Social Policy and Research Centre

The Better Health and Housing Program

Evaluation

Tracey Pahor

2023

Brotherhood of St Laurence
Working for an Australia free of poverty

ST VINCENT'S HOSPITAL MELBOURNE

Launch HOUSING
IT'S TIME TO END HOMELESSNESS

The Brotherhood of St. Laurence (BSL) is a social justice organisation working alongside people experiencing disadvantage to address the fundamental causes of poverty in Australia. Our mission is to pursue lasting change, to create a more compassionate and just society where everyone can thrive. Our approach is informed directly by the people experiencing disadvantage and uses evidence drawn from our research, together with insights from our programs and services, to develop practical solutions that work. For more information visit <www.bsl.org.au>.

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 7000 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. For more information visit <https://www.svhm.org.au/>.

Launch Housing is a Melbourne-based, secular and independent community agency whose mission is to end homelessness. With a combined history of over 75 years serving Melbourne's community, we provide high quality and evidence-based housing, support, education and employment services to people across 15 sites in metropolitan Melbourne. We also drive social policy change, advocacy, research and innovation. For more information visit <http://www.launchhousing.org.au/>.

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Summary

The Better Health and Housing Program (BHHP) aims to support health, housing and wellbeing outcomes for individuals experiencing chronic homelessness and co-occurring health conditions by offering integrated health and housing support. Operated in collaboration between Launch Housing, St Vincent's Hospital Melbourne (SVHM) and the Brotherhood of St. Laurence (BSL), the BHHP commenced as a demonstration project in August 2022, providing up to a six-month residential stay as well as support from specialist staff from Launch Housing and SVHM. The initial capacity for 15 residents was increased to 20 residents in March 2023, and the program was still in operation as of August 2023.

This evaluation report intends to:

- document the extent to which housing, health and wellbeing outcomes for residents are realised
- contribute to the evidence base for future BHHP model development and interventions impacting on health and housing.

Three key evaluation questions are explored:

1. To what extent have intended health, housing and wellbeing outcomes been achieved by residents at the end of their stay at the BHHP and at the end of their post-stay support?
2. To what extent, and with what variation, have the principles of care been implemented through the way of working in the BHHP?
3. In what ways, and under what conditions, has the BHHP way of working contributed to realising intended health and housing outcomes for residents?

Data for the evaluation includes analysis of program data, resident interviews, staff interviews and staff workshops.

Residents with planned exits reported notable improvements in subjective wellbeing

Positive outcomes realised by residents

BHHP residents achieved positive outcomes during their time in the program.

- **Housing:** All residents with a planned exit attained stable accommodation (12 of 12 residents, 100%). This was an improvement from all residents experiencing homelessness at entry (12 of 12 residents, 100%).
- **Health:** All residents with planned exits left with one or more health condition that had either been resolved in the six months prior or was actively being managed (12 of 12 residents, 100%). This was an improvement from two out of three residents with a planned exit at entry (8 of 12 residents, 67%; p=0.05). Most of the residents with planned exits were able to access planned health care on exit (10 of 12 residents, 83%), an improvement from half of these residents at entry (6 of 12 residents, 50%; p=0.05). Most residents with planned exits were linked to a general practitioner (GP) on exit (10 of 12 residents, 83%), whether that was an individual GP or a community health service that included GPs. This was an improvement from entry (7 of 12 residents, 58%; p=0.08).
- **Wellbeing:** Residents with planned exits reported notable improvements in subjective wellbeing, measured using the Personal Wellbeing Index (PWI-A)(International Wellbeing Group 2013); this group's average score at entry was 44.6 out of 100 which rose significantly to 74 at exit (p=0.01), almost reaching the Australian mean score of 75.3 (International Wellbeing Group 2013).

All residents were experiencing homelessness with unmanaged health conditions. Therefore, these are notable, positive outcomes considering the significant challenges faced by people experiencing homelessness with compounding disadvantages.

Summary of program reach, length of stay and housing outcomes	
A total of **43 residents**, August 2022 to June 2023	
16 residents residing at the BHHP at the end of June 2023	
27 residents had exited by the end of June 2023	
Of the 27:	**Of the 27:**
12 residents had planned exits (44%) Average length of stay: 19 weeks Exited to: • community housing: 8 • public housing: 2 • health accommodation: 2. Have managed or resolved health conditions: 12 (100%) Able to access planned health care: 10 (83%) Have a GP: 10 (83%) PWI-A of 44.6 at entry and 74 at exit (data available for 10 of 12 residents; difference 29.4, p=0.01).	**15 residents had unplanned exits (56%)** Average length of stay: 12 weeks Exited to: • emergency accommodation: 5 • motel: 3 • sleeping rough or couch surfing: 3 • unknown: 4. Have managed or resolved health conditions: 8 (55%) Able to access planned health care: 7 (47%) Have a GP: 11 (73%).

A way of working that prioritised actionable goals and resident engagement

Partner organisations developed principles of care to guide an effective way of working that would support residents to achieve outcomes that matter to them. They included:

- purposeful partnerships
- a goal-directed approach
- person-centred care
- fostering autonomy.

Program staff prioritised actionable health and housing goals and resident engagement in their way of working. Actionable goals, which align with residents' interests, motivations and resource availability, were central to the program's effectiveness. Without resident engagement, staff could not effectively guide residents towards these goals while upholding the principles of care.

How closely the team's way of working reflected the principles of care varied with factors such as resource availability, resident engagement and the complexities of residents' individual circumstances. Program staff worked collectively across the housing and health partnership, and were informed by residents, to influence these factors and navigate other challenges.

Residents built engagement that enabled positive outcomes

Residents who participated in interviews described their experience in the program as being offered genuine opportunities and encouraged to make meaningful choices. Residents described the BHHP as a secure base and an encouraging social environment, with care that enabled them to engage in taking challenging steps towards their goals. They valued contributing to the BHHP community. Residents found this setting conducive to engagement and the program a catalyst for realising housing and health outcomes. Program staff could draw on their engagement with residents to tailor care for individuals and inform decisions about day-to-day service operations.

Staff resourcing, program duration and access to services and other resources were important conditions for success

The availability of expert staff, the program's six-month duration, and access to services and other resources from the housing and health systems are distinctive, and key elements of the program design. These elements were the conditions essential in enabling timely, flexible and effective support for residents to progress towards positive outcomes. The conditions for program success were delivered through the health and housing partnership.

Future opportunities

As the evaluation was conducted during the initial year of this demonstration project, it is important to interpret results within this context. Nonetheless, the report provides valuable insights for stakeholders, service providers and policymakers intending to further develop the BHHP model. Learnings from the evaluation can also contribute to evidence on ways to achieve improved health and housing outcomes for people experiencing chronic homelessness with co-occurring health conditions. There is considerable value in the BHHP's novel integrated service approach and the way it supports resident engagement with services and progress towards goals. The evaluation highlights five key future opportunities for the BHHP:

1. **Integrate health and housing responses:** Continue to provide and develop a residential integrated health and housing program to people experiencing chronic homelessness and co-occurring health conditions.
2. **Centre resident engagement in service delivery and development:** Ensure that engagement between residents and program staff remains at the centre of the service to enable residents to develop actionable goals and take the steps to realise them.
3. **Provide residents with time and support:** Enhance the capacity of the program team to provide each resident with the time and support they need to develop actionable goals and take the steps to realise them.
4. **Offer genuine opportunities to residents:** Continue to provide a secure base, encouraging a social environment and enabling care to promote resident engagement. This will offer opportunities and encourage choices that are meaningful to residents.
5. **Use partnership as the foundation:** Maintain the partnership model as the foundation of the approach and build further partnerships to extend the collective expertise of the staff team and the service's capacity to broker access to services and resources, bridging service gaps for residents beyond the health and housing sectors. For residents to have access to responsive and flexible alcohol and other drug services, targeted relationships may be required. Having a strong relationship with the Aboriginal Hospital Liaison Officers within the health service was important for the BHHP but may not be able to be assumed in all health services, so partnerships with Aboriginal and Torres Strait Islander-led services will be important for scaling-up new sites.

There is considerable value in the BHHP's novel integrated service approach and the way it supports resident engagement with services and progress towards goals.

1 Introduction

Why do we need a better health and housing program?

The link between health and housing is clear in the case of poor health and homelessness. People who have experienced homelessness are at an increased risk of premature death (Seastres et al. 2020; Zordan et al. 2023), largely from conditions that can be addressed with appropriate and timely health care (Aldridge 2019). Australian data has shown that an increased risk of premature death persists even for those people who experience a brief period of homelessness, and is elevated for those at risk of homelessness compared with people who have stable housing (Zordan 2023). Consistent with this, Launch Housing recorded 47 known deaths among clients of its homelessness services in the 12 months to June 2019, with a median age of 42 years old and over three-quarters reporting a mental illness (Howard et al. 2022). Providing service responses that improve outcomes for a cohort with persistent unmet health and housing needs is a human rights consideration (Clifford et al. 2022).

In addition, homelessness has a compounding negative effect on primary healthcare access, pushing people into the acute health system (Davies & Wood 2018). This is evident in the significant overlap in the people accessing both Launch Housing services and the health service at St Vincent's Hospital Melbourne (SVHM) (Howard et al. 2022). People with a history of homelessness are among those patients considered 'at risk' for multiple presentations to the SVHM emergency department or longer stays once admitted. This cohort are also most likely to belong to two or three of four risk groups: 'Aboriginal and Torres Strait Islander people; people diagnosed with a mental illness; [and] people with a history of alcohol and other drug (AOD) use disorder or dependence' (St Vincent's Health Australia 2021). These patterns observed by Launch Housing and SVHM are repeated in national data. Among those accessing specialist homelessness services (SHS) in Australia in 2021–22, 28% of all clients were Aboriginal and Torres Strait Islander people and 31% of clients had a current mental health issue (AIHW 2022).

Improving health outcomes for people experiencing homelessness in Australia will require effective action in mainstream health services and targeted service provision (Davies & Wood 2018; Clifford et al. 2022). Integrated service responses that can provide access to housing and health care for people experiencing homelessness have the potential to offer a way forward (National Institute for Health Care Excellence 2022; Clifford et al. 2022). However, there are challenges in integrating services and systems as this requires intentional commitment and is not easy to achieve (RACP 2018).

Medical respite centres are an example of an integrated health and housing initiative, providing a place to stay along with support to manage health and find stable housing. Residents of medical respite centres, such as the Medical Respite Centre established 2021 by Homeless Healthcare in Perth and the Boston Health Care for the Homeless Program (USA) centre on which it is based, are referred into the centre after a hospital stay instead of being discharged to homelessness. Medical respite centres provide medical care during a short stay. The programs also include non-medical beds sometimes known as a 'step-down' service. Even in a short stay, these medical respite services seek to provide a safe and supportive stay and to facilitate referrals to housing and health services. At the Homeless Healthcare Medical Respite Centre in Perth, two in five residents were discharged from the medical respite beds directly into housing (Wood, Vallesi & Tuson 2023). The centre also provides community-based health care in Perth, with two-thirds of medical respite residents continuing to see these services post-stay (Wood, Vallesi & Tuson 2023). The Boston Health Care for the Homeless Program also facilitates referrals to long-term housing and provides outreach and in-reach health services for people experiencing homelessness.

SVHM has operated a short-stay medical respite service, The Cottage, for people experiencing or at risk of homelessness, since 1995. The average stay in 2015 was nine days (Nolan 2020). This service works alongside the assessment, liaison and early referral team for people experiencing homelessness and other hospital services to provide continuity of care within the health system and referrals to housing, but the model does not include integrated access to housing (Wood et al. 2017). SVHM reports that their staff, residents of The Cottage and external stakeholders have repeatedly raised concerns regarding housing options for discharge, but such a critical issue has been beyond the hospital's remit to address alone (Nolan 2020).

The arrival of the COVID-19 pandemic brought a new urgency for effective service responses in health and homelessness. SVHM partnered with Launch Housing and the Brotherhood of St. Laurence (BSL) to provide a 40-bed COVID Isolation and Recovery Facility (CIRF) for people experiencing homelessness in 2020. During periods of lower COVID-specific demand in 2020–21, the partners worked together to develop a distinctive integrated health and housing service. This would provide support for people experiencing homelessness with co-occurring health conditions who would face barriers to meeting their health needs in the hotel accommodation made available at the time. The value of such a distinctive integrated service was established and plans were developed for a demonstration project.

