DEPARTMENT OF HEALTH AND AGEING

REVIEW OF INNOVATIVE HEALTH SERVICES FOR HOMELESS YOUTH PROGRAM

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FINAL REPORT

C

CONTENTS

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   ii

APPENDICES

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   iii

T

TABLES

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   iv

E

EXECUTIVE SUMMARY

The Australian Government Department of Health and Ageing (DoHA or the "Department") engaged Health Outcomes International (HOI) in February 2007 to undertake a review of the Innovative Health Services for Homeless Youth (IHSHY) program and to recommend future policy directions for the program.

E.1 TERMS OF REFERENCE

The review of the IHSHY program was undertaken to consider the future policy directions from the perspective of formulating the next set of Commonwealth and state/territory Agreements. In particular the Review was to:

- Assess the current performance of the program; and
- In light of this assessment and the overall goals for the program, formulate recommendations about policy directions for the next set of Commonwealth and state/territory Agreements.

E.2 REVIEW METHODOLOGY

The Review was undertaken in six (6) stages commencing on 2nd February 2007 and was completed on 18 May 2007. The methodology included:

- Project planning;
- Environmental analysis which included a literature review of homeless and at-risk youth service models and program evaluations that have been undertaken in Australia and overseas and the development of a review framework;
- Consulting with a range of stakeholders including representatives from state and territory health Departments; IHSHY program service providers; Department of Employment and Workplace Relations (DEWR); Department of Families, Community Services and Indigenous Affairs (FaCSIA); DoHA Mental Health, Drug and Alcohol and Population Health Branches.
- Data analysis;
- Assessment of policy options; and
- Preparation of a draft and final report.

E.3 PROGRAM OVERVIEW

The Program was introduced in response to the Burdekin Report's findings that homeless young people exhibited chronic health problems (such as malnutrition and diet-related diseases, AIDS and sexually transmitted diseases, and drug and alcohol abuse) but are reluctant to seek treatment through mainstream services which they regard as judgmental and unsympathetic to their needs and life situations[1]. To address this problem the 1989-90 Federal Budget allocated $7 million over four years (jointly funded with state/territory governments) to develop and implement innovative health care services for disadvantaged young people. The program was developed to

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[1]   House of Representatives. Standing Committee on Community Affairs, Report on Aspects of Youth Homelessness, 1994, p80

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   1

respond to the complex health needs of homeless and otherwise at-risk young people and their dependents and was targeted to high needs (primarily metropolitan) locations.

Reviews of IHSHY program undertaken in 1992-93, 1997 and 2002, found that clients were continuing to gain benefits from accessing services and that the ongoing program plays an important strategic role in terms of facilitating the access of young, marginalised people to health services.

E.3.1 PROGRAM GOAL

The Program goal is to contribute to improving health outcomes for homeless and at-risk youth by:

- Improving access to mainstream health services or providing access to specialised health services for homeless and at-risk youth: and/or

- Providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth.

The Program operates at the interface between those young people who are marginalised within our society, and the health system. Program funds are intended to be directed to innovative responses to young people who are homeless, or 'at-risk' of homelessness (i.e. young people and their dependants at-risk of developing, or exhibiting, a range of individual and social problems, including, but not limited to, mental health problems and problems associated with substance use, or who are engaging in risky behaviours that may impact on their health and well being).

E.3.2 SERVICES PROVIDED

Services to the target group are provided directly to clients or may assist the client group through referral, advocacy and support in gaining access to mainstream health or other services. In addition the Program plays an important role in facilitating access to health services by marginalised young people. There is a diversity of IHSHY Program services operating across Australia.   The range of services can be categorised into direct and indirect services.

1. **Direct services.** These include health promotion education and information, counseling and support, clinical consultations (clinic based, outreach and mobile), group activities (including recreational activities) and personal care support.

2. **Indirect services.** These services include referral/linking client to mainstream services, advocacy for client group, secondary consultations to support workers in other agencies providing services to the client group and enhancing the body of knowledge by participating in limited research conference and related activity.

The Program adopts a social view of health in that the focus is not only on meeting immediate clinical needs, but also in assisting clients to address issues that may impact on their life circumstances (e.g. parenthood programs, social and other recreational skills, housing, assistance in relation to income support issues and employment related activities).

E.3.3 PROGRAM MANAGEMENT STRUCTURE

The Program structure is managed at three levels namely, the Commonwealth represented by DoHA, state and territory governments through respective health departments and service providers (both government and non-government).

1. **Commonwealth responsibilities.** The Commonwealth is responsible for the national administration of the IHSHY program including negotiation of the Commonwealth/state and territory Agreements, resource allocation and monitoring and reporting on the performance of the Program.

2. **State and territory Health Department responsibilities.** State and territory Health departments are responsible for purchasing services, negotiating service agreements, monitoring and reporting on service provision and resource utilisation as specified in the Agreements.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   2

3.   **Service provider responsibilities.** Service providers are responsible for staff recruitment, service delivery and monitoring and reporting of service provision and resource utilization as specified in the Service Agreements with state and territory health departments.

E.3.4 PROGRAM FUNDING

The IHSHY program is jointly funded between the Australian Government and state and territory governments under a Special Purpose Payment, with state and territory governments matching, and in five(5) instances exceeding, the Commonwealth's contribution. Funding from the Commonwealth is allocated to state and territory health departments on an historical basis. The current funding agreement covers the period July 2004 to June 2007.

E.4   ASSESSMENT OF PROGRAM PERFORMANCE

The Review conducted an assessment of the appropriateness, effectiveness and efficiency of Program performance with respect to four (4) Key Result Areas as identified in the Review Framework.

- Program policy and structure (including funding arrangements, eligible services and the level of service coordination);
- Program administration;
- Program implementation; and
- Impact and outcomes.

A summary of the key findings for each Key Result Area is presented below.

E.4.1 ASSESSMENT OF PROGRAM POLICY AND STRUCTURE

The key Review findings relating to the assessment of the appropriateness, effectiveness and efficiency of the Program policy and structure from the perspective of the funding arrangements; eligible services provided and the level of service coordination were as follows.

1.   **Eligible services.** The eligible services as specified in the Funding Agreement are appropriate and well targeted. There is a need to allocate additional funding to support projects aimed primarily on undertaking research into evidence-based service models and needs assessment.

2.   **Program management.** Program management responsibilities as identified in the Agreement are clear and appropriate. With some notable exceptions the Program is operating in isolation from other programs (at state and territory health department and Commonwealth levels) and there is very limited strategic analysis and policy work undertaken within the Program.

E.4.2 ASSESSMENT OF PROGRAM ADMINISTRATION

The key Review findings relating to the assessment of the extent to which allocated Program resources were managed effectively and efficiently by state and territory health departments in accordance with the Funding Agreement were as follows:

1.   **Funds management.** The management of the funds is efficient with funding being deployed in accordance with the Agreement; resources are maximized at service provider level and service provider reports are completed and forwarded to the DoHA.

2.   **Issues impacting on program administration.** Our assessment of the administrative arrangements relating to the Program identified the following issues:

   –   The Program was not being continuously monitored in four (4) state and territory health jurisdictions;
   –   The quantitative data set needs improvement. There are no data definitions, activity data provided was highly questionable and there are some data that

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   3

could be collected that would better reflect the nature of the services being provided;

– An evaluation of the Program operations at the health jurisdictional level had not been undertaken during the Agreement period except in Western Australia;

– Most service providers are operating in isolation from other IHSHY service providers (with WA being the notable exception), and do not have an opportunity for information sharing;

– In three States communication between the health jurisdiction and the service providers is very limited; and

– Overall, in a majority of jurisdictions there is little if any communication on strategic and policy issues at any level in the Program.

E.4.3 ASSESSMENT OF PROGRAM IMPLEMENTATION

The key Review findings relating to the assessment of the effectiveness and efficiency of Program implementation were as follows:

1. **Service providers meeting client needs.** Service providers are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in coordinated manner.

2. **Service provision.** A wide range of services are being provided utilising a range of successful service models. Gaps and barriers to effective services and emerging issues are identified at service provider level and reported in their annual reports. They are addressed at service provider level where practical. Service providers have adopted evidence-based practices and aim to provide quality services. Non-government stakeholders are involved in the planning and development of services and services have the appropriate level of staff (to match funds) who are appropriately trained and experienced.

3. **Need to address service gaps and barriers.** There is little evidence of a policy response at the health jurisdiction or national level to address service gaps, barriers to provision of effective services and emerging issues.

E.4.4 ASSESSMENT OF PROGRAM IMPACT AND OUTCOMES

The key Review findings relating to the assessment of Program impact and outcomes to determine whether the Program goal and the benefits achieved are sustainable are as follows:

1. **The Program is achieving positive short-term impacts for the client group.** There is a positive short-term impact due to direct outputs meeting the immediate client need. Young people's knowledge has improved in relation to appropriate behaviours that will improve health outcomes and they are engaging with service providers and with peers where applicable. Mainstream service providers are increasing their knowledge of client group needs and IHSHY program funded services often receive referrals from these services. Significant innovations are occurring in some health jurisdictions and service providers are generally trialing innovative approaches within the confines of their existing services and budgets.

2. **Long term outcomes.** There is no systematic evidence to demonstrate longer-term outcomes associated with the IHSHY program. Anecdotal evidence is suggestive of positive and sustainable long-term benefits. It is likely that personal health is improving, that there is less risk-taking behaviour, that self-esteem and client connectedness is improving and that service providers are modifying services within service models and budgetary confines to meet young people's needs.

3. **Data limitations.** With the exception of output data provided with respect to the provision of direct services there was no quantitative data available to enable Program benefits to be quantified.

4. **Program evaluation.** There was no evidence of program evaluations being undertaken by seven state/territory health jurisdictions or at the service provider level.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   4

E.4.5 ASSESSMENT OF PROGRAM GOAL

Based on the evidence gathered in the conduct of this evaluation, the Review has concluded that the IHSHY program is contributing to improving health outcomes for homeless and at-risk youth. The Program is doing this by:

1.   Providing access to specialised health services for homeless and at-risk youth who would otherwise be unlikely to receive similar services in mainstream health systems (and if they did present to mainstream health services, would do so at a later date with additional complications and at increased costs).

2.   Providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth. The level of service innovation (where it is occurring) is at the service provider level.

3.   Improving access to mainstream health services (to a limited extent) as well as to other related welfare programs. Often mainstream services will refer to IHSHY program due their inability to cope adequately with the client group.

E.5   FUTURE POLICY DIRECTIONS

Based on the findings of the Review a range of opportunities aimed at improving the future policy directions for the IHSHY program and the associated Commonwealth state/territory Agreements have been identified and categorised from the perspective of:

- Commonwealth and state/territory Agreements; and
- Opportunities to improve IHSHY program access and service delivery.

The Review has also provided recommendations in relation to the program improvement opportunities.

E.5.1 COMMONWEALTH AND STATE/TERRITORY AGREEMENTS

The key Review findings relating to opportunities aimed at improving the future policy directions for the IHSHY program in relation to Commonwealth and state/territory Agreements are as follows:

1.   **Increased focus on service innovation.** It is important that the Program maintains the focus on service innovation. The Program should seek to reinforce its aim to harness and build upon the many innovative service delivery projects currently being undertaken by both public and private agencies across Australia. To ensure this is achieved, it is suggested that the next Agreements include pilots to improve service delivery. These pilot projects should be undertaken within an agreed framework which will ensure all stakeholders are clear as to the intent of the innovative focus of the Program.

