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BETTER HEALTH AND HOUSING PROGRAM

Impact Evaluation and Economic Analysis

Launch Housing,
St Vincent's Hospital Melbourne and Urbis

October 2024

Launch Housing, St Vincent's Hospital Melbourne and Urbis acknowledge the Traditional Owners of the lands on which we live and work. We pay our respects to all First Nations people and Elders, past and present, and recognise their ongoing connection to land, waters, and community. We share a commitment to supporting First Nations people in strengthening their health, wellbeing and housing outcomes through partnerships grounded in self-determination and cultural respect.

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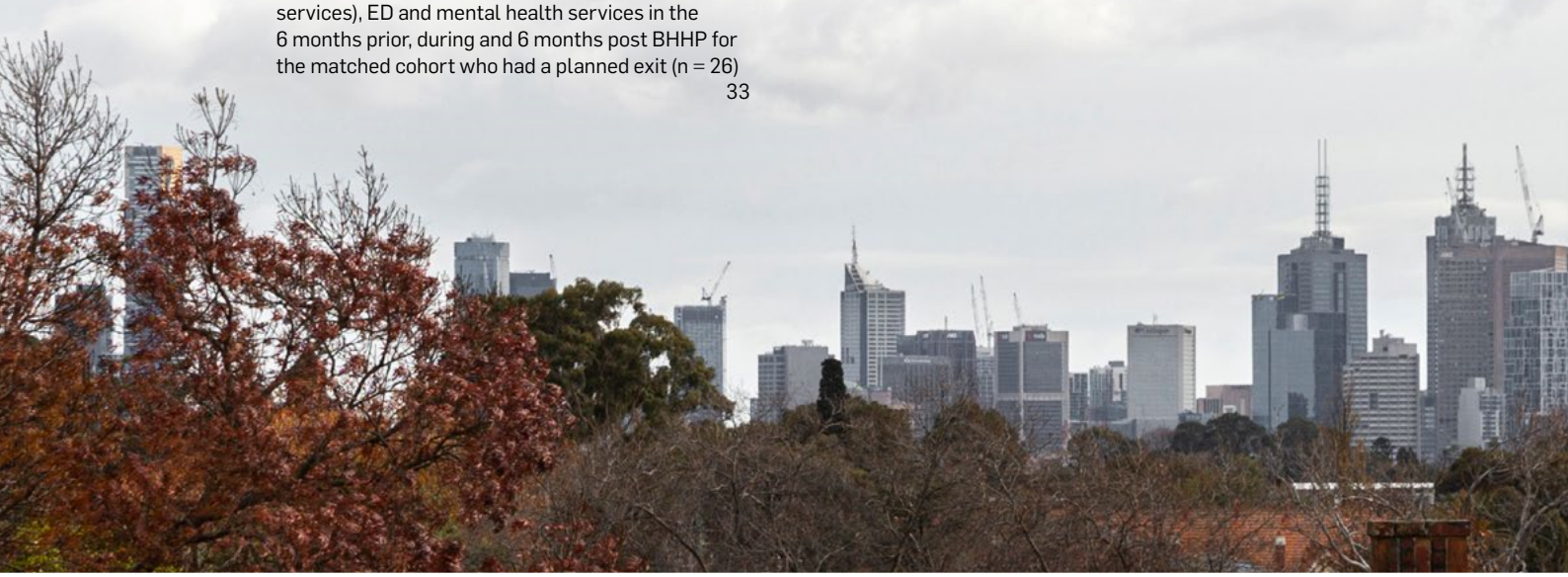

THANKS TO

The evaluation team would like to express their appreciation to the staff and residents at the Better Health and Housing Program for sharing their experiences and time.

About Launch Housing

Launch Housing is one of Victoria's largest secular and specialist homelessness organisations. Launch Housing is passionately committed to ending homelessness, by providing immediate and practical solutions for people who are at risk of – or experiencing- homelessness. With high quality affordable housing and an innovative range of wrap around care and support, we bring solutions together under one roof for thousands at risk of - or experiencing - the daily crisis and trauma of homelessness.

About St Vincent's Hospital Melbourne

St Vincent's Hospital Melbourne (SVHM) is a tertiary not-for-profit provider of public healthcare services including acute medical and surgical services, emergency and critical care, sub-acute care, cancer services, aged care, correctional health, mental health services, diagnostics and a range of outreach and community-based services. SVHM is part of the St Vincent's Health Australia group of companies and one of the Mary Aikenhead Ministries. SVHM works with a wide network of collaborative partners to deliver high quality treatment, teaching, education and research. We have more than 5000 staff and 880 beds in daily use across our services. SVHM responds to the healthcare needs of a diverse population, with a particular focus on serving and advocating priority populations including: patients who are prisoners, those who identify as Aboriginal and/or Torres Strait Islander, and those experiencing mental illness, drug and/or alcohol addiction and homelessness.

About Urbis

Urbis is a multidisciplinary consultancy with a mission to shape the future of cities and communities across Australia through a comprehensive range of services including urban planning, design, development and social impact measurement. Urbis works closely with government agencies, developers, and community organisations to create housing solutions that meet the needs of all Australians, ensuring vibrant and inclusive communities. Urbis is committed to delivering impactful, data-driven insights that shape better urban environments and improve the quality of life for people across Australia.

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EXECUTIVE SUMMARY

PROGRAM OVERVIEW

The Better Health and Housing Program (BHHP) emerged from the Victorian Government's COVID-isolation response, developing into a **supported integrated care residential facility** for residents experiencing chronic homelessness and co-occurring health conditions. The Victorian Government funds program partners St Vincent's Hospital Melbourne and Launch Housing to deliver intensive coordinated support for residents at Sumner House. Since the program started in August 2022, **71 residents have entered the program, staying for an average of 138 days** (figures to 31 May 2024).

The program seeks to deliver improved resident outcomes, with flow-on effects for government and the broader service system.

Three key program aims for residents

- Placement in safe, suitable and secure housing
- Enhanced utilisation of health and community services
- Maintained or improved health and wellbeing

Broader system aim

- Break the cycle of chronic homelessness and poor health, improving residents' quality of life and reducing strain on health, welfare and justice systems

Evaluation approach

This evaluation **assesses the extent to which the intended outcomes for BHHP residents and system-level impacts have been achieved.** It also identifies key lessons by outlining the main determinants of program effectiveness and overall impact. An **economic evaluation** was also undertaken as part of the evaluation.

The evaluation uses **a mixed methods approach**, drawing on qualitative and quantitative data from administrative datasets, staff and resident interviews, resident surveys and organisation-wide service data from each partner organisation. The evaluation aims to answer four key evaluation questions (KEQs):

1. How and to what extent is the program impacting health and wellbeing and housing outcomes for program participants?
2. How and to what extent is the program changing how residents are utilising health and housing support services?
3. What economic benefits have been realised due to program impacts?
4. What have we learned about delivering an efficient and high-quality BHHP service?

About the resident cohort

By the point of evaluation (end May 2024), 71 residents had entered BHHP, with 59 residents exiting the program; 28% of the residents are First Nations people, reflecting the program's focus on supporting First Nations populations. Of the 59 residents with program exits, the average length of stay was 138 days. The program appears to be successfully reaching its intended cohort, with high levels of complexity and multiple stressors among residents upon entry. The majority of residents were sleeping rough immediately prior to entering the program, underscoring the program's focus on addressing chronic homelessness.

Key evaluation finding: The cross-sectoral approach enhances resident outcomes

> **The combination of health, wellbeing and housing outcomes along with a marked reduction in acute service use indicate that the BHHP is empowering individuals to break the cycle of chronic homelessness and poor health.**

Findings from KEQ 1: Impact on health and housing

Since its inception in August 2022, the BHHP has delivered a wealth of benefits to residents of the program, including:

- **Resolution of health conditions –** more than a quarter of residents resolved a health condition while living at BHHP.
- **Considerable and sustained improvements in the management of health conditions –** 51% increase in the number of health conditions being actively managed from entry to exit.
- **Significant enhancements in subjective wellbeing** – all domains of the Personal Wellbeing Index showed a statistically significant change in subjective wellbeing scores from entry to exit.
- **Suitable housing outcomes –** 91% of residents with planned exits secured a housing outcome (54% across all residents), a considerable achievement for this complex cohort. Housing attainment was higher for First Nations residents, at 64% across all exits.

While the program duration is, at this point, insufficient to understand the extent to which program impacts are sustained in the resident cohort, there is evidence to suggest positive outcomes may endure. For residents who completed the program, there is significant evidence that suggests that the program has strengthened their individual capabilities while also supporting them to establish meaningful and genuine connections to specialist, longer term support. These strengthened capabilities, combined with other outcomes – for example, improvements to health management, attainment of secure housing and substantial increases to wellbeing – are positive indicators that program impact may endure, leading to long-lasting systemic benefits.

Findings from KEQ 2: Service utilisation

The BHHP is having a considerable influence on the way residents are utilising services, including:

- A substantial reduction in presentations to an emergency department (ED) – 40% reduction in the number of residents presenting to EDs across the whole resident cohort (comparing six months pre- to six months post-program data). For residents with planned exits, there was a 76% decrease in total number of presentations to the ED across the same time period.
- Improved utilisation of community mental health services – residents with a planned exit showed high levels of linkage and engagement with mental health services during the program and sustained a sound level of involvement after exit.
- Reduced utilisation of the homelessness system – instances of crisis-driven homelessness support services provided by Launch Housing more than halved.
- Strong indication of reduced pressure on justice and other systems – including considerable engagement with legal supports, among others.

While these improvements are noteworthy across both health and housing, they were largely observed in residents with planned exits who more frequently exited into long-term, sustainable housing, reinforcing the decision to report outcomes between the planned and unplanned cohort separately in the analysis of program impact on health and housing.

Findings from KEQ 3: Economic value

Economic analysis of the program demonstrates that through breaking the homelessness cycle BHHP has profound impacts on residents while also reducing long-term government costs:

- The program delivers long-term, sustainable and scalable value to government, with cost savings estimated to be between $11.8 million and $18.6 million, or $200,700 and $314,800 per participant, over 10 years.
- It is estimated that BHHP has broken even, with over $280,000 of benefits per participant over 10 years across government cost savings and personal benefits.

Findings from KEQ 4: Key lessons from implementing the model

The evaluation identifies 10 critical lessons and six recommendations aimed at strengthening the model for future enhancement. These lessons reflect staff and resident thoughts, focusing on the key determinants of program effectiveness and impact.

The first seven lessons focus on key factors enabling or impeding achievement of program outcomes:

1. The importance of a strong, cross-sectoral partnership
2. The critical role of trust and relationship development with residents
3. The significance of coordination and advocacy functions
4. The importance of managing mental health and alcohol and other drug (AOD) conditions
5. The length of time required to support residents to achieve outcomes
6. The value in strengthening support for residents transitioning out of the program
7. The considerable role of brokerage funding

Lessons 7 to 10 focus on that the impacts of funding reductions on the program since during October 2023. These lessons demonstrate there were key trade-offs to the care model resulting from funding reductions:

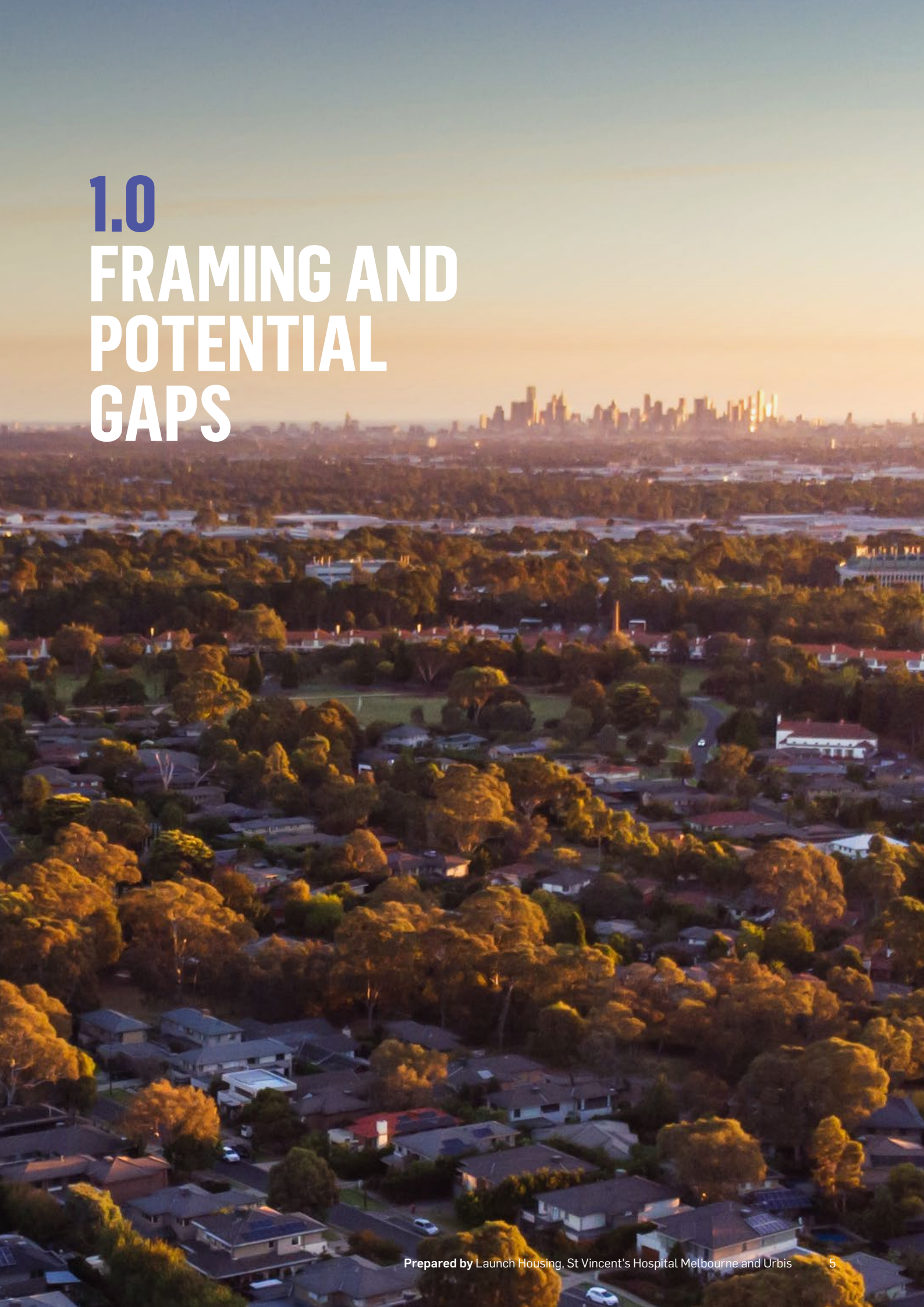
8. Reduced funding impacts service delivery and supports available for residents
9. Funding change and uncertainty interferes with program continuity for staff and residents
10. Adapting the model of care has created efficiencies, but more works needs to be done

RECOMMENDATIONS

Six recommendations were developed, with considerable input from program staff and managers who participated in the evaluation sense-making workshop. The six recommendations cover funding, systems change, cross-sectoral partnerships and coordination, program design and continuous improvement, and monitoring and evaluation.

Funders and policymakers	▪ **Recommendation 1.** Maximise return on investment through long-term, targeted program funding ▪ **Recommendation 2.** Invest in service reform and coordination to strengthen the collaborative approach to people experiencing chronic homelessness and embed programs into system reform efforts
Program managers and the program team	▪ **Recommendation 3.** Continue to emphasise and strengthen cross-sectoral relationships at program and system-wide levels ▪ **Recommendation 4.** Streamline service delivery under the revised care model ▪ **Recommendation 5.** Continue to prioritise reducing unplanned exits and consider additional approaches to maintain engagement if unplanned exits occur
To strengthen the evidence base	▪ **Recommendation 6**. Invest in monitoring and evaluation to strengthen understanding and sharing of the program benefits across the whole service system

1.0 FRAMING AND POTENTIAL GAPS



1.0 FRAMING AND POTENTIAL GAPS

1.1 ADDRESSING THE INTERSECTION OF HEALTH AND HOMELESSNESS IS A SOCIAL POLICY IMPERATIVE

There is substantial evidence demonstrating the interconnections between poor health and homelessness.

People experiencing or at risk of homelessness face significantly higher rates of poor health and frequent experience co-occurring physical, mental health and alcohol and other drug (AOD) conditions (St Vincent's Health Australia, 2021). Homelessness exacerbates mental illness and poor health, increasing susceptibility to chronic diseases and premature death. Poor health, in turn, can also be a significant determinant of homelessness, as those with complex health conditions are also more likely to experience homelessness (Launch Housing, 2024).

The intersection between health and homelessness is increasingly drawing attention from governments. People experiencing homelessness frequent hospitals and emergency departments (ED) for care, in preference to attending the primary and specialist services they need for complex conditions. This results in considerable system-wide costs, fragmented care and a lack sustained, coordinated healthcare support. A recent study in NSW found that government incurs a median cost of $81,481 in health services for every person experiencing homelessness, totalling $548.2 million between 2008 and 2021 (Mitchell et al., 2022). In Victoria, data from St Vincent's Hospital Melbourne (SVHM) shows that the average cost of healthcare for individuals experiencing homelessness prior to involvement in a specialist program was $14,602 per person over six months (Wood et al., 2017). Homelessness also places significant burden on the justice system, which incurs costs through interactions with ambulance services, child protection, police (as both victim and offender), appearances in court and incarceration. A study commissioned by the NSW Department of Communities and Justice found that government spends $186,000 on each person using homelessness services, nearly four times the amount spent on the general population, with most of these costs occurring in the health and justice sectors (NSW Government, 2021).

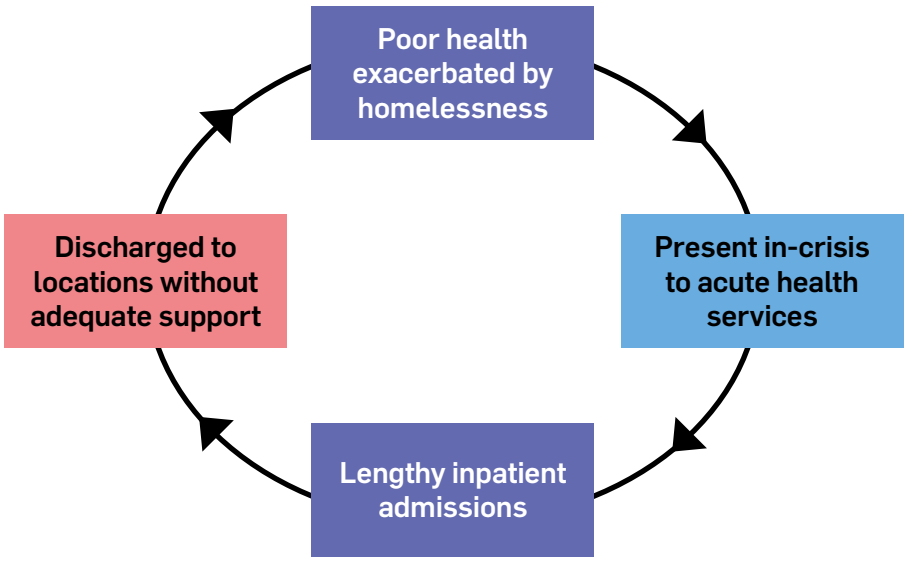
The interconnections between homelessness and poor health are receiving increasing attention in Victoria. At the whole-of-government level, the Early Intervention Investment Framework and Partnerships Addressing Disadvantage initiatives (led by the Department of Treasury and Finance) are driving considerable investment aimed at reducing reliance on acute services, including hospitals and homelessness services. The Royal Commission into Victoria's Mental Health System (State of Victoria, 2021) also emphasised the critical role that additional housing and support services play for people experiencing mental ill-health, particularly for those who are experiencing or at risk of homelessness.

Addressing persistent unmet health and housing needs is also a human rights issue (Clifford et al., 2022). Launch Housing recorded 47 known deaths among residents of its homelessness services in the 12 months to June 2019, with over three-quarters reporting a mental illness (Howard et al., 2022) The median age for those who died was just 42 years. A population-based study in the United Kingdom concluded that nearly one in three homeless deaths was due to causes amenable to timely and effective health care (Aldridge et al., 2019),

1.2 BHHP AS AN INTEGRATED CARE APPROACH

Integrated care models address the limitations of traditional care models in meeting the needs of people experiencing chronic homelessness and poor health. These tailored approaches respond to known barriers to service access, aiming to create lasting change to improve the health, wellbeing and livelihoods of those experiencing homelessness. An emerging body of evidence highlights the potential of integrated care models to disrupt cycles of chronic homelessness and poor health, while reducing reliance on costly acute services (Clifford et al., 2022; Velasquez et al., 2022).

Figure 1 The interconnection between health and homelessness (adapted from Wood et al., 2018)



The Better Health and Housing Program (BHHP) model draws from this evidence base, as well as from the integrated service delivery experience of the program delivery partners. Analysis of Launch Housing and SVHM administrative data shows a significant overlap of service users between the two services (Howard et al., 2022). BHHP aims to support the cohort with high service use for both organisations to address poor health outcomes and break the known cycle of homelessness, poor health and acute service dependence. Section 3 of this report presents a more detailed overview of the program and its resident cohort

1.3 CONTEXT FOR EVALUATION

A first phase evaluation of BHHP completed in 2023 identified a series of positive outcomes for residents, including improvements to health, wellbeing and housing. It also identified key strengths in the integrated service model, including the considerable value of BHHP's novel integrated service approach and the way it supports resident engagement with services and progress towards goals. This current evaluation builds on the initial evaluation by further developing the evidence base for the program.

2.0 METHODOLOGY

2.0 METHODOLOGY

2.1 SCOPE AND AUDIENCE

This evaluation study develops the evidence base for the program in three ways. First, it identifies the extent to which outcomes are achieved, including health, wellbeing and housing outcomes, as well as changes in health and housing service utilisation. Second, it uses a break-even analysis (BEA) methodology to undertake an economic analysis of the program. Third, it identifies key lessons and recommendations from implementation to date, including for funders, management and the program team. The aims of the evaluation are captured under four key evaluation questions (KEQs):

1. How and to what extent is the program impacting health and wellbeing and housing outcomes for program participants?
2. How and to what extent is the program changing how residents are utilising health and housing support services?
3. What economic benefits have been realised due to program impacts?
4. What have we learned about delivering an efficient and high-quality BHHP service?

The evaluation design adopts a utilisation-focused evaluation approach, identifying key audiences for the evaluation, defining their intended use for the evaluation and designing the methodology based on these assumptions (Patton, 2003). Table 1 identifies the intended uses for the evaluation for our key audiences. BHHP residents were identified as an additional, secondary evaluation audience who must access key results of the evaluation. The evaluation was approved by the SVHM Human Research Ethics Committee, application reference HREC 048/24.

