monetise SHS benefits described in Section 3.8.2.

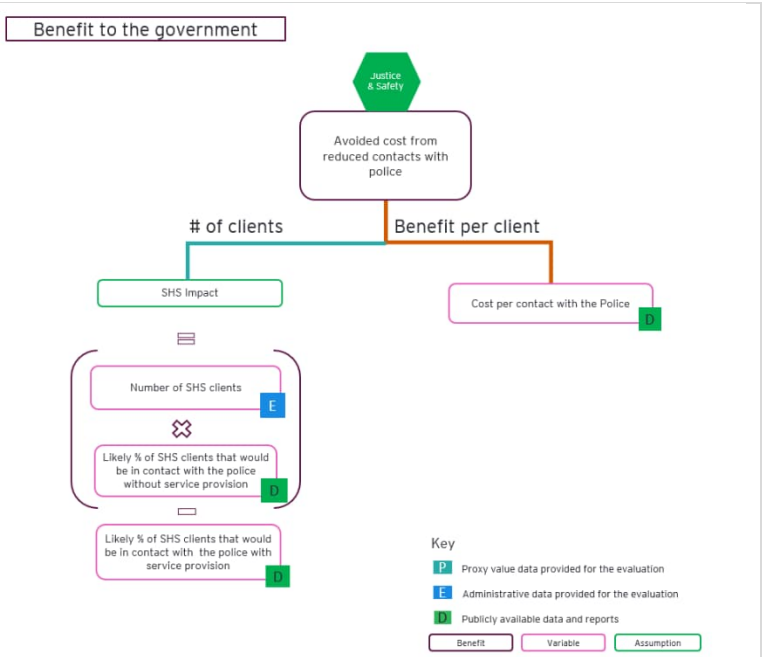
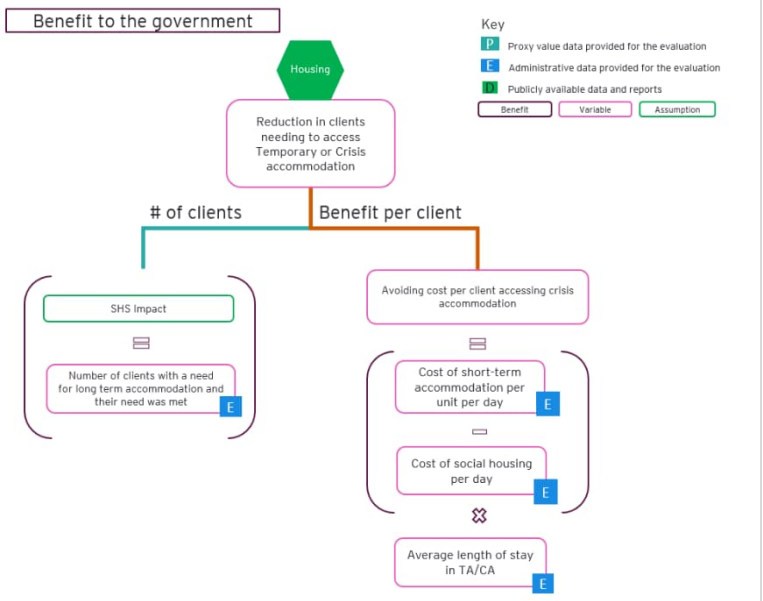
Table 17: Benefit monetisation approaches

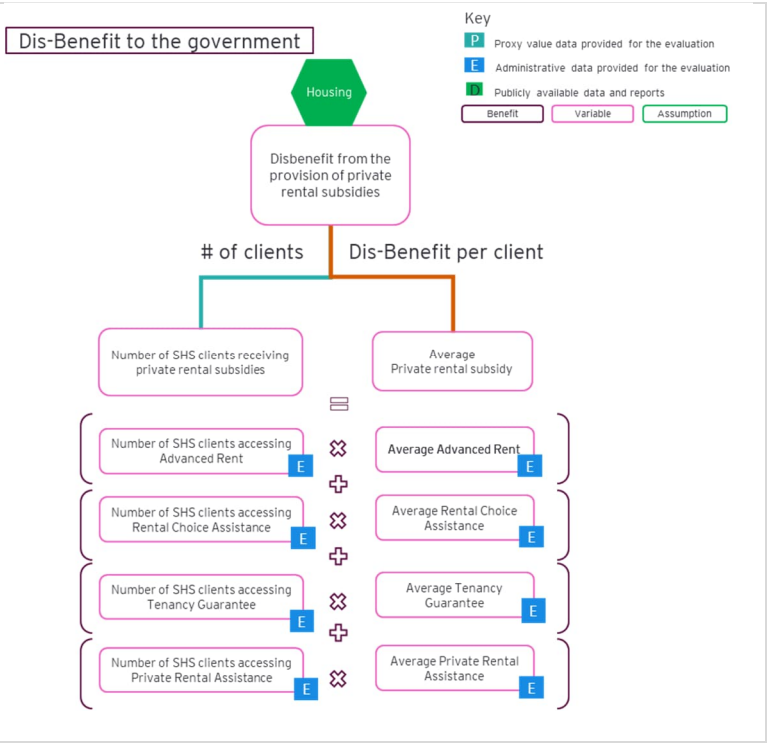
Health Benefits	Figure 42: Benefit quantification: Avoided cost to government from reduced avoidable psychotherapy and counselling services	
Health Benefits	Figure 43: Benefit quantification: Improved quality of life due to improved mental health	