2.   **Improve communication processes.** To improve communication at all levels within the Program, the following initiatives and associated responsibilities could be considered in the formulation of the next Agreements:

- **Establishment of a national web site.** To assist with communication and promulgating relevant information, research and types of services being provided.
- **Convening of national meetings.** The Commonwealth could convene two meetings during the period of the Agreements. The first meeting could focus on discussing the Program operational issues and the future directions for the forthcoming Agreement period. A second meeting could be held at the midpoint of the Agreement period, to focus on new developments, developing responses to emerging issues and addressing barriers to providing or improving services. The meetings could be attended by the DoHA, health jurisdiction representatives and a selection of service providers from each jurisdiction.
- **Development of a Program communication strategy.** It is suggested that DoHA develop a communication strategy in association with state/territory health jurisdictions and nominated IHSHY program service providers. The strategy could promote the ongoing value of the IHSHY program to key stakeholders so that there

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   5

is ongoing commitment to, and support for, all aspects of the implementation of the Commonwealth and health jurisdictional policy for providing innovative health services to homeless and at-risk youth.

3. **Improve annual program monitoring:** There is an opportunity to streamline and improve the data collection and reporting processes in the next Agreement by:

   – **Improving collection and reporting of quantitative data.** To improve the quality of the quantitative data collection, a review of data items is suggested to ensure they are more reflective of the activity being undertaken in the Program. It is proposed that standardised data definitions be developed and circulated to stakeholders to ensure consistency in data collection and reporting.

   – **Improve collection and reporting of qualitative data.** A review could be undertaken of current data items reported to the DoHA with a view to reducing the reporting burden on service providers. It is important that wherever possible, the richness of the information that is currently provided should be maintained.

   – **Guidelines for annual Program reporting.** The Review proposes that guidelines for annual Program reporting be reviewed in association with state/territory health jurisdictions and service providers which would outline the key reporting areas including:
     ➢ The background of the projects undertaken under the auspices of the IHSHY program;
     ➢ Analysis of projects in terms of strengths, weaknesses, opportunities and threats; and
     ➢ The actions proposed to improve the Program.

   These guidelines could then be included in the Agreement as part of the performance measurement requirements.

4. **Frequency of data reporting.** Currently Program data is reported by state/territory health jurisdictions to the DoHA on an annual basis. In the interests of improving the effectiveness and efficiency of Program monitoring and to facilitate a timely follow-up of relevant issues, the Review proposes that data reporting should be on a six-monthly basis. Jurisdictions could provide a consolidated report to the Commonwealth which includes an analysis of trends, emerging issues, barriers and other matters of importance as well as highlighting responses to the issues raised.

5. **Strengthen Program evaluation.** To support the need to measure the impacts and outcomes for IHSHY program the following opportunities have been identified:

   – **Reinforcement of the conduct of Program evaluations by state/territory health jurisdictions.** The Agreements could reinforce the need for state/territory health jurisdictions and other recipients of IHSHY program funding to undertake an evaluation of specific projects aimed at demonstrating the appropriateness, effectiveness and efficiency of these projects in meeting specified Program objectives. It is proposed that the timing of such evaluations be specified in the Agreement and could include a mandatory evaluation report to be submitted by each jurisdiction prior to the end of the Agreement.

   – **Measuring client outcomes.** A generic tool to measure health and social functioning in the client group could be developed and tested in a small number of service providers (so that changes in individual clients can be evaluated over time). This tool could then be made available for all IHSHY program service providers who wish to evaluate client outcomes. It is recognised that there will be difficulties in administering any tool to the target group due to their mobility. However, if supported, investment in such a tool would provide some evidence of client outcomes.

   – **Develop Program evaluation guidelines.** In order to provide support to state/territory health jurisdictions and service providers who will be involved in undertaking Program evaluations, the Review proposes that program evaluation objectives/ guidelines/ principles be included in the Agreement.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   6

6. **Estimate number of homeless and at-risk youth.** There is a paucity of data relating to trends in the number of homeless and at-risk youth since the 2001 census data was analysed. To assist in understanding trends in the size of the target group, the adequacy of the overall level of program funding and distribution of those funds across jurisdictions, the estimate of the numbers of homeless and at-risk youth will need to be updated. This could be done in conjunction with FaHCSIA.

7. **Review the eligible funding criteria to include research and needs assessment.** It is suggested that a review of the eligibility criteria be conducted to include projects aimed primarily on research and needs assessment (currently excluded by the Agreement). This would assist to identify service gaps and assess the applicability of various service models and strategies that best meet the needs of the client group.

E.5.2 INITIATIVES TO IMPROVE SERVICE DELIVERY AND ACCESS

The following opportunities are focused on improving service delivery and access.

1. **Develop and adopt best practice principles.** Service providers are committed to the provision of quality services. Whilst there have been several initiatives in relation to identifying best practice service delivery guidelines across Australia, there has been no attempt to adopt best practice principles for the Program. As part of a commitment to best practice and quality, the IHSHY program could formally develop and adopt best practice principles for service providers and these could be included in service provider service agreements.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   7

1

INTRODUCTION

The Australian Government Department of Health and Ageing (DoHA or the "Department") engaged Health Outcomes International (HOI) in February 2007 to undertake a review of the Innovative Health Services for Homeless Youth (IHSHY) Program and to recommend future policy directions for the program.

1.1 TERMS OF REFERENCE

The review of the IHSHY program was undertaken to consider the future policy directions from the perspective of formulating the next set of Commonwealth and state/territory Agreements. Specific consideration was given to:

- An assessment of the current performance of the program against its stated goals;
- Possible policy directions for the next set of Commonwealth and state/territory Agreements; and
- Program administration/improvement opportunities.

1.2 BACKGROUND TO THE REVIEW

The IHSHY Program was established in 1991 to assist in the provision of health services to homeless youth or youth at-risk of becoming homeless. The program is jointly funded by the Commonwealth and the state and territory governments and is governed by Commonwealth/state and territory agreements. The current agreement commenced in 1 July 2004 and operates until 31 June 2007. The program's services are currently provided by 46 community groups across Australia.

1.3 REVIEW METHODOLOGY

The methodology for this review comprised six (6) stages as set out below.

1. **Project Planning.** HOI met with the DoHA project management team to receive an initial project briefing and finalise the parameters for the review. The discussion established the project management and communication processes, arranged the transfer of the relevant documentation to HOI, developed a list of key stakeholders, and finalised the process for consultations. A project plan was subsequently drafted and agreed with the DoHA.

2. **Environmental analysis and review framework.** This stage included the conduct of a literature review to consider the evidence base with respect to the implementation of homeless youth programs and the findings of similar program evaluations that have been undertaken and a review of the documentation relating to the delivery of homeless youth health services. At the conclusion of this stage a review framework (refer Appendix A) was developed by the project team and subsequently approved by the DoHA.

3. **Stakeholder Consultations.** A stakeholder consultation protocol was developed which was used to guide the stakeholder consultations. Interviews were conducted on a semi-structured basis where specific questions were asked in addition to providing interviewees with the opportunity to add any additional information that was considered appropriate. Overall we consulted with a total of 94 individuals representing three Commonwealth agencies, eight state and territory state/territory health jurisdictions and 27 service provider organisations.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007
8

4. **Synthesis and analysis of review findings.** The focus of this stage was the drawing together of information gained in preceding stages of the project, which specifically addressed the specified review objectives.

5. **Assessment of policy options.** This stage included the assessment of policy options to streamline the policy and administrative functions of the IHSHY program to improve effectiveness and efficiency; undertake an impact analysis of each option in terms of strengths, weaknesses, risks and benefits and identify opportunities to enhance future policy direction.

6. **Final Report.** HOI prepared a final report (this document) that brought together the findings from the consultations and the environmental analysis outlining the review findings.

1.4   CONSULTATION METHODOLOGY

A broadly based stakeholder consultation methodology was adopted which included face-to-face interviews and telephone interviews with a range of stakeholders including representatives of:

1. **Commonwealth Agencies.** Telephone interviews were conducted with Departments nominated by the DoHA. The Departments were the Department of Employment and Workplace Relations (DEWR), the Department of Families, Community Services and Indigenous Affairs (FaCSIA), and the DoHA Mental Health, Drug and Alcohol and Population Health Branches.

2. **State Government health representatives.** A telephone interview with the eight State Health Department representatives with responsibility for the IHSHY program (a face-to-face meeting was conducted in two States).

3. **Combined State Commonwealth consultation.** A teleconference was conducted with all State and DoHA representatives simultaneously.

4. **Service Providers.** Telephone consultations were undertaken with two service providers in Queensland (QLD), New South Wales (NSW) (one regional and one metropolitan) and the single service provider in the Australian Capital Territory (ACT), Northern Territory (NT) and Tasmania (TAS). The services interviewed were determined by the state and territories Health Departments and they were selected based on the range of services they were providing so that the respondents would be able to provide a representative perspective on the IHSHY program.

5   **Stakeholder workshops.** Workshops were conducted with a group of service providers in Victoria (VIC) and Western Australia (WA). In Victoria 16 people attended representing 10 service providers and the Department of Human Services. In WA eight people attended representing five service providers and the Department of Health. In addition a workshop was conducted with nominated representatives from the DoHA and state and territory health jurisdictions to seek further considered feedback in relation to key issues pertaining to the future directions of the IHSHY program and the options for improving the Program.

6. **Service provider visits.** Site visits to IHSHY program funded service providers in South Australia and Western Australia and one regional service was visited in Victoria. The services visited were:

    –   Hindmarsh Centre - Mission Australia, and the Streetlink Youth Health Service - Uniting Care Wesley in South Australia;
    –   Bendigo Community Health Service in Victoria;
    –   Ruah Young Women's Program, Daughters of Charity and the Hills Community Support Group Inc) in Western Australia.

1.5   STRUCTURE OF THIS REPORT

This document represents the revised draft final report for the review. Accordingly, the structure of the remainder of the report is:

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   9

- Chapter 2 provides a summary of the literature review findings, an overview of the IHSHY program operations and the analysis of Program activity and expenditure over the three year Agreement;

- Chapter 3 presents the findings of the stakeholder views from the perspective of the Program, policy structure, administrative arrangements, program implementation and the key program impact and outcomes;

- Chapter 4 provides an assessment of the performance with respect to the Program policy and structure; administrative arrangements; implementation and impact and outcomes; and

- Chapter 5 discusses a range of opportunities to improve the future policy directions for the Program and the formulation of future Commonwealth and state/territory Agreements.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   10

2

ENVIRONMENTAL ANALYSIS

This chapter provides an overview of the operations of the IHSHY program and encompasses an overview of:

- The literature review findings related to the provision of homeless youth services in Australia and overseas and the factors impacting on service delivery;
- An overview of the IHSHY program including operational arrangements, range of services provided and program management structure; and
- Analysis of Program activity and expenditure.