Table 1 Evaluation audiences and their information needs

PRIMARY AUDIENCE	USES AND INFORMATION NEEDS
Victorian Government stakeholders Department of Families, Fairness and Housing Department of Health Department of Treasury and Finance	▪ Understand the impact and value of the program ▪ Inform funding and policy decisions
Executives from Launch Housing and St Vincent's Hospital Melbourne	▪ Understand the impact and value of the program ▪ Identify priorities for advocacy ▪ Identify opportunities to strengthen the model
The BHHP team	▪ Understand the impact and value of the program ▪ Identify opportunities to strengthen the model and implementation

2.2 METHODOLOGY

Theoretical approach and division of roles

The evaluation adopts a theory-driven approach, focusing on interrogating and testing the intended outcomes and understanding how the program contributes to these. The current program logic (see Appendix 2) captures the intended outcomes and causal pathways of interest in the evaluation. Refinements to the initial program logic were made following the first evaluation report.

In line with the Department of Treasury and Finance's *Economic evaluation for business cases: Technical guidelines* (2013), the economic analysis in this evaluation uses a break-even methodology. This approach uses program financial and staffing data to first understand the economic cost of delivering the health and housing services at the program level, down to a per-participant and per-participant per-night level. After a detailed data analysis and literature review, the economic value of each benefit area is then compared against costs to calculate the quantum of each benefit that would have to be delivered to cover program costs. This is known as the 'break-even point' and is the

minimum level of benefit delivery that would have to be substantiated on each outcome for the program's economic benefits to cover its financial costs. Program data is then used to consider the likely level to which the program is breaking even.

This evaluation is delivered in partnership between an internal evaluation team representing SVHM and Launch Housing and a team of economists from Urbis Consulting. The internal evaluation team collated and analysed data to determine the effectiveness, impacts and opportunities for program improvement (KEQs 1, 2 and 4). The external evaluation team completed a BEA study to provide an indication of the economic value of the program to date (KEQ 3).

Data collection, analysis and limitations

The evaluation uses a mixed method approach to measure effectiveness and impact. The three key areas of data used in the mixed methods evaluation were administrative data, semi-structured interviews and a sense-making workshop (Table 2).

Table 2 Data sources for the evaluation

DATA SOURCE	COUNT
Semi-structured interviews (residents)	5 residents
Semi-structured interviews (staff)	9 staff
Program administrative data	All program data relating to health issues and residents between August 2022 and May 2024
Broader service data from each organisation	Organisation-wide service data, including data 6 months prior to entry and 6 months post-program exit
Sense-making workshop	9 staff members from Launch Housing and SVHM, including program and portfolio managers as well as representation from the external economic evaluation team

Key limitations of the evaluation

- **The limited sample size** for analysis, which includes 71 residents in the program, 59 for the exit cohort and 35 for the planned exit cohort. Due to this, the attribution of impact in some instances is not possible. These instances are addressed case by case throughout the report.
- **A lack of longitudinal data**, as the program has been running for less than two years. The period available to analyse post-service utilisation was also minimal; pre- and post-service utilisation was limited to six months.
- **Evolution of the program** and discontinuity with certain aspects of the model, partly as a result of funding reductions during the pilot, which detracts from the strength of impact evidence. For example, comparison of outcomes over time are difficult, as is the attribution of certain functions of the model to program impact.
- **Interpretation of surveys** by some residents, which may be limited and can therefore influence outcomes data.

See Appendix 1 for further details of the evaluation methodology.

3.0 OVERVIEW OF BHHP AND RESIDENT COHORT

3.0 OVERVIEW OF BHHP AND THE RESIDENT COHORT

3.1 OVERVIEW AND EVOLUTION OF THE BHHP MODEL

In response to the 2020 COVID-19 pandemic, SVHM, Launch Housing and the Brotherhood of St. Laurence established a 40-bed COVID isolation and recovery facility (CIRF) in 2020 to support people experiencing homelessness to safely isolate. As the need for the CIRF decreased, the Department of Families, Fairness and Housing commissioned partner organisations to pilot an integrated health and housing service designed to help those experiencing chronic homelessness who also had co-occurring health conditions. This partnership led to the development of the BHHP. The BHHP started in mid-August 2022, initially providing care to 15 men, with the model scaled up in March 2023 to provide an additional five beds for women. As of 31 May 2024, a total of 71 residents have entered the program.

The BHHP is designed to support housing and health outcomes by fostering collaboration among services and applying a trauma-informed, person-centred approach. This supports individuals experiencing homelessness holistically and considers their individual goals and needs. The program targets people with poor health who frequently present to EDs and who are concurrently experiencing chronic homelessness. A range of health, housing and community services make referrals to the program. The BHHP triages these using a prioritisation matrix (see Appendix 3), while also considering the needs of residents living at the BHHP at the time. Due to high demand, there is a capped waitlist for entry.

The BHHP provides residents with accommodation for up to six months in a facility collocated with health and housing support staff. In addition to the six-month residential support period, residents have the option of receiving six months of post-stay support from SVHM staff to ensure connections with local health services are established and embedded, and the needs of the residents are handed over to their community support team. Residents pay a service fee of 25% of their income – comparable to rent for social housing. During their stay, residents are supported by a team of program staff from Launch Housing and SVHM to develop and work on a care plan based on their goals. Launch Housing provides case managers and after-hours staff coverage, while SVHM employs care coordinators (with nursing and allied health backgrounds) and lived-experience workers (peer workers). Each organisation also employs a team leader and a manager. See Appendix 4 for further details on the model and staff roles.

In October 2023, a funding reduction led to changes to the staffing and support model. These included a reduction in total staff, changes to roles and responsibilities, the introduction of a wellbeing worker to address residents reporting boredom and isolation in the evenings, and a reduction in resident brokerage, as summarised in Table 3.

Table 3 Overview of changes to the program

CATEGORY	CHANGE
1. Funding	▪ Overall reduction in funding ▪ Reduction in funds available for brokerage
2. Changes to care-team staffing	▪ Reduction in staffing for Launch Housing (approximately 5 FTE) and a minor reduction to staffing for SVHM (0.9 FTE) ▪ Transformation of roles, including reducing the number of case managers and their function in model, a new wellbeing officer and after-hours support roles, and removal of overnight concierge worker ▪ Shifts in responsibility, with many case managers now working as after-hours engagement workers and no longer needing to conduct resident assessments ▪ Shift from a shared case management model to a 1:1 case management model, where each Launch Housing case manager is allocated a caseload
3. Reduction in non-program staff	▪ Reduction in non-care staff – security guard and reduced cleaning team
4. Partnership	▪ Shift in the balance of responsibilities between organisations ▪ Change in the type and frequency of cross-organisation meetings ▪ Additional responsibilities for the SVHM team, including increased concierge responsibilities and care coordinators taking on transitional support for residents

3.2 ABOUT THE RESIDENT COHORT

Understanding the target cohort

The evaluation included all residents between 1 August 2022 and 31 May 2024 (22 months). In this timeframe, the data shows there were:

- 71 residents who entered the BHHP
- 59 residents who exited the BHHP.

The BHHP originally opened as a male-only facility, with five additional beds for females added in March 2023. Of all participants who have entered the program, 77.5% were male and 22.5% were female. Residents ranged in age from 30 to 67 years old, with 71% of participants in the 35–54 age bracket. The target group for the program includes people with a combination of the following indicators:

- Older than 30 years
- Homeless for one year or more
- Three or more health conditions
- Poorly supported mental health
- High substance users, but open to addressing this
- Involvement with the justice system
- Identifying as Aboriginal or Torres Straight Islanders
- Not currently engaging with health and housing supports

Living and health conditions of residents prior to entry

Administrative data detailing resident circumstances at program entry shows that residents have conditions and experiences which are generally aligned with the target cohort. As Figure 2 shows, all but one person had at least one health condition that wasn't being managed (99%) at entry. A small percentage had seen a health condition resolve in the six months prior to BHHP entry (10%) with 65% of residents actively managing one or more health conditions at entry. As shown in Figure 3, most residents entering BHHP were sleeping rough just before entry, with the remaining residents living in other insecure housing and only one person having a rental lease. The high proportion of residents sleeping rough and the prevalence of health conditions among residents suggests that the program is reaching its intended cohort.

Figure 2 Percentage of residents with at least one health condition managed, not managed or resolved in the 6 months prior to BHHP

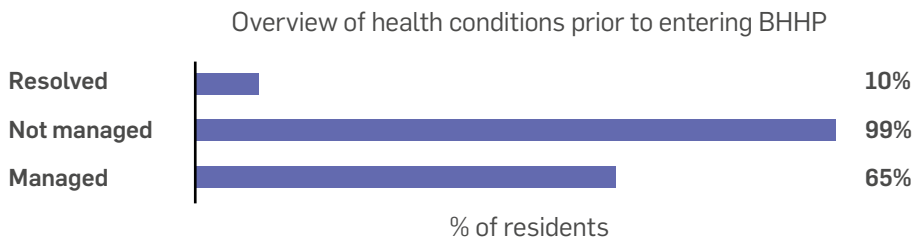
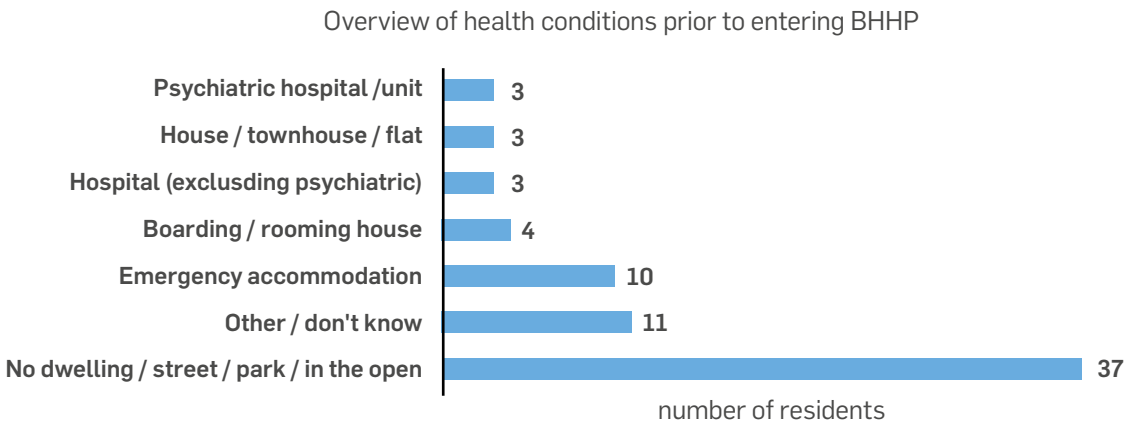


Figure 3 Categories of living conditions prior to entry for all residents (n = 71)



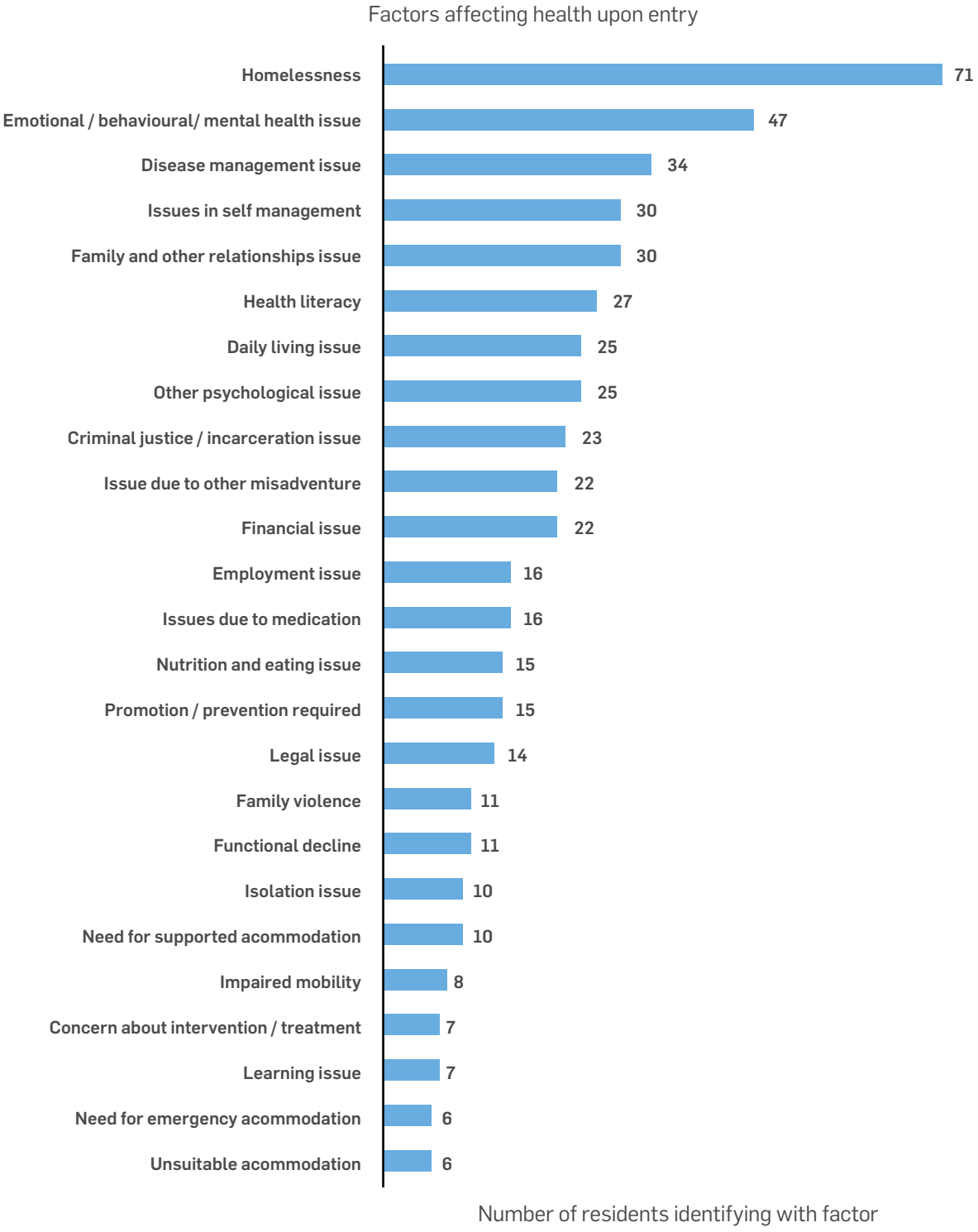
Staff reflections gathered through the evaluation supported the evidence that the intersection of poor health and homelessness is considerable among the resident population.

> *Pretty much most people who are experiencing rough sleeping or some kind of homelessness have some pretty full-on health stuff going on, whether it's AOD, mental health or physical health. – Staff*

Entry data showed a high level of complexity and multiple stressors for residents at entry, all of which impact on a resident's capacity to attend to their health, housing and wellbeing. As Figure 4 shows, 'homelessness', 'emotional / behavioural / mental health issue' (which includes AOD) and 'disease management issue' were the highest rated factors affecting a resident's health upon entry into the BHHP. For the 'emotional / behavioural / mental health issue' and 'family violence' categories, staff noted that these figures are likely to be considerable undercounts due to under-reporting from residents during the initial intake interview. Notably, 'health literacy', 'family and other relationships issue', 'issues in self-management' and 'criminal justice / incarceration issue' also scored highly, affecting a large proportion of the residents at entry. In interviews, staff spoke of the multi-morbidity that many residents presented with. Staff recounted instances of residents with intellectual disabilities, acquired brain injuries and complex physical health issues, as well as a high proportion with AOD and mental health concerns. Beyond this, staff also reflected that trauma was a consistent theme for BHHP residents.

Majority of residents sleeping rough immediately prior to entering the program

Figure 4 Factors identified as affecting a person's health at entry into BHHP (n = 71)



Homelessness, disease management and emotional, behavioural and mental health issues were the most prevalent factors affecting resident health at program entry

First Nations representation among the resident cohort

Around 13% of people accessing homelessness services across Victoria are Aboriginal and Torres Strait Islander people, and First Nations people are over-represented in the rough sleeping population (AIHW, 2024b). Given this, the BHHP prioritises referrals of First Nations people through its prioritisation matrix. As a result, 28% of all BHHP residents identified as First Nations (20 of 71). Of all residents who have exited the program, 24% identified as First Nations (14 of 59). The sample size for First Nations people when analysed by gender was insufficient and therefore was not reported.

28% First Nations representation in program

Length of stay in the program

The average length of stay in the BHHP across all exit types was 138 days. However, planned exits had a considerably longer stay than unplanned exits (168 days for planned exits compared to 75 days for unplanned exits). Factors influencing length of stay are discussed in later sections of the report.

Differentiating between planned and unplanned exits

The program distinguishes between two exit types, planned and unplanned. Planned exits were residents who completed the program. Between the program's start and the point of evaluation, there have been 35 planned exits and 24 unplanned exits. At times, the evaluation findings include disaggregated data that differentiates between planned and unplanned exits. This is due to the considerable differences in experience and outcomes between the two cohorts. A key difference is length of stay and engagement in the program. Residents with planned exits averaged 168 days in the program, more than three months longer than the 75 days average of the unplanned exits. Staff interviewed identified two key reasons for residents staying in the program until their planned point of exit. First, residents with planned exits were more likely to adhere to the program boundaries and expectations, which were developed to ensure a safe environment for staff and other residents. Second, residents with planned exits engaged in working towards their goals and were available at planned times to work with staff throughout their stay. Those with an unplanned exit were observed to find it challenging to be available onsite at planned times and often stayed overnight away from the BHHP.

4.0 PROGRAM IMPACT ON HEALTH, WELLBEING AND HOUSING

4.1 SUMMARY OF FINDINGS

The BHHP is leading to significant health and housing outcomes for the cohort, with outcomes exceeding program expectations for the group who completed the program.

- **Health impact: Improvements in health and wellbeing have been recognised by all residents at exit from BHHP. From point of entry, the program led to a considerable number of physical, AOD and mental health conditions being resolved in the past six months (29% increase) or actively managed (14% increase) at point of exit. While all residents engaged to address their physical health conditions, residents with a planned exit concurrently addressed their AOD and mental health conditions (increase of 18 AOD / mental health conditions actively managed at exit) compared to unplanned exit residents who showed no shift from entry to exit levels. Subjective wellbeing scores across all domains of the Personal Wellbeing Index – Adult (PWI-A (see page 21) show a statistically significant improvement from entry to exit ($p < .05$).**
- **Housing impact: The program delivered 91% of residents with planned exits into secure housing[1] (32 of 35). Of all 59 residents who have exited the program (planned and unplanned), 54% exited into secure housing. The evaluation found that program impacts are largely concentrated among the group with planned exits. The program is also delivering for First Nations residents, with outcomes exceeding that of non–First Nations residents for secure housing (64% compared to 51%).**

1 Secure housing refers to housing that is stable, safe and designed to meet the specific needs, circumstances and preferences of each BHHP resident. It includes a spectrum of housing types – private rental, public and community housing, permanent and supported options, transitional housing and palliative care, as well as residential rehabilitation provided there is a pathway to stable housing upon exit. The broad scope reflects the substantial and varied support needs of residents.

4.0 PROGRAM IMPACT ON HEALTH, WELLBEING AND HOUSING

Key evaluation question 1: How and to what extent is the program impacting health and wellbeing and housing outcomes for program participants?

Intended outcomes and context

As shown in the BHHP program logic (see Appendix 2), the program's intended health, wellbeing and housing impacts are:

- residents maintaining or improving their health and wellbeing (**health and wellbeing impact**)
- residents housed in safe, stable housing that is a 'good fit' for their circumstances (**housing impact**)
- residents improve utilisation of health and community services in their local community (**health and wellbeing impact – see KEQ 2 in Section 5**).

Staff interviewed expected that maintaining health (a shift from declining health while experiencing homelessness) was a realistic program outcome for residents, and in some instances, residents would also experience an improvement in their overall health. Given the complex psychosocial stressors and multi-morbidity conditions that were found to commonly manifest across the BHHP cohort at entry (see Section 3), a period of stability to enable a resident to begin addressing their multifaceted health and wellbeing conditions was viewed as a positive program impact. These expectations align with the intended outcomes outlined in the program logic.

About the analysis

The health and wellbeing administrative data presented in this section is collected at two time points in a resident's journey through BHHP – namely, at a resident's entry and then exit from the program. Administrative data relating to a residents' health conditions, links to health services and the PWI-A are collected at each point, with additional data collected at exit about the resident's subjective experience of the program in relation to their health and housing outcomes (International Wellbeing Group, 2024).

The following analysis uses a matched dataset comparing entry and exit data, which in most cases includes 58 of the 59 residents who have exited the program (one resident's exit data was unavailable). For analysis of administrative data at exit that sought direct input from residents (PWI-A, subjective experience of the program), the number of residents included in analysis was limited and included, in most instances, residents who experienced a planned exit.

Sample sizes in the analysis vary for this reason and are explicitly reported, including statistically significant results.

Regarding housing impact, the program tracked housing outcomes for all residents who exited the program, as well as the category of housing attained.

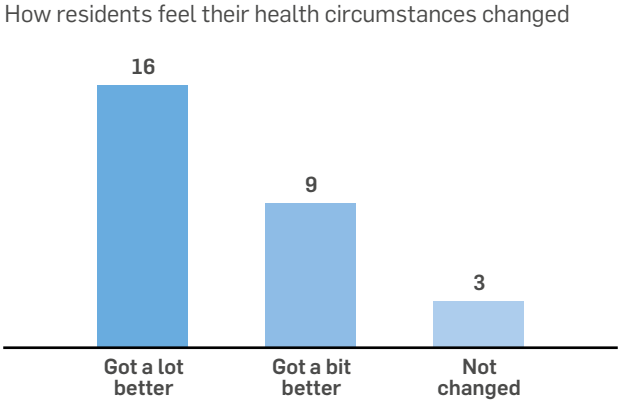
Additionally, the evaluation identified case studies and qualitative information regarding the impact of the program on health and housing outcomes and the significant determinant factors for those outcomes. The data analysis is presented next.

4.2 HEALTH AND WELLBEING IMPACTS

There is considerable evidence suggesting the program is stabilising or improving health circumstances for engaged residents

At exit, 89% of residents reported that circumstances in their overall health had changed for the better (Figure 5). Approximately two-thirds of these residents rated their change in health circumstances as 'a lot better' compared to pre-program levels. This finding was echoed in the resident interviews, with four of the five residents describing how their health had improved over their time in the program.