Health Benefits	Figure 44: Benefit quantification: Avoided cost to government from reduced hospital admissions	
Justice Benefits	Figure 45: Benefit quantification: Avoided cost from reduced number of adult custodies	

Justice Benefits	Figure 46: Benefit quantification: Avoided cost from reduced number of juvenile custodies	
Justice Benefits	Figure 47: Benefit quantification: Avoided cost from reduction in police recorded victim incident	

Justice Benefits	Figure 48: Benefit quantification: Improved quality of life from reduced police recorded victim incidents	
Justice Benefits	Figure 49: Benefit quantification: Avoided cost from reduced number of court appearances	

Justice Benefits	Figure 50: Benefit quantification: Avoided cost from reduced contact with police	
Housing Benefits	Figure 51: Benefit quantification: Reduction in clients needing to access temporary or crisis accommodation	

Housing Benefits	Figure 52: Benefit quantification: Disbenefit from the provision of private rental subsidies	

Appendix 4. Emerging and Narrowing Cohorts

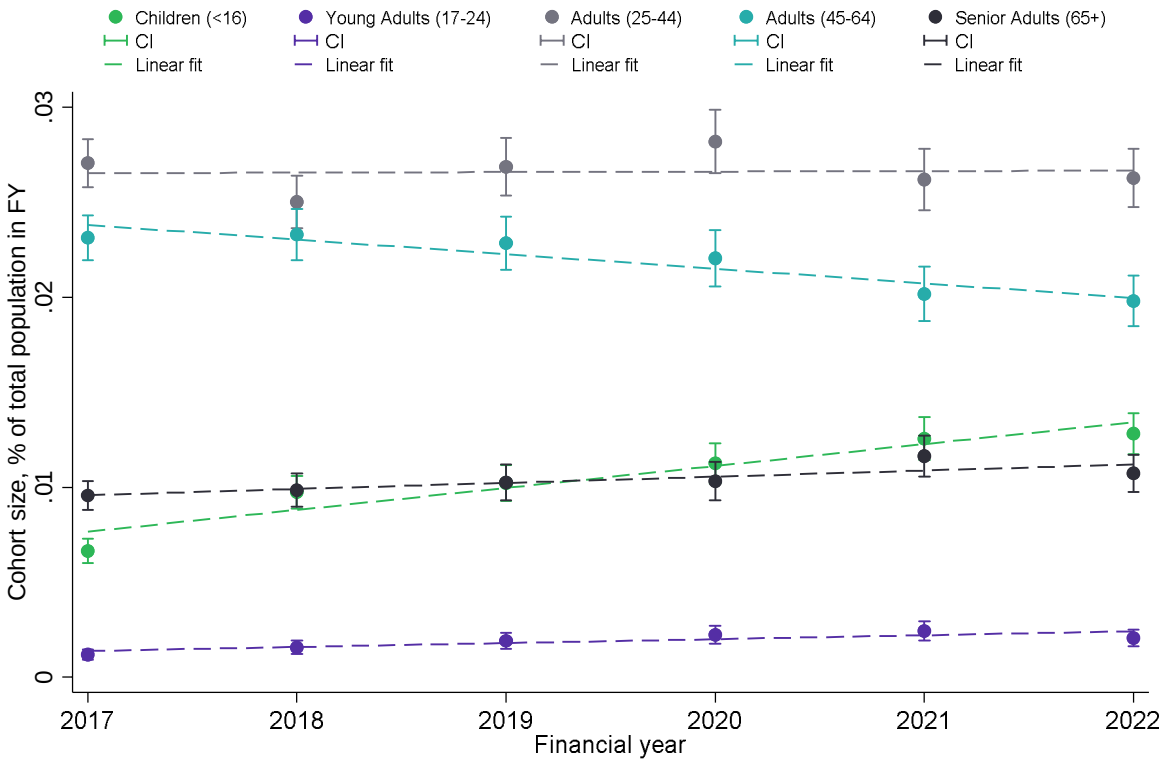
The following cohorts were identified to be emerging and narrowing during the evaluation.

Emerging Cohorts

Children previously in hospital

Figure 53 shows that presentations to SHS of children (green) who were previously in hospital increased.