2.1 LITERATURE REVIEW

A review of the literature was undertaken to consider the evidence base with respect to the implementation of homeless youth programs and the findings of similar program evaluations that have been undertaken. As part of this we aimed to identify what key performance indicators (KPI's) may have been used in relation to similar programs.

There is very limited information available in the literature on the operation of homeless youth programs (a fact confirmed by similar observations made in the articles that were identified and from consultations with health jurisdiction representatives who had undertaken similar searches).

2.1.1 AUSTRALIAN RESPONSE TO YOUTH HOMELESSNESS

The history of the policy approach to youth homelessness; the scale of the problem; the rationale for dealing with the issue and the difficulties in monitoring progress were comprehensively set out in a paper delivered at the Australian Social Policy Conference in 2005[2]. This paper highlights a number of issues impacting on homeless youth. One of the major impacts cited on this target group is the lack of stability of a secure home. However, homelessness also leads to social exclusion, precluding young people from participating in education, training and employment. Other complexities such as health and mental health problems, substance abuse, social isolation and deviant behaviour are also associated with the homeless experience, further jeopardising their capacity to make the complex transition into adulthood successfully.

Addressing the issue of youth homelessness is vital to ensure that young people are given the opportunity to make the transition into adulthood as integrated members of society, well positioned to take advantage of the opportunities afforded to them.

It is acknowledged that homelessness is not an event – but a process which occurs over time; and that the transition out of homelessness is also a process which requires support over a period of time. Research has contributed to the increased understanding of the complex sphere of issues contributing to homelessness. It has been shown that young people, and particularly disadvantaged young people, do not deal well with complex packages of health services and therefore, there is a need to streamline services delivery in a coordinated manner. Addressing these issues requires governments and community partnerships to be developed to deliver the services required to meet the needs of homeless youth.

The problem of youth homelessness is far from resolved but over the years, sustained efforts have led to progress, however to date there has been limited formal evaluation of the effectiveness and

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[2] Wood,E. &Yipp,D. (2005). *Youth Homelessness- The Policy Journey.* Delivered at the Australian Social Policy Conference 2005

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   11

efficiency of homeless youth programs and the degree to which they have contributed to positive client outcomes.

HOMELESS YOUTH DEMOGRAPHICS

Chamberlain and Mackenzie developed a model for estimating youth homelessness which indicated that there was an increase of 8.4% in the rate of homelessness among teenagers aged 12 to 18 during the period 1994 to 2001. The Australian Bureau of Statistics has gathered data on homelessness as part of the last two Censuses. Estimated figures show a slight overall decrease in the number of homeless people on census night (down from 105,304 in 1996 to 99,900 in 2001) however much of this numerical decrease can be attributed to changes in measurement methodology[3]. On the whole, it is generally accepted that the overall size of the homeless population has remained stable and this is a positive outcome given the rise in Australia's total population.

Nevertheless, the size of the population we are dealing with is very hard to measure precisely, making it difficult to show the success or otherwise of our interventions in homelessness overall, added to which is our increased emphasis on prevention and early intervention. We cannot say at this stage how many young people will not become homeless ten years from now because of the family support strategies we now have in place. The perennial dilemma faced by early intervention strategies relates to the fact measurement tools to gauge long-term effectiveness are difficult to devise.

STRATEGIES TO ADDRESS YOUTH HOMELESS NEEDS

Considerable progress has been made in terms of addressing youth homelessness at its early stages. *Reconnect* and other early intervention and prevention programmes continue to operate and receive ongoing funding. The focus on family relationship education, family mediation and family violence prevention also continues to be a priority for the Australian Government, with indirect benefits being achieved in the area of youth homelessness prevention.

Significant steps can, however, still be taken to ensure that our response to youth homelessness and the health of homeless youth is encompassing and increasingly coordinated. Holistic policy responses and service linkages continue to be a high priority area with new innovations and initiatives receiving support and funding.

It is increasingly apparent that young people who are homeless require a complex package of services, delivered in a flexible and individualised way. The confounding problem is that developing and implementing these packages presents considerable challenges and a range of initiatives have been implemented to address these issues. Implementation of the IHSHY program is a small part of the Commonwealth and state/territory response to addressing these issues.

2.1.2 INTERVENTIONS TO IMPROVE HEALTH OF THE HOMELESS

The rationale for homeless youth health interventions is clearly articulated in an unpublished paper[4] which states that the health system has a duty and responsibility to provide services to those people who are most in need. But in the case of marginalized and at-risk young people, they are often perceived as too hard to reach, or are invisible because they do not access services until they are in crisis.

There is an urgent need to provide cost effective care to young people, many of whom are Aboriginal, whose needs are not met by mainstream health services. These clients typically have complex physical and mental health issues and related social issues. If they are not supported, these needs exacerbate leading to presentations at emergency departments and an increased burden on hospitals and other services. Neglect of at-risk and marginalised young people results in disproportionate costs to the health system and to government as a whole through:

- Increased pregnancies;

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3   Chamberlain, C. and MacKenzie, D. Counting the Homeless 2001, Australian Bureau of Statistics, 2003.

4   Robinson, M. IHSHY Program Indicators of Need, Unpublished Paper, Department of Health WA, 2006.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   12

- Increased mental health and comorbidity issues;
- Increased incidence of suicide and self harm;
- Increased substance misuse issues;
- Increased incidence of blood-borne viruses;
- Increased presentations to hospital emergency departments;
- Children in out-of-home care or foster care;
- Young people in prison or detention; and
- Crime.

All of these are to a large extent preventable through the implementation of targeted health services.

In 2005, Hwang[5] undertook a systematic review to summarise the existing evidence on interventions to improve health-related outcomes in homeless people. In undertaking the study he noted that to date, no comprehensive and rigorous survey has been undertaken of the literature in this area. Of 4,500 articles found on homelessness 2% met inclusion criteria in their review. The study found a relatively small number of good and fair-quality controlled studies were available to guide the selection of interventions to improve the health of homeless people. The evidence was more prevalent with respect to the treatment of homeless single adults with mental illness or substance abuse.

Overall, the study findings suggested that clinicians should focus on ensuring that homeless people were able to receive health care through coordinated treatment and support programs that are specifically tailored to the needs of the homeless. Rather than focusing on identifying the "most effective" treatment modality, it was more important to ensure the availability of at least one modality that has been shown to be effective. The study concluded that:

- Coordinated treatment programs for homeless adults with mental illness or substance abuse usually resulted in better health outcomes than conventional care;
- Health care for homeless people should be provided through such programs whenever possible; and
- Research is lacking on interventions for youths, families, and conditions other than mental illness or substance.

Some of the key findings of the Review of Inner City Homeless Primary Health Care Project undertaken in 2004[6] provided reinforcement of the need for the IHSHY program and an insight into successful interventions. In summary the report identified that:

- The health needs of homeless people were complex and multi-factorial, with delayed medical attention often leading to complex conditions;
- Inner city homeless people experience substantial financial, social, practical, and psychological barriers to accessing primary health care services;
- Declining rates of bulk billing represent a significant financial barrier to homeless people accessing general practice services, as well as social marginalisation and organisational factors such as the use of standard appointment systems;
- Key stakeholders overwhelmingly advocate an outreach model of primary health care for the homeless which is supported by international evidence demonstrating that outreach models contribute to increased health care utilisation among the homeless, reduced costs, and decreased use of hospital emergency departments; and
- Evidence suggests that public funding of salaried medical and nursing practitioners ensures that health care services for the homeless are viable and sustainable, allowing for longer consultations and assertive follow-up.

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5   Hwang, S.W. et al. (2005). Interventions to Improve the Health of the Homeless: A systematic review. American Journal of Preventative Medicine, 29(4), 311-319.

6   Department of General Practice. Review if Inner City Homeless Primary Health Care Project, University of Adelaide, 2004

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   13

In order to be effective, the report identified that general practice services need to be delivered within the context of a multidisciplinary primary health care approach, where physical, psycho-emotional, and social health needs are understood to be interrelated and contingent upon one another. While this is true for primary health care in general, it is particularly relevant for the homeless because their health needs arise in the context of historical and continuing social and economic disadvantage, often against backdrops of physical, psychological, and sexual abuse.

An Australian randomised controlled trial undertaken in 2003[7] has shown that young mothers benefit from sustained support in the form of home visitation and this has been used in part as the basis for one funded IHSHY program service in Western Australia. The study indicated that with support young mothers can return to school and re-enter the workforce and are less likely to have adverse childhood outcomes such as child protection notification and court interventions.

2.1.3 OUTCOME MEASUREMENT

A paper focusing on outcomes measurement[8] did not reveal the existence of any single outcome measurement instrument that could be used for the homeless system of care. At the program level outcome measurement is typically based on the aggregation of client-level outcomes. These can include:

- Days of reduced substance use;
- Increased improved mental health status; and
- Increased client participation and engagement.

At the client-level of measurement, several instruments were identified that have potential for providing the basis for outcome measurement. Outcomes can be tracked by multiple testing of clients over time, with change scores used as indicators of client goal attainment. In considering the application of appropriate outcome measurement instruments it is critical to identify instruments with known psychometric properties.

A study whose purpose was to develop homeless-youth-identified process and outcome measures of quality health care using qualitative methods was undertaken in Washington in 2002.[9] The findings of this study demonstrated that homeless youth most often stated that cultural and interpersonal aspects of quality of care were important to them. Physical aspects of quality of care reported by the youth were health care sites separate from those for homeless adults, and sites that offered a choice of allopathic and complementary medicine. Outcomes of health care included survival of homelessness, functional and disease-State improvement, and having increased trust and connections with adults and with the wider community.

The majority of youth felt that improvement in health and functional status was one of the most important desired outcomes of health care. "So we're not in a lot of pain and can get around and do what we need to do" was a representative comment. The youth linked this improvement in health and functional status to enabling them to get out of homelessness, "You can't keep a job and get a place of your own if your health sucks." Youth also frequently mentioned outcome measures of improvements in certain common health conditions for homeless youth, including nutritional status ("weigh us so you know we're not losing a ton of weight from not getting enough food"), mental health ("see if our mood and personality improves"), as well as overall reductions in pregnancies and sexually transmitted diseases. Additionally, many youth said that "surviving homelessness" was an important outcome of health care for homeless youth.

Youth consistently stated that desired outcomes of health care for homeless youth were more global in nature, and included fostering a sense of purpose in life and connectedness to the wider community. They talked about positive health care experiences helping them to be able to trust adults and to make positive changes in other areas of their lives.

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7   Quinlivan JA, Box H and Evans SF. (2003) "Postnatal home visits in teenage mothers: a randomised controlled trial", Lancet Vol 361, 893-900

8   Crook, W.P., Mullis, R.L., Cornille, T.A., & Mullis, A.K. Outcomes Measurement in Homeless Systems of Care. Evaluation and Program Planning,
     28, 379-390. (2005)

9   Ensign,J. Quality of Health Care: The Views of Homeless Youth Health services Research (pp695-708) (2004)

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   14

In the USA the Department of Health and Human Services (DHHS) has been involved in the development of core performance Indicators to measure success across the four for Homeless Serving Programs Administered by DHHS.[10] Three Health status Indicators have been proposed as shown in Table 2.1 below.