The Better Health and Housing Program

Building on the collaborative development of the CIRF, Launch Housing, SVHM and BSL formed a consortium to deliver an integrated residential-based service together – the Better Health and Housing Program (BHHP). Funded as a demonstration project by Homes Victoria, the BHHP commenced in mid-August 2022 with 15 beds for men only and scaled up in March 2023 to add five beds for women. A total of 43 residents had entered the program to the end of June 2023 – the period covered in this evaluation. The program is still in operation at the time of writing in August 2023.

The program intends to support residents to realise outcomes of stable housing, manage health and improve wellbeing. Residents can stay up to six months and have the option of receiving post-stay support from their BHHP care coordinator for up to six months after they transition out of the residential program. Residents pay a service fee of 25% of their income – comparable to rent for social housing – which contributes to flexible funding and brokerage that can be used to support their exit pathways. During their stay, residents are supported by a care team of program staff from the housing and health services to develop and work on a care plan based on their goals. Launch Housing provides 24-hour staff coverage, including support workers, while SVHM employs care coordinators and lived-experience workers (peer workers) who work business hours, seven days per week. Each organisation also employs a team leader and a manager.

The site is a former residential aged care unit owned and maintained by BSL, a block away from the main campus of SVHM. Residents have ensuite rooms with basic kitchenette facilities. Meals, internet and Netflix are provided. There are also common spaces, with an open-plan lounge-dining room and an outdoor courtyard. Staff provide access to the building and residents have keys to their rooms. There is a curfew and there are rules against AOD onsite. There is a program of optional wellbeing activities, including a weekly BBQ that is also open to former residents.

The model of care was developed by Launch Housing and SVHM, with input from BSL and Homes Victoria. As a new demonstration program in an early pilot phase, the consortium expected the BHHP model to be further refined during implementation. Governance is provided by a group with a representative of each of the three consortium members – Launch Housing, SVHM and BSL – and regular meetings are held with the funder.

The evaluation

Roles

The evaluation was funded as part of the demonstration project by Homes Victoria and commissioned by the consortium members: Launch Housing, SVHM and BSL. The evaluation was conducted by the BSL Monitoring and Evaluation team, and BSL acted as the sponsor with the consortium members entering a Research Collaboration Agreement. Governance approval was provided by SVHM.

The ethical aspects of this research project were approved by the Human Research Ethics Committee of SVHM, application reference HREC 168/22.

A steering committee representing the consortium members and the funder was convened to facilitate the collaboration necessary to undertake the evaluation project.

Purpose

The evaluation aims to document the extent to which outcomes for residents have been realised, and to contribute to the evidence base for program development and similar interventions that address health and housing outcomes. Situated within the broader framework of monitoring and evaluation activities conducted by Launch Housing and SVHM, the evaluation intends to support model development.

Approach and scope

This evaluation, conducted by BSL, focuses on resident outcomes and program activities, giving particular attention to the way of working. A principles-focused approach was used for the evaluation due to its suitability for assessing evolving interventions such as the BHHP. Principles-focused evaluation makes evaluative judgements based on 'effectiveness principles – how to work to get the desired results', particularly when you need 'rudders for navigating complex dynamic systems' (Patton 2017). This enables examination of how the program can achieve desired outcomes in dynamic and complex contexts. As the program is still in its early stages and subject to ongoing development, evaluating the program through key principles helps to understand if and how the way of working can translate into real-world outcomes.

The BHHP partners agreed on a set of principles to guide the work, which provided the flexible program logic for evaluating the way of working and its contribution to resident outcomes. The evaluation focuses on the four principles with the most bearing on day-to-day practice:

- purposeful partnerships
- a goal-directed approach
- person-centred care
- fostering autonomy.

A resident outcomes framework was developed by the partners. The outcomes to be measured at exit of better managed health, stable housing and improved wellbeing were in scope for this evaluation. Longer-term outcomes were identified in reduced emergency department presentations and sustained housing. These outcomes were out of scope for this evaluation project as it is anticipated that it would be possible to measure outcomes that could provide an informed assessment of impact and economic analysis at two years post-stay.

Key evaluation questions

This evaluation answers three key evaluation questions (KEQs):

1. To what extent have intended health, housing and wellbeing outcomes been achieved by residents at the end of their stay at the BHHP and at the end of their post-stay support?
2. To what extent, and with what variation, have the principles of care been implemented through the way of working in the BHHP?
3. In what ways, and under what conditions, has the BHHP way of working contributed to realising intended health and housing outcomes for residents?

Activities

The evaluation data collection integrated program administrative data, interviews with residents (6 interviews) and program staff (11 interviews), and two collaborative sense-making workshops with BHHP staff.

Program data collected during service delivery was used in the evaluation for counts of demographics, other characteristics of the resident cohort and resident outcomes. The BHHP measurement, evaluation and learning framework was used to identify the data to be included in the evaluation. Using data collected through service delivery allowed for good coverage without duplication of effort.

Interviews conducted by the evaluator provided accounts of the program from the perspective of residents and program staff, including illustrative examples of BHHP implementation.[1] Interview schedules and analysis were structured around the principles of care. Residents and program staff only participated in an interview if they gave informed consent. Overall, there was good coverage of the different staff roles across the two organisations but only a small proportion of residents participated in interviews.

The two evaluator-facilitated workshops with partner staff were also organised around the principles of care and provided information on program implementation. It is important to note that these workshops did not include any residents and only limited program data for a small cohort was available at the time of the workshops as they were held part-way through data collection for the evaluation. The workshops were used to inform how outcomes were reported and contributed to the analysis of the way of working. The results also supplemented the aggregated program data and contributed to sense-making. The de-identified notes were collated by the evaluator and returned to the program team to follow-up on any identified actions. Program staff said that they continued to reflect on and build their practice after conversations in the workshops.

In this report, all resident names and some details have been changed to protect privacy.

Limitations

This report provides valuable learnings and identifies opportunities for the future of the BHHP and similar programs. However, care should be exercised in interpreting the results due to the program's early stage and limitations in the evaluation methodology.

The early stage of the program limits the depth of outcome analysis. Interim results provide initial insights but longer-term outcomes are yet to be fully realised. Future evaluations could use linked administrative data to measure the longer-term impact on residents.

Residents and program staff who chose to participate in an interview may not be representative of the broader group. In particular, the exclusion of residents unable to give informed consent for interviews and the small number of residents who chose to participate in interviews may affect the representativeness of findings. Supported consent, proxy interviews and co-designing data collection activities with residents could result in more inclusive methods and better representation.

Although early program data collected by staff was presented at sense-making workshops, the timing and absence of resident or other stakeholder input in the workshops limits the extent to which the workshops provide a check on data quality and contribute to triangulating claims of the BHHP's contribution to resident outcomes. Recommendation-building workshops or other processes were also absent from the evaluation design. Hearing from staff, residents and other stakeholders in any future sense-making and recommendation-building processes would offer more rigorous findings and future directions.

This report provides valuable learnings and identifies opportunities for the future of the BHHP and similar programs.

1 Program staff were able to participate during paid work time and residents were provided with a 'thank you' of an eftpos voucher. Residents had the option of bringing a support person to interviews, although no residents took this option.

2 The BHHP residents

The BHHP aims to reach people experiencing a cycle of chronic homelessness and co-occurring health conditions and support them to achieve positive housing, health and wellbeing outcomes. People experiencing homelessness live with stigma and discrimination, and face barriers to accessing health care. Overriding negative narratives presents a challenge for engaging with this cohort.

This section reports the characteristics and prior experiences of the residents. Information was gathered in the program's first 10 months of operation.

Program reach

Since its establishment in August 2022, the BHHP has seen a total of 43 residents enter the program, with 27 exiting and 16 remaining by the end of June 2023. The program initially opened with a capacity to accommodate 15 residents in August 2022 and capacity was increased to 20 residents in March 2023. It is important to note that the relatively small size of the resident group was a distinctive aspect of the program, which was highlighted by both interviewed residents and program staff. As a resident described:

> ***I used to stay at [another service] when it was there ... it was 60 or 70-bedder, so it was a bit more hectic than here with 15 people.***

Referring services

Any service can refer to the BHHP, and the referring services for the BHHP residents to end of June 2023 were mostly split between hospital, community health and homelessness services. Hospital-based health services referred nearly half of residents (21 residents, 49%). Community-based health services referred nearly a third of residents (13 residents, 30%). Services with SHS funding referred nearly one out of five residents (8 residents, 19%). One resident was referred by another community service (1 resident, 2%).

Figure 2.1 Referring services

Referring service	Residents (%)
Community-based health	13 (30%)
Hospital-based health	21 (49%)
Housing or homelessness	8 (19%)
Other community service	1 (2%)
Total residents	**43 (100%)**

Residents did not independently self-refer, but residents and program staff who participated in interviews reported that there had been cases of people experiencing homelessness seeking a referral after hearing from residents about the value they were finding in the program. The interest from a range of services and prospective residents suggests that the BHHP has been perceived as valuable and distinct in the service landscape.

Program eligibility

The program's eligibility criteria were designed as a matrix aiming to prioritise individuals who shared characteristics commonly associated with experiencing chronic homelessness and co-occurring health conditions. Some criteria include:

- initially men over 40 years of age, and subsequently women when capacity allows
- people experiencing chronic homelessness including rough sleeping and staying in emergency or temporary accommodation
- people eligible for social security payments
- people of Aboriginal and/or Torres Strait Islander descent
- people experiencing physical or mental health issues that are preventing them from thriving in unsupported accommodation and this health issue is able to be addressed during their stay.

- It was also noted that men between 40 and 49 years are shown to be disproportionally represented in SVHM emergency department presentations and a majority of all emergency presentations by people experiencing homelessness at SVHM are male (St Vincent's Health Australia 2021).

The program's prioritisation recognised the overrepresentation of First Nations Australians among people experiencing homelessness and health disparities affecting them (AIHW 2022; Productivity Commission 2023; St Vincent's Health Australia 2021). Accordingly, priority was given to Aboriginal and Torres Strait Islander people below the age of 40. The program also placed emphasis on accessibility for this community with active involvement of SVHM Aboriginal Hospital Liaison Officers in service delivery.

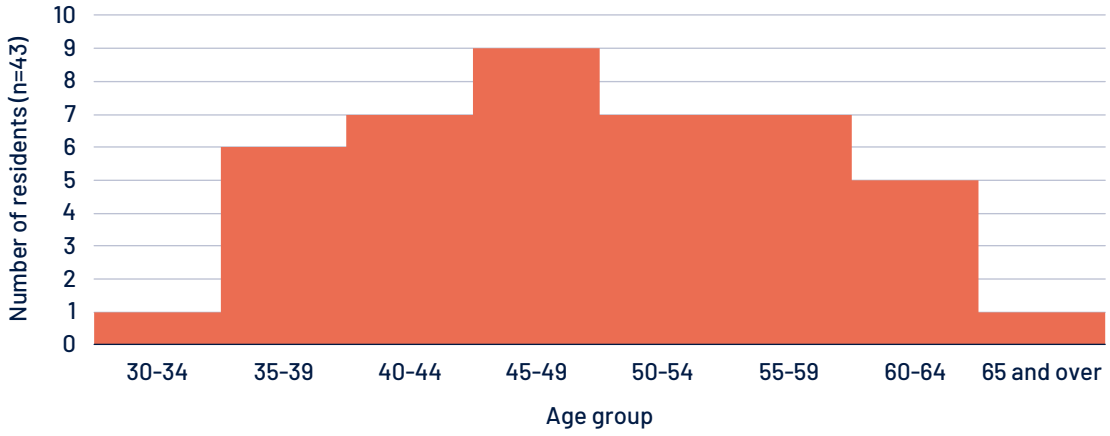
The eligibility criteria also considered who the BHHP team could safely and effectively support with the available staffing resources. The program aims to prioritise those most in need and those for whom the program was expected to have positive outcomes. Over time, the program team have refined the referral, assessment and intake processes to provide the best experience for referred people and to offer spaces to residents more likely to thrive in the program.

Characteristics of residents

Initially, the program only accepted men as residents. Consistent with this, since August 2022, 37 of the 43 residents (86%) have been men. Women have been accepted into the program since March 2023 and were allocated a separate floor for privacy and safety. In an interview, a male resident identified that it was important for the program to accept women to give them the opportunity to also benefit from participation. The small cohort of six women, three of whom had exited by June 2023, limits our ability to draw conclusions about their specific outcomes and experiences. No residents were identified as non-binary, or with any gender labels other than male or female, in the program data. It is noted that the program actively promoted inclusion through the display of posters and by encouraging an accepting atmosphere for diverse gender expression and self-presentation.