Figure 53: Previously in hospital by age group

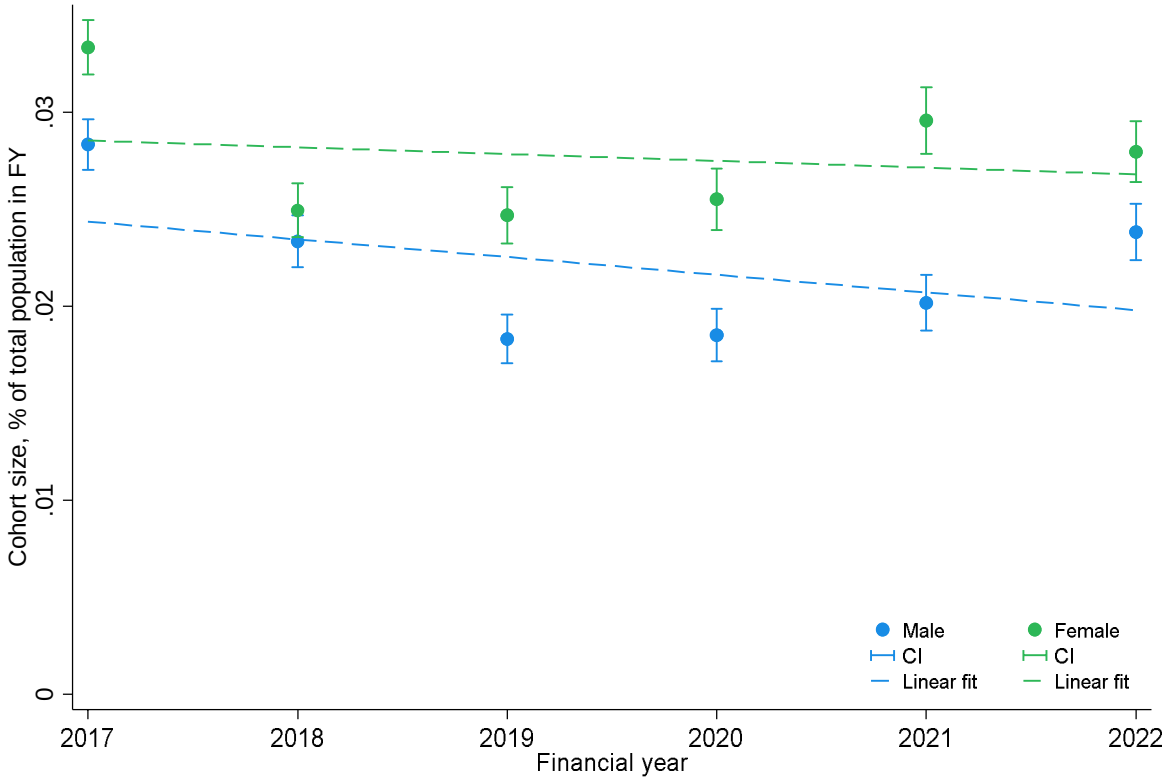


Narrowing Cohorts

Clients living with a disability

Figure 54 shows that both male (blue) and female (green) SHS clients living with disability decreased over the evaluation period.

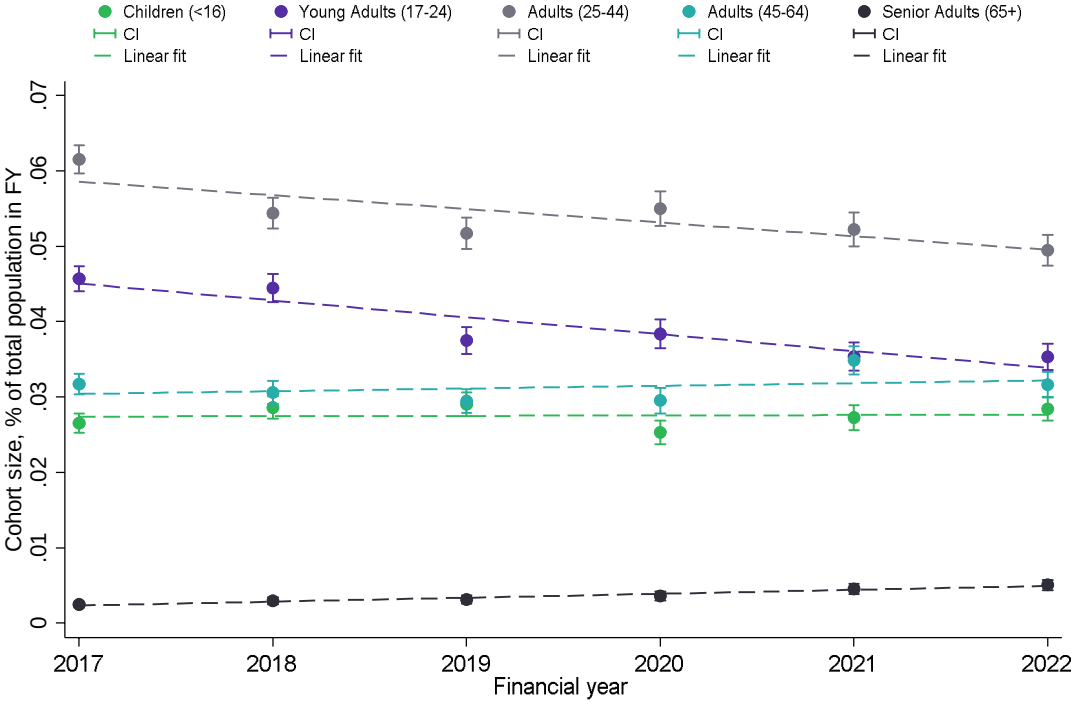
Figure 54: Trends in SHS clients living with a disability by gender