Figure 5 Change in health circumstances from the program (n = 28, 22 planned exits, 6 unplanned)



89% of residents health circumstances changed for the better

Data from interviews shows that the program also played a considerable role in supporting residents to stabilise and recover after lengthy periods of rough sleeping, which considerably impacted their physical and mental health and overall wellbeing. Most staff interviewed described how residents were supported to improve their health not only through what staff were providing but also through a safe and comfortable place to live and three healthy meals a day. This observation is consistent with the literature, which describes the positive impact housing can have on health, mental health and wellbeing outcomes (Carnemolla & Skinner, 2021), and the findings from the first BHHP evaluation (Pahor, 2023).

Overall, health conditions are stabilising or resolving

From program entry to exit, improvements in managing categorised health conditions (physical, AOD and mental health) have been realised across the total matched cohort during the program period (n = 58). As indicated in Figure 6, overall there has been:

- an **increase** of 51% in the number of health conditions being **actively managed** at exit
- a **decrease** of 38% in the number of health conditions **not actively managed** from entry to exit
- more than triple in the number of health conditions **resolved** in the last six months.

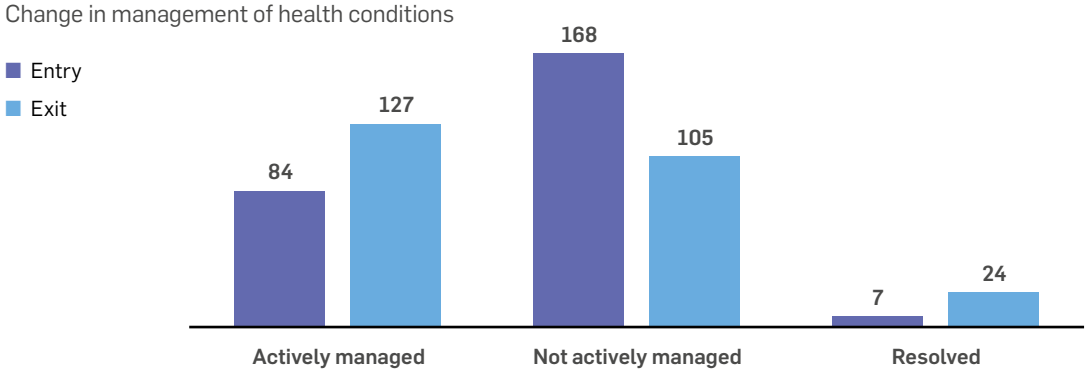
Of note is the number of health conditions being resolved while residents are staying at BHHP. At program exit, it was found that 24 health conditions (22 physical, 2 AOD) had resolved in the past six months. Of these 24, a possible seven health conditions indicated at entry had resolved in the past six months, leaving a difference of 17 conditions. This reflects that at least a quarter of residents are resolving at least one health condition while they are at BHHP.

Across the cohort at entry, 100 **physical** health conditions were identified as being 'not actively managed'. This number reduced by almost half (52) at program exit, indicating that residents were actively engaging with the program to address their physical health conditions.

The above findings are supported by qualitative evidence, with interviewed staff describing how they observed physical health improvements for all residents entering the program. Examples of physical health conditions being addressed are wound management, recovery from surgery and recovery from injuries sustained. Staff reported that residents showed an improvement in their understanding and self-management of health conditions which before the program and a period of stability would have been too challenging. This increase in capability to manage health conditions has been critical to how resident health has been managed after exiting the program. Staff described key enablers to longer term effective management as:

- linking residents to services that they know and trust
- ensuring residents are in a pattern of regularly attending appointments
- ensuring residents know who to go to for their health needs.

Figure 6 Number of health conditions actively managed, not actively managed and resolved in the past 6 months all residents comparing entry to exit (n = 58)

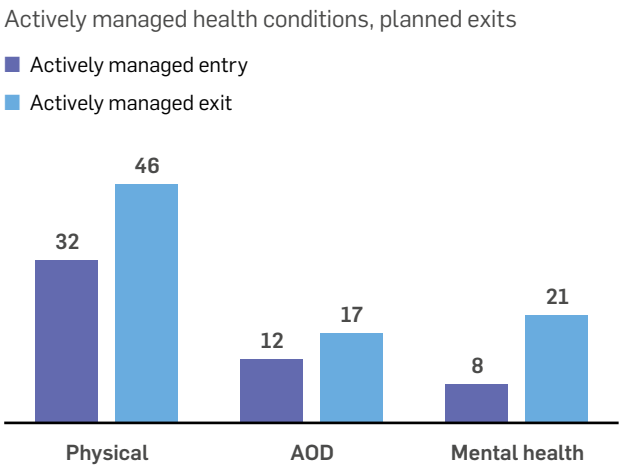


Physical health conditions are being managed and resolved

Mental health and substance use are being actively managed among planned exits

When the matched data is separated by exit type, profiles of interest emerge. Interestingly, residents who had a planned exit (*n* = 34) exhibited notable shifts in the number of physical, AOD and mental health conditions that were initially **not** actively managed to being **actively managed** across the program period (Figure 7).

Figure 7 Comparison of actively managed physical, AOD and mental health conditions at entry and exit for **planned** exit cohort (n = 34)



Qualitative data provides examples of residents using harm reduction techniques to address their AOD dependencies or even stopping altogether. The combination of housing and health support staff onsite seemed to provide the right mix of support to implement strategies to reduce substance use and give residents direction on their AOD journey.

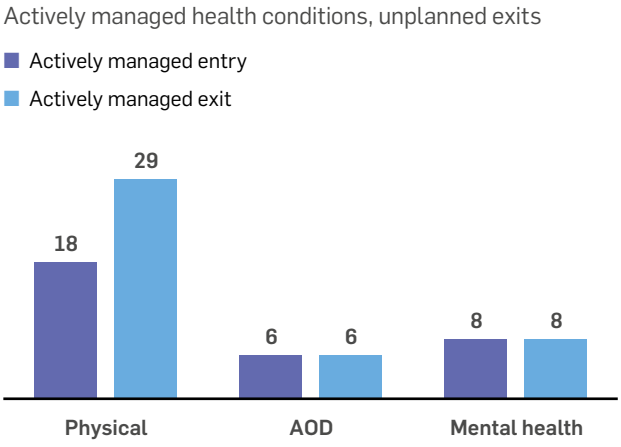
> *[BHHP has] just basically given me a chance. I'm buying myself things again. […] Usually I sit in the park and drink a four-pack. The fact that I had somewhere to go on my pay, did my shop and then come home. I've never really lived, I've just survived. – Resident*

Corroborating the data and resident interviews, staff likewise noted that some residents significantly reduced their substance use while participating in the program. According to staff, a combination of appropriate pharmacotherapy, support from the Department of Addiction Medicine team at SVHM and the strong relationships built over time with local pharmacies were key enablers for residents to achieve these outcomes.

Residents have seen their mental health and AOD conditions improve

On the other hand, while residents with an unplanned exit showed shifts in physical conditions being **not** actively managed at entry to **actively managed** at exit, this trend was not observed across the AOD and mental health domains (Figure 8).

Figure 8 Comparison of actively managed physical, AOD and mental health conditions at entry and exit for **unplanned** exit cohort (n = 24)

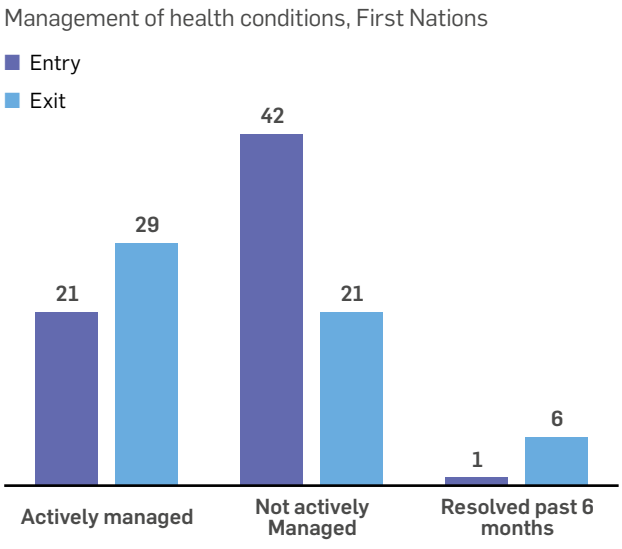


These findings lead evaluators to believe that there is an emerging character profile of resident who is more likely to exit the program in a planned way; this includes residents who upon initial assessment indicate that they are in the 'preparation' or 'action' stage of change with regard to their AOD or mental health management when applying the Stages of Change model (Raihan & Cogburn, 2023). Those with an unplanned exit are more likely to be in the 'contemplation' or 'pre-contemplation' stage of change, which would indicate that a more nuanced and proactive response upon entry to BHHP would need to be initiated to support the resident to stay for the program duration.

Health outcomes for First Nations residents exceed those for the non–First Nations cohort

Positive findings were observed for residents identifying as First Nations specific to the number of health conditions being actively managed or resolved from entry to exit (Figure 9). Notably, these findings remained consistent when separating the data between First Nations residents who had a planned exit and an unplanned exit, but numbers remain too small to draw any significant meaning at this stage.

Figure 9 Comparison of First Nations management of health conditions at entry and exit (n = 13)



**Data for one resident was unavailable.*

Subjective wellbeing has been positively and significantly influenced over the duration of the program

Personal wellbeing index – adult

The Personal Wellbeing Index – Adult (PWI-A) measures a resident's subjective wellbeing (International Wellbeing Group, 2024). It consists of an overarching question about 'global life satisfaction' (GLS) and a further seven questions about various life domains, which generates a PWI-A score for an individual. Residents respond to each question using a 11-point scale with the anchors of 'No satisfaction at all' and 'Completely satisfied'.

For the BHHP, residents complete the PWI-A at entry, exit and then, if receiving support after exit, at discharge from the program. An average score for the GLS, overall PWI-A and each individual PWI-A domain are calculated at each measurement point. Scores are then compared against the diagnostic triage for the subjective wellbeing of individuals.

The PWI-A categorises respondents into three levels. Those whose subjective wellbeing is rated higher and is relatively stable are called the 'Well' group. They are able to maintain their wellbeing through various good and bad life experiences (the literature calls this 'normal homeostatic control'). Those whose subjective wellbeing is rated lower are called the 'UnderWell' group, and their ability to maintain their wellbeing is more compromised. Finally, those whose subjective wellbeing is even lower are categorised as the 'NoWell' group. They generally have no individual ability to maintain or improve their wellbeing. However, targeted interventions can help them to improve their sense of wellbeing.

Table 4 Subjective wellbeing categories, index range and description

OVERALL WELLBEING	PWI-A CATEGORY	INDEX RANGE	DESCRIPTION
Good	Well	70–100	Person can maintain their subjective wellbeing
Average	UnderWell	50–69	Person can be compromised maintaining their subjective wellbeing
Poor	NoWell	0–49	Person is unable to maintain their subjective wellbeing, but targeted intervention may help

Representing just 4% of national samples, people in the 'NoWell' group can experience an increase in subjective wellbeing, as long as interventions address the actual causes of their subjective ill-health.

At entry to the program, residents' GLS and PWI-A scores (cumulative and domain specific) ranged between 32 and 49, placing the entry cohort in the 'NoWell' population of subjective wellbeing for GLS and all domains (Table 5). These scores indicate that the BHHP residents at entry were significantly challenged in many aspects of their life. This then represents an opportunity for BHHP, as a targeted intervention for this cohort, to lead to an improvement in PWI-A.

Table 5 GLS and PWI-A scores at ENTRY (n = 57; 60)

HOW SATISFIED ARE YOU WITH …	N	INDEX SCORE
Your life as a whole? (global life satisfaction)	57	42
Your standard of living?	60	36
Your health?	60	41
What you are achieving in life?	60	32
Your personal relationships?	60	39
How safe you feel?	60	49
Feeling part of your community?	60	40
Your future security?	60	36

To identify if the group who completed the PWI-A at exit had a similar profile to the total group who entered the program, entry scores for the GLS and PWI-A were compared and found to have similar levels of subjective wellbeing at entry (n = 20 GLS; n = 19 PWI-A). The exception was the domain 'how safe you feel', which fell in the 'UnderWell' category (52) for the matched entry/exit group, noting only a small difference of three points (see Table 6).

Importantly, improvements in GLS and PWI-A scores across time for the matched entry/exit cohort were statistically significant overall across each domain ($p < .05$). Remarkably, with six domains at entry being categorised as 'NoWell' and one ('how safe you feel') as 'UnderWell', five domains indicated scores in the 'Well' category at exit (see Table 6), equalling the general national populations usual level of subjective wellbeing. The five improved domains were:

1. Standard of living (78)
2. What you are achieving in life (71)
3. How safe you feel (88)
4. Feeling part of your community (71)
5. Your future security (75)

Table 6 GLS and PWI-A scores for matched ENTRY and EXIT cohort (n = 20; 19)

HOW SATISFIED ARE YOU WITH ...	N	ENTRY	EXIT	*T* SCORE	*P* LEVEL	*P* < .05
Your life as a whole?	20	41	68	3.35	.0033	Yes
Your standard of living?	19	38	78	4.81	.00014	Yes
Your health?	19	46	65	2.56	.0198	Yes
What you are achieving in life?	19	34	71	5.98	.00001	Yes
Your personal relationships?	19	41	67	2.95	.0086	Yes
How safe you feel?	19	52	88	4.79	.0012	Yes
Feeling part of your community?	19	42	71	3.71	.0016	Yes
Your future security?	19	36	75	5.43	.00004	Yes

Table 7 GLS and PWI-A scores for matched ENTRY, EXIT and DISCHARGE cohort (n = 10)

HOW SATISFIED ARE YOU WITH ...	N	ENTRY	EXIT	DC	*T* SCORE	*P* LEVEL	*P* < .05
Your life as a whole?	10	39	73	71	3.84	.0039	Yes
Your standard of living?	10	39	74	70	2.79	.021	Yes
Your health?	10	52	66	63	1.32	.221	**No**
What you are achieving in life?	10	35	70	59	4	.003	Yes
Your personal relationships?	10	41	72	58	1.189	.265	**No**
How safe you feel?	10	59	81	78	3.61	.0056	Yes
Feeling part of your community?	10	39	71	64	2.55	.0312	Yes
Your future security?	10	34	68	67	4.11	.0027	Yes

The BHHP is helping residents achieve significant changes to their subjective wellbeing.

A smaller cohort completed the discharge PWI-A (n = 10). The data indicate that changes in most domains were maintained post exit, with six of the eight categories showing statistically significant differences from entry to discharge (see Table 7). The two domains that did not maintain statistically significant changes in scores from entry to discharge were 'health' and 'your personal relationships'. The matched cohort who completed the entry, exit and discharge PWI-A (n = 10) were found to have higher subjective wellbeing scores for the 'health' domain at entry when compared to the total cohort and the matched entry/exit cohort. An explanation could be that this small group had been referred to the program from a health service, and their health needs were already being addressed to a degree. This could have led to the perception that other areas in their life were more challenging specific to subjective wellbeing compared to their health. The 'personal relationships' domain also did not maintain statistical significance over time, which could be explained by BHHP creating a homely and welcoming place for residents. Moving to a new space that perhaps did not provide this same level of connection could explain why the scores in this domain weren't maintained. It must be noted however that the 'exit, entry, discharge' matched PWI-A scores are from a very small group; further exploration of maintenance of scores post exit is required to understand the longer term impact BHHP may have on subjective wellbeing.

Qualitative insights

The quantitative findings align with qualitative data from staff and resident interviews. Staff described numerous changes they had seen in residents' mental health and wellbeing from entry through to service exit, including:

- residents beginning to participate in activities
- strengthened connections and social bonds among residents
- seeing changes in trust in staff and being more communicative with staff
- residents telling staff they felt at home at BHHP.

> *I've just anecdotally observed an improvement in people's general wellbeing and they're a lot more bright and personable and happy when they're on site after a few months. So many things* [have improved]. – Staff

Staff interviews also reinforced the stabilising effect a safe and consistent environment has on improving the general wellbeing and mental health of residents. Key factors mentioned included regular meals, a clean living space and opportunities for social interaction with other residents. Some staff also noted that friendships formed among residents led to improved social skills and confidence for certain individuals.

> *And when* [they] *moved in here, I think* [they] *just rediscovered and started enjoying that social side of things like participating, organising the barbecue, going out for the activities that were organised by the lived experience workers.* – Staff

Residents similarly reported feeling settled and at home. Multiple residents interviewed described how they felt hopeful and optimistic for their future, with one resident mentioning that they were feeling optimistic about the possibility of reunification with their children.

A home-like environment has a stabilising effect on wellbeing

4.3 HOUSING IMPACTS

The program is delivering strong housing outcomes across the cohort

BHHP has achieved considerable outcomes in securing stable housing for residents. Of all program participants, 54% exited into secure housing (Figure 10, 32, n = 59). Among those with planned exits, 91% successfully secured housing on program exit (32, n = 35).

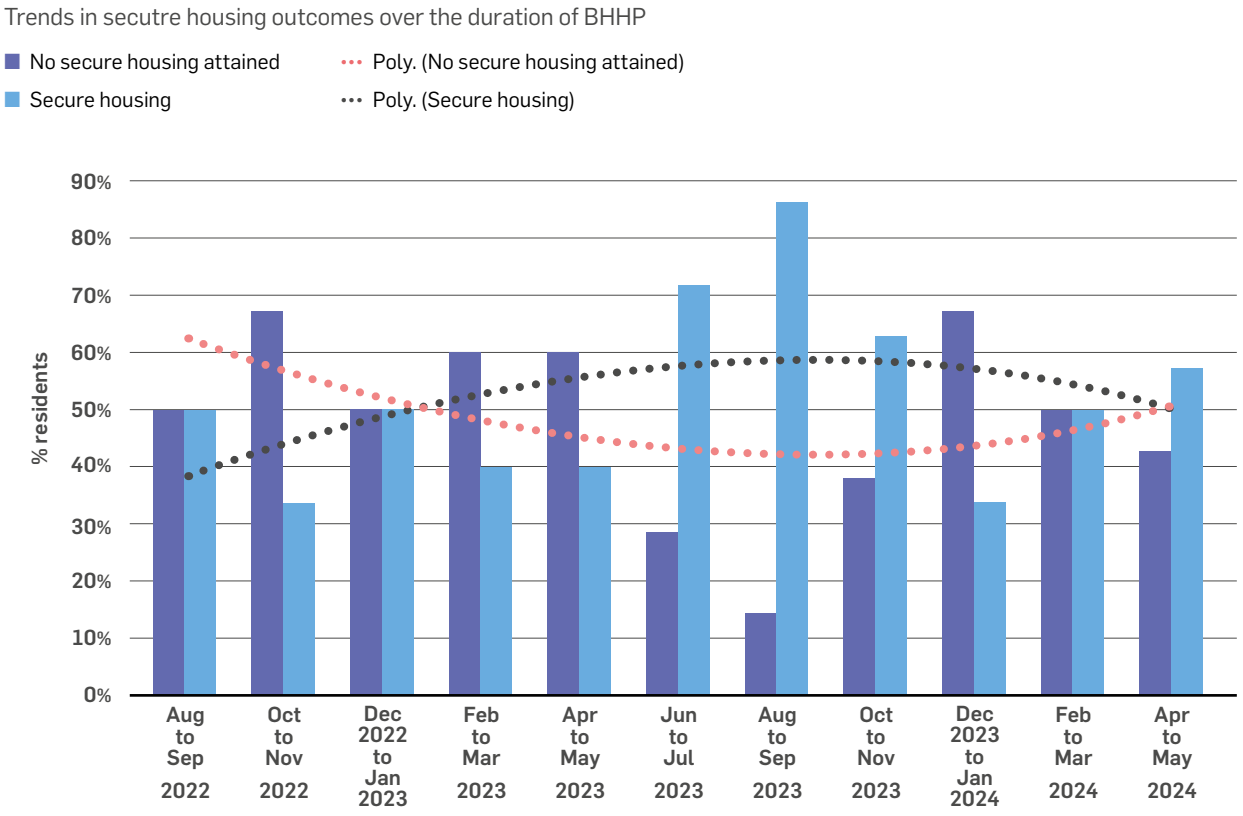
Most residents exited the program into secure housing

Analysis of housing outcomes over time shows that the rates of secure housing attainment have mainly trended upwards. Excluding the first eight months of housing outcome data, the rate of secure housing attainment increases to 60%. In interviews, staff described how the program underwent a sharp initial learning curve regarding how best to manage residents who were at risk of exiting the program, suggesting that the increase in housing outcomes can be explained by initial 'start-up' pains. Staff described that, initially, the challenging behaviours of residents were met with a rigid enforcement of rules and swift program exits. A change in practice regarding the management of challenging behaviours, the application of lessons specific to resident intake, balancing the mix of residents and the strengthened connections with housing providers were described as the main drivers behind the reduction in unplanned exits over time.

There is a substantial housing shortage in Melbourne, with long waitlists for public, social and supported accommodation options. Given the significant challenges this resident cohort faces in securing housing, the rates of housing attainment in BHHP suggest the program is meeting and exceeding program expectations in this area.

60% secure housing attainment since the eight-month mark of the program

Figure 10 Proportion of exits with secure housing outcomes by time since the beginning of the program



Residents are moving into housing suited to their needs

Evidence from the evaluation suggests that secure housing outcomes are well suited to the needs of residents, including those with ongoing support needs, with a considerable range of housing outcome categories attained through the program. Figure 11 shows that nearly half of these exits were to community housing, private rental or public housing, while a quarter of secure housing outcomes were to permanent supported housing or supported residential care. For those who were unable to secure a housing outcome on exit, two-thirds exited into emergency accommodation (Figure 12).

Staff interviews revealed that ensuring residents found housing that met their needs was a high priority for program staff, as appropriate housing increased the likelihood of sustaining housing and health outcomes over time.

> *We have quite a mix of housing outcomes, we don't really have one channel where most of our residents exit to. We have great relationships and have seen a few exits to different community housing providers, so that is like St Kilda Community Housing Service, Abbeyfield, a number of local and also further out Launch-owned properties, like Viv's Place as well and Common Ground, we've had a few exits there to more long-term supportive housing. We have had a small number of residents exit into long-term affordable housings that have been tenancy management through Launch Housing.* – Staff

Unsurprisingly, given their homeless status prior to entering the program, nearly four in five residents who exited the program said that their housing circumstances had improved due to their participation in the program (*n* = 28, 22 planned exits, 6 unplanned). This provides some indication of resident satisfaction for housing, which was supported by resident feedback in interviews.