The program has been specifically tailored for individuals aged 30 years and above, with a particular focus on those aged 40 years and older. The 45–49 age group had the highest frequency among residents, with residents predominately between 35 and 64 years (Figure 2.2).

Figure 2.2 The age distribution of residents



Priority has been given to Aboriginal and Torres Strait Islander people, and one in five residents identified as Aboriginal or Torres Strait Islander (9 residents, 21%). This indicates the program did reach Aboriginal and Torres Strait Islander people as a priority group.

English is the primary language used in the program. Two residents had spoken a language other than English at home (5%), and one of these residents required an interpreter. Program staff acknowledged the presence of residents with additional language skills and observed the positive impact of opportunities for residents to communicate with each other in their shared languages. Program staff also recognised the importance of using spoken communication to support any lower literacy rates among residents.

Although residents are assisted to address payment-related issues, and exceptions could be granted, eligibility for social security payments is included in the criteria for program entry. Most residents (39 residents, at least 91%) already had a stable source of income, primarily from social security payments such as the Disability Support Pension (DSP) (21 residents, 49%) and JobSeeker Payment (17 residents, 40%). This income served as an indicator of eligibility for other government-funded social services such as Medicare and social housing. Having a stable source of income has meant residents have been able to maintain a stable tenancy and access necessary health care and housing support when they exited the program. The program's alignment with eligibility criteria for social security payments enables the program to support residents' access to the broader health and housing systems.

The program seeks to serve individuals who had experienced a cycle of homelessness and co-occurring health conditions that could be managed within a residential program. All residents had at least one unmanaged health condition identified at entry, with most residents having chronic conditions (42 residents, 98%). Either at entry or during their stay, a majority of residents were identified as having substance use (33 residents, 77%) or mental health conditions (30 residents, 70%) and all residents were identified as having a physical condition (43 residents, 100%). Half of the residents (23 residents, 51%) had tri-morbidity with mental health, substance dependency and physical health conditions at program entry.

All 43 residents were experiencing homelessness at entry, and it was most common for residents to be sleeping rough or couch surfing (19 residents, 44%), followed by staying in a health service (e.g. a hospital or rehabilitation service) (11 residents, 26%) and thirdly, in temporary homelessness accommodation (10 residents, 23%)[2]. One of the residents staying in a health service was transitioning out of prison. Nearly half of the residents had been experiencing homelessness on and off for over five years (20 residents, 47%) and most of the remaining residents had been experiencing homelessness for between one and five years (19 residents, 44%).

All residents had at least one unmanaged health condition identified at entry, with most residents having chronic conditions (42 residents, 98%).

2 Residents in temporary homelessness accommodation were in emergency accommodation (7 residents, 16% of all residents), a motel (2 residents, 5%) or transitional housing (1 resident, 2%).

Figure 2.3 Overview of resident characteristics

Resident characteristics		Count (%)
Gender	Male	37 (86%)
	Female	6 (14%)
Identifying as Aboriginal or Torres Strait Islander	An Aboriginal or Torres Strait Islander person	9 (21%)
	Neither Aboriginal nor Torres Strait Islander	34 (79%)
Language	Languages other than English spoken at home	2 (5%)
	Uses an interpreter	1 (2%)
Main source of income at entry	JobSeeker Payment	17 (40%)
	Disability Support Pension	21 (49%)
	Other income	1 (2%)
	Nil income	2 (5%)
	Unknown	2 (5%)
Health conditions identified at entry	Unmanaged health conditions	43 (100%)
	Acute unmanaged health conditions	4 (9%)
	Chronic unmanaged health conditions	42 (98%)
	Substance use condition	33 (77%)
	Mental health condition	30 (70%)
	Physical health condition	43 (100%)
	Tri-morbidity (substance use, mental health & physical health)	23 (53%)
Housing situation at entry	Sleeping rough or couch surfing	19 (44%)
	Boarding/rooming house	1 (2%)
	Emergency accommodation	7 (16%)
	Motel	2 (5%)
	Transitional housing	1 (2%)
	Health service	11 (26%)
	Other renter, not otherwise specified	1 (2%)
	Unknown	1 (2%)
Duration of homelessness	Over 5 years	20 (47%)
	1–5 years	19 (44%)
	6 months to 1 year	1 (2%)
	Under 6 months	3 (7%)
	Not homeless	0 (0%)

Residents had low wellbeing at entry. Measuring satisfaction with life across wellbeing domains, the average Personal Wellbeing Index – Adult (PWI-A)(International Wellbeing Group 2013) score at entry was only 38.8 out of 100 (available for 35 of 43 residents). This indicates much lower wellbeing than the Australian population, for which the normative score is 75.3 (International Wellbeing Group 2013).

Residents' experiences of homelessness, poor health and services

The program data above excludes residents' experiences of health challenges, insecure housing and traumatic events. Through interviews and accounts by program staff, residents shared their experiences of homelessness and poor health. These accounts illustrate barriers residents face to achieving stable housing, well-managed health and wellbeing. Residents' experiences provide important context for understanding resident outcomes and the contribution of the BHHP towards them.

Homelessness exacerbates health and safety issues

In interviews, BHHP residents highlighted the interconnections between homelessness and poor health and the diverse life circumstances that can initiate and aggravate these issues. Many of the residents have described how homelessness exacerbated existing health conditions and contributed to a downward spiral in overall wellbeing. For example, one resident recounted suffering an assault while sleeping rough, leading to hospitalisation and seizures after being discharged back into homelessness:

> ***I basically got assaulted in the city and ended up in hospital and I was almost paralysed, couldn't walk for a while and had seizures that I never had before. … [After leaving hospital], lightning strikes twice – I had another seizure. Ended up in hospital.***

Another resident faced similar challenges managing an injury that had deteriorated during their time of homelessness, which resulted in repeated hospital stays. One resident emphasised the importance of the program accepting women, describing distinct experiences of assaults and the profound challenges women face while homeless. Moreover, interviewees noted that an experience of family or domestic violence had led to homelessness for some residents.[3]

Homelessness itself can act as a direct impediment to receiving care – for example, stable accommodation is a prerequisite for receiving treatment of hepatitis C. As one staff member explained:

> ***[A resident] was on the waitlist to get Hep C treatment, but then the GP had said that once you get into housing, I mean a stable accommodation, then we can start the treatment, which they started eventually when [they] got here.***

Difficulty accessing healthcare services contributes to health inequity

BHHP residents interviewed emphasised the direct impact of health conditions on their housing insecurity. For example, one resident identified work restrictions imposed by a health practitioner as a key factor in the resident's homelessness. When it was identified work activities may have been exacerbating a life-threatening condition, the practitioner reportedly liaised with the employer to force the resident to give up their job. This was not the medical care the resident was hoping to receive. It resulted in the resident losing a job that provided meaning as well as their income. In cases like this, being unable to work due to health issues can lead to a loss of income, eviction and homelessness.

A staff member also described ineffective communication from health providers based on discriminatory attitudes, such as attributing a patient's homelessness status as a reason for the health provider not making contact, which hindered access to necessary care. According to program staff, one resident had been requesting mental health care through emergency departments for an extended period but was unable to be assessed until joining the program.

The compounding nature of barriers was explained by a staff member:

> ***It's almost impossible to navigate health and housing services … especially if you've got complex mental health and addiction issues.***

3 Adults accessing SHS who have experienced family and domestic violence are predominately women. In 2021–22, 89% of Australian SHS clients 18 years and older were women (AIHW 2022).

Repeated experiences of barriers may influence future engagement

Most residents interviewed expressed fatigue from repeatedly encountering barriers. As one resident explained:

> ***I've been on and off the streets half my life ... Being on and off the streets wears most people down.***

The scarcity of crisis and longer-term accommodation options increases the difficulties experienced by people seeking stable housing. SHS in Victoria received an average of 41.7 unassisted requests per day for emergency accommodation in 2021–22, underscoring the limited availability of resources (AIHW 2022). However, these figures are expected to exclude people who do not seek temporary accommodation because they think it will not be helpful. In interviews, some residents shared their experiences in crisis accommodation services, describing feelings of unease due to a lack of privacy and a chaotic environment where individuals often lacked necessary provisions, leading to increased tension. Residents shared stories either about temporary sites or services that have since been redeveloped. One resident also expressed a desire to avoid rooming house accommodation, due to the unfavourable environment, which they described as the only accommodation offered by homelessness services. While hospitals were described as an escape from the streets, they were also considered stressful environments only providing a temporary stay and lacking a homely atmosphere. One resident explained that, for them, returning to an AOD rehabilitation service where they had to put all other options on hold and comply with strict monitoring requirements was a difficult commitment to make without being in a program that aligned with their interests.

Beyond the challenges recalling and identifying relevant information a person with significant health conditions can face, repeatedly encountering barriers to services and resources can affect trust and impact engagement with services. Care coordinators noted that at times, residents would not freely share information with health providers that the coordinators thought was relevant. Program staff from both SVHM and Launch Housing also noted that residents may not seek out help for conditions or in situations for which staff thought help was warranted.

Barriers to the social service system compounded challenges faced by residents. Program staff have identified that requirements for receiving social security payments were difficult and sometimes unexpected. In one case, a resident was required to prove they had been residing in Australia but for them, identifying and obtaining this kind of evidence was almost impossible due to their long-term unstable housing situation. One resident interviewee had given up on trying to access payments before coming to the BHHP. They described being directed by Centrelink staff to apply for payments using a computer. Living with cognitive condition and not knowing how to use a computer, the resident felt unable to apply for payments in that setting. According to this resident, inaccessible systems such as this are 'broken'.

When dealing with referrals, program staff considered that prospective residents would have encountered repeated access barriers to services and resources. Program staff also understood that residents' expectations of the BHHP may have been shaped by poor experiences, breaking trust in the value of engaging or seeking help. To reduce barriers, staff have adopted flexible and responsive approaches to resident needs.

3 Resident outcomes

KEQ 1: To what extent have intended health, housing and wellbeing outcomes been achieved by residents at the end of their stay at the BHHP and at the end of their post-stay support?

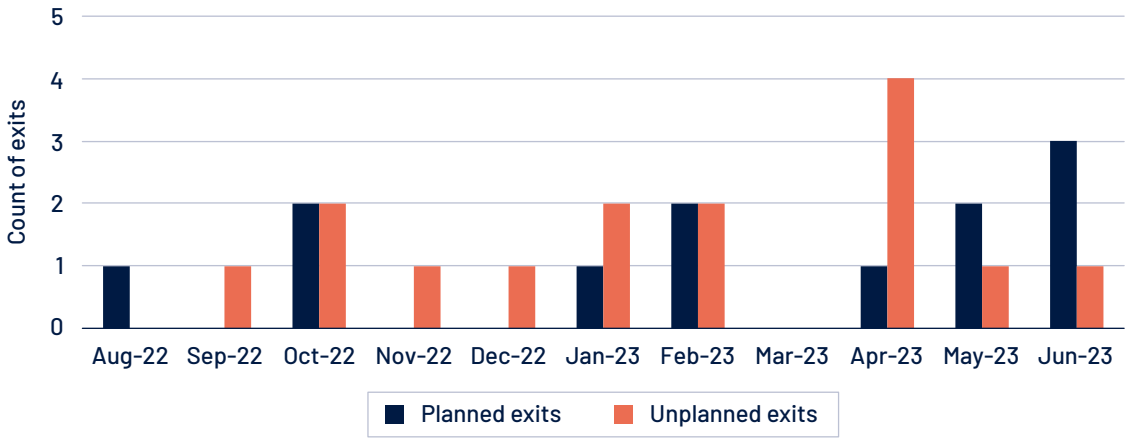
Residents of the BHHP realised notable, positive changes in their housing and management of their health and wellbeing. Residents with a planned exit saw the strongest outcomes, however, important steps towards outcomes were achieved by residents with unplanned exits. This section documents resident outcomes, differentiating between the outcomes for residents with planned and unplanned exits.

At the end of June 2023, 27 residents had exited the BHHP with an average stay of 15 weeks, with seven residents completing the post-exit support. The program aims to support all residents to achieve stable housing and better health outcomes, acknowledging that individual journeys may not be linear. Of the 27 of residents, 12 (44%) had planned exits, averaging 19 weeks of stay. All seven of the residents who completed post-exit support had planned exits.

The remaining 15 residents (56%) had unplanned (involuntary) exits after breaches of the resident agreement. The program initiated involuntarily exits when residents repeatedly breached the resident agreement, although only after residents were offered support and provided with repeated notices of concern. These breaches typically involved repeated violations of house rules related to violent behaviour, aggression or substance use. Unplanned exits also occurred due to the resident not engaging with the program for an extended period of time in situations that included the extended non-payment of rent or the resident abandoning their room.[4] Despite these 15 residents having a shorter average stay of 12 weeks, this average length of stay indicates that residents with unplanned exits still engaged with elements of the program and made progress towards improving their health and housing situations.