People sleeping rough

Figure 55 shows young adults (aged 16-24 years) (purple) and Adults (aged 25-44 years) (grey) entering the SHS system after reporting sleeping rough (last month) decreased over the Evaluation period.

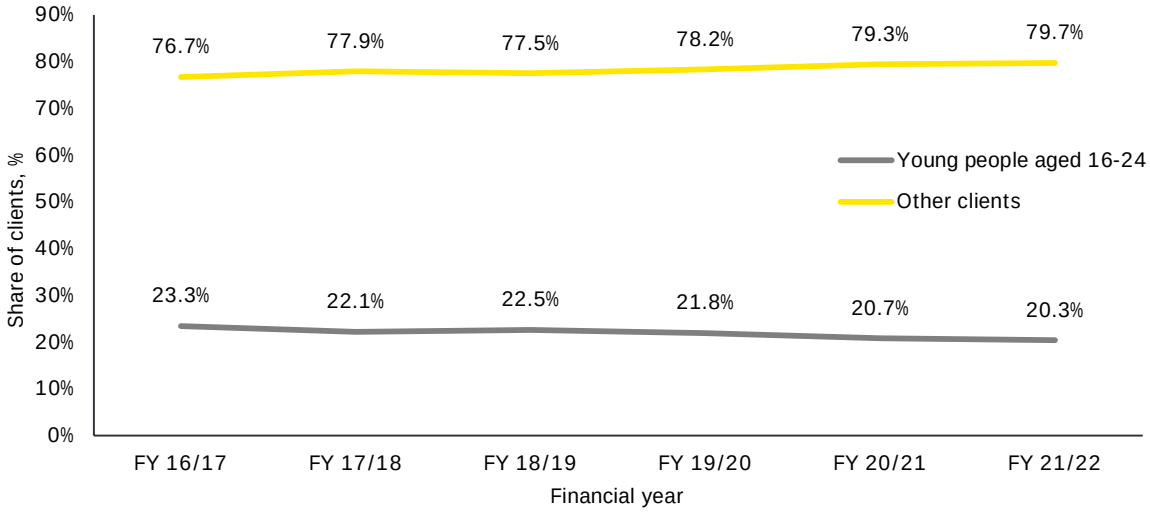
Figure 55: Trends in sleeping rough (last month) by age group



Young people aged 16–24 years

Service providers and adjacent service stakeholders also noted the challenges in providing services to the youth cohort (aged 16-24) of SHS clients. Figure 56 presents the proportion of SHS clients aged 16-24 years-old by financial year. The frequency of presentation for this cohort was found to decrease by 3% over the evaluation period.