79% of residents felt their housing circumstances improved as a result of the program

> ***Where I find myself now with my own apartment, it's furnished, it's comfortable, safe. I can make food, eat healthily now.*** – Resident

Figure 11 Breakdown of housing outcomes for planned exits (n = 35)

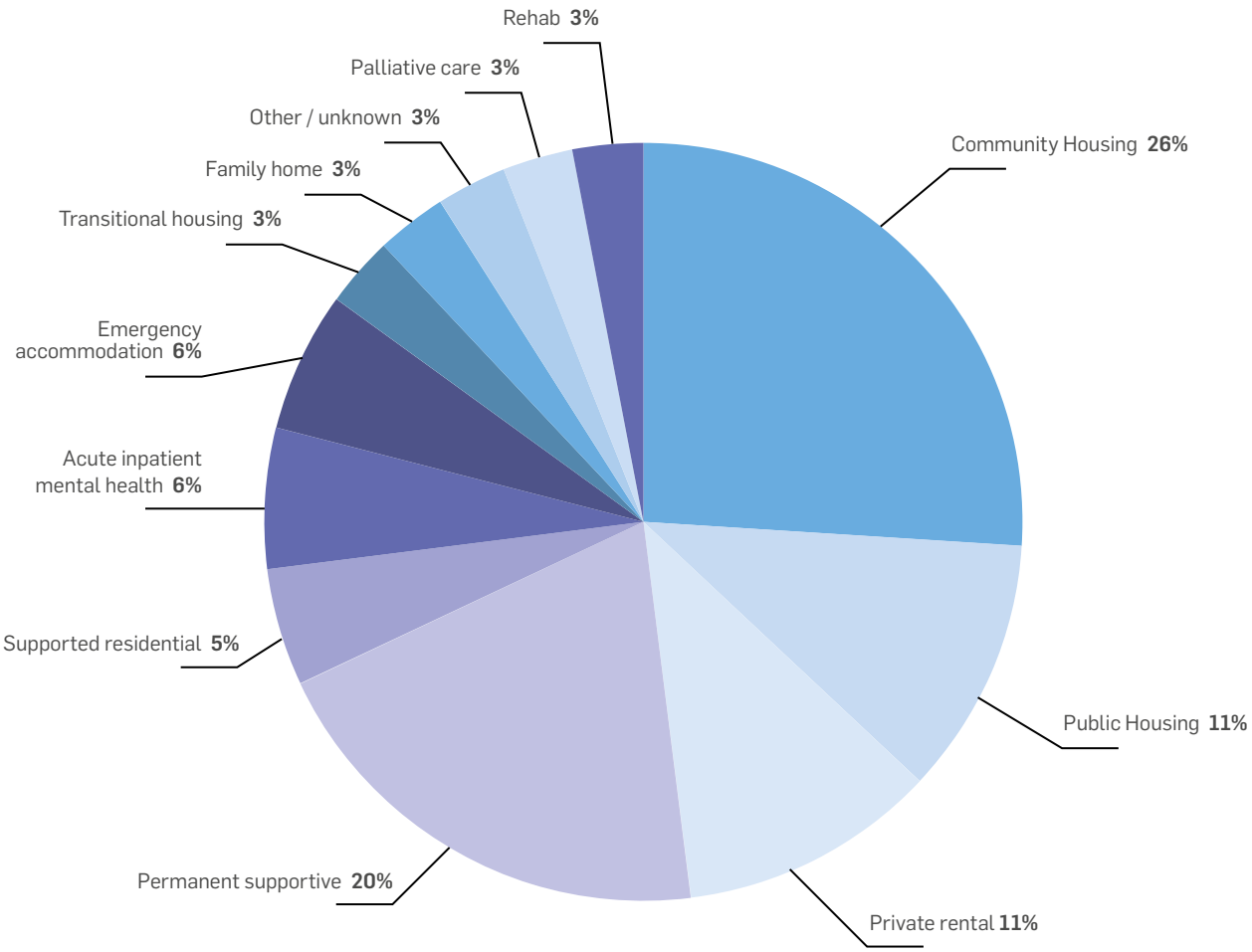
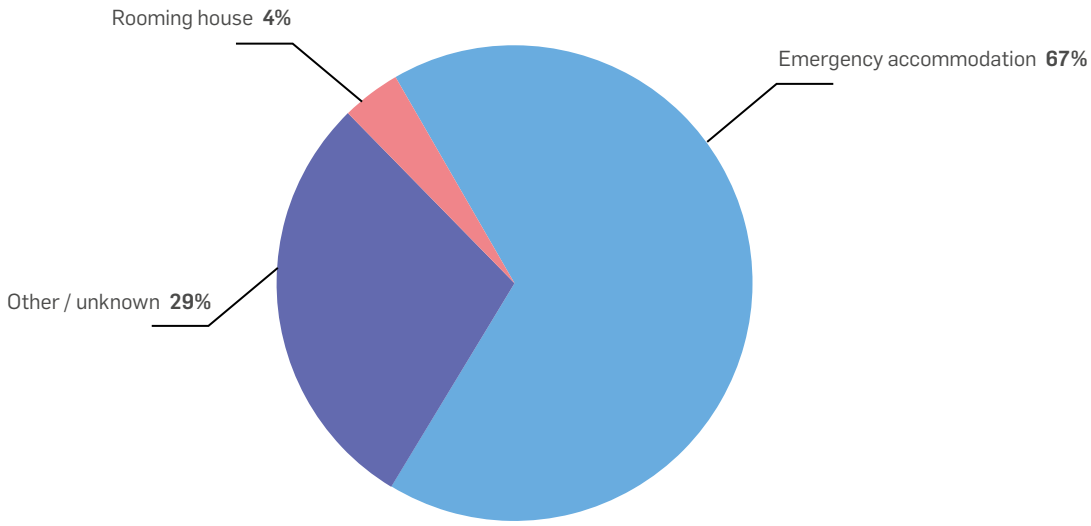


Figure 12 Breakdown of housing outcomes for those with insecure housing upon exit (n = 27[2])



Housing outcomes for First Nations residents exceed those of the non–First Nations cohort

The program has achieved favourable housing outcomes for First Nations residents, with the rates of secure housing for First Nations residents substantially higher than the general resident group. First Nations residents attained secure housing at a rate of 64% compared to the general cohort at 51%. Evidence suggests that a positive relationship with Aboriginal Housing Victoria and prioritisation on housing register lists contributed to the strong rates of secure housing for First Nations residents.

> *We have had [...] really good housing outcomes for* [First Nations residents], *and I think that's sort of due to ... different housing register lists and priority access. ... then I think St Vincent' s does do First Nations health very well compared to other hospitals.* – Staff

Housing category data shows that most secure housing outcomes for First Nations people were into public or community housing (5 of 9). In interviews, staff described how maintaining connection with mob was an important consideration for many First Nations residents, and this meant that housing location was an important factor in ensuring that First Nations residents were satisfied with their housing outcome.

Despite strong housing outcomes, there remain clear barriers to housing program residents

In interviews, staff described the numerous barriers facing the resident cohort, including:

- the necessary time it takes for residents to stabilise and build capability to move into housing outside of the program
- significant shortages and long wait times for appropriate housing, including community, public and supported housing
- strict substance use policies from certain housing providers, preventing some residents with AOD dependency from accessing housing aligned with their needs
- challenges meeting resident preferences, including location preferences and a desire to live alone when this may not be feasible for the individual.

2 Made up of 24 unplanned exits and three insecure housing outcomes for planned exits.

COMPOSITE CASE STUDY #1

The most significant I think was someone who, they came in and their ill-health was primarily attributed to using substances. When he moved in here, he was really sad and would also experience really serious bouts of poor mental health. He had also been sleeping rough for a significant amount of time. Coming here, it can take a while to move from the chaos they have been in. They can sleep; they are really tired. They can't do any of that when they are homeless. They can't get to appointments.

Over time, he got help with his ID, linked to a recovery support group, and now he has a sense of community. When he moved in here, I think he just rediscovered and started enjoying that social side of things like going out for the activities that were organised by the lived experience workers. It inspired hope for him. This person shared that they were suicidal before coming here. Now he has hope.

As he progressed in the program, I would slowly see there would be more days that he would be well and then less days where he would be unwell, so his use would reduce, or he wouldn't use as often. He was also linked in with the SVHM addiction medicine team and was given some medication to assist him to stop using, which he gradually did. He is managing his mental health with a psychologist. He really used the supports here. Recovery is an ongoing thing, but he is keeping it up. He has a good attitude and is achieving so many goals. It was a significant turnaround.

In the program, we have that six months to really be able to build the relationship with the resident, to then have those difficult conversations, which has been very important in this case. Something that we often say at Sumner House that we don't see in other places is that we have a lot of space for people to show up as themselves. We don't have a hard and fast rule about being substance free or abstinent from substances, and we have a level of understanding and flexibility and adaptability when people are unwell to sit in that space and there not being any impact on their tenancy or their support with us. All our staff make sure it's a judgement-free space.

He really took to the wraparound care, took to the community supports. He now hasn't used for six months. I don't know how he would have gone without those supports.

COMPOSITE CASE STUDY #2

There is one resident who was referred here by his case manager from an adult mental health clinic to Sumner House. He had been sleeping in his car for a long time, has schizophrenia and was just pretty unstable in general when he was referred here.

Prior to coming in here, this person was very unwell, and trying to get any consistency with his health management had been impossible. They came in here, and not only did we get that very consistent relationship, but this person would rock up to the clinic, and would ask, when's my appointment? Now for this person, this is huge as he wasn't engaging with any other health care prior to coming in. And then if for some reason we couldn't take them to the appointment, he would just show up there, and that was a massive win. It's something that this person is still very consistent about.

We were also able to support him to exit the program into a Launch Housing rental. He was very mindful of this being a great housing option for him and in a brand-new building with a huge balcony. He was also very thankful to the program for all the furniture, as he got to furnish his apartment with brokerage funding.

I think that's a really nice outcome to see someone that was here for the six-month duration of the program. Not only the housing outcome but also managing to re-engage with his mental health team and be open to a referral to a different team now he has moved. He's able to do this because he's now sure about his achievements and has that self-confidence that he built in. This comes with feeling that you've got the right supports, which can help you to achieve the things that you've got in mind for yourself.

5.0 SERVICE UTILISATION FINDINGS

5.1 SUMMARY OF FINDINGS

- Residents with a planned exit had 74 presentations to the ED in the six months prior to BHHP compared to only 18 in the six months after exiting – a 76% decrease. Promisingly, residents with a planned exit showed a sharp increase in the uptake of mental health services while in the program. This connection was maintained to an adequate level in the six months post exit (357 and 155 contacts respectively), noting that this cohort was relatively disconnected with community mental health before arriving at BHHP (41 contacts in the six months prior). A 17.5% increase was found when examining the number of residents linked with a GP or health service at entry compared to exit, with staff reflecting that the improvement in quality of an existing or new relationvnship with a healthcare professional was significant.
- Regarding homelessness service utilisation, there is a significant reduction in support post-program exit compared to pre-program figures, with support periods for residents reducing from 37 in the six months prior to program entry to 20 in the six months after program exit.
- There is also some emerging evidence to suggest the program is contributing to positive outcomes in other areas such as within the justice system.
- While these improvements are noteworthy across health and housing, they were largely observed among residents with planned exits, reinforcing the stratification in outcomes between the planned and unplanned cohort that is seen in the analysis of program impact on health and housing.

Image source: © Mat Lynn

5.0 SERVICE UTILISATION FINDINGS

Key evaluation question 2: How and to what extent is the program changing how residents are utilising health and housing support services?

Intended outcomes and context

Changes in health and housing service utilisation are a primary aim of the program and are of interest as a determinant for quality and length of life, as well as due to the significant costs that crisis-driven service use has on health, homelessness and other service systems. These benefits mirror the Victorian Government's key considerations in funding programs to address homelessness in Victoria. Recently, Homes Victoria's impact investment strategy has focused on funding programs that can deliver improved life outcomes while preventing people experiencing homelessness from reaching the point where they must rely on high-cost acute interventions (Victorian Government, 2024, p. 7). Improved service utilisation, by reducing dependence on crisis-driven care as well as increasing access to specialist care, are key focuses of the program.

In line with the program logic (see Appendix 2), the BHHP is primarily concerned with changes to utilisation of the ED and other unplanned acute healthcare services, such as unplanned admissions, alongside reduction in the use of emergency and crisis homelessness services. Regarding healthcare utilisation, there are two key program aims: first, to reduce unplanned service utilisation, for example the use of EDs for primary healthcare needs; and second, to increase the use of planned healthcare services so that health conditions are managed in a more planned and coordinated way. Regarding homelessness service utilisation, the relationship between changes to service utilisation and program objectives is straightforward. As a result of the support provided, the program should reduce crisis-oriented, responsive service contact with residents, as it is expected that residents who have completed the program should need less support overall, with remaining supports being from case management style programs. The distinction between crisis-oriented and case management supports is significant. Crisis-style supports are typically reactive and aimed at addressing immediate needs or emergencies whereas case management supports tend be more proactive, longer term and personalised, focusing on helping residents achieve long-term stability and secure housing. In addition to healthcare and homelessness service utilisation, the evaluation identified other system benefits, for example, changes in use of the justice system. Though evidence of these changes is limited, they are included in findings given the strong connection between homelessness and contacts with the justice system demonstrated in the literature (Mitchell et al., 2023).

About the analysis

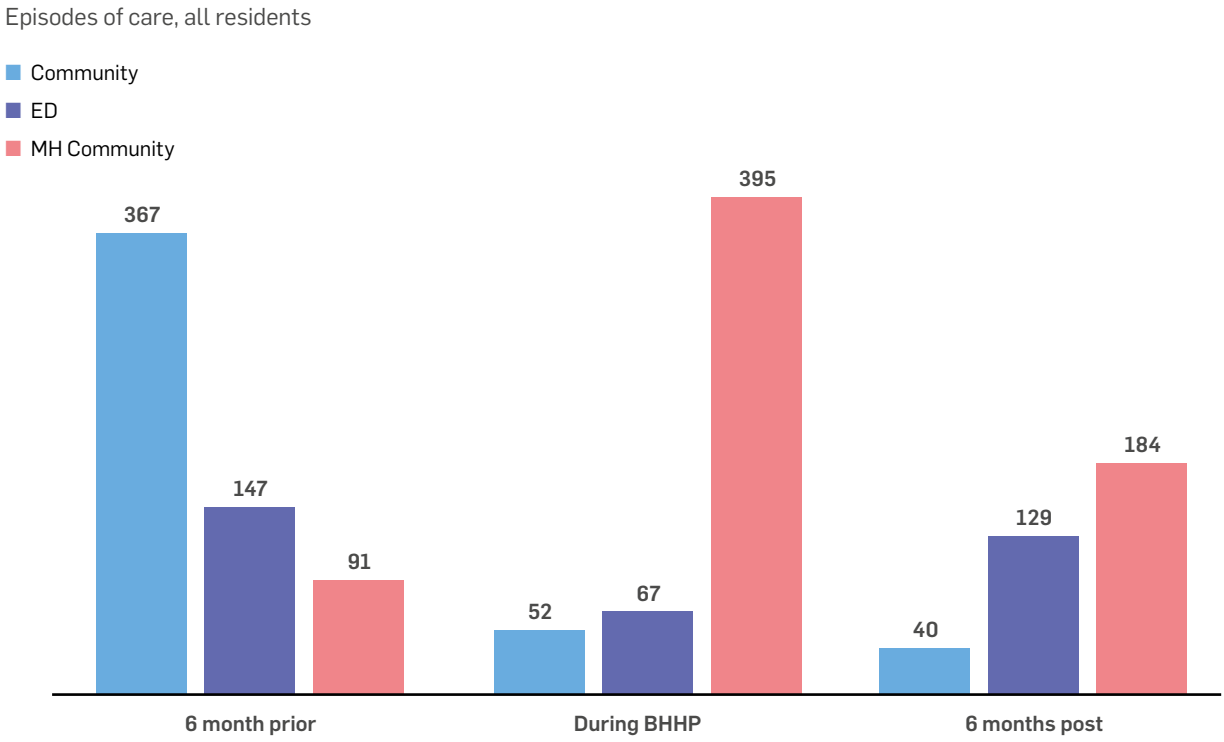
Analysis of service utilisation draws from SVHM and Launch Housing's service-wide administrative data. The focus is on understanding changes in service utilisation over three periods: six months directly before program entry, during a resident's time at the BHHP and the period six months directly after program exit. Given the datasets are specific to each organisation, it is possible that residents will have used other healthcare or specialist homelessness services during the analysis period. Analysis in this section reflects former residents who exited the program less than six months ago (n = 59) and, where noted, includes only those who have been out for over six months (n = 45). The sample sizes are stated in the analysis. This analysis only provides an indication of changes to healthcare service utilisation over time, indicating the need for a broader, statewide data-linkage study when sufficient study power is obtained. This will enable understanding of the full extent to which changes in service utilisation could be attributable to the program

5.2 HEALTHCARE UTILISATION

Reduction in emergency department use coincides with the uptake of community mental health services

There was an overall reduction in ED presentations over time (Figure 13), with a significant drop in use during the program period. This finding suggests that the program is linking residents to appropriate healthcare providers who can attend to a resident's health needs when engaged in the program.

Figure 13 Number of contacts with community (ALERT/HIP services), ED and mental health services in the 6 months prior, during and 6 months post BHHP for the matched cohort (n = 45)



Further examinations shows that nearly two-thirds (17, 65%, n = 26) of residents with a planned exit from BHHP accessed the ED in the six months prior to program entry, with this decreasing to less than one in five residents in the six months after exiting the program (19%). Positively, this cohort showed a significant decline in the use of the ED while a resident of the program, with this trajectory sustained and further minimised in the six months following exit (Figure 14).

A steady decline in Emergency Department presentations over time

For those with an unplanned exit, ED use reduced while they were a resident at BHHP, from 13 in the six months prior to eight during the program. However, this reduction wasn't sustained in the six months after the program, with the number of residents using the ED returning to 13 (of a possible 19). Considering both planned and unplanned exits (n = 45), there remained a considerable reduction (40%) in overall utilisation of the ED comparing six months pre- to six months post-program data.

Figure 14 Number of residents seeking care through the ED in the 6 months prior, during and 6 months post exit from BHHP, by exit type

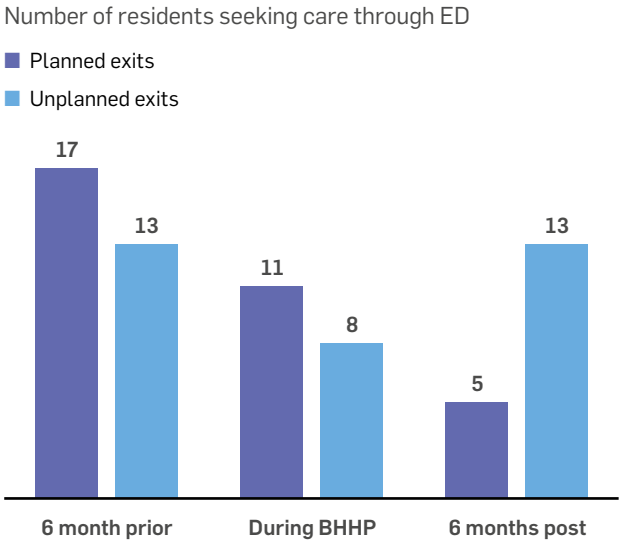
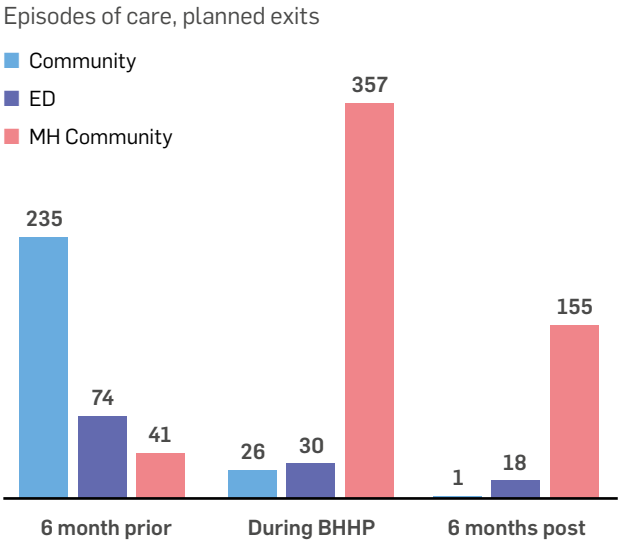


Figure 15 Number of contacts with community (ALERT/HIP services), ED and mental health services in the 6 months prior, during and 6 months post BHHP for the matched cohort who had a **planned exit** (n = 26)



When further unpacked, residents with a planned exit showed a significant increase in contacts with community mental health services while a resident of the BHHP and likewise in the six months post exit (Figure 15). This cohort was relatively under-represented in the six months pre-BHHP data, with only 41 contacts recorded on the system. This demonstration of linkage speaks to the reduction in 'community' contacts over time. Community contacts include any episodes of care involving any SVHM Health Independence Program (HIP) service providers or the Assessment Liaison Early Referral Team (ALERT), a team of care coordinators that prioritises working with residents who frequently present to the ED. With just one recorded contact with the planned exit group in the six months post exit, the data demonstrates that this cohort appears to be relatively settled and linked in to planned healthcare services.

Previously a disengaged group, residents with a planned exit are seeking mental health care support in a planned way

Observed differences in healthcare service utilisation for planned and unplanned exit residents

Among planned exits, ED presentations dropped considerably, from an average of 2.85 per resident prior to BHHP to 0.69 per resident post exit (see Table 8).

Similarly, those with a planned exit from BHHP (n = 26) showed a reduction from an average of 1.08 unplanned acute admissions six months pre BHHP to 0.50 per resident in the six months post exit. As indicated previously, the planned exit cohort showed an increase in engagement with community mental health services, from an average of 1.58 contacts per resident in the six months pre BHHP to 5.96 contacts per resident in the six months post BHHP. These findings align and are represented within the planned exit cohort experiencing a reduction in ED presentations. Of note, many acute unplanned admissions are captured in the ED, with residents being admitted to the SVHM Mental

Health & Alcohol and Other Drug Hub (MHAOD Hub) for short-term management of their AOD and mental health conditions. As findings from KEQ 1 showed, planned exit residents shifted their AOD and mental health conditions from not being actively managed to being actively managed while a resident in the program. Active management of these conditions while at BHHP and post exit are reflected in a reduction in ED presentations and an increase in community mental health contacts, as well as through a reduction in unplanned acute admissions data.

Among residents with an unplanned exit (n = 19), no reduction in acute unplanned admissions was identified, with the number of contacts exceeding pre-program numbers in the period after exiting the program (Table 8). Likewise, while the unplanned exit cohort appeared to be engaged with community mental health services in the six months pre BHHP, this trend also reduced in the six months post exit from the program. In turn, these findings depict the opposite of what was occurring for the planned exit cohort. The unplanned exit cohort continue to use the ED for unplanned healthcare needs after exit, leading to acute unplanned admissions, likely in the MHAOD Hub, which is reflected in the reduction of community mental health contacts and the increase in acute unplanned admissions data in the six months post exit.