As the program matured, a greater proportion of residents had planned exits (Figure 3.1). In the last two months of the evaluation period (June to July 2023), five residents had planned exits and only two residents had unplanned exits. This contrasts favourably with the nine months prior (August 2022 to May 2023), during which seven residents had planned exits and 13 residents had unplanned exits. Given the average stay for current residents at the end of June 2023 was 14 weeks,

Figure 3.1 Residents with planned and unplanned exits over time



4 The resident agreement includes participation required such as attending regular care team meetings but program staff did not issue breach notices when residents did not meet these requirements.

it is evident that many more residents were on track for planned exits. This shift aligns with the program and governance teams' investment in refining the implementation of the program eligibility criteria, the resident selection process and service delivery.

Housing outcomes: stable housing

A transition into stable housing is an intended outcome for all residents in the BHHP. Independent housing that is affordable and had secure tenure is expected to be realised through a social housing tenancy. Launch Housing program staff aim to assist residents to submit or update their Victorian Housing Register (VHR) application as soon as possible and have advocated for expedited processing or for applications to be backdated where appropriate.[5] Long or medium-term accommodation with supports, such as that delivered by health providers, was considered a stable housing outcome if this was a good fit for the resident and consistent with their care plan. Stable housing was expected to provide residents with a safe and secure place to live, making it easier for them to manage their health and enjoy wellbeing.

In addition to the program enabling residents to undertake VHR processes, program staff proactively encouraged residents to consider options that would be a good fit for them. Residents looking for social housing have been encouraged to consider community housing in addition to public housing and a wider range of geographic areas to increase the likelihood of a timely offer. Launch Housing staff hold relationships with community housing providers, which gives access to information about vacancies. The housing staff have actively supported residents to visit prospective areas and properties, fostering familiarity with these locations and the public transport connections back to the BHHP.

In situations where program staff have raised concerns about the suitability of independent housing for residents with an identified cognitive impairment, program staff have worked closely with the residents to explore solutions that aligned with their needs and preferences. This included considering community housing options with onsite support as an intermediate step and, in some cases, encouraging residents to explore residential aged care.

Transition into stable housing

A transition to stable housing at the conclusion of the residential stay has been achieved by the 12 residents (44%) who had a planned exit from the program. Most of these residents successfully secured community housing (8 residents) while a small number have been allocated public housing (2 residents) (Figure 3.2). There were also two residents who moved into health service accommodation, for instance a residential rehabilitation or mental health program, or palliative care. Of the two residents who secured public housing, one had been on the waiting list for four or five years. The resident was supported to update their application and received a public housing offer within two months. All seven of the residents with a planned exit who participated in post-stay support transitioned into stable housing and maintained this accommodation at their discharge from post-stay support.

Residents who participated in interviews all held the goal of moving into 'their own' independent and affordable housing. Program staff who participated in interviews also noted that this was a goal residents generally had in common. Themes seen in the reasons given by resident interviewees for the importance of having their own place include enabling independence, fostering social connections, and providing support to friends and family. See Box 3.1 for an example of a resident's interest in securing affordable housing to be able to connect with friends and family.

5 Social housing applicants in Victoria for both public and community housing must be on the VHR. This paperwork can be completed or updated by housing staff with the resident and submitted to the government department (Homes Victoria). People experiencing homelessness are eligible for faster allocation through the priority list for social housing but still must wait for their applications to be approved before joining the waiting list to potentially receive an offer of housing. Program staff reported they observed the processing and approval time to be three to four months in 2022. The target waiting time for those with priority access approval is 10.5 months but the average waiting time in 2022–23 was 16.5 months (Department of Treasury and Finance 2023).

BOX 3.1 What an outcome of stable housing would mean to Adam*

Adam hopes that coming to the BHHP means his long stretch of homelessness is over. He had a break from sleeping rough for a couple of years when he was able to stay with a friend, but that had ended more than a year ago. Since then Adam sometimes stayed in crisis accommodation or couched surfed for the odd night with other friends, and otherwise usually slept rough.

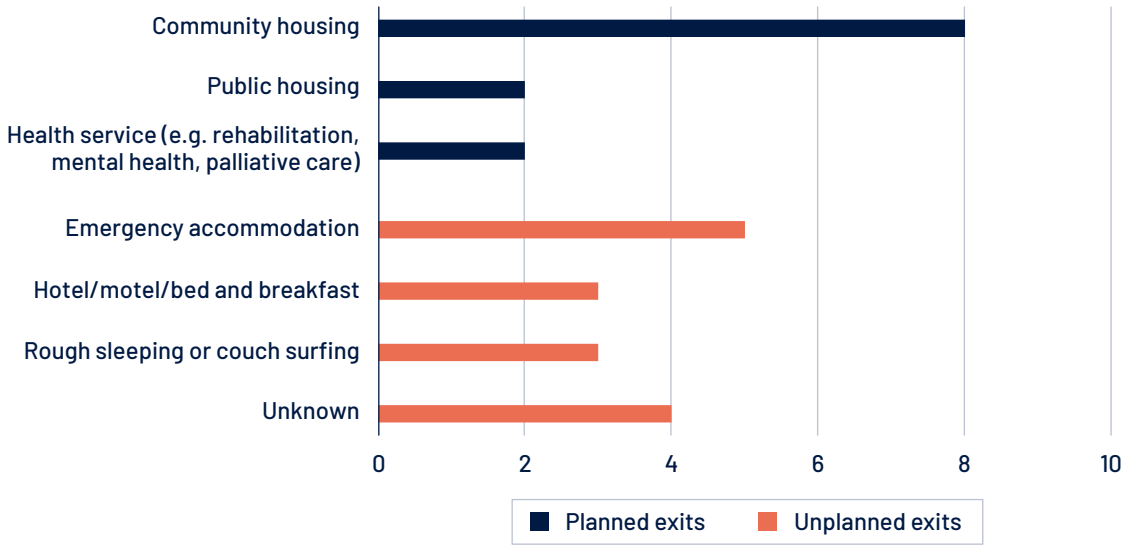
Adam's first priority in finding a place to live is for it to be affordable. He knows that he wants to be able to keep living there, and that will not be possible if it is outside his budget. He would prefer to go back to an area he has lived in before. It would be familiar, and he would know how to get from there to see friends and family. Adam also hopes he can get a two-bedroom home. With two bedrooms, the friend that Adam stayed with earlier could have a home again too.

Wherever Adam ends up making his home, he has set his goals to make sure it's a good fit. He hopes having a stable home will make it easier to stay in touch with friends and family.

* All resident names and some details have been changed throughout the report to protect privacy.

The pattern of change in housing between entry and exit of the 15 residents who had unplanned exits was less clear than the pattern for those with planned exits. All 15 residents with unplanned exits had returned to some form of homelessness but some residents transitioned from sleeping rough or hospital care to receiving some housing support in the form of emergency accommodation or a motel stay. While three residents had made unplanned exits to sleeping rough or couch surfing and the housing at exit for four residents was unknown, over half of the residents (8) exited to emergency accommodation or a motel stay (Figure 3.2).

Figure 3.2 Housing at exit for residents with planned or unplanned exits (note: all residents were experiencing homelessness)



While this evaluation cannot definitively claim sustained changes in housing trajectory for these residents, there are some indications of positive outcomes. For instance, two residents who were sleeping rough before joining the program exited into emergency accommodation. Notably, according to the information provided at entry these individuals had not accessed emergency accommodation in the year prior to entering the program, which suggests increased engagement with homelessness services and a potential step forward in their journey through the housing system. Additionally, two other residents who exited to emergency accommodation had transitioned from hospital stays.

This suggests that the initial support provided by the BHHP may have facilitated a transition from hospital care to emergency accommodation for these residents. The housing outcomes for residents with unplanned exits indicates the program's potential in serving as a valuable step out of sleeping rough or a step-down option from hospital settings.

Housing applications

Program staff reported that the program had contributed to enabling residents to complete the VHR application process. It is important to note here is that this was a new and significant step towards realising housing for some residents who were eligible for the VHR and had been offered support previously. Residents already on the VHR were supported to update their details. An example of one resident who submitted a VHR application during their stay at the BHHP is shared in Box 3.2. For residents who did not have a planned exit into stable housing, if they consented and participated in completing or updating an application, their waiting list progress will continue.

Health outcomes: better managed health

The program intends for residents to better manage their health, including shifting reliance from emergency services to planned health care, accessing primary health care through a GP[6] and the effective use of medications.

Through discussions with residents and facilitating appropriate assessments, the program supports residents to identify and address health issues that impact their lives. The care coordinators work closely with residents to navigate administrative processes. This includes facilitating referrals and residents' connections with GPs or community health services and specialised services, as well as NDIS applications. Residents also receive support to access prescribed medications or fortified foods to address malnutrition. The degree of staff oversight in the management of medication is tailored to each resident. Although residents may have degenerative and even terminal conditions, being better able to manage their health should ultimately contribute to better overall health outcomes and wellbeing.

BOX 3.2 A staff member describes being able to support Peter to complete a VHR application at the BHHP

Peter came to stay at the BHHP after experiencing a downturn in his heath. According to Launch Housing staff, Peter had been sleeping rough for more than five years. From time to time, Peter attended a health service co-located with Launch Housing. Staff there had offered Peter support to complete a VHR application to access social housing. However, Peter declined these offers and had not engaged with other housing services.

Once he was at the BHHP and in a stable environment, program staff were able to support Peter to complete his VHR application and start exploring housing options. Peter was also engaging with health care and staff saw his health stabilise.

6 Most commonly residents are linked to a GP through a community health service.

Management of health conditions

Three out of four residents (20 of 27 residents, 74%) who exited the BHHP by June 2023, left with one or more health condition that had resolved in the six months prior or was actively being managed. This was an increase from 16 residents (60%) at entry (p=0.16[7]). The high rate of managed health conditions not only demonstrates the high burden of disease among the cohort but also the impact of access to health care. All residents with planned exits left with one or more health condition that had either been resolved in the six months prior or was actively being managed (12 of 12 residents, 100%). This was an improvement from two out of three residents with a planned exit at entry (8 of 12 residents, 67%; p=0.05[8]). There was no change in the overall count of residents with an unplanned exit who had one or more health condition that had resolved in the six months prior or was actively being managed at exit compared with entry (8 of 15 residents, 53%; p=1[9]).

All residents who exited had entered with one or more unmanaged health condition (27 of 27 residents, 100%), and most residents had one or more unmanaged health condition on exit (24 of 27 residents, 89%; p=0.08[10]). These high numbers show the health inequality faced by people experiencing homelessness. There were three residents who did not have any unmanaged health conditions on exit, and they were residents with planned exits (3 of 12 residents, 25%; p=0.08[11]).

A shift from accessing emergency services to planned health care

Of the 27 exited residents, 17 (63%) were assessed by their care coordinator as being able to access planned health care at exit, up from 12 residents (44%) at entry (p=0.05[12]). Most of the residents with planned exits were able to access planned health care on exit (10 of 12 residents, 83%), an improvement from half of these residents at entry (6 of 12 residents, 50%; p=0.05[13]). Less than half of those residents with unplanned exits were able to access planned health care at exit (7 of 15 residents, 47%), and this group had a lower rate of being able to access planned health care at entry of 40% (6 of 15 residents; p=0.56[14]). Of the seven residents who participated in post-stay support, five were assessed by their care coordinator as being able to access planned health care at discharge from post-stay support (71%).

All residents with planned exits left with one or more health condition that had either been resolved in the six months prior or was actively being managed (12 of 12 residents, 100%).

7 Matched pairs Chi-squared test for difference in having one or more health condition that had resolved in the six months prior or was actively being managed between entry and exit.

8 Matched pairs Chi-squared test for difference in having one or more health condition that had resolved in the six months prior or was actively being managed between entry and exit, among those with planned exits.

9 Matched pairs Chi-squared test for difference in having one or more health condition that had resolved in the six months prior or was actively being managed between entry and exit, among those with unplanned exits.

10 Matched pairs Chi-squared test for difference in having one or more unmanaged health condition between entry and exit.