Figure 56: Share of young people aged 16-24 years-old by financial year

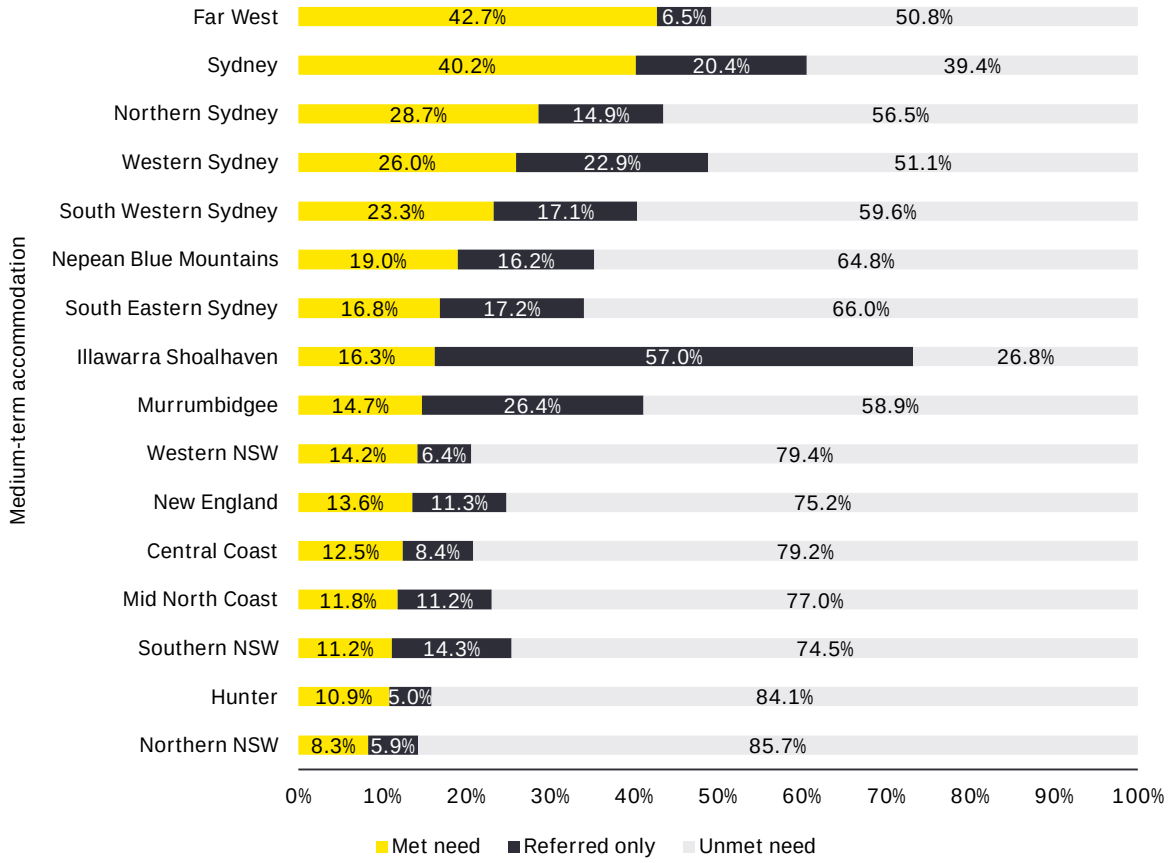


Based on consultative evidence, there appears to be minimal availability of dedicated SHS youth-specific services and accommodation options, when compared to the growing size of the youth cohort of clients. Many SHS clients that were interviewed for this evaluation were under the age of 18 and reported needing to travel a significant distance from where they had previously been living in order to access appropriate and timely supports. Stakeholders also highlighted the importance of provision of wraparound supports for this cohort when transitioning into long-term accommodation, due to the variation in supports provided in crisis accommodation and transitional accommodation.

"Young people (15 – 18) years who are at risk of homelessness due to family conflict are limited in what accommodation they are able to access. They have no DCJ support, no parental support and usually nil to low income supports. They are an extremely vulnerable cohort." – SHS service provider

Figure 57 presents the regional variation across DCJ Districts in met need for medium-term accommodation for the youth (aged 16-24) cohorts of SHS clients.

Figure 57: Regional variation in medium term accommodation



Other stakeholders noted their perceived impact of OOHC policy reforms, which aim to reduce the number of children in OOHC[305], as contributing to an increase in the demands on the SHS sector for children and young people with child protection needs. The Premier's Youth Initiative (PYI) is available in several DCJ Districts for eligible young people between the ages of 16 and 9 months and 17 years and 6 months and may support young people with subsidised accommodation to transition from OOHC, amongst other services. An early evaluation of the PYI for the Department found some evidence that the program was supporting prevention of vulnerable young people from becoming homeless after the age of 18, as well as reducing the frequency of SHS presentations if PYI clients do present to SHS after the age of 18.[306] It should be recognised that a range of additional supports for young people in OOHC have also been available since February 2023, to support them to transition from care to independence until the age of 21 (increased from the age of 18), including living allowances and specialist aftercare services for young people with complex needs, which became available from July 2023.[307]

[305] Audit Office of New South Wales (2020). Their Futures Matter. Retrieved 13 June, 2023, from https://www.audit.nsw.gov.au/our-work/reports/their-futures-matter.

[306] DCJ. (2020). Evaluation of the Premier's Youth Initiative. Retrieved from Evaluation of the Premier's Youth Initiative | Family & Community Services (nsw.gov.au).

[307] NSW Government Department of Communities & Justice, (2023). Your Choice, Your Future – new aftercare supports for carers, Retrieved from https://www.facs.nsw.gov.au/families/out-of-home-care/children-in-oohc/planning-for-your-future-and-support-after-care/your-future,-your-way-new-aftercare-supports-available-from-early-2023