Table 2.1: Homeless Youth Health Status Indicators Developed by the DHHS

Type of Measure	Core Performance Measure	When Data Item Could Be Collected	Comment
Outcome - Substance Abuse	• Number/percent of homeless individuals enrolled and assessed with substance abuse problem that have no drug use the past month (or quarter)	• At intake/enrolment • 3, 6, and/or 12 months after point of enrolment • At termination/exit	• Drug screening could be used
Outcome -Physical Health Status	• Number/percent of homeless individuals enrolled and assessed with physical health problem that have good or improved physical health status during past month (or quarter)	• At intake/enrolment • 3, 6, and/or 12 months after point of enrolment • At termination/exit	• May be difficult to objectively measure "good or improved
Outcome -Mental Health Status	• Number/percent of homeless individuals enrolled and assessed with Mental Health Problem that have good or improved mental health during past month (or quarter)	• At intake/enrolment • 3, 6, and/or 12 months after point of enrolment • At termination/exit	• May be difficult to objectively measure "good or improved"

In addition three outcome measures were proposed for youth but none of these related to health.

A Canadian study[11] identified that epidemiological studies quantifying specific disease risks in street youth remain limited with only a single estimate being currently available on the incidence of HIV infection. Mental health studies that were identified had important limitations with only 3 of 25 studies identifying a control group. It was noted that no longitudinal studies were identified to exist. It was also noted that there was very limited data available on other outcomes such as dental, reproductive history and various infections.

In Australia NSW Health have run a pilot project[12] in relation to data collection and measuring health outcomes. It was noted that there had been very little done on measuring outcomes in the sector, in NSW or elsewhere. Most reporting relates to inputs (i.e. client numbers, budgets, hours, types of service) and processes. Even the national pilot funding program IHSHY seems to be principally collecting input and process data. The data collection proformas designed and piloted aimed to answer four questions, namely

• Are the group of young people using Youth Health Services predominately from a disadvantaged background which could inhibit their accessing mainstream health services?

• Do young people approaching Youth Health Services have health related problems which the services are addressing?

• Are the young people approaching Youth Health Services experiencing 'environmental challenges' (defined in terms of; economic stability, accommodation, employment or education participation and related factors) which the Youth Health Services are addressing?

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10 Department of Health and Human Services (2003) "Core Performance Indicators for Homeless-Serving Programs Administrated by DHHS" Final Report (2003) http://aspe.hhs.gov/HSP/homelessness/perf-ind03/execsum.htm

11 Boivin, JF., Roy, E., Haley, N. & Glabaud du Fort, G. (2005) "The Health of Street Youth: A Canadian Perspective". Canadian Journal of Public Health, 96 (432-438)

12 Bruce Callaghan & Associates. (2006) "Measuring the Impact of NSW Youth Health Service Interventions on Health Outcomes for Young People" (unpublished). NSW Association for Adolescent Health Inc. Funded by NSW Health

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   15

- Do the young people in contact with Youth Health Services exhibit personal capabilities and strengths, which can be developed or supported? Are Youth Health Services working effectively to strengthen young people's resilience or supporting them to make better use of mainstream health and community services?

- The findings of the pilot were that key performance indicators can be put in place and outcomes measured and that this could be done in a way which could support case planning, benchmarking and continuous improvement in the sector. To achieve this however some administrative and managerial changes would be required. These things would require investment and time. The pilot indicated that the investment is very likely to deliver significant system improvements and will impact indirectly on health outcomes through better management.

2.1.4 SUMMARY OF LITERATURE REVIEW FINDINGS

The level of resources allocated to homeless youth heath programs is relatively small when compared to other Commonwealth programs that have been implemented to address youth homelessness. This may be indicative of a lower priority in this policy area and/or of structural problem in the program in that it is not integrated into other policy areas and is effectively a small "orphan" program.

The evidence from the literature is that there is a strong justification for the establishment of the IHSHY program to address the need of the target group and that the innovative, flexible and responsive adapted service approaches that the structure aims to facilitate are the best approach.

In relation to measuring outcomes, it was identified that there is no single outcome tool available to be used in measuring outcomes. Program outcomes if they are to be measured can be done so by aggregating client level outcomes, and these can be tracked by multiple testing of clients over time and calculating improvement in scores. The fact that very few if any organisations have attempted to do this underlies the difficulties of studying this client group.

Client outcomes improvements can be measured by improvement in health and functional status and improvements in common health conditions for homeless youth including nutritional status (weight), reductions in pregnancy and STIs. Whilst recognised as fundamentally important no measures were identified to measure community connectedness.

NSW Health funded a pilot project which was focused on measuring the impact of NSW Youth Health Service interventions on health outcomes for young people and the next steps are currently being considered following a forum in December 2006. The focus of this project was on developing management information to ensure the programs are well targeted as well as developing an understanding of outcomes. It will provide rich learning for any work that may be undertaken in the IHSHY program in this area.

The literature review findings together with the feedback received from stakeholders consulted provide strong evidence supporting the implementation of innovative health services that are flexible, locally based and providing at least one service that has been adapted for the client group. There is also evidence that demonstrates:

- GP services that are sessionally funded are the best model to address the medical needs of the client group;

- That the client group seeks complementary as well as an allopathic medical response and this should be considered in planning at the local level.

- The importance of outreach services and these should continue to be a key component of the IHSHY program.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   16

2.2 BRIEF HISTORY OF IHSHY PROGRAM

A major crisis response element of the 1989-90 Youth Social Justice package was the Innovative Health Services for Homeless Youth (IHSHY) pilot programme[13]. The program was introduced in response to the Burdekin Report's findings indicating that homeless young people exhibited chronic health problems (such as malnutrition and diet-related diseases, AIDS and sexually transmitted infections, and drug and alcohol abuse) but were reluctant to seek treatment through mainstream services which they regard as judgmental and unsympathetic to their needs and life situations.[14]

To address this problem the 1989-90 Federal Budget allocated $7 million over four years (jointly funded with state/territory governments) to develop and implement innovative health care services for disadvantaged young people. The program was developed to respond to the complex health needs of homeless and otherwise at-risk young people and their dependents and was targeted to high needs (primarily metropolitan) locations.

Reviews of the program undertaken in 1992-93 and 1997 found that the program had strong client support for its ability to meet client needs. The program's sustained positive outcomes have encouraged continued joint funding from the Australian Government and state/territory governments.

In 2004, new funding agreements were signed with each state and territory to continue funding the IHSHY program for a further three years (through to June 2007). The Australian Government committed approximately $7.4 million under this agreement to continue providing targeted, effective and essential health services for young people.

A review of IHSHY program undertaken in 2002, found that clients were continuing to gain benefits from accessing services and that the ongoing program plays an important strategic role in terms of facilitating the access of young, marginalised people to health services[15].

2.3 OVERVIEW OF THE IHSHY PROGRAM

This section provides an overview of the IHSHY program including program operational arrangements, the range of services provided and the program management structure.

2.3.1 OPERATIONAL ARRANGEMENTS

The IHSHY program is jointly funded between the Australian Government and State Governments. The IHSHY program is funded under a Special Purpose Payment, with State governments matching, and in most instances exceeding, the Commonwealth's contribution. Funding from the Commonwealth is allocated to state/territory health jurisdictions on a historical basis. The current funding agreement covers the period July 2004 to June 2007.

The program goal is to contribute to improving health outcomes for homeless and at-risk youth by:

- Improving access to mainstream health services or providing access to specialised health services for homeless and at-risk youth: and/or
- Providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth.

As stated in the Funding Agreement, the IHSHY program operates at the interface between those young people who are marginalised within our society and the health system. Program funds are intended to be directed to innovative responses to young people who are homeless, or 'at-risk' of homelessness (i.e. young people and their dependants at-risk of developing, or exhibiting, a range of individual and social problems, including but not limited to mental health problems and

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13   Wood,E. &Yipp,D. (2005). Youth Homelessness- The Policy Journey. Delivered at the Australian Social Policy Conference 2005

14   House of Representatives. Standing Committee on Community Affairs, Report on Aspects of Youth Homelessness, 1994, p80

15   Community Link Australia, Review of Innovative Health Services for Homeless Young People, Commonwealth Department of Health and Ageing, February 2003.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   17

problems associated with substance use, or who are engaging in risky behaviours that may impact on their health and well being).

2.3.2 RANGE OF SERVICES PROVIDED

To achieve its objective, the IHSHY program provides funding for innovative health and related services for homeless, marginalised and at-risk young people and their dependents that respond to their complex health needs. Service providers may deliver services directly or may assist the client group through referral, advocacy and support in gaining access to mainstream health or other services.

The IHSHY program plays an important role in facilitating access to health services by marginalised young people. There is a diversity of IHSHY program services operating across Australia.   The range of services can be split into direct and indirect services.

1. **Direct services.** These include health promotion education and information, counselling and support, clinical consultations (clinic based, outreach and mobile), group activities including recreational activities, and personal care support.

2. **Indirect services.** These services include referral/linking client to mainstream services, advocacy for client group, secondary consultations to support workers in other agencies providing services to the client group and enhancing the body of knowledge by participating in limited research conference and related activity.

The Program adopts a social view of health in that the focus is not only on meeting immediate clinical needs, but also in assisting clients to address issues that may impact on their life circumstances (e.g. parenthood programs, social and other recreational skills, housing, assistance in relation to income support issues and employment related activities). There is a diverse range of services and service models and the IHSHY program is characterised by a high level of flexibility to allow an appropriate response to local needs and to the changing needs of the client group. The Funding Agreement outlines a range of IHSHY program eligible and ineligible services which are presented in Appendix B.

2.3.3 PROGRAM MANAGEMENT STRUCTURE

There are three levels in the program hierarchy, namely the Commonwealth represented by DoHA, state and territory governments through respective state/territory health jurisdictions and service providers (both government and non-government). Responsibilities of the DoHA and state/territory health jurisdictions as outlined in the Agreements are:

The Commonwealth maintains responsibility for the national administration of the IHSHY program including:

- Managing the negotiation of the Commonwealth/state and territory Agreement;
- Payment of IHSHY program funds to the State;
- Ensuring that the State meets its obligations under the Agreement;
- Providing national leadership in the development of the Program; and
- Reporting to the Australian Government on the funding, activities and outcomes of the IHSHY program.

The state/territory health jurisdictions have responsibility for administering the IHSHY program with respect to:

- Advertising and processing applications for IHSHY program funding and/or continue funding existing service providers where it is demonstrated that they are effectively meeting the objectives of the IHSHY program;
- Where appropriate, briefing the State Minister, or their nominee, on recommendations for funding allocations;
- Drawing up appropriate contractual agreements with approved service providers;
- Providing the Commonwealth with a comprehensive description of services to be funded in the approved format at the beginning of each financial year;

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   18

- Monitoring service provider performance;
- Providing the Commonwealth with a Final Report at the end of each financial year which includes a comprehensive final report on each service funded in the approved format and a financial acquittal;
- Making payments to service providers;
- Obtaining audited returns from service providers at the end of each financial year; and
- Ensuring that funded services meet the eligibility criteria for funding as set out in the Agreement.

The role and responsibilities of service providers include:

- Recruiting staff;
- Delivering services in accordance with their specific agreement; and
- Providing Reports (service and financial) as specified.

The Agreements also specify that services and organisations applying for IHSHY program funding are required to include an evaluation component in their funding proposals, including maintaining data on clients and service operations.