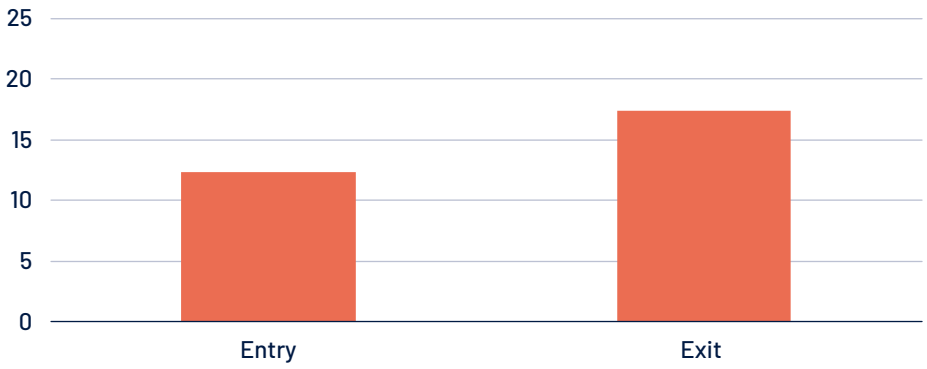
11 Matched pairs Chi-squared test for difference in having one or more unmanaged health condition between entry and exit, among those with planned exits.

12 Matched pairs Chi-squared test for difference in ability to access planned health care between entry and exit.

13 Matched pairs Chi-squared test for difference in ability to access planned health care between entry and exit, among those with planned exits.

14 Matched pairs Chi-squared test for difference in ability to access planned health care between entry and exit, among those with unplanned exits.

Figure 3.3 Able to access planned health care at entry and exit (n=27 residents)



In cases where residents realised changes, the outcomes were practically significant – with real-world importance. For example, according to program staff, one resident who had been presenting at the hospital emergency department (ED) almost weekly prior to entering the program had not presented at the ED for 12 weeks in a row (Box 3.3).

Some residents were accepted as NDIS participants, which could include access to ongoing support for attending medical or other appointments if deemed disability specific.

Linked with a GP

Of the 27 exited residents, 21 residents (78%) had been linked with a GP at exit, up from 16 (59%) at entry (p=0.06[15]). Most of the residents with planned exits had been linked to a GP on exit (10 of 12 residents, 83%), an improvement from entry (7 of 12 residents, 58%; p=0.08[16]). Many of the residents with unplanned exits also had a GP at exit (11 of 15 residents, 73%), also an improvement from entry (9 of 15 residents, 60%; p=0.31[17]). The difference between the proportion of residents with planned and unplanned exits who were linked with a GP at exit was smaller than that for being able to access

BOX 3.3 staff member describes Scott's 12+ week cessation of ED presentations

Program staff knew Scott had been presenting at the hospital ED almost weekly before he came to stay at the BHHP. Initially, Scott ate and slept onsite but spent much of his time offsite, returning substance affected. The medication he was prescribed often remained uncollected. However, over the weeks at the BHHP, Scott started to spend more time onsite and began regularly taking medication to treat one of his health conditions. Scott's presentation to the ED significantly reduced in frequency, with no presentation within a 12-week period at the time Scott's story was shared.

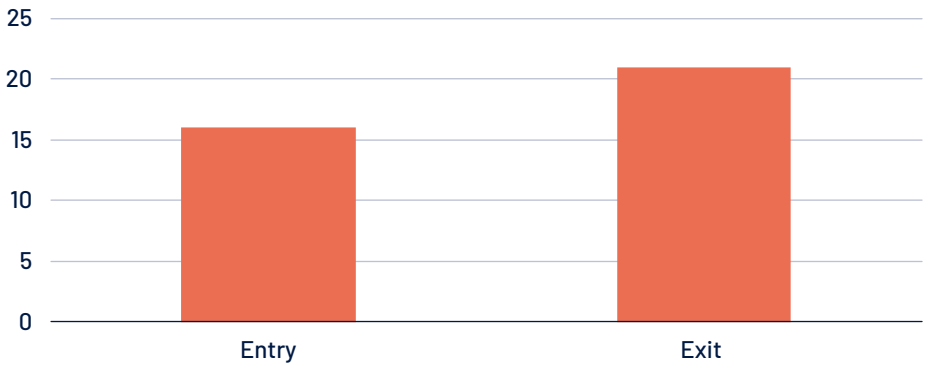
Program staff said that Scott was now on track to have one of his health conditions resolved before he left the program. As resolving this health condition required regular and sustained care, this was not a health outcome that could be realised with costly ED presentations while Scott had been homeless.

15 Paired Chi-squared test for difference in linkage to GP between entry and exit.

16 Paired Chi-squared test for difference in linkage to GP between entry and exit, among those with planned exits.

17 Paired Chi-squared test for difference in linkage to GP between entry and exit, among those with unplanned exits.

Figure 3.4 Linked with a GP at entry and exit (n=27 residents)



planned health care. Of the seven residents who participated in post-stay support, six had been linked with a GP at discharge from post-stay support (86%).

Program staff noted that many residents changed their healthcare provider after entering the program. This could have been due to geographical relocation or seeking better access to appropriate health care. Program staff also highlighted instances where the GP or community health services accessed by residents did not offer adequate support for health management. In such cases, the care coordinators identified another GP or community health service that would be a better fit. One care coordinator stated that residents had felt really listened to and 'heard' by their new health provider. It was reported that when residents relocated to new areas they had joined waiting lists for suitable health services. However, in such cases, residents could still access their existing GP or community health service via public transport, ensuring continuity of care during the transition.

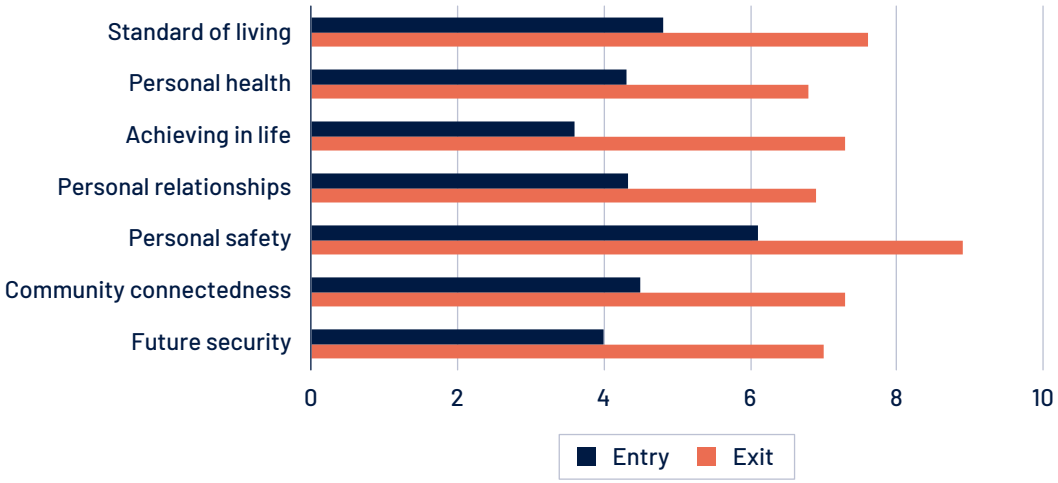
Most of the residents with planned exits had been linked to a GP on exit (10 of 12 residents, 83%). Many of the residents with unplanned exits also had a GP at exit (11 of 15 residents, 73%).

Wellbeing outcomes: more satisfied with life

In addition to improving health outcomes, the BHHP intends to contribute to residents improving their overall wellbeing, recognising that stable housing and better managed health are essential components of wellbeing. The PWI-A (International Wellbeing Group 2013) has been used to measure residents' subjective wellbeing at both entry to and exit from the program. This information is not available from residents with unplanned exits.

Residents' subjective wellbeing, as measured by the PWI-A index and domain scores, shows improvements for those with a planned exit. Of the 12 residents who had a planned exit into stable housing or appropriate health accommodation, 10 completed the PWI-A at both entry and exit. Residents in this cohort recorded improvements in each of the seven domains contributing to the PWI-A score (Figure 3.5), with the greatest average change observed in their satisfaction with what they are achieving in life – an average of 3.6 out of 10 at entry and 7.3 at exit. The average index score for this group of residents represents a noteworthy improvement. The average index score out of 100 was 44.6 at entry and 74 at exit ($p=0.01$[18]). The average of 74 at exit is close to the average in the Australian normative data provided of 75.3 (International Wellbeing Group 2013).

Figure 3.5 Average wellbeing domain scores from PWI-A (n=10 residents, all with planned exits)



18 Paired t-test for a difference in PWI-A score between entry and exit.

4 Working within the principles of care to foster engagement and develop goals

KEQ 2: To what extent, and with what variation, have the principles of care been implemented through the way of working in the BHHP?

In the BHHP way of working, program staff prioritise actionable health and housing goals and resident engagement. Their adherence to the principles of care has been influenced by factors such as resource availability, resident engagement and the complexities of individual circumstances.

This section considers the implementation of each of the selected principles of care. It describes how program staff worked collectively across the housing and health partnership and were informed by residents to not only identify but also influence these factors. Most notably, working in a way aligned with the principles fostered resident engagement in the program and progress towards important health, housing and wellbeing outcomes.

Purposeful partnership

The program is structured as a health and housing partnership to provide an integrated approach to address access barriers faced by residents seeking health and housing outcomes. Program staff across delivery partners work collaboratively on the care plans developed with residents. Services and other resources are accessed by program staff from Launch Housing and SVHM through their respective agencies, as well as through other organisations where possible.

Operational decisions are made collaboratively by the relevant leaders from each organisation. Decisions that include which resident referrals to accept and when residents would be involuntarily exited are informed by expertise from representatives of both the health and housing systems. Collaborative decision-making takes time, especially during the early stages of service delivery, but it provides an avenue for the team to negotiate and develop a shared approach between the delivery partners. The value of this shared approach is evident in the increase in planned exits as the service has matured.

Day-to-day collaboration across the teams is guided by the individualised care plans developed with each resident. Residents develop their plans with cross-agency care teams. Non-management program staff (other than the overnight staff and the peer worker) are divided into the care teams, with a care coordinator employed by SVHM and a group of key worker staff from Launch Housing who covered a range of shifts across seven days. This means a Launch Housing care team member is available into the evening seven days a week. This contributes to rapid communication with residents about any appropriate community housing opportunities that arise, potentially giving them an advantage in applying. SVHM staff take the lead in supporting residents to develop health-related goals on their care plan. Launch Housing staff also support residents in health-related activities as there are fewer care coordinators, covering less of the roster. Residents who participated in interviews noted that different members of the staff team had provided different types of support, and one resident described the diverse professional backgrounds among the team as a 'good recipe' (Box 4.1).

BOX 4.1 The range of expertise in the staff team is a 'good recipe' for connection with residents

The BHHP staff team is composed of individuals with diverse qualifications and experiences, transcending both health and housing domains. They don't just bring their professional expertise; they also share their personal interests and passions. One small sign of this hangs in the BHHP entrance foyer, where posters display staff photographs along with profiles and their personal interests. This practice, borrowed from previous experiences of some Launch Housing staff with Youth Foyers and some SVHM staff with the Safewards program, is a way to establish rapport and build relationships.

Residents interviewed valued the wide-ranging professional support offered by staff and appreciated the opportunity to use shared interests to connect with the team.

In the words of one resident:

> ***[The staff team is] a good recipe ... You've got some people that have come from hard upbringings, and then you've got others that [have] done psychology, nursing, and then you've got the housing people, and then that falls in with, what's it called, team workers and that. Caseworkers. That sort of thing and yeah ... But very, gently done ... and half the time they're just being them. It's not textbook, so to speak ... You're not a patient ... [The staff] [a]ctually, have an interest.***

The staff team combined professional expertise with a touch of personal connection, resulting in a service that inspired trust and offered effective support.

As part of their facilitation of access to services in their agencies, SVHM and Launch Housing staff provide specialist support. Launch Housing staff can submit, update and backdate VHR applications with residents. Although external to the BHHP, SVHM Aboriginal Hospital Liaison Officers support Aboriginal and Torres Strait Islander residents and contribute to the capability of the BHHP staff to offer a culturally safe and effective service. As SVHM care coordinators are employed by the hospital they can easily check for upcoming appointments on behalf of residents. Care coordinators are also well placed to support residents to access neuropsychologists and other specialised services through SVHM that can help to progress goals such as becoming a NDIS participant or receiving mental health care. The program has also quickly developed a strong working relationship with the local community mental health service homelessness outreach team from SVHM. As a program staff member described:

> ***Once [the residents] come here, they're in our St Vincent's [SVHM] catchment, so they get referred to Clarendon.[19] And they're then case-managed by St Vincent's mental health. And I think that because St Vincent's mental health now know us, they know that they have got so many clients here, I think that that has also added a bit of trust there as well and has facilitated really good communication between us and them.***

Program staff have credited the relationship between the BHHP team and the local mental health service with facilitating timely responses when a resident's symptoms changed. Such timely service responses help avoid symptom-related escalations. A collaborative approach is taken in working with external providers such as community health services, although the program has faced challenges securing responsive services when there were capacity limitations in the sector. Care coordinators proactively share information about the program's objectives and target cohort with external health services dedicated

19 Clarendon Clinic is the local Community Mental Health Centre operated by SVHM.

to assisting people experiencing homelessness. This proactive approach enables external health service staff to promptly process referrals for eligible residents who could benefit from their service. However, some residents have remained on the waiting list for the community health service in their new area after exiting the BHHP.