Appendix 5. Service Provider Survey Responses

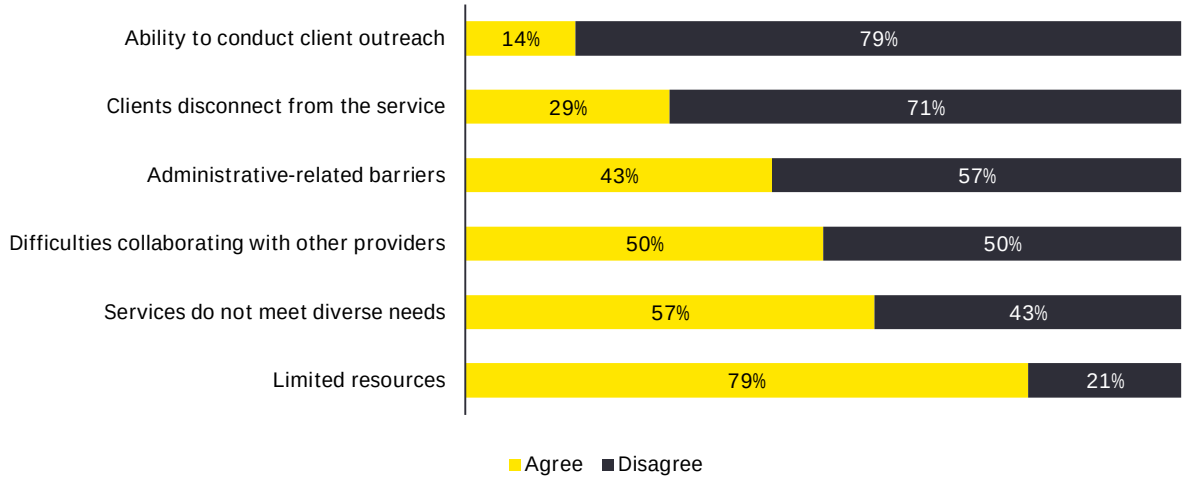
The following figures contain data from responses to the survey issued to SHS service providers for the purpose of the Evaluation. Key statistics from these figures have been integrated throughout Section 5.2 Process Evaluation.

Barriers to service delivery

Figure 58 represents service providers' rankings of the key barriers to providing the services needed by clients from service provider survey responses (n=14). Responses to this survey question were largely consistent with consultative evidence, with the exception of the identification of workforce issues as a significant barrier to service delivery across the sector.

As evident in Figure 58, limited resources and capacity to provide services, and the inability of services to meet diverse client needs were identified by service providers as the key barriers to SHS delivery, with almost 80% of service providers (*n*=11) identifying resourcing constraints as a barrier to service delivery and almost 3 in 5 service providers (*n*=8) identifying that services offered do not meet diverse client needs. These barriers and the underlying drivers are explored in further detail below.

Figure 58: What do you think are the key barriers in providing services to your clients?

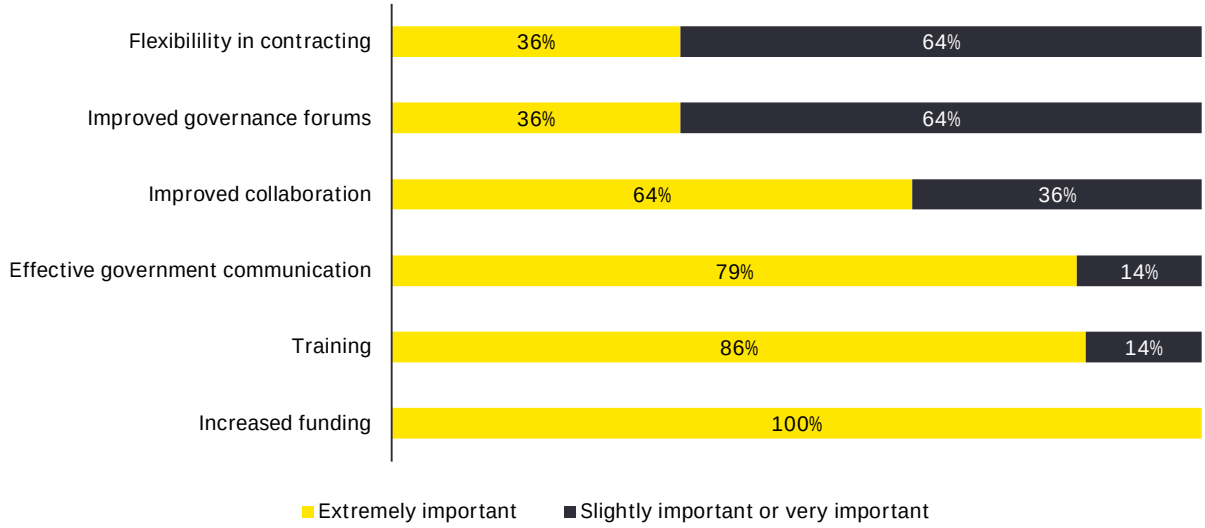


Source: SHS Service Provider Survey conducted by the Evaluation Team.

Improvements to SHS

Figure 59 describes the service provider survey respondents' views on which areas of improvements to SHS should be prioritised (n=14). Increased funding was identified as a key area of need by 100% of respondents (n=14), with additional training opportunities being identified by 86% of respondents (*n*=12) as an area for increased focus to enable the SHS Program to achieve better outcomes.

Figure 59: What do you think is needed for the SHS Program to achieve better outcomes?