While those experiencing an unplanned exit appear to continue to be using unplanned healthcare services for the management of their health conditions, it can't be overlooked that this cohort to a degree has been re-linked with community care coordination services at some stage on their exit journey (7 linked in 6 months pre, 6 linked in 6 months post). This is an indicator that some unplanned exit residents continue to engage with appropriate services that have the capacity to support them to navigate health and housing services.

Table 8 Number of healthcare service contacts in the 6 months prior, during and 6 months post BHHP for planned and unplanned exits (n = 45, 26 planned, 19 unplanned)

	PLANNED EXITS: N; AVERAGE			UNPLANNED EXITS: N; AVERAGE		
Type of contact	Pre BHHP	During	Post BHHP	Pre BHHP	During	Post BHHP
Community (HIP*)	235; 9.04	26; 1.0	1; 0.4	132; 6.95	26; 1.37	39; 2.05
ED presentation	74; 2.85	30; 1.15	18; 0.69	73; 3.84	37; 1.95	111; 5.84
Mental health community	41; 1.58	357; 13.73	155; 5.96	50; 2.63	38; 2	29; 1.53
Acute admission UNPLANNED	28; 1.08	17; 0.65	13; 0.5	36; 1.89	12; 0.63	42; 2.21
Acute admission PLANNED	0; 0	11; 0.42	3; 0.12	45; 2.37	30; 1.58	43; 2.26
Outpatient ATTENDED	25; 0.96	80; 3.08	31; 1.19	20; 1.05	5; 0.26	10; 0.53
Outpatient DID NOT ATTEND	27; 1.04	33; 1.27	17; 0.65	22; 1.16	9; 0.47	30; 1.58
Subacute admission	0; 0	1; 0.04	0; 0	0; 0	0; 0	0; 0
Mental health and AOD admission	1; 0.04	0; 0	0; 0	7; 0.37	0; 0	9; 0.47

**HIP: Health Independence Program; includes care coordination and support in the community; SVHM only*

The number of residents needing outpatient care before, during and after BHHP varied across the planned and unplanned exit cohorts (see Table 8). For the planned exit cohort (n = 26), while data suggests that the number of residents needing outpatient appointments dropped off in the six months after exit from the program, this could mean that the health need the resident had during the program was resolved and they no longer required outpatient care. This appears to be a reasonable conclusion given the number of residents needing outpatient care appeared to be nine in the six months after BHHP. However, those with an unplanned exit (n = 19) showed a high non-attendance rate of outpatient appointments in the six months post BHHP, with 10 residents not attending scheduled appointments. These high rates of non-attendance could lead to residents seeking unplanned healthcare.

Considerable improvements in engagement with planned healthcare services

Substantial evidence from the evaluation showed improvements in resident connections with primary health care, including general practitioners (GPs) and other specialist services, as well as an overall improvement to planned healthcare service use. This shift is positive given the literature shows that people experiencing homelessness commonly experience barriers accessing primary health care in general due to a combination of complex individual and systemic issues (Davies & Wood, 2018).

Program administrative data available for residents with an exit (n = 58 [3]) shows that almost a third of residents (31%) were not linked with a GP or health clinic on entry (Figure 16). By program exit, 81% of residents identified being linked with a GP or health clinic – an improvement of 17.5%. Using this same matched cohort, there was a 23% increase in residents using healthcare services in a planned way (an increase of 7 residents at entry compared to exit). While these improvements are largely seen among the cohort of planned exit residents, the data indicates that some unplanned exit residents were able to access health care in a planned way at exit, indicating that meaningful linkages had occurred during their stay.

81% of residents linked with a GP or health clinic at exit

Additionally, retrospective estimates of referrals conducted over the first 22 months of the program provide further evidence of the extent of health utilisation during the program. Residents went to more than 350 GP appointments throughout the program and 340+ appointments with allied healthcare providers, while 165 instances of AOD support services were accessed. In interviews, staff spoke of the breadth of appointments scheduled, singling out GPs, opiate replacement therapy, dental and optometry as important for residents.

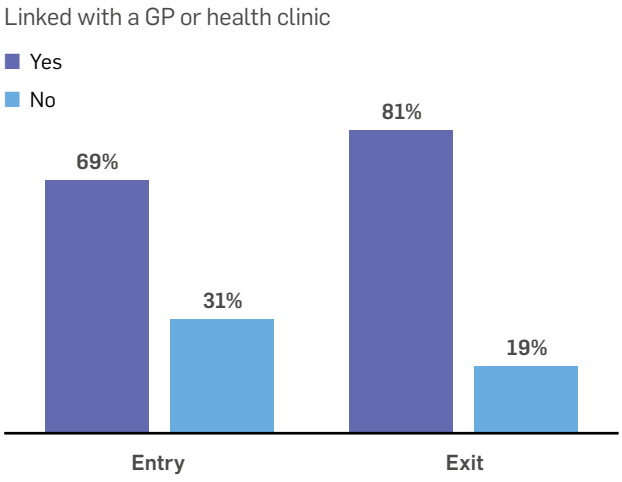
> *I've had my teeth done. That's the main thing … and if your mouth is healthy, the whole body is going to be healthy, isn't it? […] I've been working on [having my teeth fixed/removed] for so long. And I was on the streets, and I could just never get it done. So I finally got it done.* – Resident

Staff reflected that the number of residents being connected with a GP or health clinic during their stay did not accurately represent the positive changes in this outcome area, as the data does not reflect the quality of the relationship that was built or enhanced between the resident and the GP or health provider. Staff described how, for many residents, the quality of the connection between the GP or health clinic upon exit from BHHP was significantly improved from the relationship that existed at entry. Quality connections with health providers lead to greater engagement and subsequent improved management of health conditions in the long term for people experiencing homelessness. Quality relationships break down the barriers that exist so often in health care for people experiencing homelessness – for example, the feeling of stigma and being judged, or likewise the risk of being retraumatised by telling their story (Miller et al., 2024).

GP, opiate replacement therapy, dental, optometry, allied health – just some of the various healthcare appointments planned and attended

3 One resident is missing from this dataset.

Figure 16 Percentage of residents linked to a GP or health service at entry compared to exit



The role of healthcare coordination and advocacy in long-term health management and impact

Staff described how improvements to utilisation of planned health care and a coordinated health response was delivering wraparound health support, which leads to improved health and wellbeing outcomes. Key factors mentioned by staff for improving the management of health conditions included:

- establishing a coordinated health response to manage health appointments and day-to-day health concerns
- all staff in the program assuming responsibility for care coordination
- perseverance with residents through rescheduling missed appointments and accompanying residents to appointments.

Evidence from interviews indicated that through comprehensive health assessments, a care plan that reflected the resident's needs could be developed and specialist assessments could be arranged and completed, leading to identifying and securing critical long-term supports for residents. Residents and staff described how participation in BHHP allowed residents to access specialist assessments for their health needs – for example, a neuropsychological assessment – that they would not have had access to otherwise. These assessments are the cornerstone for referral to appropriate healthcare support services, including the NDIS, and inform decision-making about appropriate housing options to consider for exit.

These outcomes required considerable advocacy from program staff, combined with significant brokerage funding to secure the assessments. Staff said such progress would be considerably more difficult if residents were not in a residential setting, as perseverance, relationship development and trust are important factors contributing to the achievement of these health service connection outcomes.

Residents need considerable advocacy to be able to access the service they need

> *Getting those partnerships in place, getting that rapport in place, building that trust so that when our residents leave here – and I feel confident in saying that a lot of our residents, they leave with that linkage in place and that the linkage is strong, there's some trust there. And they're already in a pattern of accessing that service.* – Staff

> *So, things like just getting linkage with the GP, getting their health issues reviewed. Assessments is really one key thing that I think we do really well in BHHP. Neuropsych assessments getting really thorough assessments of mental health needs. I think we're able to pull in those services really well. And I feel confident in saying that almost everyone we've had go through the program has had some level of assessment that they didn't otherwise have or didn't have before coming into the program.* – Staff

5.3 CHANGES TO ENGAGEMENT WITH HOMELESSNESS AND OTHER SERVICE SYSTEMS

Reduction in homelessness service use, particularly for planned exits

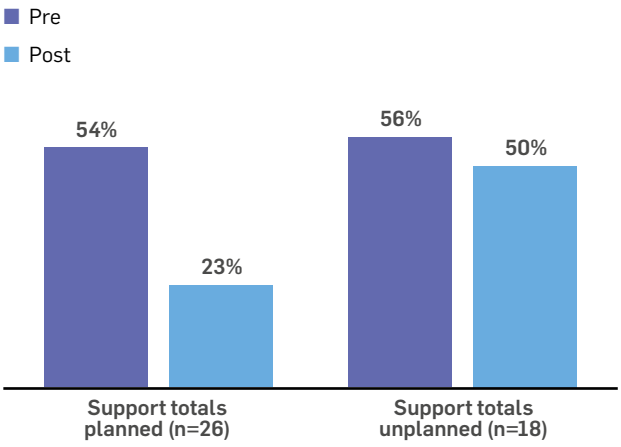
Launch Housing service utilisation data shows a considerable reduction in people who received support in the six months following program exit compared to the six months before entry, from 37 to 20 (Table 9). This data includes all residents who, at the time of evaluation, had exited the program for at least six months (n = 44). As Table 9 shows, nearly all pre-program support periods were for a homelessness entry point response or for Assertive Outreach, a service targeting people sleeping rough.

Table 9 Comparison of homelessness support before and after program

SUPPORT CATEGORY	6 MONTHS PRIOR	6 MONTHS POST
Entry point service	21	12
Assertive Outreach	10	3
Case management	5	2
Crisis bed	1	0
Tenancy support	0	2
Long-term housing	0	1
TOTAL	**37**	**20**

When comparing residents with planned exits to those who did not complete the program, data shows that there is a considerably greater reduction in number of people presenting to services for the planned exit cohort. As Figure 17 shows, the comparison between planned and unplanned exits who received support from Launch Housing services in the six months before entering the program is almost the same (54% compared to 56%). However, for those who completed the program, the number of people who required homelessness supports in the six months after exiting more than halved, from 14 people to six. This difference is even greater when considering only crisis-style presentations, with the nature of engagements after the program for some planned exits being case management support, which is considered a requisite for some secure housing outcomes.

Figure 17 Comparison of pre- and post program service use across planned and unplanned exits



The reduction in utilisation of crisis-oriented supports among the planned exit cohort contrasts with service usage patterns among the cohort of residents who accessed Launch Housing services and who had an unplanned exit from the program. Of the residents with unplanned program exits who received support from Launch Housing in the six months before the program (10), all but one presented to a crisis-type service (entry point or Assertive Outreach). The same number of residents (9) received crisis-type services in the six months after exiting the program.

Evidence of changes in other areas

While evidence of benefits to other systems was not a primary focus of the evaluation, feedback from interviews and program referral data showed that that the BHHP supported residents considerably in other services, and these may have flow-on effects for overall service utilisation. The potential impacts of broader system benefits are explored in Section 6.

Justice system utilisation

There is a strong link between imprisonment and homelessness. Research related to people in prison in NSW, Victoria and Tasmania found that one-third of prison entrants were previously homeless, with 28% living in short-term or emergency accommodation and 5% sleeping rough or in improvised shelter in the four weeks prior to entering prison (Martin et al., 2021). There is also strong evidence that people who have secure housing are less likely to have interactions with the justice system (Martin et al., 2021).

Launch Housing case managers described their role and the interventions they provided beyond housing support, including helping residents resolve legal matters. Staff documented over 60 referrals to legal support, including to Legal Aid, Fitzroy Legal Service, Justice Connect, Mental Health Legal Aid and the Neighbourhood Justice Centre. Residents interviewed also described the help they had received with legal matters.

> *... we will also be involved in other things legal matters, liaising with lawyers. And services like community corrections orders, supporting residents to attend a hearing, providing a support letter, [...] getting birth certificates, phones, sim card activation, accessing, community services for emergency relief or a variety of tasks that when you've been sleeping rough for a long time or being homeless and moving you just lose many things. [...] after a couple of months, you can see that once that's been done, they are ready to move forwards onto the next goal.* – Staff

> *So, the improvements I've made in the (three) weeks, basically I've only had one week to really engage in, and I've got the court sorted out. I missed court two months ago.* – Resident

One resident interviewed had left prison not long before coming to BHHP. His stay at BHHP allowed him to get the health assessments he needed and to subsequently connect with long-term support through disability support pension (DSP) income and the NDIS.

Improvements in income and employment

People sleeping rough typically have low incomes, which acts as a barrier to getting and maintaining secure housing. Those who may be eligible for a DSP are also unlikely to be able to gather the evidence required while experiencing homelessness. Due to the nature of their situation it can be common for a person sleeping rough to lose their Jobseeker income due to not meeting reporting requirements.

Administrative data shows improvements to incomes for BHHP residents. Considering all residents, including those who were current residents at the point of evaluation (n = 71), six had a change to their income category. Of these, five were able to secure a DSP during the program, and one secured Jobseeker payments. Importantly, three of these residents had no income when they entered the program; of those, two subsequently obtained a DSP, and one obtained a Jobseeker payment. In addition, one resident interviewed spoke of how he had re-entered the workforce.

> *I've finally found myself back in the workforce. I'll be debt free in about three weeks.* – Resident

Table 10 Overview of changes to income source category

INCOME CHANGE	INCOME LISTED AT ENTRY		
	Nil income	Jobseeker allowance	**Total**
Disability support pension	2	3	**5**
Jobseeker	1	0	**1**

6.0 FINDINGS FROM THE ECONOMIC ASSESSMENT

6.1 SUMMARY OF FINDINGS

A break-even analysis (BEA) of BHHP reveals that there are significant, system-wide benefits being delivered by its intensive intervention model of delivery. These benefits span health and wellbeing, economic participation and cost savings to government resulting from a model that follows a capability approach which improves the capability of participants to self-manage their health, housing and personal priorities. Annual impacts aligned to program outcomes for nine economic benefit categories have been estimated at between $5,700 and $44,000. These impacts are likely to be long term, as captured in an expected $286,200, 10-year blended benefit for each participant. With a break-even point of 30 participants, or 46% of total exits captured in program data to date, it is highly likely that the program is delivering a net benefit to the State of Victoria. In line with the Early Intervention Investment Framework, the cost savings to government have also been isolated over the 10-year impact period and compared to the existing outcome profile of emergency accommodation interventions. This comparison shows that BHHP delivers the greatest absolute cost saving at between $200,700 and $314,800 per participant in savings over a 10-year period, depending on the assumed drop-off of benefits within the cohort. This yields between $1.90 and $2.99 in savings for each $1 invested in the program. BHHP is expected to deliver a cost saving within five years and has a greater savings ratio compared to traditional emergency accommodation programs due to the intensity of support delivered.

6.0 FINDINGS FROM THE ECONOMIC ASSESSMENT

Key evaluation question 3: What economic benefits have been realised due to program impacts?

6.2 METHODOLOGY AND SUMMARY OF COSTS

To holistically answer KEQ 3, the following sub-questions were considered within the economic assessment:

1. What are the costs and benefits of BHHP?
2. Can BHHP operate to deliver a net economic benefit to the community?
3. To what extent has the program resulted in, or is it likely to result in, improved health, housing and wellbeing outcomes and individual benefits to participants?

BHHP costs, benefits and system-level cost savings have been estimated to address these questions. A BEA was also conducted in line with Department of Treasury and *Finance Economic evaluation for business cases: Technical guidelines* (2013) to provide insight into the economic costs and benefits of the BHHP model, as well as to understand whether the model is likely to deliver a net economic benefit to Victoria. BEA was chosen as it reflects the most comprehensive economic assessment possible given the available data.

A BEA estimates the minimum level of benefit required from a program to cover its total costs, known as the break-even point. This demonstrates the scale of economic impact produced by the model and the efficiency with which BHHP can achieve this impact. While the net impact of the program cannot be determined (due to limitations in available data to quantify the baseline outcomes that have been achieved), an assessment of the program's impact can be made by comparing the outcomes of BHHP against these break-even points and the break-even points of comparable programs. Further, an assessment of program scalability and sustainability has been made based on the BEA findings.

More comprehensive economic impact assessments, such as a cost–benefit analysis, may be possible in future if consistent data is available for long-term outcomes of BHHP participants. Comprehensive and consistent outcome data of a comparable baseline group would then allow change to be attributed to the BHHP model

6.3 TOTAL COSTS

Total costs across the program are estimated to be $8,461,688 over 22 months, split across $975,058 for site costs, $6,339,972 in staff costs, and $1,146,658 in operating costs.

As shown in Table 11, the total costs for the program over the 22-month evaluation period were $8,461,688, averaging $4,230,844 per 11-month period and including estimated site costs for Sumner House and CIRF costs. A substantial proportion of costs were expended in the first seven months of the program towards set-up costs, such as staffing, training and equipment, before the program scaled up to full operation in the following seven-month phase. BHHP operated on a leaner model of delivery in its last eight-month phase. This 'lean' model may have reduced total costs but is unlikely to reflect the total ongoing funding required for BHHP.

Estimated total program costs per participant are $119,179, or $105,445 when excluding site costs.

Figure 18 captures the breakdown of BHHP costs based on the partners within the model. Approximately 55% of the program's economic costs were borne by Launch Housing, 34% by SVHM, including staff and medical costs, and 12% have been estimated to relate to site costs covered by Brotherhood of St. Laurence (BSL). BSL site costs have been estimated on a pro-rata basis by scaling budgeted costs for FY25 based on use of the facility in FY23 and FY24. All other cost data is informed by realised expenditure.

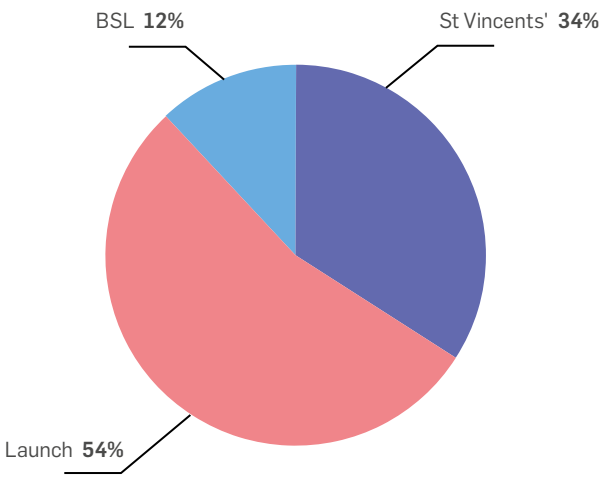
Table 11 Economic cost breakdown of BHHP

COST	FY23*	FY24*	TOTAL
Site	$431,167	$543,891	$975,058
Staff	$3,485,582	$2,854,390	$6,339,972
Operating	$796,147	$350,511	$1,146,658
Total	$4,712,896	$3,748,792	$8,461,688

**Proxy financial year periods have been adopted for the program's full 22-month evaluation period:*

FY23	*Start: 1 August 2022 22*	*End: 30 June 2023*
FY24	*Start: 1 July 2023*	*End: 31 May 2024*

Figure 18 Economic cost attribution to BHHP partners



BEA shows high-impact program outcomes for participants and the Victorian economy

A BEA was conducted to estimate the minimum level of outcome delivery that would see BHHP deliver a net benefit to Victoria. Table 12 reflects the break-even point for each outcome area achieved for program participants. It is reported as the number of outcomes that need to be sustained over a 10-year period per person for the model to achieve break-even and cover its costs. Achieving any of these points would see BHHP achieve a break-even point.

Due to the varied outcome profiles of residents, two break-even values have been estimated for the total program costs ($8,461,688) and operational costs only ($7,486,630) over the 22-month evaluation period:

- **Per outcome,** which considers the number of individual outcomes that need to be achieved for the program to break even. This allows for an estimate of a single benefit area, such as stable housing, to achieve break-even in isolation.
- **Weighted outcomes,** which consider a baseline blend of outcomes across the cohort based on evaluation insights and program data (see Appendix 5). This allows for an estimate of how many participants need to maintain the range of outcomes attributed to BHHP over 10 years for the program to break even.

Break-even values have been calculated against the total program costs. Detailed calculations and methodology for the BEA are in Appendix 5.

As shown in Table 12, BHHP is delivering a range of high-value outcomes. The impact of the intervention in a cohort experiencing long-term homelessness is significant and spans cost savings to government through to individual improvements in quality of life and wellbeing for residents. The value of these impacts ranges from $5,700 to $44,000 per year, or a net present value of $8,700 to $240,300 over 10 years, including a 10% benefit drop-off rate, demonstrating potentially large economic impacts are being delivered compared to other homelessness and housing programs.'

> **BHHP is delivering a range of high-value outcomes**

Considered against the costs of the program, there is a high likelihood that the program has broken even on its costs. Per outcome values show that operational costs can break even if 44 participants manage a substance abuse issue, 45 residents maintain a stable housing outcome, 49 avoid the observed pre-intake use of acute hospital-based mental health care, or 32 residents maintain employment over a 10-year horizon because of the program.

Individually, these break-even points may not be achieved. However, BHHP delivers a mix of preventative health practices, improved individual wellbeing and placement into stable housing. Initial insights into resident outcomes have been used to weight each outcome according to qualitative and quantitative program outcomes (see Appendix 5). It is estimated that over $280,000 of value is being delivered across government savings, wellbeing improvement and ability to engage in employment to each participant. Figure 19 shows the key break-even points, with 27 participants maintaining weighted outcomes for operational costs or 30 for whole-of-program costs covers the program. Benefits are weighted toward management of physical health conditions and maintaining housing. This estimate includes an annual drop-off rate of 10% per year over the 10 years as a conservative estimate of impact.

Overall, the BEA demonstrates that significant value has already been delivered to participants, the Victorian Government and the Victorian economy. The BEA also indicates that while the model is more resource intensive than other homelessness interventions, there is clear scope for additional funding and specialist service provision

that would still see the model deliver a net benefit to the economy. If outcome realisation and longevity of impact were improved due to more funding, it is likely that a greater net impact will be delivered, demonstrating the model's scalability.

BHHP takes a capability approach which focuses directly on the quality of life that individuals are practically able to achieve. This quality of life is analysed in terms of the core concepts of 'functionings' and 'capability'. Functionings are states of 'being and doing', such as being well nourished, having shelter and the capacity to participate in employment. BHHP is providing shelter and access to medical care so that those experiencing long-term homelessness in Victoria can begin to improve their capability to self-sustain their health, employment and stable housing.