Accessing drug and alcohol services proves difficult, as there is no team-based service (equivalent to the area mental health service) to provide timely responses when opportunities have arisen to engage residents proactively. Launch Housing has advertised unsuccessfully for a dedicated drug and alcohol specialist to improve secondary consultation and capacity building for staff and direct support for residents. The program staff team does include an SVHM peer worker, with lived experience in overcoming addiction, who can provide useful information to residents and program staff. The value and challenging nature of this part-time role has been recognised by program management and, in addition to the peer member joining SVHM's network for peer workers, two additional part-time peer workers were recruited to support the BHHP. The program team discussed these constraints and limitations, making informed decisions about their work and ambition.

A partnership approach allows for more integrated and comprehensive responses, while also providing insights into gaps in support faced by some residents. By working together, program staff can better understand the limitations in both systems and address many of these gaps effectively. This avoids barriers to accessing support from multiple agencies and separate systems that residents encounter before they come to the BHHP.

Goal-directed approach

The program team takes a goal-directed approach by supporting residents to develop and work towards their personal housing, health and other goals. This approach recognises the importance of residents' ownership of their goals, as they are more likely to engage with goals that are personally meaningful to them. Goals need to be broken down into actions that aligned with what, how and when residents will take action. Program staff have also identified that for residents to realise timely outcomes, goals need to be actionable within the existing systemic context of the services and resources available.

The care team structure brings together Launch Housing key workers and SVHM care coordinators to support residents to develop and action a care plan. This facilitates communication across the program staff roles, as well as with residents, ensuring coordinated efforts in working towards goals when residents are engaged in the process. The evaluation has found that when residents expressed their goals, program staff put forward options for breaking goals down into manageable tasks or identifying goals consistent with what the resident valued and wanted to achieve (Box 4.2). However, it often took time for residents and their care team to identify a resident's goals and the actions to take to realise them. Residents are expected to participate in care team meetings and to work towards both housing and health goals.

The most direct example of goal development is when residents develop their housing goals. Residents work with Launch Housing staff to develop housing goals that are a good fit for the resident and consider the properties available. Program staff reported that many residents initially named their goal to be public housing but, as residents gained a better understanding of community housing, they became more willing to explore this option. Although the initial rental costs of community housing might seem higher, residents discovered that they would be eligible for Commonwealth Rent Assistance, which would make their out-of-pocket expenses comparable to public housing rent (around 25% of their income). Residents also became more open to considering a wider range of geographic areas for relocation once they understood the constraints on housing availability and had a chance to develop a sense of connection to areas with available housing. The sense of community that formed among residents within the program meant that they often knew others who were relocating to areas with housing availability, increasing their interest in moving there.

BOX 4.2 A staff member describes their role in supporting Nathan to realise his goal

Many years ago, when he was living in a different part of Australia, Nathan had had a session with a counsellor. Now, he told his care coordinator that he wanted to return to counselling and wished to see the same person. He shared the few details he could recall with his care coordinator and they worked together to overcome the barriers to realising this goal.

Nathan and his care coordinator found and contacted the counsellor, who agreed to provide telehealth sessions to Nathan. The full cost of private telehealth sessions was outside of Nathan's budget, but Nathan's care coordinator was able to provide guidance on accessing Medicare funding.

Nathan engaged with his GP to build a Mental Health Care Plan around his mental wellbeing goal that would help fund the sessions.

Initially, the counselling sessions were scheduled via video call. However, because he had to use a tablet at the BHHP which meant being there at the correct time, Nathan missed two consecutive counselling sessions. On the suggestion of his care coordinator, they move the session to a call to Nathan's mobile phone and Nathan was able to meet with the counsellor successfully.

Although Nathan's care coordinator played an enabling role when it came to setting a path to reach his goal, returning to see this counsellor was Nathan's goal and he took the steps for it to be realised.

Program staff described limited resident engagement as a significant barrier to working in a goal-directed way – and indeed more of a barrier than the complicated processes to access the resources or services necessary to work towards goals. While initially there was discussion as to whether the program should only admit residents who were 'ready' to engage – or prioritise those residents who were least likely to find other services accessible – this is difficult to assess during intake. Potential residents who demonstrate strong motivation to enter the program and clearly articulated relevant goals during the referral and selection process do not necessarily maintain engagement in working towards those goals after entering the program. Furthermore, the program team has sought to expand the capability of residents to work in a goal-directed way and, accordingly, some residents came to articulate and work towards goals during their time in the program.

In some cases where residents had not identified clearly actionable goals, program staff adopted a more directive approach, especially around health-related goals. This included involuntary health assessments where medically appropriate and legally accepted. Some program staff suggested the program should have a longer stay, noting the progress made once residents had time to settle in and build trust with staff.

With time and trust, program staff and residents had been able to engage in a productive two-way information exchange, which staff found vital in collaboratively developing goals and creating plans to achieve them.

Person-centred care

The program's person-centred approach intends to reduce barriers to health and housing by placing individuals at the centre of care. The program team have achieved this through providing tailored support and a positive experience for engagement. This approach is also expected to foster engagement and therefore build the capacity of residents to engage with services and resources, ultimately facilitating better outcomes for residents in the broader systemic context.

To accommodate the diverse needs and preferences of residents, adaptability is built into the core structure of the program. Examples of adaptability identified by program staff include allowing residents to have a staged entry and exit from the residential stay, as well as flexible communication methods for both day-to-day plans and when raising matters of concern. This personalised approach came from listening to the voices of residents and building trust – demonstrated in improved resident engagement.

The program team has used feedback to tailor care for individuals and inform decisions about day-to-day service operations, making several changes to better meet residents' needs. For example, residents' request for a pool table for the common room has been fulfilled, enhancing the social environment and recreational opportunities within the program. Additionally, after a resident raised concerns about posters related to the Stop Black Deaths in Custody campaign triggering distress for them, the program team immediately actioned change (Box 4.3).

Program staff have also looked to residents' actions to anticipate the resident's goals and preferred course of action. One common example shared by program staff in both interviews and workshops involved residents agreeing to attend meetings, activities or appointments but not following through. Program staff acknowledged that this behaviour could have various origins, such as the goal not genuinely resonating with the resident or the need to address underlying issues, such as building trust or other capabilities, before proceeding with certain goals. Program staff identified the solution in such cases to be taking the time to understand residents' unique needs and preferences and adapt the support offered. For example, the members of one resident's care team noticed a positive shift in the resident's response to a scheduled care team meeting when held offsite over a coffee or a milkshake, compared with remaining onsite for the meeting. Although it took many unattended meetings before an invitation to meet offsite was extended, a member of this care team reflected that it was an approach they would be confident to offer to other residents who may find it helpful.

The program's commitment to a person-centred and adaptable approach is demonstrated when program staff creatively problem-solve and support residents to achieve their goals in ways that work for them. This relies on staff actively listening to residents and responding to their needs. It was reported that this was only possible when staff were available and flexible with time, and residents had a long enough stay for the work to be done in this way. Staff showed they could work like this in the BHHP, although there were always limits on their time and a need to plan for a timely resident exit. Although working with a person-centred approach requires an investment in resourcing, with a greater staff–resident ratio and lower through-put of residents, program staff found this way of working valuable for building resident engagement and it provides better outcomes.

BOX 4.3 A staff member describes an example of valuable resident feedback

BHHP staff sought to provide effective, tailored support to residents by fostering an environment where residents felt safe to share their thoughts and concerns. An example of increased trust is shown through a resident's response to posters he found upsetting.

To create a welcoming and inclusive space, staff had put up posters in solidarity with issues affecting the resident cohort. However, Stop Black Deaths in Custody posters were upsetting for one Aboriginal resident. During his stay at BHHP, he had developed a level of comfort where he was able to ask to have them taken down.

> ***[The resident] is an Aboriginal person and said, 'They are really triggering for me. I've spent a lot of time in prison.' [They] said, 'I know that they're to shine a light on that problem. They're anti Aboriginal people being in custody, but nonetheless, they're super triggering for me. Can you take them down?'***
>
> ***I thought that was the most brilliant moment, because [they] felt comfortable enough to say, 'I don't feel comfortable with those. Can you take them down?' And we were like, 'Yep. We can take them down. We don't want you to feel like that.' What an amazing thing that [they] could articulate – they felt safe enough – to articulate that.***

Fostering autonomy

The BHHP seeks to foster resident autonomy by providing an environment and support that encourages residents to make informed choices and exercise independence. In implementing this approach, program staff considered what services, resources and advice residents should access to realise outcomes that were meaningful to them. They have also considered service connections that could be sustained and sought to individualise support based on each resident's circumstances.

Staff also focus on the safety of everybody at the program site. Having onsite support reduces barriers to residents seeking assistance but invests authority in program staff and places limits on residents' privacy. On one hand, residents can easily seek out support by phone and at the office windows, as well as by sitting in part of the common space program staff often pass through. On the other hand, there is an awareness of staff surveillance of common spaces via CCTV from the locked office, which highlights the power imbalance. To respect residents' personal space and privacy, program staff have adjusted their communication approach. While knocking on residents' doors was common earlier in the program, staff soon began using phone calls to engage. The program enabled this by providing residents with a mobile phone or credit where necessary and supported one resident to learn to use a smart phone. Providing residents with what they needed to make meaningful choices has enabled a way of working that fosters autonomy.

Program staff have also considered ways to facilitate access to resources and services without negatively impacting on residents' independence. Staff observed residents' capacity to take initiative and enabled autonomy, tailoring support according to individual situations to avoid providing too much assistance. For instance, a resident who had been accompanied to all appointments was given the option to travel independently using a cab charge, which struck a balance between autonomy and support. In another case, a resident experiencing a downturn in their health was offered, and agreed to receiving, more support for keeping track of their many appointments.

At times, program staff have provided access to important medication, dietary supplements or health care based on health advice. One care coordinator explained that when residents were expected not to remain in the program care coordinators took a more directive approach and perhaps worked 'faster'.

Exploring and revisiting ways to foster autonomy has required time and expertise from the staff team as well as resident engagement. This process has benefited from deliberations about how best to deliver the program in the dynamic context of each resident's care plan.

The health conditions experienced by residents in the program had an impact on their autonomy. While fostering autonomy was a fundamental principle, certain circumstances, particularly concern for safety, necessitated limitations on resident decision-making. In cases where there was a risk of harm to themselves or others, ensuring safety took precedence over autonomous decision-making.

The BHHP seeks to foster resident autonomy by providing an environment and support that encourages residents to make informed choices and exercise independence.

Some residents faced restrictions on their autonomy due to factors such as administrative orders or compulsory treatment orders (CTOs), and these varied by the conditions experienced by the resident. For example, one resident who had a CTO removed upon becoming stable in the program later experienced a decline in their mental health after deciding not to take their medication. As a result, they needed to re-engage with mental health services. In another case, a resident who was experiencing severe mental health issues received an involuntary mental health admission during which they were clinically assessed and received a diagnosis. However, the diagnosis attributed their symptoms to substance use rather than a mental health condition, which meant they were not required to participate in mental health care. Program staff expected the resident to experience a temporary abatement of symptoms, however, having a diagnosis that linked symptoms to substance use allowed the same negative cycle to continue. These examples show the complexity of the contexts in which people exercise autonomy, and the importance of skilled program staff at BHHP contributing to the support network available to residents in challenging situations.

Program staff described implementing behaviour management plans with some residents as valuable for fostering autonomy and enhancing safety within the program. In developing behaviour plans, residents took an active role to identify situations they found challenging and strategies they could use in these situations. This empowered residents to be supported by program staff to enact strategies or for program staff to refer residents back to their own strategies, contributing to a safer and more supportive environment within the BHHP. While some residents with behaviour management plans still exited involuntarily, in one of the workshop program staff said they thought even having the experience of using such plans could have lasting benefits for residents. According to program staff, some residents had never previously developed or used behaviour management plans, although they are commonly used across services. By learning to make and follow such plans, staff thought residents gained a useful strategy for engaging with services in the future, potentially contributing to more successful interactions with services for stronger outcomes.