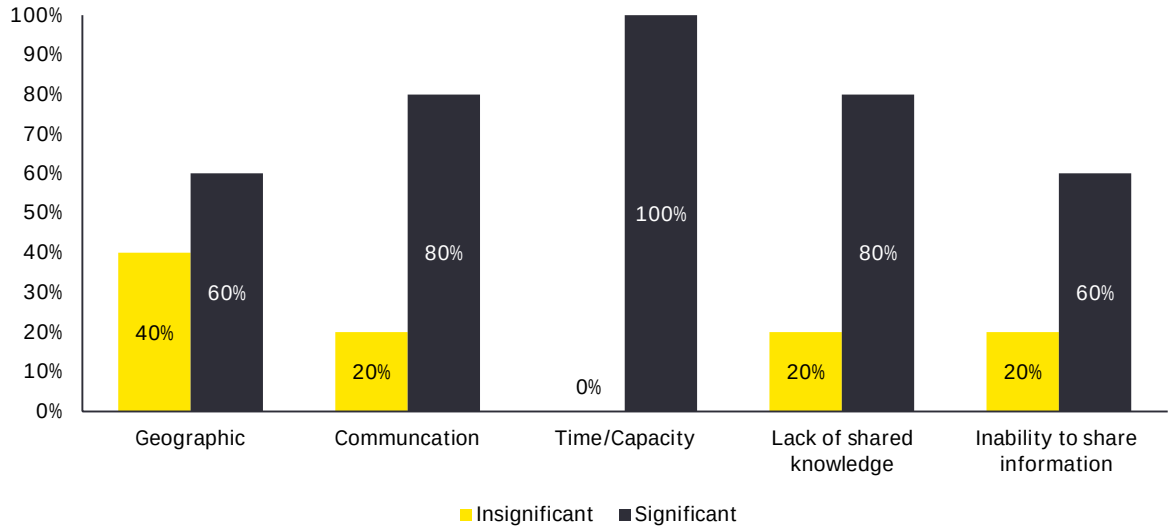


Source: SHS Service Provider Survey conducted by the Evaluation Team

Barriers to effective collaboration

Figure 60 represents the key barriers to effective collaboration, as identified by service providers. The responses are largely consistent with consultative evidence, indicating the key barrier to effective collaboration as time/capacity, with 100% of respondents highlighting this as the key barrier (n=5).

Figure 60: What are the key barriers to effective collaboration?

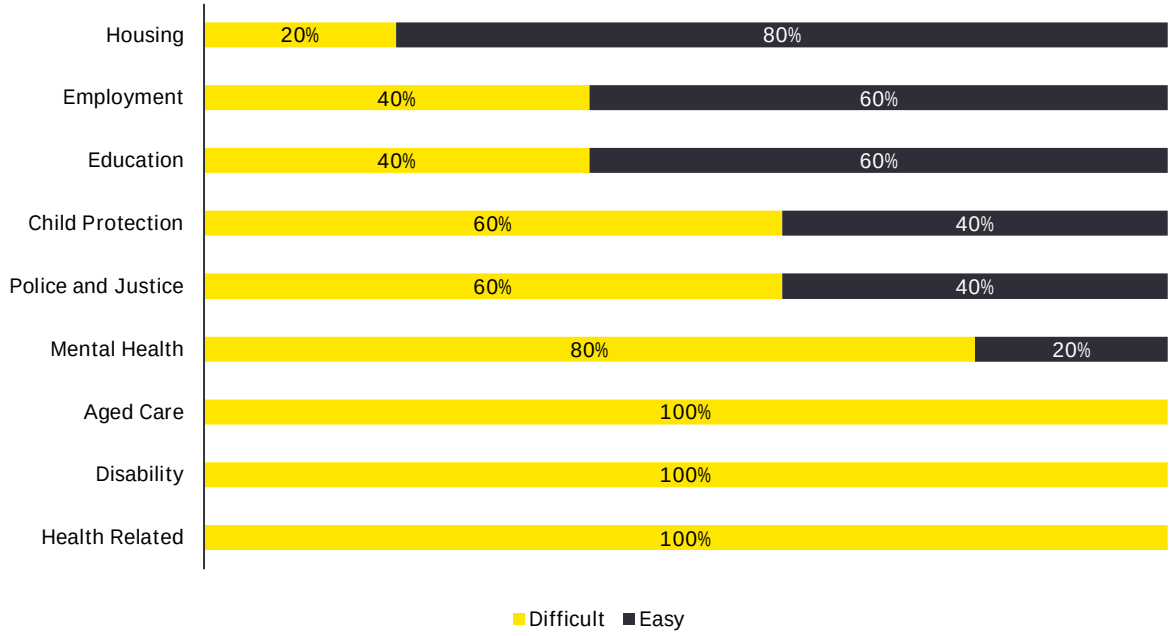


Source: SHS Service Provider Survey conducted by the Evaluation Team.