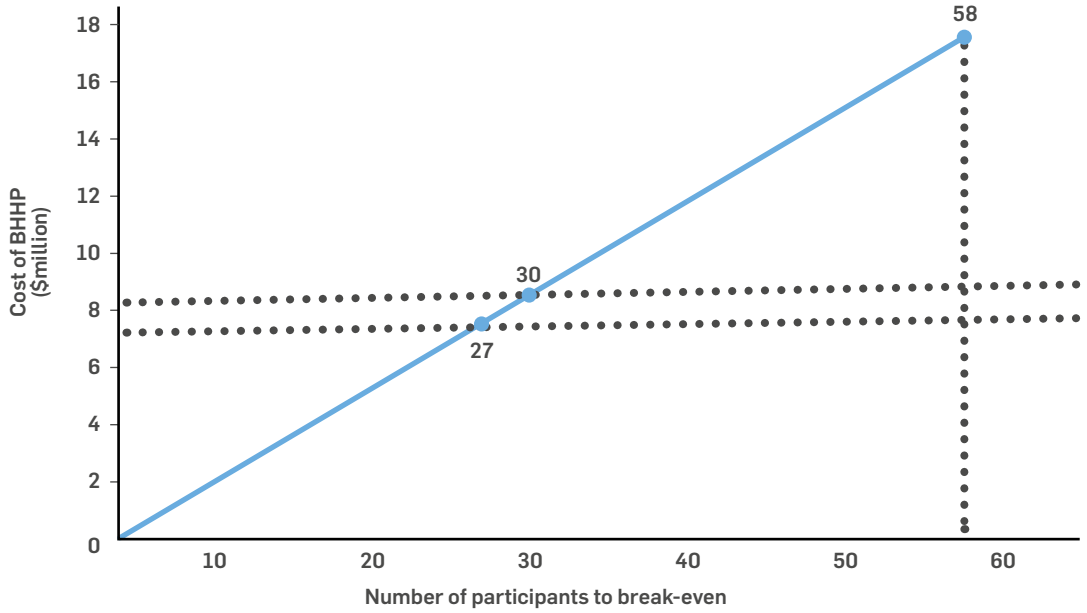
Future funding will need to be based on this understanding, recognising the longer term accrual of benefits and value being delivered by BHHP. The nature of the participant cohort and their complex needs requires significant up-front and staff resources to ensure adequate support is provided. The value generated by this support, as shown in our analysis, is system wide.

Table 12 Break-even points per economic benefit category

ECONOMIC BENEFIT CATEGORY	VALUE PER YEAR	10-YEAR NPV VALUE	NO. RESIDENTS FOR BREAK-EVEN (10-YEAR NPV) *Whole-of-program costs*	NO. RESIDENTS FOR BREAK-EVEN (10-YEAR NPV) *Operational costs*
Avoided emergency medical costs	$13,100	$71,500	119	105
Avoided community-based public mental health services costs	$19,400	$105,900	80	71
Avoided hospital-based mental health costs (acute)	$28,200	$154,000	55	49
Ongoing mental health improvement	$10,400	$56,800	149	132
Stable housing outcome	$29,100	$167,900	51	45
Avoided justice system costs	$5,700	$31,100	273	241
Increased economic participation	$44,000	$240,300	36	32
Improved personal wellbeing	$9,000	$8,700	973	861
AOD management	$31,800	$173,600	49	44
Total potential economic value per person	**$190,700**	**$1,009,800**	**9**	**8**
Weighted – 10 years		**$286,200**	**30**	**27**

Note: NPV = net present value

Figure 19 Key break-even points for BHHP



Note: the lower dotted line represents operational costs and the upper dotted line represents total program costs.

Comparison of cost-saving ratios to similar interventions

By improving access to healthcare and providing stable and safe housing for vulnerable Victorians, BHHP will have a significant impact on spending across the health and housing support portfolios. To demonstrate this, cost-saving ratios have been calculated purely on the cost savings estimated within the BEA. These cost-saving ratios demonstrate the direct budgetary 'bang for buck' of BHHP over a five- and 10-year horizon, as shown in Table 13. The comparison with emergency accommodation was chosen due to the resident cohort and their service utilisation patterns (see Section 5).

Launch Housing provided comparable cost data for emergency accommodation programs run in Victoria. When comparing BHHP to emergency accommodation models over an equivalent period of stay (138 days), BHHP compares favourably from a net cost-savings perspective. Cost savings have been considered in the central case, including a conservative 10% drop-off of benefits each year. An assumed 0% drop-off means benefits are sustained each year across the cohort. The per-annum savings to government are represented in Figure 20.

For every $1 invested, the BHHP delivers between $1.01 and $1.40 back to the Victorian Government over five years and $1.90 to $2.99 over 10 years. This yields a net saving of between 90 cents and $1.99 per dollar invested over the 10-year benefit horizon. The cumulative savings over five years total between $6.3 million and $8.7 million, while over 10 years there are potential savings of between $11.8 million and $18.6 million.

Data provided for comparable models show significantly lower per-person savings to the government. Further, traditional emergency accommodation interventions are estimated to have a lower 10-year saving to the government because of the more limited range of impacts being delivered when only housing needs are being met, as opposed to the integrated approach at BHHP.

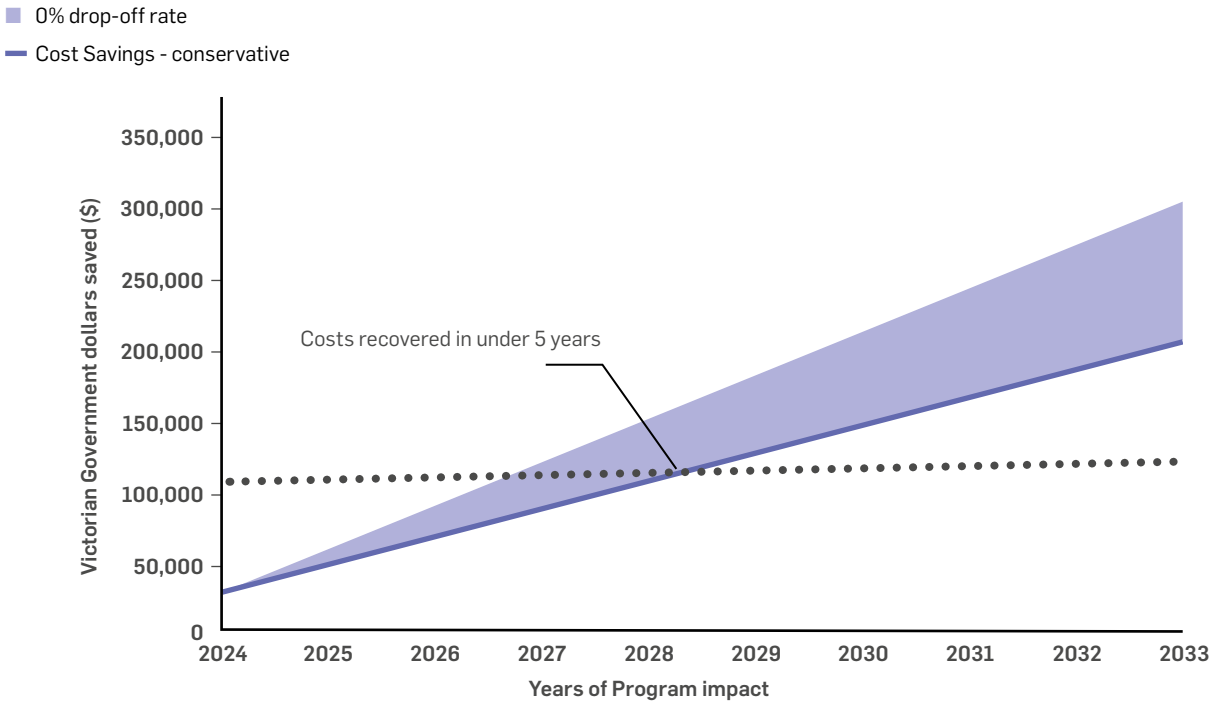
This comparison shows that the delivery of comprehensive wraparound services and support at BHHP is not only delivering significant economic benefits to the economy and participants but also lowering upstream, longer-term costs to government at a greater rate than an emergency accommodation option. This is attributable to a move from emergency to preventative health care and a significant improvement in secure accommodation upon BHHP residents' exit from the program.

Ultimately, by investing in the BHHP, the Victorian Government is likely to save money over the long term at a system level.

Table 13 Cost-saving ratio comparison – Operational costs

PROGRAM	COST (OPERATIONAL)	WEIGHTED OUTCOME VALUE (5 YEARS)	WEIGHTED OUTCOME VALUE (10 YEARS)
Better Health and Housing Program			
Value per average length of stay (138 days, 10% drop-off)	$105,445	$106,437	$200,730
Cost-saving ratio: 10% drop-off		$1.01	$1.90
Value per average length of stay (138 days, 0% drop-off)	$105,445	$147,690	$314,788
Cost-saving ratio: 0% drop-off		**$1.40**	**$2.99**
'Standard' emergency accommodation			
Cost of 138 bed days	$20,490	$24,211	$44,333
Cost-saving ratio		**$1.18**	**$2.16**

Figure 20 Cost savings to Victorian Government from BHHP outcomes



Qualitative findings further demonstrate the impact BHHP is having on participants and the economy

Outside of the quantifiable benefits being delivered by BHHP, a range of economic impacts is increasing the likely net benefit BHHP is delivering.

BHHP saw statistically significant wellbeing improvements across all PWI-A areas

The PWI-A considers people's subjective health, relationships and standard of living, as well as how they are tracking in personal life development goals and areas (refer Section 4). PWI-A improvements were seen across the whole cohort. Wellbeing upon entry was almost universally 'NoWell' and improved consistently to at least an 'UnderWell' subjective assessment. No research was found to determine the economic value of improvements in the PWI-A assessment. Nonetheless, there would be unquantified links between this improvement and quality-adjusted life year (QALY) improvements, alongside known willingness to pay (the maximum price that a customer is willing to pay for a product or service) for individuals related to safety, security and maintaining personal relationships. These benefits would further increase the estimated $9,000 uplift related to improved personal wellbeing (see Table 12).

Resolving chronic illness will deliver a long-term QALY uplift to participants

Self-management of chronic disease has a substantial lifetime benefit, but a specific benefit to participants could not be quantified for this analysis due to the unique circumstances of participants. In a study of chronic disease management programs in the US, Basu et al. (2015) found a relationship between management of a chronic disease and at least a 0.014 QALY uplift over two years of managing the disease. This has an estimated value of $3,438 AUD to an individual over this two-year period; however, QALY improvements may be as high as 0.30 (equivalent to $73,465 AUD) for lifetime management of diseases such as diabetes (Brownson et al., 2009).

BHHP outcomes will improve as the model is further refined

Improved understanding of the personal circumstances of participants that enhance BHHP's effectiveness will lead to a more targeted intervention. There are clear differences in the profile of those who have a planned and unplanned exit. Notably, unplanned exits tended to occur due to AOD-related challenging behaviours or a feeling of overwhelm to remain engaged with the program. Planned exits have a much higher average impact profile, with a greater proportion entering stable housing, overcoming mental health or AOD challenges and reporting greater wellbeing outcomes. In future program iterations, concentrating efforts on improving rates of residents exiting the program in a planned way would increase the value of the weighted benefits estimated within the BEA, with greater benefit attributable to the program.

Staffing costs may rise in an optimal operating model

Launch Housing and SVHM staff reported that they were given unsustainable workloads in order to deliver the last seven months of the program within the 'leaner' budget. This indicates that the costs of the program may be understated when considering unpaid overtime or out-of-role responsibilities. To ensure the model is sustainable, additional funding for more staff is likely to be required. A potential additional benefit of this may be in improved outcomes, particularly for participants that require a more resource-intensive intervention. The weighted benefit value of $286,200 per participant indicates additional staff can be accommodated while a net benefit is still delivered to Victoria.

7.0 MODEL FINDINGS

7.1 SUMMARY OF FINDINGS

- The evaluation identified 10 key lessons with consequences for the future funding, design and implementation of BHHP and for others invested in integrating similar health and housing models.
- The first seven lessons focus on key factors enabling or impeding achievement of program outcomes. These lessons include the importance of a strong, cross-sectoral partnership, the critical role of trust and relationship development with residents, the significance of coordination and advocacy efforts by staff, the importance of managing mental health and AOD conditions through specialist supports, the length of time and flexibility required to influence outcomes, the potential to strengthen support for residents transitioning out of the program, and the role of brokerage funding including at program entry and exit.
- Lessons 7 to 10 focus on the impacts of funding reductions on the program since they came into effect in October 2023. The lessons demonstrate there were key trade-offs to the care model resulting from the funding reductions. The reduction in brokerage and staffing is having a direct result on the intensity of support provided to residents, risking the sustainability of the program and future achievement of outcomes. The funding changes also created considerable uncertainties for the program, which has impeded effective delivery of the model. Despite the challenges, the change to a case management approach for Launch Housing has resulted in some efficiencies and improvements to the model which are partly offsetting the challenges.

7.0 MODEL FINDINGS

Key evaluation question 4: What have we learned about delivering an efficient and high-quality BHHP service?

About the analysis

This section draws primarily on interviews with staff and residents, mainly in response to questions about the most significant enablers and challenges to the program to date. This qualitative analysis also draws on suggestions made by interviewees and through the collaborative sense-making workshop regarding how the program could be improved. This section factors in key findings from other sections of the report, including impact, service utilisation and economic findings.

7.2 KEY LESSONS SINCE PROGRAM INCEPTION

Lesson 1. The cross-sectoral partnership is critical to the success of the model

The strength of the integrated health and housing partnership between the two lead organisations, SVHM and Launch Housing, emerged as a critical enabler to the key achievements of the program. All staff interviewed for the evaluation reflected positively on the partnership and the value of a multidisciplinary, integrated support model, including describing how:

- many outcomes would not have been achieved without the integrated support model, while other outcomes were fast-tracked or enhanced due to cross-sector care, connections and expertise
- cross-sectoral knowledge sharing within the program team has been critical to the effective navigation of the homelessness, housing and health systems, enabling more coordinated and effective support
- staff from both organisations play important roles in the achievement of outcomes for residents.

> *I think the most valuable thing is the partnership model, so having Launch Housing and St Vincent's on site together … and having a multidisciplinary team, having that nursing background, social work background and other kind of allied health and community welfare background, it allows there to be a pretty quick response.* – Staff

Staff also described how the strong partnership is resulting in improvements in understanding from management regarding the roles and complementary nature of services from the health and homelessness sectors. These lessons are helping the partner organisations to understand what it takes at the organisation and sector level to deliver an effective integrated care model. These lessons have translated into a strengthening of the partnership over time while also identifying opportunities to strengthen integrated care partnerships in the future.

Improvements implemented

Staff interviewed described how the partnership has evolved and strengthened, helping the program team to overcome challenges in the start-up phase of the pilot model. Improvements made to the partnership include:

- improved understanding of the respective roles and value of each organisation in delivering integrated care, particularly when it comes to connecting residents to their respective specialist service systems, and the expertise and skills required for individual roles
- improved working relationships between frontline staff and service management
- integrated and clearer processes and procedures, which have improved cross-organisation communication and overall work processes.

The improvements realised are evidence of the maturation of the cross-sectoral partnership.

> *… the outcomes speak to our partnership as well. There was a fair bit of work required between St Vin's and Launch … A lot of meetings and discussion with leadership, that was really such a big feature of this person's care whilst they were here.* – Staff

Avenues to strengthen partnership further

The evaluation also surfaced opportunities to further strengthen the partnership, mainly related to challenges with collaboration across sectors and organisations. For example, there are some differences in organisational policies and procedures, which staff indicated are reflective of broader differences across sectors. Additionally, some policies and procedures developed at the onset of the program require modifying to reflect the evolution of the program.

Despite listing these challenges, interviewees described how robust and constructive dialogue between management has resulted in resolution or workaround of challenges. An adaptive and open approach from program management appeared to be critical in identifying and overcoming challenges emerging in the partnership.

Lesson 2. The program's approach to building trust and rapport with residents is fundamental

The importance of a person-centred and flexible approach to care focused on building trust and relationships emerged as a key theme from interviews with staff and residents. Program staff described how the person-centred and flexible approach to care, combined with a focus on relationship development, is a critical first step in the provision of care and support for residents and how the establishment of trust was an important precursor for:

- building engagement in the program and in the goal-directed approach of the program
- resident participation in other program activities geared towards building capabilities, including social and independent living skills
- developing trust in systems of care, which leads to engagement with service providers on and off site
- engaging with services that continue to support residents' health and wellbeing journey after exiting the program.

Staff described how the program team has gained an appreciation of the value of this way of working for achieving lasting impacts with residents, while acknowledging the challenges of this approach. Staff described contributing factors, including the capabilities of residents on entry into the program, trauma and the considerable levels of disconnection from and mistrust of services among the resident cohort.

> *[Rapport building is important to residents] … because they've been let down so many times and there's so much trauma and a lot of trauma unfortunately, is a really consistent theme for our people. That ability to feel like, you're not going to abandon me. You are not going to let me down. Trust is really important, and that sort of, I'm protecting myself by keeping you away, by keeping you at a distance and breaking through that … I feel that's what it all comes back to really. It's like you can go in with this really well-intentioned plan and have all these goals for someone, but if the rapport and the trust isn't there, and you haven't worked hard at that … You just don't get anywhere.* – Staff

Trust and relationship building can therefore take considerable time and perseverance and do not necessarily lead to prolonged resident engagement,[4] with disengagement from the program remaining a key challenge and a significant contributor to unplanned exits. When describing reasons for residents disengaging and exiting the program, staff described how it was important for residents to cooperate and show a willingness to work together with staff on their care plans. Staff also described instances where residents disengaged from the program despite building a degree of trust, with substance dependency viewed as a contributing factor in these circumstances (see Lesson 5).

Willingness to engage therefore emerged as a critical determinant for achieving program outcomes and is a key focus for the program team, particularly in the early months of the program when the likelihood of an unplanned exit is higher. In interviews, staff described some value in continuing to refine the intake process based on program-wide learnings about resident engagement and willingness to participate in the program approach.

> *… participating in the program really hinges on that cooperation and working on goals. I think that's the biggest challenge. I'd say it's critical* [to the success of the program]. *We hold that firmly in our approach because it's not a housing service, we're a health program as well, and we are really focused on walking alongside you* [and saying], *'What is it that we can help with?'* – Staff

4 Engagement meaning the willingness to comply with requirements to receive a service (p. 4, Opening Doors Framework, Victorian Government, 2008, p. 4). In the context of BHHP, the requirements for engagement include adhering to house rules and efforts to work towards achieving goals in care plans.

Lesson 3. Coordination and advocacy functions are essential enablers for the program

Residents and staff interviewed described how care coordinators and case managers were using their expertise and existing networks to connect residents to specialist health care and housing opportunities which were previously unattainable. For health, relationships with specialist services across the hospital were mentioned as key, including with mental health teams, addiction medicine and the ED.

> *While we're not based in the hospital, we're sort of speaking to them from an internal colleague point of view rather than sort of another community service. And I think that that's really beneficial [...] that connection that we have with the hospital I think is really significant.* – Staff

For housing, staff described how connections with housing providers had strengthened over time and that these relationships were important for securing appropriate housing outcomes for residents.

Across health and housing, staff also mentioned past experiences and relationships as key factors to enable outcomes. Residents interviewed appreciated the efforts of program staff in supporting them to connect with services and supports, describing how staff were going out of their way to help them and get things done.

While connections with broader supports were described as critical, there remain considerable challenges in connecting residents to specialist services and care, highlighting the ongoing systemic challenges the cohort faces in accessing appropriate care. Referrals and connections appeared to work best when an existing relationship was in place between the program or a staff member and the external service. When this was not the case, residents faced barriers to receiving necessary care and support, demonstrating the importance of a coordinated, system-wide approach.

Specific barriers include:

- a lack of understanding about the program from service providers that staff are referring residents to
- stigma and resistance to the people experiencing homelessness as well as to certain prevalent characteristics of the program cohort such as AOD dependency
- a shortage of appropriate housing, particularly for people with AOD dependency and for residents who require long-term supported residential care.

The considerable advocacy required from program staff to secure specialist supports for residents (see Section 5) is further evidence of the ongoing barriers residents face in securing critical supports.

Lesson 4. Desirable housing and health outcomes are realised when residents have time to address their individual needs

In interviews, staff described how working with residents to achieve significant changes takes considerable time and that this varies between residents. The time required to achieve program outcomes is supported by administrative data that shows on average residents take 168 days (five and a half months) to achieve a planned exit. Staff identified phases of care that were particularly time-consuming, including the time it takes residents to:

- reset, decompress and stabilise after significant periods of sleeping rough
- build up trust and relationships with staff and other residents
- participate in health assessments to identify care support needs and to support care planning
- increase uptake with specialist external supports.

Staff described how persistence, perseverance and a degree of flexibility are important in ensuring that residents engaged with program supports and accessed specialist services. These factors are particularly important residents, many of whom have received little planned support in the years leading up to admission into the program and who face significant barriers to receiving care, including distrust of authorities. The work of peer-support workers and after-hours staff was described as having an important role to play in walking alongside residents during this journey, including by demonstrating the value of continuing to work on their goals.

Administrative data suggests that certain cohorts may require more support over longer timeframes to secure housing outcomes. Though the sample size is small ($n = 9$), First Nations residents with planned exits generally stayed in the program for longer than non–First Nations residents with planned exits.[5] While the evaluation did not gather viewpoints regarding the reasons for longer stays for First Nations residents, staff suggested that these differences speak to the value of having a flexible care model whereby residents could access longer term support if necessary to not interrupt progress in achieving an outcome.

Lesson 5. Addressing substance dependence and mental health conditions is a considerable determinant for positive resident outcomes, though there is opportunity to strengthen the program response in this area

AOD dependency and mental health conditions are prevalent in the resident cohort and remain significant determinants of unplanned exits. Resident entry survey data shows that two-thirds of residents are affected by these issues, though staff suggest this is likely a significant undercount. Staff noted that AOD dependency and mental health challenges have been difficult to manage at times, with high alcohol consumption among multiple residents creating a disruptive environment. One resident interviewed described the trade-offs of living alongside others with AOD experience: while peer support can be a significant enabler of recovery, those actively using substances can also create challenges during the program, as it can at times be tempting to resume consumption of AOD.

The notable outcomes relating to improved management and resolution of mental health and AOD-related conditions among the cohort with planned exits outlined earlier in the report is further evidence of the program enablers that influence change in this area. The connection between sustained engagement and positive AOD and mental health outcomes demonstrates the value in sustaining residents in the program.

In interviews, staff described how they have improved their approach to AOD dependency over time, moving towards a more deliberative approach with residents that is focused on harm minimisation and reduced use. This contrasts with the approach employed in the early months of the program where a lower tolerance to challenging behaviours was observed. Program data suggests that the maturing approach to managing challenging behaviours in the BHHP environment over time may have translated into an improvement in outcomes for residents. The rates of unplanned exits have reduced since the approach has been implemented.