For situations where a resident breaches house rules, the resident is offered additional support and the program team assists the resident to make meaningful choices. In staff interviews and one of the workshops it was identified that the program team took on feedback from a resident on how they preferred to have concerns raised. Attempts were also made to attend carefully to language used, with one staff interviewee describing the shift from a 'warning' to a 'notice of concern', intended to provide a person-centred approach where the program team and resident could work together to address underlying issues. A resident who breached house rules by returning to the BHHP intoxicated explained that they got sent to stay offsite for the night, allowing for a constructive conversation the next day when they were no longer intoxicated and in a more positive frame of mind. This resident's report is consistent with the program team taking an approach that was not simply enforcing rules for their own sake but prioritised fostering autonomy in a way that respected the safety of all residents and staff.

Applying principles of care in ongoing practice

The program team works in partnership in a way that is goal-directed, takes a person-centred approach and fosters autonomy. When residents actively participate in their own care, the program can better understand their unique needs and preferences, enabling more effective support that encourages residents to make meaningful choices. By working together with residents, program staff gain valuable insights into the complexities and challenges faced by residents, enabling them to tailor their approach and provide more meaningful and person-centred care. However, it is essential to acknowledge that addressing these challenges and filling the gaps is not a one-time effort. It requires ongoing dedication, time and flexibility to engage with residents and provide them with the necessary support and resources to achieve positive outcomes.

5 Enabling residents to engage and realise outcomes

KEQ3: In what ways, and under what conditions, has the BHHP way of working contributed to realising intended health and housing outcomes for residents?

The way of working at the BHHP has been able to foster resident engagement in the program and support residents to develop actionable goals. This section first considers the ways that residents interviewed described the program as enabling them to engage and realise outcomes through providing a secure base, encouraging social environment and enabling care. Second, it looks at the conditions under which program staff have been able to work in this way and under which residents could realise intended outcomes. These are identified as the key program design elements of the availability of expert staff, the program's six-month duration, and access to services and other resources from the housing and health systems.

The BHHP offered residents genuine opportunities

Residents who participated in interviews said they had been able to engage with the program and that it provided ways for them to develop and work towards their goals. They described how the program helped them regain control over their lives in a context that enabled them to make meaningful choices between the opportunities available to them. Having this agency facilitated engagement, fostering empowerment and autonomy in decision-making. These opportunities were not prescriptive but rather flexible and responsive, allowing residents to explore various avenues that align with their personal preferences and circumstances to develop and work towards their goals for positive outcomes.

Secure base: the place from which residents can make new plans

At the heart of the program's success is the provision of a secure base for residents. Residents transitioning from sleeping rough and unstable housing said they had been able to meet their material needs and find respite at the BHHP. Residents who participated in interviews described this sense of security as instrumental in their ability to envision and work towards their goals. It provided a foundation upon which they could work towards better managing their health and their aspiration for 'their own place' – an independent home of their own.

Residents said the program contrasts positively with not only sleeping rough but also rooming houses, crisis accommodation or hospital stays. For one resident, even a motel stay had meant spending sleepless nights feeling unsafe, in contrast to being able to get some rest at the BHHP. For many, the BHHP was the first place in a long time where they could truly rest and make plans for their future. As one resident described their experience, after coming to stay at the BHHP they 'didn't have to sleep with one eye open'. For this resident and others, after sleeping better they could also tackle other challenges (Box 5.1).

BOX 5.1 Paul uses the BHHP as a secure base to get on his feet

Paul had been in an accident and had difficulty making and remembering plans. While homeless, Paul had known of services but thought the only accommodation they could offer him was a rooming house. He avoided rooming houses at all costs, seeing them as violent places where he would be stuck in his room protecting it from being broken into. Without somewhere to stay, Paul had felt stuck and that he was not the positive person he thought himself to be.

Now at the BHHP, Paul said he felt life was moving in a positive direction. He was using it as a chance to get back into things. He was eating better and getting back to a healthier weight. Paul felt part of a community of residents who supported each other. He found it helpful that program staff set out clearly his options for health and housing, broke down complicated processes and prompted him with reminders.

Paul felt positive about being at the BHHP. He said he saw it as a chance to get on his feet after spending the last few years sleeping rough. Paul appreciated the support of the BHHP and looked forward to moving into his own place.

Residents enjoy autonomy in their own rooms, having control over factors like heating and cooling, and decoration. Interviewees recognised that this autonomy was limited to available resources and looked forward to having greater control once in independent housing. For example, one resident was positive about their upcoming transition out of the program into social housing because at the BHHP they could not have visitors and lacked access to full cooking facilities.

It is not just the safety and comfort of having a room but also the responsiveness of the program to residents' health conditions that has contributed to a comfortable stay. Residents described program staff delivering material supports in a way that met their individual needs. For example, although one resident was relieved that the service did not have the institutional feel of hospital, the health service staff had also organised equipment to accommodate their injuries, which significantly improved their sleep quality. There were also examples of residents having their needs anticipated by staff, such as smoothies being prepared for them after dental treatment. More commonly, residents spoke positively about flexibility in accessing meals or food outside mealtimes, although the length of mealtimes were later reduced – a change intended to encourage residents to plan to either attend mealtime or to ask program staff to put a meal aside for them if they knew they would be out. The person-centred approach, along with the health service expertise, has been valuable to tailor responses that provide genuine opportunities for residents to meet their needs in their own distinct circumstances.

Encouraging social environment: an environment that encourages resident engagement

A standout feature of the program is the encouraging social environment. The BHHP has become a place where residents can foster meaningful connections with their peers and become part of a supportive community. Residents interviewed had built confidence through celebrating their strengths when sharing their skills and participating in a community of people who helped each other.

In interviews, residents often compared the supportive social environment favourably to other housing or health services and even public spaces. Communal spaces serve as not just places for relaxation but also for seeking staff support or having conversations. Residents said they felt encouraged to engage as part of a community that helped each other, bringing their talents and knowledge to activities. One resident described the helpfulness of residents as well as staff:

Everyone here's really – it's not a family environment, but you can literally go to anyone, any time. And that's the people that actually live here. But then on the other hand you've got all the staff here that – yeah, they're all like, I could not fault them one bit, not one bit.

Residents described this positive environment as one where they and others were encouraged to engage in activities and pursue interests that were previously inaccessible. For instance, in response to resident feedback the BHHP added a pool table in the common area. Residents saw this as a desirable enhancement, providing a drama-free space for leisure and the opportunity to learn a new hobby, away from traditional venues like pubs.

Participation in optional wellbeing activities delivered by visiting professionals appears to have fostered a constructive atmosphere, even if individual residents did not identify themselves as a primary beneficiary. Interviewed residents were most enthusiastic about participating in the optional planned activities when they saw them as an opportunity to share their talents and knowledge with others – such as by recommending songs during music therapy. Similarly, resident interviewees said the weekly Friday BBQ is particularly valuable for the former residents who would attend, as it provides a chance to maintain connections. Some interviewees said they enjoyed seeing others benefiting from activities such as animal therapy. These examples show that residents experienced person-centred delivery through a relational approach that built engagement and that residents leveraged to take pride in their strengths.

Residents who participated in interviews perceived the program's rules and monitoring as fostering a well-functioning site without being overly restrictive. Even in a case where a resident received a breach notice due to intoxication, they acknowledged the need to limit their alcohol intake, viewing it as a challenging but worthwhile goal that the BHHP was supporting them to achieve. However, some residents did repeatedly act in violent ways. In such cases, after repeated offers of support, program staff had to exit these individuals from the program. Residents spoke positively in interviews about staff taking such steps, stating it was necessary to maintain the safety and wellbeing of others within the program's community. As one resident described:

Some people have come back, been inappropriate. If that was my house or workplace, I wouldn't invite them back. But they gave them a chance. No, they gave them another chance ... But they were really kind about the way they – it wasn't like here's the door, out. It was, 'Where are you going? How can we help you?' ... It wasn't one of those situations where you're out and that's it. Some people unfortunately have been on the streets so long that, yeah, sometimes it's just second nature to them – or first nature, I suppose.

Enabling care: care that empowers residents to take steps towards their goals

In contrast with resident interviewees' prior poor experiences of other services, interviewees described being well supported in their health and housing goals by the BHHP staff. For one resident, an important step for their health goals was linking with a GP:

[I've] gone to the consultation [with my new GP] and start from there because I've got a few issues to sort out with myself with well, physical and mental [health].

Program staff have the expertise to put forward relevant options and took the time to hear residents' decisions. One resident explained how support from BHHP staff was helping them to identify their options and make meaningful choices to work towards their goals:

They're a big help in my eyes ... It just makes things so much harder on your own. You don't know where to start ... They've helped me get things in order and get things in progress ... They give me some options, and I'll go ahead or not. No problem. And yeah, it makes a big difference because it shows they care, and then that helps me get back in the swing of things.

Staff can help overcome the barrier of not knowing how to reach goals, as well as barriers compounded by health conditions. Reminders for meetings and appointments have been an important tool for residents who had conditions affecting their memory. As one resident described:

> ***Since [my brain injury], I've never really been the same. I'm always just getting lost in the cloud, sort of thing. Yeah, so these guys have helped me … they remind me because I don't remember things as much as I should anymore.***

Under different conditions a person with similar support needs might have missed appointments preventing, or further complicating, the issue they were seeking help to address. Program staff observed that as progress was made on goals, residents had fewer non-routine appointments and residents who became participants of the NDIS were able to start establishing their ongoing supports while at the BHHP.

The availability of staff members outside office hours or pre-scheduled times in the stable and encouraging environment of the BHHP has made it easy for residents to clarify plans or work on goals when they had the energy and motivation. One resident described that, when they experienced an 'embarrassing' health event, they felt comfortable asking for assistance. With support, the resident was able to manage the health event and get on with their week. Under different conditions the experience may have been less positive, potentially undermining the person's trust and affecting their confidence in the value of taking the steps to manage their health and work towards other goals.

Residents drew on the available support to take challenging steps towards their goals, including with health concerns that had been unaddressed prior to attending the BHHP. One of these residents described the stress of navigating confusing hospital buildings and undergoing medical tests, but their care coordinator was able to provide the guidance and encouragement to follow through (Box 5.2).

In this and other instances, residents recognised the significance of the actions they needed to take. There were also many other reasons resident interviewees gave for continuing to overcome challenges to take steps to realise their goals: getting glasses means being able to enjoy watching TV or read without headaches; dental care can elicit better interactions with people through an improved appearance; and a stable home is where passions can be pursued. By tailoring support and services to individual needs, the program has assisted residents to navigate through various challenges, allowing them to take positive steps towards achieving personally meaningful goals. The program staff provided options, which residents could choose

BOX 5.2 Andrew accesses the medical care he needs

Andrew spoke highly of the support he found at the BHHP. After cycling through hospital stays and sleeping rough, he was used to receiving medical advice. Andrew followed it in hospital, but returning to the streets made it impossible and his health deteriorated.

Andrew expected to find another hospital-like setting when he came to the BHHP, but he quickly noticed it was not the same. The beds were adjustable, much like hospital beds, but his room was his own space he could set up to suit him. Staff did carry out room inspections, but they respected his privacy. At times when he felt like talking with staff, Andrew knew he could find them in the office, or he could simply sit in the common areas where conversations naturally happened. When Andrew shared his symptoms, he received practical support to access the health care and equipment he needed.

On one occasion, Andrew went to a medical appointment and got lost trying to find a room in the unfamiliar building. He considered giving up. Instead, he went to his care coordinator who was waiting out front and they found their way to the right place together.

Taking important steps to manage his health, Andrew explained he was working to stay alive so he could support his family and friends.

to pursue or not, exercising agency and control over their lives. This approach signalled that staff genuinely cared about residents' preferences and empowered them to pursue their goals.

Residents realising outcomes through conducive conditions

Key elements of the program design including the availability of expert staff, the program's six-month duration, and access to services and other resources from the housing and health systems. These have all established conditions that were conducive to program staff working in an effective way and residents realising outcomes.

Staff resourcing

The BHHP's partnership model of delivery brings together health and housing service staff in co-delivery, with care team staff rostered on into the evening seven days a week as well as 24-hour staff coverage. The program's staffing model blends expertise from both the health and housing sectors and includes a peer-support worker. Staff members not only bring knowledge of and access to the health and housing systems but also often had the availability to offer the relatively small resident cohort flexible engagement. Residents can interact with program staff without the constraints of scheduled appointments, fostering a more accessible and responsive environment. Importantly, the staff team can draw on their collective expertise and external networks to provide informed and effective support. Many program staff said that although the BHHP was well staffed, there was still a need to make decisions about day-to-day activities with residents within limits on staff availability.