Access to mainstream services

Survey responses to the question 'which mainstream service is most difficult for clients to access' echo consultative evidence which highlighted challenges with collaboration between health services, including mental health, with SHS service providers. 100% of survey respondents (n=5) identified difficulties engaging health related, disability and aged care services for clients, whilst 80% of respondents (*n*=4) identified challenges supports clients to access mental health services. Qualitative evidence suggests that ineffective collaboration may be driven by lack of transparency with referrals and barriers to information sharing.

Figure 61: Which mainstream service is the most difficult for clients to access?

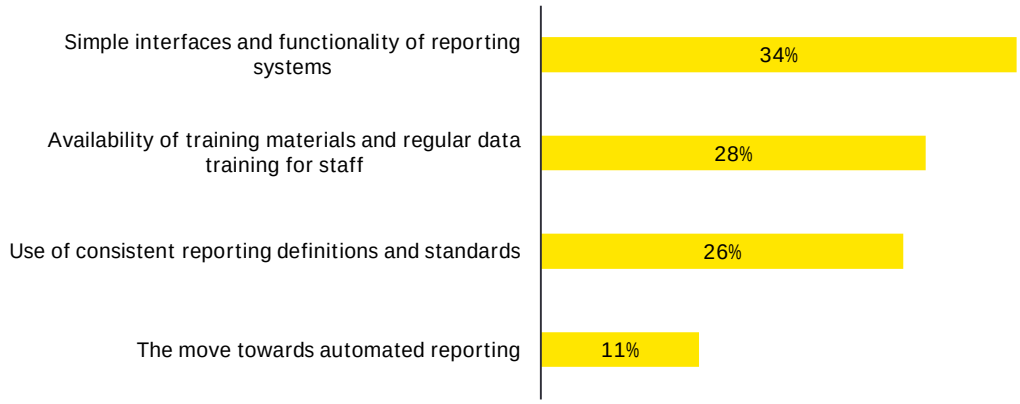


Source: SHS Service Provider Survey conducted by the Evaluation Team.

Strengths in current data collection and reporting mechanisms

Figure 62 represents survey responses regarding strengths in current data collection and reporting mechanisms (n=38), with 34% of respondents (*n*=13) indicating the key strength of mechanisms was simple interfaces and functionality of reporting systems.

Figure 62: What are the strengths in the current data collection and reporting mechanisms?[308]

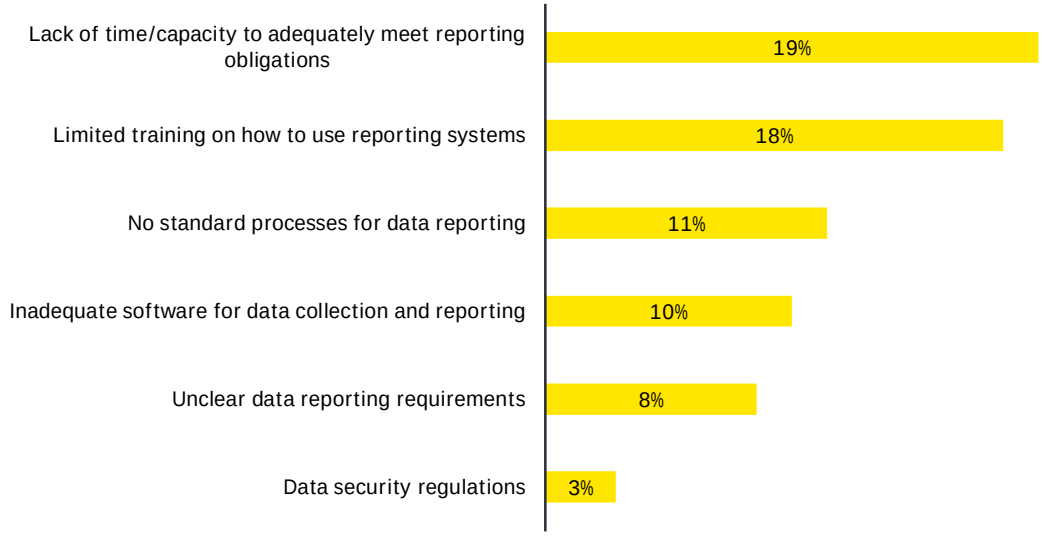


Source: SHS Service Provider Survey conducted by the Evaluation Team.

Figure 63 shows the responses to a survey question regarding challenges faced by service providers in meeting their reporting obligations (n=38). Survey responses are largely consistent with consultative evidence, demonstrating that a lack of time and capacity across the sector and limited training on use of data collection and reporting are the primary challenges experienced by service providers in meeting reporting obligations.

[308] Respondents were permitted to select more than one entry.

Figure 63: What challenges do you face in meeting your reporting obligations?[309]



Source: SHS Service Provider Survey conducted by the Evaluation Team.

[309] Respondents were permitted to select more than 1 entry.

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