Staff also outlined the importance of maintaining discretion at the time of intake so that the needs of the current resident cohort can be considered and a balanced and informed decision can be made about resident intake. Assessing the resident's stage of change (Raihan & Cogburn, 2023) specific to their AOD and mental health needs at intake could support care planning and determine what AOD and mental health supports may need to be provided and with what level of urgency. Understanding what a resident wants to achieve and the stepping stones to achieve this can support building in harm reduction principles to their care plan and provide an avenue to reassess the residents' stages of change across their BHHP stay.

> *"The fact that we're able to meet with people, do an assessment with people, and that we can kind of triage them based on who's referred but also based on who's on site, I think that that lends itself very much to hopefully having the right mix of people on site.* – Staff

Other aspects identified by staff as being effective in managing AOD and mental health challenges include the adoption of a trauma-informed, harm minimisation approach and the significance of having a shelter and place to call home. These themes are consistent with key enabling factors for positive resident outcomes identified in the first evaluation report. While the progress made with residents in these areas is significant, nearly all staff interviewed also called for additional expert support for AOD and mental health conditions to strengthen outcomes in these areas. With specialist AOD support currently limited to one day per week and mental health support dependent on referrals to other parts of SVHM as well and to external agencies, staff feel that a strengthened onsite focus would benefit residents. They also described how additional resourcing for the peer-support worker role could help in these areas, as they were having a considerable positive influence on residents in relationship to AOD dependency and mental health.

5 The average stay for planned exits for First Nations residents was X (n = 191), whereas it was 161 for the other residents.

Lesson 6. There is potential value in strengthening supports for residents after they transition out of the program, though more evidence is required to determine the approach

There is value in strengthening the support mechanisms for residents to transition out of the program, though an improved understanding of resident circumstances post exit would help to clarify priorities for improvement.

For residents with a planned exit, there is considerable evidence to suggest that the program is resulting in outcomes that are having a substantial positive effect on their wellbeing (e.g. the statistically significant improvements in subjective wellbeing scores). The efforts to supports residents to transition out of the program, including through building life skills and capabilities, is also viewed by staff as an important part of the program, with activities such as meal planning and cooking classes, the development of healthy routines, and cleanliness and personal hygiene said to be key. The program also maintains contact with many residents with planned exits, including through post-exit care coordination support, a weekly barbecue for current and previous residents, and through referrals to external agencies whose focus is on supporting residents to transition from homelessness to secure housing.

> [The Friday community BBQ is] *important because you can come back, see your old friends, know where other ones are at, and you can have a feed. And it's pretty good, they get some healthy quality food for you as well. But, yeah, we (only) come back on Friday, especially with [the peer-support workers], when they're here, you know, and the other staff.* – Resident

However, for unplanned exits there is limited evidence of longer term impact beyond improvements in the rate of physical conditions being managed or addressed and some evidence of re-engagement with care coordination services. Though limited through a small sample size and lack of availability of longitudinal and linked data, there appears to be little evidence of change in the areas of health and housing service utilisation. There are currently no mechanisms to continue support of the unplanned exit cohort except through a referral through to ALERT (the care coordination team at SVHM) or to understand how and whether time in the program may have affected their health and wellbeing in the longer term. In time, once a larger cohort of residents have moved through the program, lessons can be learned about the trajectory and future service use of those with unplanned exits, which can be applied to program decision-making.

Staff identified value in further strengthening supports around post-program readiness and life skill building. These improvements have the potential to enhance the likelihood that outcomes would be sustained post-program exit. There may also be value in strengthening connections with other housing services or programs at the point of exit to set residents up with a greater chance of accessing continued care and support. By better understanding residents' longer term outcomes after leaving the program, the program and broader service system could adapt supports to improve health, wellbeing and housing outcomes.

Lesson 7. Brokerage funding is playing an important role in supporting residents to build capabilities and independence

Brokerage funding plays an important role in the program as it allows staff to purchase essential items for residents, such as furniture, clothing and footwear. Staff described how this was particularly important for people sleeping rough, with many residents arriving with very few possessions. At program exit, brokerage funding is playing an important role in ensuring residents have basic furniture and equipment for their new housing. Staff described how accessing brokerage has been increasingly challenging. At the beginning of the program, staff were able to access leftover brokerage from the CIRF, whereas recently they have described instances where they were unable to purchase essential items for some residents. While the significance in the reduction of brokerage available to staff has not been fully realised, staff are concerned that this could impact resident outcomes in the longer term.

7.3 EARLY LESSONS FROM IMPLEMENTING THE REVISED MODEL

Summary of changes

As detailed in Section 3, program funding was reduced in October 2023, leading to a reduction in staffing and changes to the model that were necessary to continue operation of the program. The program team also used this as an opportunity to apply lessons from the first year of implementation. The key trade-offs between the first and second phases of the program (pre October 2023 versus post October 2023) identified through the evaluation are presented below.

Lesson 8. Reduced funding impacts service delivery and supports available for residents

Most staff interviewed felt that the reduction in overall staffing increased pressure on roles and could jeopardise effective delivery of the model when the program is operating at full capacity.

> *I think the resources that we are currently operating on, financial resources, are, like I've said, the minimum that we can run on. I don't believe that there is anything that we could take away that wouldn't impact the outcomes. […] if we removed any of the team at the moment, it would absolutely have negative outcomes on the program.* – Staff

> *The case managers, my only query around that would be the caseload, when we're at full capacity, that both of them are running with a lot of residents around housing and it's not just housing, the case managers are helping out with the legal things and other stuff as well, that feels heavy-duty. That you've got residents that might need more or have more of a complex housing need that needs supported housing, and I just think is there would it be better to have a third, some more EFT for the case management space.* – Staff

The impacts of reduced staffing on the intensity of care provided and the resulting health and housing outcomes remain unclear. Given the timeframe of the evaluation, any changes to outcomes would not yet be reflected in the data.

The reduction in staffing, particularly at night, including no longer having a security guard onsite, was cited as a risk to the safety of staff, particularly when multiple incidents were occurring. Increasing numbers of after-hours staff to manage difficult situations may also increase harmony and connection among the resident cohort and potentially reduce unplanned exits.

The reduced brokerage available under the new funding structure also appears to have impeded the support staff can provide. Staff reflected that since the changes to the model have come into effect, there are less resources to pay for social and community activities with residents as well as less staff to be able to take residents to external activities and appointments. Staff are spending more time searching for ways to meet resident needs and already stretched housing and health systems are searching for additional resources to meet those needs.

Lesson 9. Funding change and uncertainty interferes with program continuity for staff and residents

The evaluation also suggests that funding insecurity has impacted both staff and residents. There were two critical points of uncertainty regarding ongoing funding: September 2023 (ending 29/9/23) and May 2024 (ending 30/6/24). During these times, staff worked with residents to try to secure housing outcomes before the program potentially closed, while the uncertainty resulted in a pause in new resident intakes. The lack of job security also led experienced staff to seek more secure and long-term positions elsewhere. Staff interviews highlighted that considerable changes to the program can slow resident intake, which is seen as necessary to maintain the integrity and quality of program delivery amid these upheavals. While the data regarding housing outcomes does not suggest that housing outcomes were negatively affected during these periods, one resident interviewed shared that they had to exit the program to a motel because of the uncertainty of funding, before eventually moving to community housing.

Further, changes to the model were significant, with feedback from staff indicating that it took time for everyone to adjust to their new roles, particularly after-hours staff, who experienced more substantial changes. Overall, the adjustment period seems to have impeded program delivery and reduced overall capacity.

Lesson 10. Adapting the model of care has created efficiencies, but more work needs to be done

The program began with a model whereby Launch Housing staff worked with all residents. With changes to program funding, BHHP has implemented changes to staffing, moving to an approach in which case managers from Launch Housing are assigned individual residents to work with. Evidence from interviews suggests that this switch to a 1:1 case model has strengthened the model of care by simplifying the division of roles, which has benefited staff and residents and reduced team meetings. Staff described how the efficiencies resulting from changes to the care model and staffing structure have offset some of the drawbacks associated with reduced program resourcing overall. Staff described how, before the model change, residents would get confused about who they should speak to in their care team, and the division of roles is clearer now for residents. While this change appears to have resulted in improvements to the program, the evaluation identified the potential for further clarity in the division of roles among staff under the new model, as well as opportunities to improve communication between day and night staff. Role clarity was seen as an inevitable part of change. At the time of evaluation, program managers identified the need to bed down new practice and provide clarity to staff as a current priority.

The evaluation also identified value in the function of newly created positions, with the addition of the wellbeing role seen as beneficial to support residents in planning their time and to ensure that there was an allocated person driving and organising activities. The after-hours staff are also seen to be providing valuable and practical supports to residents, with staff noting that this support is well suited to evenings, when more residents are present.

> *I think there have been really great changes to the staffing model. Having a dedicated case management team has meant that the residents know who to go to for support, and tasks, and things like that, and more streamlined, and there's been anecdotal feedback from St Vincent's that it's much easier for them to know who to go to for certain resident questions, so I think that change has been really positive.* – Staff

8.0 CONCLUSION AND RECOMMENDATIONS

8.1 OVERVIEW OF RECOMMENDATIONS

- This report presents the results of the second evaluation of the BHHP, which assesses the outcomes and economic value of the program. It provides insights from the first 22 months of operation, which are relevant for decision-making regarding the future of the program. The evaluation is relevant for policymakers and program designers working in integrated health and housing, especially those aiming to develop or enhance supports to people who are experiencing chronic homelessness and who have complex health conditions.
- The recommendations in this section were developed with considerable input from program staff and managers during the evaluation sense-making workshop. Participants engaged with the preliminary findings and analysis, identifying lessons learned and implications for the future of the program. The process involved identifying and prioritising key take-aways for the primary audiences of the evaluation, including funders, program managers and the program team. The evaluation team reviewed contributions from the workshop and triangulated them with evidence from the evaluation to generate recommendations.
- The six recommendations span the areas of funding, systems change, cross-sectoral partnerships and coordination, program design and continuous improvement, and monitoring and evaluation. The recommendations aim to strengthen the broad service sector response to ending homelessness and improving the health and wellbeing of people experiencing chronic homelessness.

8.0 CONCLUSION AND RECOMMENDATIONS

8.2 RECOMMENDATIONS FOR FUNDERS AND POLICYMAKERS

Recommendation 1. Maximise return on investment through long-term, targeted program funding

The break-even analysis and cost-saving ratio (see Section 6) demonstrate that significant economic value is being created and costs avoided because of program impacts. This is exemplified through a low break-even value of 27 participants for operational costs, or 46% of those exited. This means that only 46% of participants would need to experience the expected 10-year benefit profile for the program to deliver a net benefit to the economy. Further to this, every dollar invested in the program is expected to save between $1.90 and $2.99 across the Victorian Government in areas spanning health, housing and justice due to improved early intervention outcomes. These findings suggest that, from an economic standpoint, there is considerable value in funding the program into the future.

The significant ongoing demand for the program, coupled with opportunities for future growth, further underscores the value of targeted funding. The lessons presented in Section 7 provide further insights into how the program could benefit from longer term focused funding. Staff interviews revealed the ways that short-term funding cycles have hindered service implementation, forcing resident exits, limiting intake into the program and contributing to staff turnover and dissatisfaction. While the partnership between Launch Housing and SVHM was identified as a critical enabler in the model, the evaluation also identified challenges inherent in integrated service delivery across sectors and the time it takes to establish effective ways of working between teams. The evaluation demonstrates how program partners have adapted to these lessons and continued to strengthen their shared approach.

Securing long-term funding for the program will allow for the partnership to capitalise on the maturation of the relationship, while avoiding inefficiencies associated with restarting the program should funding stop and then start again in future. The evaluation also identifies areas where additional funding could further strengthen health and housing outcomes. The prevalence of AOD dependency and mental health conditions are notable characteristics in the resident cohort, and these conditions were a critical factor in unplanned exits and a strong outcome area for the program. Staff emphasised the value in resourcing additional specialist mental health and AOD supports through funding of dedicated program positions.

> *I think if we had more peer-support workers here more often, I think that it is something that would have a really great outcome or great impact on the residents.* – Staff

Recommendation 2. Invest in service reform and coordination to strengthen the collaborative approach to people experiencing chronic homelessness and embed programs into system reform efforts

The BHHP focuses on building connections with the health and housing systems, as well as with other sectors such as justice. The program's collaborative approach has contributed significantly to the achievement of outcomes. However, ongoing challenges in service coordination suggest there is value in strengthening connections between health and homelessness services at the system level, as well as across other sectors involved in addressing chronic homelessness.

In interviews, staff recounted instances where, despite persistent advocacy on behalf of residents, they were unable to connect residents to essential services. These instances highlight the siloed nature of the service system and the inability of some mainstream services to meet the needs of the resident cohort. These challenges are central to the program design. While BHHP works to bridge these cross-sector gaps, maximising the impact of the program may require a broader, coordinated and strategic system-wide approach.

Policymakers should consider the avenues available to them to further strengthen cross-sector coordination, including by:

- enhancing connections between sectors and services at the executive level through policy coordination and governance, including interdepartmental groups focused on addressing homelessness and health inequities
- investing in cross-sectoral education and training to build capability, raise awareness and influence policy change specific to care for populations experiencing homelessness

- supporting initiatives that strengthen coordination and connections within local service delivery systems, addressing shortages in specialist support identified in the evaluation. This might also be achieved by strengthening existing local initiatives focused on service coordination and cross-sector engagement, including Regional Homelessness Networks and Advance to Zero.

Strengthening post-program support (Lesson 6) is another area where funders and policymakers could play an enabling role. An increased focus in this area could enhance outcomes, though it remains largely outside the current scope of the program due to resource limitations.

Finally, additional investment in strengthening service coordination and systems connections should be matched with ongoing evaluation efforts. The evaluation has already identified unexpected outcomes in service utilisation beyond the health and housing sectors, such as in justice and employment. A strengthened evidence base in these areas will help to quantify the full range of avoided costs and further demonstrate the value of the program.

8.3 RECOMMENDATIONS FOR PROGRAM MANAGERS AND THE PROGRAM TEAM

Recommendation 3. Continue to emphasise and strengthen cross-sectoral relationships at program and system-wide levels

As outlined in Section 7, the evaluation identified the partnership between Launch Housing and SVHM as a critical enabler of program outcomes (Lesson 1) and there is potential value in strengthening partnerships with other services (Lesson 3), given the focus and dependence on the broader service system for effective referrals in and out of the program.

As part of the ongoing maturation of the program, managers should look to strengthen and formalise relationships with other organisations in the wider network of service providers that are involved in supporting the resident cohort.

If these relationships rely solely on connections between frontline staff, there is a risk that they may dissolve if staff depart the program or external agencies. Expanding formal networks and strengthening relationships at the leadership or organisational level with a broader network of service providers could benefit the program and enhance services delivered by Launch Housing and SVHM.

Recommendation 4. Streamline service delivery under the revised care model

Given the program has been operating for under two years and has experienced some changes to its operating model over this period, it is unsurprising that further clarification of roles and streamlining of service delivery (Lesson 10) are necessary. The evaluation identified opportunities for improvement in these areas, including updating program documentation to reflect current practices and to clarify any outstanding issues regarding division of roles under the new operating model. Program partners should leverage their strong collaboration to continue to adapt the program, including integrating emerging priorities from this evaluation into their continuous improvement planning. Special attention should be given to continuing to embed critically important roles, including peer-support workers, wellbeing workers and after-hours workers, more firmly into the program.

Recommendation 5. Continue to prioritise reducing unplanned exits and consider additional approaches to maintain engagement if unplanned exits occur

TThere is interest and value in exploring ways to better support the cohort of former residents who have had an unplanned exit from the program, including through strengthening assessment processes and post-exit supports. Regarding the assessment and intake process, one avenue is improving understanding of the stage of change a resident might identify with in relation to their AOD and mental health conditions (Raihan & Cogburn, 2023). Evaluation findings suggest that there may be an emerging character profile of a resident who experiences a planned exit, with their stage of change to address their AOD and mental health conditions being in the preparation or action stage. Including questions specific to the Stages of Change model in the assessment process could support the identification of residents who may be pre-contemplative or

contemplative about addressing their AOD or mental health conditions, which would indicate to program staff the need for more intense support specific to AOD and mental health when entering the program.

Additionally, given service utilisation data identifies that residents who disengage from the BHHP return to pre-program levels of unplanned service use after exit, partner organisations should continue to consider how best to support these residents. There may be value in establishing a protocol on entry whereby residents agree to an ongoing referral to the SVHM care coordination team if they exit the program in an unplanned way. This could reduce the likelihood of residents losing contact with supports that have been established, minimising the impact on unplanned service use as far as practicable. This approach could also lead the resident to have increased trust in the service system, reduce feelings of stigma and truly support the implementation of a trauma-informed and holistic approach to care.

8.4 RECOMMENDATIONS TO STRENGTHEN THE EVIDENCE BASE

Recommendation 6. Invest in monitoring and evaluation to strengthen understanding and sharing of the benefits of the program across the whole service system

There are opportunities to strengthen the evidence base to improve understanding of the wider value of the program and provide insight into how to improve programmatic and system-wide responses to the target cohort. Though not a focus of this evaluation, there is emerging evidence showing the program may be positively contributing to other systems benefits, including through employment outcomes and by reducing contact with the justice system. Given these outcomes were not a focus of the program or the evaluation, evidence of these outcomes is limited. If the program were to strengthen monitoring of these outcome areas, then future evaluations could more rigorously determine the potential program impact and flow-on benefits for government and society. Statewide matched data may be necessary to effectively understand system-wide benefits.

This evaluation has also been conducted while the Victorian Government is maturing its understanding of system-level cost savings based on service utilisation changes and program outcomes. We acknowledge that the cost savings presented within this evaluation represent a likely lower estimate, and reanalysis of estimated cost savings using improved metrics may see cost savings increase. This is particularly relevant to savings associated with homelessness services, as these are reported at a high level and lack nuance related to emergency accommodation specific costs. The costs averted from preventing re-entry to emergency accommodation are expected to be much higher.

There is also a clear opportunity to strengthen the understanding of resident circumstances and outcomes over a longer timeframe, including tracking trajectories after they exit the program. This could have multiple benefits for the program, including identifying ways to strengthen the program's model of care, identifying opportunities to strengthen cross-sectoral collaboration, and by further strengthening understanding of program impact and value.

Finally, there is a strong representation of First Nations residents in the program, and results from the evaluation have shown that the program is delivering considerable benefits for these residents. This indicates the ability of the program to prioritise First Nations residents and make appropriate service and housing connections. Future evaluations should seek to understand in more depth what has worked well and what needs to improve in the way the BHHP supports its First Nations residents.

These additional focus areas for evaluation will yield lessons for program and policy improvement and may also be of interest to the broader health and homelessness sectors, as well as those concerned with strengthening cross-sector coordination and care responses.

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APPENDICES

APPENDIX 1. METHODOLOGY

DATA COLLECTION AND ANALYSIS

The evaluation utilised a mixed-methods approach, integrating administrative data, qualitative interviews, and a sense-making workshop for rigorous assessment of program outcomes.

Administrative data

Launch Housing and SVHM collect considerable administrative program data, including participant demographics, program activities, outcomes, and overall expenditure. Additionally, they maintain databases tracking resident use across their full range of services. This data helped the evaluation assess how the program may influence residents' use of health and housing services.

Additional data detailing program costings was sourced through the respective organisation's financial departments. As well as drawing from this program level administrative data, the evaluation also incorporates wider health service utilisation data for residents accessing other SVHM and Launch Housing services.

Interviews and sense-making workshop

The evaluation included collection of qualitative data through interviews with program residents (n = 5) and program staff (n = 9) as well as via a sense-making workshop. Program participants were key informants for the evaluation as they are well placed to talk about the program, including outcomes and lessons. The workshop is a key step in the data collection and sense-making process, allowing for further input from program staff in the sense-making process. The workshop design drew from a combination of participatory and collaborative methodologies. It also introduces a sequential component to the mixed-methods evaluation.

In the workshop, participants substantiated and contextualised evidence from existing evaluation data and to respond to this evidence by providing additional evidence (addressing data gaps), as well as participating in a sense-making process to develop findings and recommendations against the key evaluation questions.

Participant data was collected, de-identified and statistically analysed by the internal project team to determine key outcomes related to length of stay, health outcome changes, wellbeing measures, and any interrelationships with socio-demographic measures. This quantitative analysis was synthesised with analysis from interviews and workshops held with key stakeholder to justify how the program is impacting participants' housing and health outcomes.

The methodology for the financial and economic analysis is included in Appendix 5.

Qualitative data analysis

The qualitative data from interviews and workshops was thematically analysed by assigning codes based on expected and emergent outcomes, as well as alignment with key evaluation questions.

The composite case studies synthesised data from multiple interview transcripts, consolidating key quotes and insights into single narratives. Both cases draw on the direct language and opinions of the interviewees while combining data from several participants to present a unified story. Identifiable details were removed and tested with program staff for confidentiality. Relevant details were retained to preserve essential context and accurately reflect participant experiences.