Program duration

Because of the program's six-month duration, residents were better able to realise outcomes. This timeframe is longer than acute hospital stays or the intended stays for homelessness crisis accommodation services. Program staff have identified the program's staffing and six-month length of stay as a positive point of difference from short-stay crisis accommodation. For many residents, the six-month program length provided time to recuperate, engage in goal setting and work towards their objectives. Most notably many residents secured social housing tenancies because program staff supported them to develop housing goals that could be achieved within the timeframe. For those residents, the staffing and program length was adequate and the program accommodated the ebb and flow of residents' readiness and motivation, allowing for productive participation during windows of opportunity and for residents to build engagement over time. Residents who participated in interviews were positive about having time to try again if they had not been able to attend an appointment on their first try, for example. Some program staff suggested the option of a length of stay longer than six months would be helpful. A longer stay would allow residents more time to enjoy the stability the program offered, to work towards engagement and to find housing outcomes that were a good fit. Program staff thought this would be most useful for residents who did not engage as quickly, or for whom health and other conditions affecting appropriate housing options became apparent later in the resident's stay. However, in interviews staff reflected that, as they grew their collective expertise, they were developing their practice to build resident engagement with the program more rapidly.

Program staff have identified the program's staffing and six-month length of stay as a positive point of difference from short-stay crisis accommodation.

Access to services and resources

The program's success has been significantly dependent on its ability to connect residents with essential services and resources, ranging from health care to housing options. The collaborative approach, partnerships with external agencies, and staff members' ability to secure services and resources have been pivotal in ensuring residents had the means along with the required flexibility and timeframe to realise their goals. Program staff, equipped with their expertise and organisational access to the healthcare and housing systems, have played an instrumental role in securing these resources for residents. This integrated network of support ensured that residents have had access to well-informed advice and essential means to develop their goals and realise health and housing outcomes. The network of support should also include specialised areas. Access to Aboriginal and Torres Strait Islander-led and specific services has been provided through the SVHM Aboriginal Hospital Liaison Officers, while access to drug and alcohol services with a responsive and flexible model of care has been less easy to secure. However, as the program team builds their external networks and with greater cross-system attention to providing better support to residents with chronic homelessness and co-occurring health conditions, it should be possible to see further gains in securing responsive and flexible services and timely access to resources.

Conducive conditions delivered through a health and housing partnership

The availability of expert staff, the program's six-month duration and access to services and other resources from the housing and health systems are distinctive key elements of the program design. These elements were essential conditions in a way of working that has offered residents a genuine opportunity to increase engagement and overcome barriers to accessing services. The housing and health service partnership underpinning the BHHP contributes to the program having these important conditions. Both the health and housing services have provided input to develop the BHHP service model. Program staff noted that the program design was sensitive to important conditions for success in health and housing outcomes: staffing, program duration and relationships with broader service systems. However, going further than cross-system input in program design, the BHHP is an integrated health and housing service. The collaborative delivery model between a health and housing sectors means that collectively, program staff have expertise to support residents in developing and realising integrated health and housing care plans.

With greater cross-system attention to providing better support to residents with chronic homelessness and co-occurring health conditions, it should be possible to see further gains in securing responsive and flexible services and timely access to resources.

6 Key learnings

The evaluation aims to document the extent to which intended outcomes were realised and contributed to the evidence base for program development and effective housing and health responses. In line with these aims, the following key learnings offer a contribution to understanding the program's strengths and areas for improvement in operations and outcomes. It is important to note that the program is relatively new, with a small number of residents who have progressed through to a planned exit, so caution should be exercised in drawing definitive conclusions about its effectiveness for specific groups or individuals.

Positive health, housing and wellbeing outcomes

Residents with planned exits realised positive health, housing and wellbeing outcomes and residents with unplanned exits realised some steps towards positive outcomes. At entry, residents had been experiencing homelessness and co-occurring health conditions. Residents who engaged in the program through to a planned exit achieved the intended outcomes of stable housing and, on average, subjective wellbeing that had improved from very low levels at entry to close to the population norm at exit. Some residents did not remain engaged in the program for long enough to have a planned exit into stable housing, however, even with an unplanned exit from the program, residents made some progress in managing their health and pursuing stable housing. Furthermore, interviewed residents and program staff all agreed that residents realised outcomes and steps towards outcomes that were not expected to have been taken without the BHHP. The health, housing and wellbeing outcomes realised by residents indicate that the BHHP model delivers promising results.

Program staff prioritised actionable health and housing goals and resident engagement

The success of the program has occurred through program staff working in a way that prioritises actionable health and housing goals and fosters resident engagement. The program's effectiveness depends on actionable goals, which aligns with residents' interests, motivations and resources available. Resident engagement has been central to service delivery and development. Without resident engagement, staff would not be able to effectively guide residents towards their goals while upholding the principles of care. Through engaging with residents to develop actionable goals, program staff can also tailor care for individuals and use what they learned to inform their way of working. This approach aligns with the principles of care, contributing to positive outcomes within the program conditions.

Actionable goals needed to be developed with residents

Developing and pursuing actionable goals are helpful steps towards residents being able to realise the intended program outcomes of managed health and stable housing. When residents have had goals that were actionable, the goals could be used to guide the care team to support residents, progress could be made within the program duration, and goals could

be realised within the existing systemic context of the services and resources available. Often the actionable goals were developed during residents' stay at the BHHP, rather than being identified and committed to at the point of intake, which demonstrates the importance of goal development as an interim outcome for residents seeking to better manage their health and secure stable housing.

Genuine opportunities enabled resident engagement

Residents found the BHHP offered genuine opportunities that facilitated their engagement in the program through a secure base, encouraging social environment and enabling care. Resident engagement with program staff informed the care team and facilitated progress towards goals through meaningful two-way exchanges.

Adequate staff resourcing and program duration with access to services and other resources were important conditions for program success

The availability of expert staff, the program's six-month duration and access to services and other resources from the housing and health systems were important conditions enabling residents' realisation of outcomes. These conditions influenced the way program staff worked and the access residents have had to the resources required to progress towards positive outcomes. The time and effort needed to secure services and resources varied between each resident's goals and circumstances. Accordingly, staffing and program length must allow for engagement to be built over time, with individual variation in the ebbs and flows along the way.

The partnership across systems provided the conditions for success

The partnership model between health and housing services provided conditions that have delivered an effective program. The model has contributed to timely access to expert information, services and resources. The partnership has created an environment conducive to positive resident outcomes, bridging gaps in access to services and resources, especially for residents with cognitive and mental health conditions. This has relied on staff expertise, services and resources available through the partnership, and had to extend beyond the health and housing sectors alone. In some domains this was a gap, such as some residents encountering limited access to responsive and flexible AOD services. However, the health and housing sectors have also invested in providing relevant expertise, services and resources. For example, through SVHM, the support and capacity building provided by the Aboriginal Hospital Liaison Officers allowed the BHHP to offer an integrated health and housing response to a resident cohort of which one in five were First Nations Australians. Overall, because of the partnership model, service quality and a person-centred approach that fostered autonomy, the BHHP model offered more than a service based on a health or housing model alone.

These key learnings serve as a foundation for strategies that could inform future steps for the BHHP and other housing and health services.

7 Future opportunities

Lessons from resident outcomes and the ways of working that contribute to these outcomes suggest future opportunities for developing the BHHP model or other similar interventions intended to support positive health and housing outcomes. These opportunities are outlined below, along with steps that could be taken to realise them.

Integrate health and housing responses

Continue to provide and develop a residential integrated health and housing program for people experiencing chronic homelessness with co-occurring health conditions. Continuing to provide these programs would allow more people to improve their health, housing and wellbeing outlooks. An expanded offering of these responses and refinements to the model should be evidence driven, building on the success demonstrated so far.

This could look like:

- Continuing to provide the BHHP with integration at the core of the model.
- Scaling-up to new sites in areas where residents may already have social ties but also where they will be able to secure housing and access health services.
- Informing refinement of program eligibility through further outcomes evaluation.
- Undertaking economic evaluation that encompasses both cost savings and social value. These projects could be designed to inform funding decisions between alternative approaches to supporting people experiencing chronic homelessness with co-occurring health conditions to secure their rights to housing and health.

Centre resident engagement in service delivery and development

Ensure that engagement between residents and program staff remains at the centre of the program to enable residents to develop actionable goals and take the steps to realise them.

Resident engagement with the program was shown in all cases discussed by residents and program staff to be essential for developing actionable goals and taking the steps to realise them. Building resident engagement was prioritised in the way of working, and program staff drew on their engagement with residents to tailor individual care and inform decisions about day-to-day service operations. However, program staff and some residents also noted the time pressure in having to achieve actions within the duration of the program.

Centring resident engagement could look like:

- Reviewing cases where an extended engagement phase is recommended by the team. It should be considered whether changes to practice and tools or improved access to services and resources would enable residents to realise health and housing outcomes.
- Reviewing the model of care and care planning tools to continue to shape the BHHP model and embed resident engagement as central to the way of working. This should be guided by further advice from residents and others with relevant lived experience.

Provide residents with time and support

Enhance the capacity of the program team to provide each resident with the time and support they need to develop actionable goals and take the steps to realise them.

To continue to empower residents to develop and achieve actionable goals, an adequate program duration, and sufficient staff expertise and time to provide support should be maintained. This includes providing sufficient program length for residents to set, pursue and update these goals, including allowing residents an initial period when they can adjust to stability, and the option to have support dialled-up and activity slowed when needed.

This could look like:

- Ensuring the BHHP and similar programs continue to be adequately staffed to enable resident-led support. This requires continuing to have staff with the availability, flexibility, and knowledge of and access to the housing and health systems.
- Providing program management flexibility to match staffing levels to the resident cohort. This could include temporary increases to the staffing level or delaying the intake of new residents so staff are available to support high resident needs.

Offer genuine opportunities to residents

Continue to provide a secure base, an encouraging social environment and enabling care to promote resident engagement. This will offer opportunities and encourage choices meaningful to residents.

Residents who participated in interviews valued contributing to the community and had insights into what presents a genuine opportunity. It is important to involve residents individually and collectively in decision-making processes that will shape their experience in the service. Consider facilitating resident-led initiatives and enjoyable activities to boost engagement and empower residents in their housing and health journey.

This could look like:

- Maintaining elements of the program described by residents who participated in interviews as helpful for providing a secure base, encouraging social environment and enabling care.
- Increasing formal opportunities for resident voices and lived experience to guide future developments in the delivery of in the program.

Use partnership as the foundation

Maintain the partnership model as the foundation of the approach. Build further partnerships to extend the collective expertise of the staff team and the service's capacity to broker access to services and resources, bridging service gaps beyond the health and housing sectors. For residents to have access to responsive and flexible AOD services, targeted relationships may be required. Having a strong relationship with the Aboriginal Hospital Liaison Officers within the SVHM health service was important for the BHHP but may not be able to be assumed in all health services, so partnerships with Aboriginal and Torres Strait Islander-led services will be important for scaling-up new sites.

To bridge gaps between systems, it is key to foster effective communication, information sharing and joint planning. Partnerships should continue to leverage opportunities for shared training and professional development to promote a shared understanding of resident needs, enhance service coordination and inform decisions in challenging situations. Collaborative efforts can extend the collective expertise of the staff team and provide access to services and resources, maximising the program's impact and facilitating residents' progress towards health, housing and other goals to realise wellbeing.

This could look like:

- Continuing to co-deliver the BHHP with teams from a health and housing service.
- Using a partnership model in establishing new sites or services.
- Identifying gaps in residents' access to resources and services and seeking formal partnerships or other collaborative arrangements to address these gaps. This may include seeking out AOD service partnerships and maintaining a strong relationship with the Aboriginal Hospital Liaison Officers in the BHHP, or ensuring other similar programs have a comparable arrangement. Other priority areas for action may be informed by a review of care plans and consultation with residents and their care teams to determine domains in which goals are not being realised within the program duration.

Collaborative efforts can extend the collective expertise of the staff team and provide access to services and resources, maximising the program's impact and facilitating residents' progress towards health, housing and other goals to realise wellbeing.

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Tracey Pahor

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Acknowledgement of Country

The Brotherhood of St. Laurence acknowledges the Traditional Custodians of the land and waterways on which our organisation operates. We pay our respects to Aboriginal and Torres Strait Islander Elders past and present.

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