2.4   ANALYSIS OF IHSHY PROGRAM ACTIVITY

This section presents the results of our analysis of IHSHY program with respect to the activity levels provided in 2005/06.

2.4.1   SERVICE PROVIDER PROFILE

There are 45 active service providers currently funded under IHSHY program. Of the total service providers 44% are State government organisations and 56% are NGO's. The profile of service providers by state/territory is presented by In Table 2.2 below.

Table 2.2: Service Provider Profile by State – 2005/06

State	Number of Service Providers	Government	NGO
ACT	1		1
NSW	8	5	3
NT	1		1
QLD	6		6
SA	2		2
TAS	1		1
VIC	18	13	5
WA	8	2	6
Total	45	20	25

Table 2.2 shows that in New South Wales and Victoria the majority of service providers are government organisations (Area Health Services in NSW and Community Health Services in Victoria). In the remaining states/territories there are only two (2) other government organisations both in Western Australia (one a major tertiary centre, the other a primary school).

2.4.2   ACTIVITY ANALYSIS

In 2005/06 (the last complete reporting year) activity related data was requested from Program service providers including:

- Number of individual clients, including caseload and individuals receiving one-off service or intervention;

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   19

- Number of group sessions by number of participants (eg health promotion sessions, group therapy sessions);
- Average numbers attending drop in facilities;
- Number of training sessions for health professionals by number of participants (eg youth friendly GP training); and
- Other (please specify number of clients by type of service).

In addition service providers are asked to identify the client groups for whom services were being provided and the nature of those services with respect to:

- Primary Health Care; and
- Other Health Services and Support Services.

Whilst there are significant limitations in the data provided by service providers and as presented in this section, (refer to analysis below), the following information assists in understanding the scope of the Program. It should be noted that one service provider in Victoria had not provided data at the time of the Review.

Table 2.3 presents a summary of the number of clients that received IHSHY program services during 2005/06.

Table 2.3: Number of IHSHY PROGRAM Clients by State – 2005/06

State	Number of Services[16]	No. Clients	% Total Services	Comment
ACT	1	1,003	6.1%	
NSW	5	3,123	19.0%	3 services did not provide data
NT	1	2,470	15.0%	
QLD	6	5,476	33.3%	
SA	2		0.0%	2 services did not provided data
TAS	1		0.0%	data not provided
VIC	15	2,798	17.0%	data item not applicable for 2 services
WA	5	1,565	9.5%	data item not applicable for 3 services
Total	33	16,435	100.0%	

Table 2.3 shows that based on the data reported to the Review:

1. The total number of clients receiving IHSHY program services was 16,435. We wish to emphasise that this data item was not provided by 6 health services providers and data was not received for one service provider.

2. Queensland service providers appear to provide the highest proportion of total client services (approximately 33%). Given the significant variability in the proportion of services provided relative to other states/territories, the analysis presented in Table 2.6 should only be regarded as indicative.

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[16] The number of services is under represented and only includes data that has been reported by service providers.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   20

Table 2.4 presents a summary of the number of client group sessions provided by State and territory during 2005/06.

Table 2.4: Number of Group Sessions by State – 2005/06

State	Number of Services	No. Group Sessions	% Total Group Sessions	Comment
ACT	1	8	0.3%	
NSW	7	393	17.2%	1 service did not provide data
NT	0		0.0%	service did not provide data
QLD	4	183	8.0%	data item not applicable for 2 services
SA	1	12	0.5%	data item not applicable for 1 service
TAS	0		0.0%	service did not provide data
VIC	13	1,347	58.9%	data item not applicable for 4 services
WA	4	345	15.1%	data item not applicable for 4 services
Total	**30**	**2,288**	**100.0%**	

Table 2.4 shows that based on the data reported to the Review:

1. The total number of group sessions provided by the IHSHY program was 2,288. In this instance, this data set comprises of 30 service providers representing approximately 67% of the total funded providers.

2. Service providers in Victoria appeared to provide over half (approximately 58%) of the total group. Once again due to the data being incomplete, these results should not be considered as being reflective of actual group session activity.

Table 2.5 presents a summary of the number of participants in the client group sessions as reported by state/territory health jurisdictions during 2005/06.

Table 2.5: Number of Group Session Participants by State – 2005/06

State	Number of Services	No. Clients in Group Sessions	% Total Clients in Group Sessions	Comment
ACT	0		0.0%	service did not provide data
NSW	7	7,866	28.7%	1 service did not provide data
NT	0		0.0%	service did not provide data
QLD	3	1,938	7.1%	1 service did not provide data
SA	1	1,74	0.6%	data item not applicable for 1 service
TAS	0		0.0%	service did not provide data
VIC	10	7,815	28.5%	1 service did not provide data, item not applicable for 5 services
WA	3	9,581	35.0%	1 service did not provide data, item not applicable for 4 services
Total	**24**	**27,374**	**100.0%**	

Table 2.5 shows that based on the data reported to the Review:

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   21

1.   The total number of clients participating in group sessions provided by the IHSHY program was 27,374. There were 24 service providers contributing to this data set representing approximately 54% of the total funded providers.

2.   The highest proportion of group sessions (approximately 92%) was provided collectively in Western Australia, New South Wales and Victoria. These results should be regarded as indicative only.

Table 2.6 presents a summary of the number of training sessions for Health Professionals reported by state/territory health jurisdictions during 2005/06.

Table 2.6: Number of Training Sessions for Health Professionals – 2005/06

State	Number of Services	No. of Training Sessions	% Total Training Sessions	Comment
ACT			0.0%	data item not applicable for service
NSW	6	54	31.6%	1 service did not provide data, item not applicable for 1 service
NT			0.0%	service did not provide data
QLD	3	51	30.1%	data item not applicable for 3 services
SA			0.0%	1 service did not provide data, item not applicable for 1 service
TAS			0.0%	service did not provide data
VIC	8	50	29.5%	2 services did not provide data, item not applicable for 7 services
WA	1	15	8.8%	data item not applicable for 7 services
Total	**18**	**170**	**100.0%**	

Table 2.6 shows that based on the data reported to the Review:

1.   The total number of training sessions provided the IHSHY program was 170. There were 18 service providers contributing to this data set representing approximately 40% of the total funded providers.

2.   The highest proportions of training sessions (approximately 91%) were provided by Queensland, New South Wales and Victoria. These results should be regarded as indicative only.

Table 2.7 presents the number of clients participating in the health professional training sessions reported by state/territory health jurisdictions during 2005/06.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   22

Table 2.7: Number of Participants in Health Training Sessions – 2005/06

State	Number of Services	No. Training Participants	% Total Training Participants	Comment
ACT			0.0%	data item not applicable for 1 service
NSW	4	495	29.3%	3 services did not provide data, item not applicable for 1 service
NT			0.0%	service did not provide data
QLD	1	313	18.5%	2 services did not provide data, item not applicable for 3 services
SA			0.0%	1 service did not provide data, item not applicable for 1 service
TAS			0.0%	service did not provide data
VIC	6	652	38.6%	3 services did not provide data, item not applicable for 7 services
WA	1	228	13.5%	data item not applicable for 7 services
Total	**12**	**1,688**	**100.0%**	

Table 2.7 shows that based on the data reported to the Review:

1.   The total number of participants involved in the training sessions provided the IHSHY program was 1,688. There were 12 service providers contributing to this data set representing approximately 27% of the total funded providers.

2.   The highest proportion of participants (approximately 68%) were in New South Wales and Victoria.

Table 2.8 shows the number of service providers targeting each client group.

Table 2.8: Number of Service Providers Targeting Client Groups – 2005/06

Client Group	Number of Service Providers	% of Service Providers [2]
Homeless young people	42	95.5%
At-risk young people	42	95.5%
ATSI	39	88.6%
CALD	30	68.2%
Rural & remote	21	47.7%
Young parents	34	77.3%
Other [1]	21	47.7%

Note:

(1)   Other includes five service providers identifying that they were targeting same sex attracted young people, two targeting refugees two disabled young people, one pregnant young women and one incarcerated women. The balance was not specified or incorrectly identified the type of service being provided. There may be other service providers targeting these particular client groups but they were not specified.

(2)   Of the 45 service providers, one has not provided a data return. The % calculation in the table is based on the 44 service providers who provided data.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   23

Table 2.8 shows that:

1. Whilst 39 service providers identified that they were targeting Aboriginal clients, consultation with stakeholders revealed that this was a client group that needed more of a focus in the IHSHY program.

2. In both Queensland and New South Wales, there were two service providers focusing on rural and remote clients and in South Australia one, which supports the feedback obtained from the stakeholder interviews that there were significant geographical gaps in the provision of IHSHY program services.

3. Two services targeted homeless young people indirectly. One service in WA (Community and Youth Training Services) conducts an annual evaluation of services funded under IHSHY, co-ordinates workshops for IHSHY service providers and provides ongoing support for the development of the program. The service also offers a range of educational and training opportunities for marginalised and at-risk young people (funded from other sources), and this enables clients of IHSHY services to be referred to its training programs. One service in Victoria (Victorian Foundation for Survivors of Torture) facilitates access to mainstream medical services for all refugees inclusive of young people.

Tables 2.9 to 2.11 inclusive present the number of service providers categorised into three service types: Primary Health Care; Other Health Services; and Support Services. It should be noted that IHSHY program service providers do not necessarily provide this range of services solely from funding provided by the IHSHY program. Rather IHSHY workers may have assisted young people to access these services.

Table 2.9 presents the number of service providers providing primary care type services to the homeless and at-risk youth.

Table 2.9: Number of Service Providers providing Primary Care by Type – 2005/06

Service Type	Number of Service Providers	% of Service Providers [2]
Access to GPs	37	84.1%
Access to nurses	32	72.7%
Access to counsellors	38	86.4%
STI & BBV testing	28	63.6%
Provision of pharmaceuticals	25	56.8%
Drug and alcohol treatment	30	68.2%
Mental health services	32	72.7%
Maternal health services	26	59.1%
Dental services	22	50.0%
Other [1]	18	40.9%

Note:

(1) Primary care – other includes 2 services providers identifying sexual assault, one attending hospital clinics, one specialist medical services, one allied health, one complementary and a number of others that more correctly related to other areas or were not identified. There may be other service providers targeting these client groups but they were not specified.

(2) The percentage calculation in the table is based on the 44 service providers who provided data.

Table 2.9 shows that providing or facilitating access to GPs (84%), nurses (73%), counsellors (86%) and mental health services (73%) are the most common IHSHY program services

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   24

Table 2.10 presents the number of services provided for other health service types.

Table 2.10: Number of Services Providing Other Health Services by Type – 2005/06

Type of Service	Number of Service Providers	% of Service Providers [2]
Health education and promotion activities	44	100.0%
Food packs/meals	26	59.1%
Personal hygiene products	29	65.9%
Essential clothing items	20	45.5%
Laundry/showering facilities	15	34.1%
Other [1]	19	43.2%

Note:

(1)   Other health services includes 4 service providers identifying the provision of safe sex materials, two a needle exchange service, one a mail service, one a storage service, one items to assist with new born babies, one first aid, three kitchen facilities, three phone/internet and a number of others that more correctly related to other areas or were not identified. There may be other service providers targeting these client groups but they were not specified.