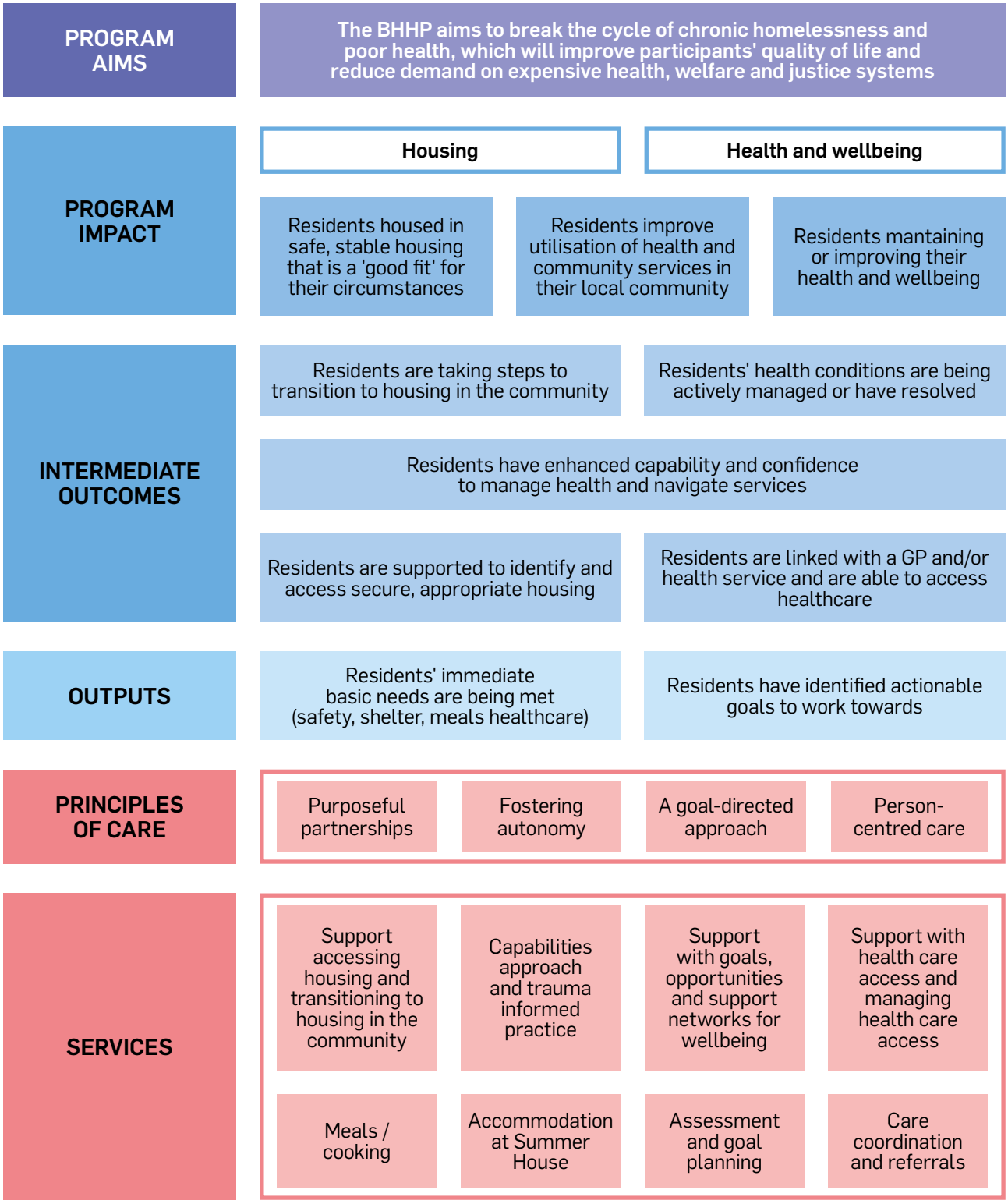
Quantitative data analysis

The quantitative analysis approach varied according to the type and structure of available data. Descriptive statistics were used as the primary method for summarising and understanding overall trends and patterns within the data. This approach allowed for a broad overview of the program's outputs and outcomes. For a more in-depth comparison of matched cohorts, specifically within the PWI-A datasets, paired t-tests were employed. This statistical approach was selected to assess whether there were significant differences in wellbeing measures before and after the program.

Key program outputs and outcomes analysed included:

- number of residents on the program and type of exit
- demographics such as age brackets.
- average PWI-A at entry, exit and discharge
- statistical significance of changes in PWI-A scores (where a matched dataset exists)
- health service utilisation comparison six months pre-BHHP admission, during stay at BHHP and six months post BHHP
- health condition management
- housing service utilisation and housing outcomes.

APPENDIX 2. PROGRAM LOGIC



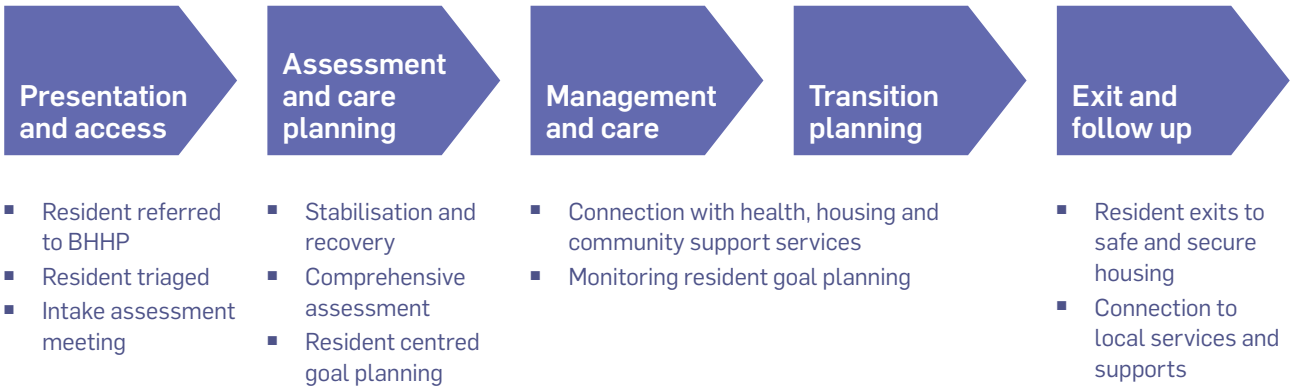
APPENDIX 3. PRIORITISATION MATRIX

Age	Duration of homelessness	Physical Health (inc. ABI)	Mental Health / Behaviours of Concern	Addiction	Involvement with Justice System	Aboriginal or Torres Strait Islander	Engagement with Supports (health and housing)
30-39 years	Less than six months	1 health condition	Stable and treated	Not using	No involvement	No	Well engaged with appropriate supports
	6-12 months	2 health conditions	Episodic treatment and/or exacerbation of condition	Episodic use	Pending legal issues	Yes	Episodic engagement
40+ years	1-5 years	3 health conditions	Chronically mildly unwell and/or poorly supported	Significant user and open to addressing this	Recent prison release		Chaotic engagement
	Over 5 years	4 or more health conditions requiring palliation	Acutely unwell	Current singnificant use, pre-contemplative	5+ years of imprisonment and recidivism		Nil engagement

- High Priority for BHHP
- Moderate Priority for BHHP
- Low Priority for BHHP / Unlikely to be considered for the program
- Not well enough got BHHP - might be considered after treatment for acute issues

APPENDIX 4. THE BHHP MODEL

Resident pathway through the program



Principles of care and practice approach

The program works on a person-centred care approach that is trauma informed and recovery focused. The program's person-centred approach aims to break down barriers to health and housing by placing individuals at the forefront of their care. This is achieved through customised support and fostering a positive engagement experience. The approach is designed to enhance resident involvement and build their capacity to interact with services and resources, ultimately leading to improved outcomes.

The BHHP uses a 'capability approach', intended to assist participants to expand their capability through harnessing people's distinct skills and interests, and addressing structural as well as individual factors. BHHP is designed to support program participants to realise outcomes in health, housing and supports that are conducive to them making meaningful choices and achieving their own goals.

Practice at BHHP is also 'trauma informed', intending to facilitate a safe environment for recovery informed by each person's distinct past and present. With the recognition of the widespread and profound effect of trauma in people who access homelessness services.

The first evaluation report also contains further information about the principles of care (Pahor, 2023)

Team functions

BHHP works on a multidisciplinary team-based approach to support the resident. The below table outlines the main team functions. These functions may be performed by one role or several but summarise the core tasks being performed at BHHP.

Healthcare coordination and support	Staff help residents to navigate the health system, advocate for relevant health needs and support and connect to health services including AOD and mental health.
Housing coordination	Residents are assisted to navigate the housing system, including housing assessments, getting on the Victorian Housing Register, advocating and applying for properties.
Community connection and support	Support with legal issues, getting personal identification and external social and community building activities and general resident advocacy in these areas.
Lived experience support	The Lived Experience functions offer a peer viewpoint to residents, foster engagement with clinicians, provide peer advocacy, assist with navigating services and provide a positive role model for participants for hope and recovery.
Activities of daily living skills and group activities	Regular activities are conducted at BHHP as well as personal interactions to help build daily living skills.
Incident and behaviour management	Management of one-off incidents as well as working on ongoing behaviour management and social harmony at the site.

APPENDIX 5. FINANCIAL AND ECONOMIC ANALYSIS METHODOLOGY DETAILS

Benefits delivered by the BHHP model

Outcomes related to BHHP impact a variety of services delivered by the Victorian Government as well as impacting the health, wellbeing and economic participation of participants. To better contextualise these outcomes, each cost-saving and economic benefit estimate has been categorised based on a practical consideration of when these costs are borne by government.

As shown in the table below, nine economic benefit categories have been defined. These are:

- **Avoided emergency medical costs**, relating to ambulance and hospital emergency department (ED) services
- **Avoided community-based public mental health services costs**, relating to community-based public mental health services including ambulatory care and residential services
- **Avoided hospital-based mental health costs (acute)**, relating to involuntary hospitalisation as a result of mental health concerns
- **Ongoing mental health improvement**, relating to reduced costs when individuals do not require mental health services
- **Stable housing outcome**, relating to homelessness services including the provision of housing and support services
- **Avoided justice system costs**, relating to justice contact savings in criminal matters disposed in Magistrate's Court and associated legal aid costs
- **Increased economic participation**, relating to an uplift in employment outcomes
- **Improved personal wellbeing**, relating to the feeling of belonging in a community
- **AOD management**, relating to an uplift in AOD outcomes.

Categories have been used to better align the economic impact to outcomes that BHHP is delivering to the Victorian economy and individuals experiencing homelessness and co-occurring chronic illness.

These values are the basis of the break-even calculation and, summed together, equate to the value of $185,400 per year.

QUANTIFIED BENEFIT	PER-YEAR VALUE	WEIGHT (see 'detailed benefit methodology')	WEIGHTED VALUE	ECONOMIC BENEFIT CATEGORY	TOTAL PER-YEAR VALUE	TOTAL WEIGHTED VALUE
Avoided cost per ambulance	$4,082	22.4%	$915	Avoided emergency medical costs	$13,085	$2,933
Avoided cost of emergency presentation	$9,003	22.4%	$2,018			
Avoided cost of ambulatory care	$13,574	60.3%	$8,191	Avoided community-based public mental health services costs	$19,420	$11,719
Avoided cost of community residential health services	$5,846	60.3%	$3,528			
Avoided cost of public hospital mental health admission (acute)	$28,160	22.4%	$6,312	Avoided hospital-based mental health costs (acute)	$28,160	$6,312
Ongoing mental health improvement	$10,353	22.4%	$2,321	Ongoing mental health improvement	$10,353	$2,321
Personal benefit of stable housing	$21,600	54.0%	$11,664	Stable housing outcome	$29,100	$15,714
Avoided cost of homelessness services	$7,500	54.0%	$4,050			
Avoided cost of justice (police and incarceration) services as a result of housing provision	$3,209	54.0%	$1,733	Avoided justice system costs	$5,694	$3,075
Avoided cost of court proceeding	$2,485	54.0%	$1,342			
Increase in economic participation per person per year as a result of housing provision	$43,963	5.3%	$2,330	Increased economic participation	$43,963	$2,330
Community inclusion per person	$8,953	75.0%	$6,715	Improved personal wellbeing	$8,953	$6,715
AOD management	$31,835	17.9%	$5,685	AOD management	$31,835	$5,685

Break-even points per economic benefit category

Economic benefits have been calculated on a 10-year and five-year horizon to capture the full scope of BHHP's impact, including cumulative benefits and delayed outcomes. The calculations for these values apply a 10% annual drop-off rate to each benefit, reducing the previous year's value to simulate a conservative estimate of the proportion of the participant cohort returning to their pre-BHHP conditions. A 4% discount rate is also applied annually to reflect the reduced present value of future benefits, in line with Victorian DTF guidelines for economic evaluation.

Cost savings to the Victorian Government

Cost savings have been calculated on a 10-year and five-year horizon to capture the full scope of BHHP's impact across Victorian Government portfolios. Comparison has also been provided for traditional emergency accommodation services. The calculations for these values apply a 10% annual drop-off rate to each benefit, reducing the previous year's value to simulate a conservative estimate of the proportion of the participant cohort returning to their pre-BHHP conditions and service utilisation. A 2.5% inflation rate is also applied annually to reflect the anticipated actual cost of this service utilisation. The cost savings calculated below align with the Early Intervention Investment Framework (EIIF) and demonstrate a clear downstream cost saving to government.

ECONOMIC BENEFIT CATEGORY	10-YEAR VALUE	5-YEAR VALUE	BHHP WEIGHT
Avoided emergency medical costs	$71,530.24	$48,157.50	22%
Avoided community-based public mental health services costs	$105,930.28	$71,317.21	60%
Avoided hospital-based mental health costs (acute)	$153,981.13	$103,667.28	22%
Ongoing mental health improvement	$56,787.37	$38,231.91	22%
Stable housing outcome	$167,889.89	$113,031.30	54%
Avoided justice system costs	$31,123.85	$20,954.02	54%
Increased economic participation	$240,254.25	$161,750.37	5%
Improved personal wellbeing	$8,653.85	$8,653.85	75%
AOD Management	$173,638.30	$116,901.40	18%

ECONOMIC BENEFIT CATEGORY	10-YEAR VALUE	5-YEAR VALUE	BHHP WEIGHT	EA WEIGHT
Avoided emergency medical costs	$93,587	$56,104	22%	5%
Avoided community-based public mental health services costs	$138,594	$83,086	60%	5%
Avoided hospital-based mental health costs (acute)	$201,462	$120,774	22%	5%
Homelessness services use reduction	$60,918	$33,436	54%	24%
Avoided justice system costs	$40,721	$24,412	54%	24%

Note: EA = emergency accommodation

Detailed benefit methodology

The following section presents the assumptions and calculations of the quantification of each outcome area within the economic analysis, including source data.

Avoided cost per ambulance

The total revenue of Victoria's ambulance service organisations between 2022 and 2023 of $1,614,400,000 was divided by the total number of incidents in Victoria (1,052,717) (Productivity Commission, 2024), for the average cost of $1,534 of a single ambulance service in Victoria.

The average no. of acute ED presentations of all BHHP participants in the six months before program admission (5.9) (SVHM, 2024b) was multiplied by the proportion of SVHM ED presentations who have a homelessness flag who arrived by ambulance (43%) (SVHM, 2024a) for an average no. of acute ED presentations who arrive via ambulance (2.5).

Multiplied by the average cost of a single ambulance service in Victoria and inflated to 2024 dollars, the avoided cost per ambulance is estimated to be $4,082. It should be noted that this is a conservative estimate, given emergency costs tend to be higher.

An assumption of 22.4% impact was applied to the weighted value of this benefit to BHHP based on the lowest increase in actively managed conditions, which related to mental health conditions, between entry and exit of the program (SVHM, 2024b).

For cost-saving calculations, an Urbis baseline assumption of 5% was applied to the value of this benefit to emergency accommodation, given there is likely to be some benefit to a housing-only intervention and health conditions being managed.

Avoided cost of emergency presentation

The average cost per acute emergency department presentation in public hospitals in Victoria between 2021 and 2022 was $1,359 (Productivity Commission, 2024). When multiplied by the average number of acute ED presentations of all BHHP participants in the 12 months before program admission (5.9) (SVHM, 2024b) and inflated to 2024 dollars, the avoided cost of one emergency presentation is estimated to be $9,003.

An assumption of 22.4% impact was applied to the weighted value of this benefit to BHHP based on the lowest increase in actively managed conditions, which related to mental health conditions, between entry and exit of the program (SVHM, 2024b).

For cost-saving calculations, an Urbis baseline assumption of 5% was applied to the value of this benefit to emergency accommodation, given there is likely to be some benefit to a housing-only intervention and health conditions being managed.

Avoided cost of ambulatory care

The average cost per treatment day of mental health ambulatory care (ambulatory care services and other services dedicated to assessment, treatment, rehabilitation

and care) in Victoria between 2021 and 2022 was $516 (Productivity Commission, 2024). This cost is multiplied by the average treatment days per episode of ambulatory care in Victoria between 2021 and 2022 of seven days (PC 2024) and the average number of outpatient appointments attended by all BHHP participants in the 12 months before program admission (3.32) (SVHM 2024). When inflated to 2024 dollars, the estimated avoided cost of ambulatory care is $13,574.

An assumption of 60.3% impact was applied to the weighted value of this benefit to BHHP based on the increased proportion of actively managed physical health conditions between entry and exit of the program (SVHM, 2024b).

For cost-saving calculations, an Urbis baseline assumption of 5% was applied to the value of this benefit to emergency accommodation, given there is likely to be some benefit to a housing-only intervention and health conditions being managed.

Avoided cost of community residential health services

The average recurrent cost per patient day for community residential mental health services [residential services that provide beds in the community, staffed onsite by mental health professionals] in Victoria between 2021 and 2022 was $738 (Productivity Commission, 2024). The average treatment days per episode of ambulatory care in Victoria between 2021 and 2022 of seven days (Productivity Commission, 2024) was adopted and multiplied by the cost per day for an estimated value of $5,242 (Productivity Commission, 2024), equivalent to $5,846 in 2024 dollars.

An assumption of 60.3% impact was applied to the weighted value of this benefit to BHHP based on the increased proportion of actively managed physical health conditions between entry and exit of the program (SVHM, 2024b).

Avoided cost of public hospital mental health admission (acute)

The average recurrent cost per inpatient bed day at psychiatric hospitals (acute units) in Victoria between 2021 and 2022 was $1,957 (Productivity Commission, 2024). This cost is multiplied by the average length of stay at public hospital acute units in Victoria between 2021 and 2022 of 13 days (Productivity Commission, 2024) and then inflated to 2024 dollars for an estimated value of $28,160.

An assumption of 22.4% impact was applied to the weighted value of this benefit to BHHP based on the increased proportion of actively managed mental health conditions between entry and exit of the program (SVHM, 2024b).

For cost-saving calculations, an Urbis baseline assumption of 5% was applied to the value of this benefit to emergency accommodation, given there is likely to be some benefit to a housing-only intervention and health conditions being managed.

Ongoing mental health improvement

The Australian government's real expenditure on mental health services in 2021–22 of $11,592,500,000 (Productivity Commission, 2024) was divided by the estimated total number of adults in Australia who had been diagnosed with a mental illness in the previous 12 months (4,300,000) (AIHW, 2024a) to determine the average cost per person that does not have to manage a mental health concern in a given year ($2,686). This cost-saving has not been included in the calculated cost-savings to the Victorian Government to prevent double-counting other mental health cost reductions.

Real QALY uplift from ongoing mental health improvement per person per year has been estimated to be 0.03 (Constellation Fund, 2024). When multiplied by the value of one quality-adjusted life year in 2023 ($235,000) (Office of Impact Analysis, 2023) and inflated to 2024 dollars, the QALY uplift per year value is $7,346.

The total economic benefit of ongoing mental health improvement per person per year is estimated at $10,353, adjusting for inflation to FY2024 terms.

An assumption of 22.4% impact was applied to the weighted value of this benefit to BHHP based on the increased proportion of actively managed mental health conditions between entry and exit of the program (SVHM, 2024b).

Stable housing outcome

Real QALY uplift from avoided return to homelessness per person per year is 9.96 and the percentage decrease in death over one year is 0.89% (Constellation Fund, 2024). When multiplied by the value of one QALY in 2023 ($235,000) (Office of Impact Analysis, 2023) and inflated to 2024 dollars, the economic benefit of a stable housing outcome per person per year is estimated at $21,634.

An assumption of 54% impact was applied to the weighted value of this benefit to BHHP based on the proportion of exits from the program by 31 May who had a secure housing outcome (SVHM, 2024b).

Avoided cost of homelessness services

The recurrent cost per resident accessing homelessness services in Victoria in 2022–23 was $5,160 (Productivity Commission, 2024). Of this funding, 29.80% relates to emergency accommodation services (Productivity Commission, 2024). This proportion was applied to costs for all non-emergency accommodation service costs of $3,744.66 per patient per year.

The cost per resident per average stay in emergency accommodation was estimated based on data provided by Launch Housing. At a cost for a single room with an average stay of seven days was estimated to be $1,868. On average residents use services twice per year (Productivity Commission, 2024), taking the annual cost of emergency accommodation services alone to an estimated $3,736. Total costs of homelessness services per year are therefore calculated to total $7,511.

An assumption of 54% impact was applied to the weighted value of this benefit to BHHP based on the proportion of exits from the program by 31 May who had a secure housing outcome (Launch Housing, 2024). For cost-saving calculations, the number of exits into stable housing was adopted for emergency accommodation services of 24%.

Avoided cost of justice services

The average avoided cost of justice contact for residents of homelessness services in Australia in 2013 was $2,397 (Zaretzky & Flatau, 2013), driven primarily by a decrease in the incidence of contact with police that resulted from being the victim of an assault or robbery, and a decrease in the average number of nights spent in prison. This is equivalent to $3,209 in 2024 dollars.

An assumption of 54% impact was applied to the weighted value of this benefit to BHHP based on the proportion of exits from the program by 31 May who had a secure housing outcome (Launch Housing, 2024). For cost-saving calculations, the number of exits into stable housing was adopted for emergency accommodation services of 24%.

Avoided cost of court proceeding

The average cost per criminal case disposed in Magistrate's Court in Victoria in 2022–23 was $1,728 (Court Services Victoria, 2023), equivalent to $1,801 in 2024 dollars. Combined with the cost of a Legal Aid lump sum general preparation fee (for a criminal matter in Magistrate's Court) of $684 (Victoria Legal Aid, 2024), the avoided cost of court proceeding is estimated to be $2,485.

An assumption of 54% impact was applied to the weighted value of this benefit to BHHP based on the proportion of exits from the program by 31 May who had a secure housing outcome (Launch Housing, 2024). For cost-saving calculations, the number of exits into stable housing was adopted for emergency accommodation services of 24%.

Increase in economic participation

The value of economic participation is estimated through an uplift in taxation receipts per person per year as a result of accessing homelessness services in Australia in 2013 (Zaretzky & Flatau, 2013).

An assumption of 10% of the housing improvement was then applied to a minimum wage value of $43,963 based on the average increase in employment as a result of resolving homelessness in Australia (Witte, 2017).

Community inclusion

The value of community inclusion is estimated through the value of a feeling of belonging to a neighbourhood (£3,753) (Housing Associations' Charitable Trust, 2014). Since this estimated value is based in pounds, this value was converted to AUD based on the average exchange rate of GBP to AUD in 2014 (RBA, 2024). After inflating this to 2024 dollars, the estimated value of community inclusion is $8,953.

A conservative assumption of 75% impact was applied to the weighted value of this benefit to BHHP based on statistically significant improvements to program participants' Personal Wellbeing Index measures of their satisfaction with feeling part of their community (SVHM, 2024b). This benefit only applies in the first year of benefits received, as it is a one-off measure of willingness to pay.

AOD management

Real QALY uplift from avoided homelessness is 0.13 and the percentage decrease in death over one year is 100% (Constellation Fund, 2024). When multiplied by the value of one QALY in 2023 ($235,000) (Office of Impact Analysis, 2023) and inflated to 2024 dollars, the economic value of AOD management per person per year is $31,835.

An assumption of 18% impact was applied to the weighted value of this benefit to BHHP based on the proportion of actively managed AOD health conditions between entry and exit of the program (SVHM, 2024b).

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