(2)   The percentage calculation in the table is based on the 44 service providers who provided data.

Table 2.10 shows that all service providers are involved in providing health education and promotion and more than half (59%) are providing food packs/meals and personal hygiene products (66%).

Table 2.11 presents the number of services providers involved in providing support services to the client group.

Table 2.11: Number of Services Providers providing Support Services by Type – 2005/06

Type of Service	Number of Service Providers	% of Service Providers [1]
Recreation activities	25	56.8%
Creative arts activities	22	50.0%
Youth workers	27	61.4%
Referral/brokerage/advocacy to health services	38	86.4%
Referral/brokerage/advocacy to non-health services	38	86.4%
Other [1]	23	52.3%

Note:

(1)   Other support services include includes 3 service providers identifying accommodation, transport and support groups, one employment training, one legal, one school support, one contraceptives, one school based drop in centres, one vocational education and others that were included in other areas or were not identified .

(2)   The % calculation in the table is based on the 44 service providers who provided data.

Table 2.11 shows that:

1.   86% of service providers are providing referral/brokerage and advocacy services to both health and non health services. Over half of service providers are providing or facilitating access to recreational (57%) and creative activities (50%).

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   25

2. 61% of service providers indicated they provided or facilitated access to youth workers. Consultations indicated that service providers considered best value for the client group in relation to the services they were providing was by employing professionals such as nurses or social workers.

2.4.3 SUMMARY OF ACTIVITY ANALYSIS FINDINGS

1. **Data definitions.** The Review noted that data definitions had not been developed which could have enabled consolidation of data at state/territory or Commonwealth level.

2. **Data reporting inconsistencies and gaps.** Following an examination of the data, the Review determined that the quality and consistency of the activity numbers provided was highly questionable. Furthermore, it was concluded that there had been different interpretations of the data reporting requirements and there were significant data gaps. In addition there are some data that could be collected that would better reflect the nature of the services being provided.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   26

3

KEY FINDINGS FROM STAKEHOLDER CONSULTATIONS

This Chapter presents the findings of the stakeholder consultations from the perspective of the IHSHY program, policy structure, administrative arrangements, program implementation and the key program impact and outcomes.

3.1 POLICY AND STRUCTURE

This section provides an overview of the key issues identified by state/territory health jurisdictions and service providers with respect to the appropriateness, effectiveness and efficiency of:

- Eligible services provided under the Program; and
- Level of service coordination.

3.1.1 APPROPRIATENESS OF ELIGIBLE SERVICES

The issues associated with the appropriateness of the eligible services identified by state/territory health jurisdictions and service providers are outlined below together with a summary of the review findings.

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

1. **Client needs assessment.**   Currently there is limited client needs assessment that is undertaken at either the health jurisdiction or service provider levels. Assessing the health service needs for homeless youth is an important part in the planning of these services. The needs assessment provides a mechanism for identifying the difference between what services exist and what should exist in order to improve the health outcomes of the target group. The results of the needs assessment can then be used to develop the respective service plans and in the formulation of future funding agreements.

2. **Research and development.**   The Review has identified that currently there is insufficient knowledge and information available to health jurisdictions and service providers to implement improved program service models and management practices. In this context there is a need to ensure that data and information systems are available to assist stakeholders to plan and monitor the effects of these processes on the outcomes of the target group. In addition, it is considered that research should be undertaken into developing and adapting evidence-based service models and management approaches that are more aligned with the Commonwealth and state/territory policies and strategies for homeless youth. It is considered that the research process should be more inclusive of homeless youth and take an interdisciplinary approach, drawing on the expertise of a range of stakeholders including representatives from government agencies, GPs, social workers, psychologists and health workers.

REVIEW FINDINGS

1. **Eligible Services.** The Review found that the range of Eligible Services as specified in the Agreement (refer Appendix B) are well-targeted to meeting the goal of the program.

2. **Needs assessment and research.** There is a need to change the eligibility criteria to include projects aimed primarily on needs assessment and research (currently excluded by the Agreement), to identify gaps and gain a further understanding of various service models and strategies that best meet the needs of the client group.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   27

Policy Improvement Opportunities
• List of eligible criteria to include projects aimed primarily on needs assessment and research.
• Determine funding source and methodology for undertaking needs assessment and research initiatives.

3.1.2 IHSHY PROGRAM COORDINATION

The issues identified by the Review with respect to IHSHY program coordination with other Commonwealth and State programs aimed at homeless youth are outlined below together with a summary of the review findings.

STATE/TERRITORY HEALTH JURISDICTIONS

1. **Program coordination.** From the perspective of the state/territory health jurisdictions, the IHSHY program is considered to be well-coordinated and complementary with other programs focused on the target group and filling a much needed niche.

2. **Program flexibility.** The flexibility of the IHSHY program allows appropriate responses to be developed at the local level as required.

3. **Access to other programs.** Accessing other programs was identified as an issue with affordable housing and mental health being the two areas most frequently identified.

SERVICE PROVIDERS

1. **Coordination strategies.** Many regions have developed local groups of service providers and government agencies to improve communication and cooperation and target gaps in services. IHSHY program service providers see it as one of their roles to ensure appropriate coordination with one provider stating "we help to make it work - IHSHY fills the gaps".

2. **Linkages with other service providers.** A number of IHSHY program service providers have made considerable efforts to develop linkages with other programs. Multiple methods of engagement were identified including outreach into other agencies, other agencies in-reaching into the IHSHY services and joint planning meetings on a regional basis.

3. **Program complementarities.** The Review noted that most other programs have relatively strict eligibility criteria (conversely IHSHY program was identified as being a very flexible program that could complement the broader service spectrum) and in many cases IHSHY workers were dealing with clients that were not eligible for other services.

REVIEW FINDINGS

1. **Program coordination at the service provider level.** The Review found that the IHSHY program is well-coordinated and complementary with other programs focused on the targeted group at the service provider level.

2. **Level of policy integration.** The Review noted there was no policy integration at a Commonwealth level and the IHSHY program is an "orphan" program operating in isolation. At the health jurisdictional level the IHSHY program target group did not appear to be a high policy priority and policy efforts are generally focused on broader issues such as improving homelessness in the city or improving mental health services where the needs of the target group can be lost.

3. **Explore options for improving policy and service integration.** The review considers there is a need to explore options for integrating the IHSHY program with the aim of strengthening continuity of service provision and improving integration between service providers who are involved in providing multi-dimensional services to the homeless and youth at-risk.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   28

Policy Improvement Opportunities
•   Explore options for improving IHSHY policy and service integration.

3.2   PROGRAM ADMINISTRATION

This section provides an overview of the key issues identified by state/territory health jurisdictions and service providers with respect to the appropriateness, effectiveness and efficiency of program administration and addresses:

- Resource allocation;
- Resource maximisation;
- Program monitoring;
- Compliance with Funding Agreement; and
- Communication.

3.2.1   RESOURCE ALLOCATION

STATE/TERRITORY HEALTH JURISDICTIONS

1. **Resources allocated on the basis of the Agreement.** All States considered that resources were being allocated to service providers in accordance with the Agreement. Funds are allocated in accordance with the previous year (unless there is a specific reason to change the allocation due to non-performance or changing priorities).

2. **Resource allocation 2007-08.** State/territory health jurisdictions advised that decisions about how the funds will be allocated for the forthcoming Agreement had not been determined.

SERVICE PROVIDERS

1. **Funding agreements.** Most service providers reported that they had three year Funding Agreements and there is flexibility in terms of funds reallocation within the budget where the level of funds facilitated this.

2. **Notification of resource allocations.** Service providers indicated that they would like notification of funding for the next funding period a soon as possible as it allows for staff contracts to be renewed. A South Australian service provider reported that they had a one year agreement with a one year right of renewal and that on occasions funds had not flowed on a timely basis.

REVIEW FINDINGS

1. **Budgetary constraints.** Existing budget allocations were focused on day-to-day services and there were insufficient resources available to implement new innovative services. Service providers indicated that unless additional growth funds were provided there was no scope to undertake further service enhancements.

2. **Administrative processes.** The administrative process of allocating funds is well-managed at all levels and funds are allocated in accordance with the eligibility criteria.

3.2.2   RESOURCE MAXIMISATION

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

1. **Service providers provided in-kind support.** All funded services are auspiced by either NGO or government organisations who have been able to attract in-kind support such as supervision of IHSHY Program workers, accommodation, information and communications technology support, sharing intake duties and training opportunities.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   29

2. **Other sources of funds.** Many funded services have been successful in attracting additional funds for the target group and/or are co-located with other services to maximise synergies and enhance service delivery. Examples include state government community health programs, drug and alcohol and Child and Adolescent Mental Health Services funding, Hospital Links Program, Policy Drug Diversion Program, Department of Corrections, Universities and NHMRC Funding.

REVIEW FINDINGS

The Review identified that IHSHY program funds are being leveraged significantly and the value the Program receives is well in excess of the funding provided.

3.2.3 PROGRAM MONITORING

STATE/TERRITORY HEALTH JURISDICTIONS

1. **Service provider Program reporting.** Regular reports (at least six-monthly) are provided by service providers to the respective state/territory health jurisdictions.

2. **Annual reports.** Annual reports are provided by state/territory health jurisdictions to the Commonwealth in the prescribed format. Western Australia indicated that they visit service providers at least on an annual basis and prepare a summary of the IHSHY program. We were unable to find evidence of any other health jurisdiction that adopted a similar practice.

3. **Reporting requirements.** A number of state/territory health jurisdictions considered that the reporting requirements were excessive given the size of the program. One jurisdiction suggested that reporting for the period covered by the agreement should be advised as early as possible and remained in place for the duration of the Agreement. This would mean service provider agreements would not be required to be amended as reporting requirements change. Another jurisdiction suggested that the reporting requirement should be simplified and to incorporate a section for "free narrative".

4. **Timeliness of reporting.** There has been no evidence from the perspective of the states or service providers in relation to timely monitoring and feedback provided by DoHA.

SERVICE PROVIDERS

1. **Program monitoring.** The Review noted that service providers in Western Australia, Tasmania and the Australian Capital Territory were provided feedback from their respective state/territory health jurisdictions regarding the performance of the Program. We were unable to find evidence of similar feedback occurring in other states/territories.

2. **Program feedback.** Many service providers indicated that more feedback from state/territory health jurisdictions and the DoHA was required covering strategic and important operational issues that arise from the reports that they provide.

REVIEW FINDINGS

1. **Quantitative data collection.** The Review noted that the quantitative data collection that is essential to monitor the effectiveness and efficiency of the Program is inadequate and in most States there was no evidence of any systematic analysis of data (quantitative or qualitative) in relation to improving services, being undertaken. There is a need to develop standardised data definitions for the collection and reporting of data to ensure data consistency and utility. In some cases the quantitative data collected does not reflect the services that are provided eg provision of secondary consultations and occasions of service, and the data is of questionable quality.

2. **Qualitative data collection.** The qualitative data collected by the state/territory health jurisdictions and provided to the Commonwealth is information-rich.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   30

3. **Feedback on reported data.** The Review noted that there was no consolidation and feedback of the reported data undertaken at health jurisdiction level. The Commonwealth does prepare a report but most considered this not to be on a timely basis.

4. **Refinement to reporting requirements.** On balance it is considered that reporting requirements should be simplified. However to assist with monitoring the performance of the Program consideration should be given to state and territory jurisdictions reporting on a six-monthly basis In addition, it was considered the reporting requirements should not be changed during the course of the Agreement.

Policy Improvement Opportunities
• Refine data collection tools and develop standardised data definitions.
• To improve the performance monitoring of the IHSHY program, state/territory health jurisdictions to provide a report to the DoHA on a six-monthly basis.
• Formulate the Program reporting framework to cover the timeframe of the Funding Agreement

3.2.4 REASONABLENESS OF ADMINISTRATIVE AND COMPLIANCE ARRANGEMENTS IN THE AGREEMENT

STATE/TERRITORY HEALTH JURISDICTIONS

Views differed widely. Two states considered that there was a lot of effort for a small program and that this was not justified. One state thought that on balance compliance was relatively costly given the program size and the other states considered that the arrangements were reasonable.

SERVICE PROVIDERS

Arrangements as they impact on Service Providers are considered to be reasonable when compared with the requirements of other program funds that they receive.

REVIEW FINDINGS

As evidenced in this Chapter, there are a range of opportunities and initiatives to be implemented that may improve the functioning of IHSHY program. It is likely that there is a diseconomy of scale operating in the program which is compounded by a lack of policy and program integration (refer 3.1.3). It is considered that the costs of effective administration may be too high relative to the size of the Program, if all activities associated with the program were being undertaken to the level they should be for a separate program.

Policy Improvement Opportunities
• Explore options for improving IHSHY policy and service integration.

3.2.5 COMMUNICATION

STATE/TERRITORY HEALTH JURISDICTIONS

1. **Commonwealth to health jurisdiction communication.** The review noted that the DoHA currently does not communicate with states/territories regarding the Program on a regular basis. State/territory health jurisdictions indicated that an improved level of coordination and communication on a national basis would be of significant benefit (in the form of a website and/or a national workshop on a regular basis)

2. **Communication with services providers.** State/territory health jurisdictions generally considered their level of communication with service providers was adequate.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   31

SERVICE PROVIDERS

1. **Communication with Commonwealth.** Service providers have no direct contact with DoHA.

2. **Improved communication with state/territory health jurisdictions.** Service providers in South Australia, Queensland and New South Wales indicated that communication processes could be improved with the state/territory health jurisdictions. In Western Australia there was a high level of communication (both with the Health Department and with other IHSHY program service providers) which was seen by service providers as adding value to their service.

3. **Improved communication on a national basis.** Service providers indicated that an improved level of coordination and communication on a national basis would be of significant benefit (in the form of a website and/or a national workshop on a regular basis).

REVIEW FINDINGS

1. **Improved program communication processes.** The Review noted that for the most part, service providers are operating in isolation (from other IHSHY service providers) and are not able to learn from the experience of others. In three states and at DoHA level, there is no systematic process of Program communication.

2. **National IHSHY program website.** There is strong support for the establishment of a national IHSHY program website to assist with communication and disseminating relevant information, research and types of services being provided.

3. **Improved consultation with stakeholders.** Regular meetings, at the beginning and mid point of an Agreement period, between service providers, state/territory health jurisdictions and DoHA representatives would assist with information sharing throughout the IHSHY Program and managing responses to emerging issues. Issues discussed at these meetings could be promulgated to all service providers for information.

Policy Improvement Opportunities
• Develop a national website.
• Conduct two national meetings per Agreement period.
• Develop program communication strategy.

3.3   IMPLEMENTATION

This section provides an overview of the key issues identified by state/territory health jurisdictions and service providers with respect to the appropriateness, effectiveness and efficiency of program implementation and addresses:

*   Service delivery models;
*   Service gaps and barriers to effective service delivery;
*   Emerging issues;
*   Evidence-based best practice; and
*   Staffing issues.

3.3.1   SERVICE DELIVERY MODELS

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

1. **Types of service delivery models.** The Review identified there were a range of service models that have been implemented using a variety of approaches and providing a range of services. There are a number of particularly innovative services with three winning national awards (in Western Australia two services have won an AMA award for

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   32

the Best Public Health Program and in the Northern Territory the service won an Australian Crime and Violence Prevention Award).

2. **Access to mainstream services.** Whilst for many service providers, effort was made to facilitate clients accessing mainstream services, in some cases it was considered that this was not being done as well as it could be or it was difficult as some clients were not "ready", or services were not available due to limited staffing and/or restrictive eligibility criteria.

3. **Referral to IHSHY program services.** In relation to health-specific mainstream services, clients were often being referred to the IHSHY program service as it was seen as being better able to manage the complex needs of the target group.

REVIEW FINDINGS

The Review has concluded that the IHSHY program provides a wide range of services utilising a range of service models and approaches which are meeting the needs of the client group. This is reflective of an innovative program. A number of evidence-based principles have been identified as being prerequisites of a successful service model including:

*   Developing partnerships and building relationships (with other programs and young people);
*   Being flexible and not turning people away;
*   Provision of outreach services and in reach services;
*   Employing skilled professionals and developing multi-skilled staff;
*   Employing the right people with the right non judgemental youth-friendly attitude in relation to the client group;
*   Providing practical assistance and services that young people want. This helps the young people want to use the service – once they seek a service you can start to understand and meet the clients' needs;
*   Offering a variety of services;
*   Providing secondary consultations;
*   Meeting clients in an environment they are comfortable with; and
*   Culturally appropriate practices – valuing and working within indigenous families and cultural structures.

In discussions with Western Australia the following factors were identified as being part of the cycle of innovation which has contributed to the success of the IHSHY program in that state and could be adopted on a national basis.

*   Undertake client needs assessment;
*   Develop service model;
*   Pilot and evaluate service model;
*   Fine tune model as necessary;
*   Ongoing evaluation networking and information sharing;
*   Identifying further need;
*   Develop new or extended models; and
*   Attract interest and funding from IHSHY program or other sources for new service models.

Policy Improvement Opportunities
*   Adopt the cycle of innovation as a principle for the ongoing development and innovation in the Program

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   33

3.3.2 SERVICE GAPS AND BARRIERS TO EFFECTIVE SERVICE DELIVERY

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

1. **Geographical gaps in service delivery.** Funding constraints were cited by stakeholders as a significant barrier to developing services and this has meant that there are significant geographic gaps in service delivery and that services have been eroded over time as funding has not kept pace with inflation.

2. **Provision of GP services.** The provision of an adequate level of GP services was identified as being an ongoing challenge due to a combination of availability, funding, and a lack of GPs willing to bulk bill and the fact that clients do not always have a Medicare card.

3. **Expansion of services provided.** The Review noted that if the funding base was expanded, most state/territory health jurisdictions indicated it was likely they would seek to expand the existing services as opposed to funding new services.

4. **Other service delivery issues.** Other issues identified included providing services to teenage parents; an inability to accommodate Indigenous youth preference for access to gender-specific health workers due to a lack of funding and workforce availability; the lack of access to services that were culturally appropriate and a lack of health professionals in some regional areas. In addition the ongoing challenge of linking clients with mainstream services was noted.

5. **Increased engagement with Aboriginal young people.** A number of service providers identified the need to engage more Aboriginal young people in services provided by the IHSHY program. However this was not possible as staff were already fully committed and it would be unreasonable to promote the service and then not be able to meet client expectations.

REVIEW FINDINGS

1. **Identification of service gaps and barriers.** Service gaps and barriers are identified at the local level and addressed where possible. There is little evidence that there is a policy response at the state/territory levels to address these issues specifically in relation to the target group except in Western Australia.

2. **Geographical differences in service access.** The review noted there were significant geographical differences from the perspective of access to homeless youth health services. In addition there were service restrictions due to resource constraints. The difficulty in accessing youth-friendly, bulk billing GP's is a common theme and some innovative approaches have been developed to assist in addressing this issue.

3. **Increased focus on Aboriginal and Torres Strait Islander homeless young people.** There is a need to engage more Aboriginal and Torres Strait Islander young homeless people in providing IHSHY program services. The exception is Western Australia where approximately 30-60% of clients are Aboriginal and Torres Strait Islanders.

Policy Improvement Opportunities
• Response to key barriers to be discussed at the proposed national meetings.

3.3.3 EMERGING ISSUES

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

The key emerging issues identified by health jurisdiction and service provider representatives include:

*   Increasing unsafe sexual practice, often at a younger age, and often with multiple partners. The incidence of sexually transmitted infections and pregnancies was increasing correspondingly;

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   34

- There is a need to improve access to services for the management of young mothers;

- Services are required to improve the nutritional habits of the homeless youth;

- Amphetamine use in general and ICE in particular is increasing;

- Dual diagnosis (comorbidity) and drug and alcohol problems continue to be key health issues;

- The need for workers to develop cultural awareness, sensitivity and practice in dealing with African cultures has emerged with the increasing African refugee population; and

- There was a strong sense from service providers that the client group was increasing in both overall numbers and the complexity of problems they were presenting with (no one had empirical evidence to support this).

REVIEW FINDINGS

The Review noted that emerging issues are identified in the annual reports and service providers respond where applicable in the context of their service. Whilst there was evidence that the Commonwealth and state/territory health jurisdictions were responding to emerging health needs, from the perspective of the target group, there were opportunities to improve program coordination and information sharing which would ultimately improve service accessibility and delivery.

Policy Improvement Opportunities
• Response to key emerging issues to be discussed at the proposed national meetings.

3.3.4 EVIDENCE-BASED BEST PRACTICE

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

There was strong support for the best practice principles as identified in the Review Framework. States and service providers considered that, where applicable, services were complying with the principles.

REVIEW FINDINGS

1. **Service providers are committed to the provision of quality services.** There has been no adoption of Best Practice principles for the Program. Twenty seven of the service providers have been accredited or have adopted a quality framework but this is not a condition of funding.

2. **Development of evidence-based service principles.** The Review has noted that Western Australia has drafted service principles together with supporting rationale (not yet published). NSW has developed through the Centre of Advancement of Adolescent Health a Youth Practice Better Practice Framework known as the Access Study Fact Sheets (it has been noted that there is no reference to homelessness in this document). The Review considers that as part of a commitment to best practice and quality, the program should formally adopt best practice principles for service providers and these could be included in the Funding Agreements.

Policy Improvement Opportunities
• Formally develop and adopt best practice service principles to be included in the Agreements.

3.3.5 STAFFING

STATE/TERRITORY HEALTH JURISDICTIONS AND SERVICE PROVIDERS

1. **Availability of staff.** The Review noted that generally service providers were able to fill vacant positions with suitably experienced and trained staff. The time limited nature of

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   35

Program funding and the lack of permanency for staff makes this more difficult for non-government funded service providers in particular.

2. **Recruitment of GPs.** Recruiting GP's and providing them adequate remuneration is the main systemic staffing issue. In those clinics that bulk bill, funds received cover only a small part of the costs of the service. Having said this, those services that have a GP as part of their service model have all the funded sessions filled (often with the significant goodwill of the GP) and all providers report that it would be difficult to find replacement GPs or expand services.

3. **Staff recruitment.** Service providers aim to recruit skilled professionals who have a high level of expertise in at least one service area. These staff can then be supported to broaden their skill base.

REVIEW FINDINGS

The Review noted there were no vacant IHSHY program funded positions. The funding of GP sessions was noted in 3.3.2 above.

3.4 PROGRAM IMPACT AND OUTCOMES

This section provides an overview of the key issues identified by state/territory health jurisdictions and service providers with respect to the program impact and outcomes.

3.4.1 PROGRAM REVIEW AND EVALUATION

STATE/TERRITORY HEALTH JURISDICTIONS

During the period of the current agreement, the Review found there was no formal review or evaluation of the IHSHY program undertaken by state/territory health jurisdictions in any systematic way with the exception of Western Australia. In that State, the Community Youth and Training Services Unit (an IHSHY program funded service) conducts an annual review of services funded under IHSHY program and provides a one-page assessment of a service based on the service provider reports and discussion during a site visit.

SERVICE PROVIDERS

From a service provider perspective, program evaluations were not undertaken. Most service providers indicated that components of their services were reviewed as part of the normal management process to identify service improvement and evaluation questionnaires in relation to client groups and direct clinical services were conducted periodically.

REVIEW FINDINGS

1. **Need to conduct program evaluation.** As indicated in Chapter 2.3.3 the current Agreement specifies that services and organisations applying for IHSHY program funding are required to include an evaluation component in their funding proposals, including maintaining data on clients and service operations. This clause is not being complied with and it would be difficult for service providers to reallocate funds from within existing provisions given the service demands. The preferred approach would be for each health jurisdiction to conduct an evaluation of their IHSHY program prior to the completion of the three-year Agreement.

2. **Measure of health and social function.** There is a need to develop a generic tool to measure health and social functioning changes in clients over time that could be used by service providers across Australia in any evaluations that are undertaken. Funds from the proposed incentive funding pool for research and need assessment could be used for this purpose. Potentially this tool could provide the empirical evidence to demonstrate the benefits of the Program and to support the need for additional resource allocation.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   36

Policy Improvement Opportunities
• Develop and test a generic tool to measure health and social functioning in the client group so that changes in impacts and outcomes can be evaluated over time. • Each jurisdiction to conduct an evaluation of its program prior to the completion of each Agreement period. • Develop evaluation guidelines.

3.4.2   IMPACT AND OUTCOME OF THE PROGRAM

STATE/TERRITORY HEALTH JURISDICTIONS

1. **Unavailability of data to measure impacts or outcomes.** All States agreed that the short-term impact and medium- and long-term outcomes identified in the Review Framework were what the IHSHY program was trying to achieve. With the exception of output data provided on direct services there is no quantitative data available to support an analysis of whether these impacts or outcomes have been achieved.

2. **Impact of Happy Kids Program.** In Western Australia, the Happy Kids Program had shown an improvement in high school completion rates; a reduction in pregnancy and self-harm rates and had a significantly reduced level of interaction with the police and court system. As a flow on from this project, a research project titled "Keeping Kids on Track" has been funded by the National Health and Medical Research Council for $1.4 million. Under the research grant there will be a retrospective evaluation of the Happy Kids project, and the model is being implemented and evaluated at primary schools in the Kalgoorlie area with high numbers of Indigenous clients. This research project commenced in 2006.

SERVICE PROVIDERS

1. **Program meets immediate client needs.** When considering short-term impacts, service providers advised that it was self-evident that the Program meets the immediate client needs particularly where clients were recipients of direct service provision and other tangible support services (eg personal hygiene support). It was considered that generally clients' knowledge had improved where educational sessions were conducted which is based on client feedback on the group sessions. In addition, service providers observed clients engaging with service workers and other clients had engaged with their peers.

2. **Level of service innovation.** Service providers considered that services they offered were innovative and were evolving as client needs changed. The point was made that there must be some point where a successful service that was introduced some years ago ceases to be labeled innovative and is regarded as 'mainstream'. Given the increasing demands for services and the resource limitations it was apparent that the level of service innovation such as the implementation of evidence-based service models was progressively being reduced due to the need to focus on delivering mainstream services.

3. **Improved awareness of mainstream health services.** Service providers reported mixed success in improving mainstream health service awareness of the needs and best approaches suited to the client group.

4. **Improved health outcomes for client population.** Services provided examples where client outcomes had improved over an extended period of time which included less risk-taking behavior, enhanced self-esteem and improved client connectedness. Some services reported that some past clients had, some years after coming into contact with the service, undertaken education that would allow them to obtain employment supporting homeless and at-risk youth. Others had contacted the IHSHY program to "see how things were going".

5. **Improved client referral processes.** A number of specific incidences were noted where links with mainstream health services had improved which had resulted in the mainstream services referring clients to the IHSHY program. Western Australia and South Australia highlighted the benefits of the Program such as reducing demand in public hospital

Emergency Departments, contributing to a reduction in suicide rates and a reduction in the number of children being taken into care of the State.

6. **Reduction in re-offending rates.** In Western Australia, the Ruah Women's Support service has evidence to suggest that re-offending rates have greatly reduced. However the data has not been aggregated over a number of years to enable figures to be quoted by this Review.

7. **Unintended outcomes of the Program.** In Western Australia, service providers emphasised the importance of unintended positive outcomes arising from the program. One example cited was Community and Youth Training Services through their involvement with the Ruah Women's Support Service developed a ground-breaking program specifically designed for Aboriginal women in prison. This service model has received funding from the State Department of Education and Training to develop 'distance education' for women in prison, with a view to maintaining client attendance on release from prison. This will mean that young and older women in prison, 80% of whom are Aboriginal, will once again have pathways into 'community services' and 'youth work' accredited training courses from Certificate III level through to Diploma status.

A quote from one new service provider manager who has wide experience in the health sector encapsulates the views of many service providers:

> *"I have been blown away by the stuff we do here and the commitment the staff have is incredible, especially considering the level of resources, the difficult client group and the lower organisation-wide priority. The impact on people lives is amazing"*

REVIEW FINDINGS

1. **IHSHY program contributes to improved client health outcomes.** With the exception of output data provided on direct services there is no quantitative data available to support an analysis of whether the impacts or outcomes identified in the Review Framework have been achieved. The qualitative information provided in the annual reports and gathered during the stakeholders consultations demonstrate that the program is making a significant contribution to improving health outcomes for homeless and at-risk youth.

2. **Increased access to specialised health services.** The program is providing access to specialised health services for homeless and at-risk youth who would be unlikely to receive similar services in mainstream health systems and if they did present they would do so at a later date with additional complications. In addition some service models have developed effective linkages with other programs at the local level for this client group.

3. **Program responsiveness to client needs.** The Review has evidence to demonstrate the IHSHY program provides a range of innovative health services which are responsive to the complex needs of homeless and at-risk youth.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   38

4

ASSESSMENT OF PROGRAM PERFORMANCE

This Chapter provides an assessment of the performance of the IHSHY program drawing on the evidence presented previously in this Report. The assessment addresses each Key Result Area and its component parts from the perspective of:

- Program policy and structure;
- Program administration;
- Program implementation; and
- Impact and outcomes.

At the conclusion of the Chapter we have provided a summary of the Program performance assessment against the IHSHY program goals.

4.1 PROGRAM POLICY AND STRUCTURE

The policy and structure of the IHSHY program was examined to identify whether the Program was designed and structured appropriately to ensure the Program goal is achieved.

4.1.1 ASSESSMENT OF PROGRAM POLICY AND STRUCTURE

In assessing the Program policy and structure the Review noted that:

1. **Eligible services.** The eligible services as specified in the Funding Agreement are appropriate and well targeted. There is a need to allocate additional funding to support projects aimed primarily on undertaking research into evidence-based service models and needs assessment.

2. **Program management.** Program management responsibilities as identified in the Agreement are clear and appropriate. With some notable exceptions the Program is operating in isolation from other programs (at state/territory health jurisdiction and Commonwealth levels) and there is very limited strategic analysis and policy work undertaken within the Program.

Table 4.1 below presents a summary of the assessment of the Program Policy and Structure to identify the extent program objectives are being met.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   39

Table 4.1: Program Policy and Structure Assessment

Key Result Area: IHSHY program is designed and structured appropriately to ensure the Program goal is achieved			
Objectives	**Performance Indicator**	**Review Findings**	**Conclusion**
Eligible services are those which best meet the Program goal.	• Number of services that do not meet goal. • Number of potential services identified that are not covered by the Agreement.	• All eligible services listed contribute to achieving goal. • Projects aimed primarily on research and needs assessment.	• Eligible Services are well targeted to meeting the goal of the program. However they could be expanded to include research and needs assessment work.
Commonwealth and state/territory programs are complementary and well coordinated.	• Satisfactory interface with other programs.	• At the Commonwealth level, there is no policy integration with other programs providing support to the target group. As a result, the Program is operating as a silo program. • At the state/territory level, the Program also tends to operate in isolation. • At the service provider level, program coordination and integration with other services is well developed.	• There is a high level of program coordination and integration at the service provider level. • There is limited policy integration and coordination at government levels.
Responsibilities between the States and DoHA are clear and appropriate.	• Responsibilities are clear and appropriate.	• Responsibilities are specified in the Funding Agreement and are clear and appropriate.	• Responsibilities as specified in the Funding Agreement are clear and appropriate.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   40

4.2   PROGRAM ADMINISTRATION

An examination of the program administrative arrangements was undertaken to assess the extent to which resources are allocated and whether the resources were managed effectively and efficiently by state/territory health jurisdictions in accordance with the Funding Agreement.

4.2.1   ASSESSMENT OF PROGRAM ADMINISTRATION

The management of the funds is efficient with funding being deployed in accordance with the Funding Agreement; resources are maximised at service provider level and service provider reports are completed and forwarded to the DoHA.

Our assessment of the administrative arrangements relating to the Program identified the following issues:

- The Program was not being continuously monitored in four (4) state/territory health jurisdictions;
- An evaluation of the Program operations at the state/territory health jurisdictional level had not been undertaken since implementation (1991);
- The quantitative data set is inadequate. There are no data definitions, activity data provided was highly questionable and there are some data that could be collected that would better reflect the nature of the services being provided.
- An evaluation of the Program operations at the state/territory health jurisdictional level had not been undertaken during the Agreement period except in Western Australia;
- Most service providers are operating in isolation from other IHSHY service providers (with WA being the notable exception and more recently Victoria), and do not have an opportunity for information sharing;
- In three states, communication between the health jurisdiction and the service providers is very limited; and
- Overall, in a majority of jurisdictions there is little, if any, communication on strategic and policy issues at any level in the Program.

These problems are compounded because of the relatively small size of the Program.

Table 4.2 below presents a summary of the assessment of the Program Administration to identify the extent program objectives are being met.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   41

Table 4.2: Program Administration Assessment

Key Result Area: Funds are efficiently and effectively managed and deployed by the States and allocations are consistent with the agreement			
Objectives	**Performance Indicator**	**Review Findings**	**Conclusion**
Funds are allocated in accordance with eligibility criteria.	• Funded services in accordance with eligibility criteria. • Innovative projects funded.	• All services funded in accordance with criteria specified in the Agreement. • No new innovative services funded. There was evidence of service innovation at the service provider level.	• Funds are allocated in accordance with eligibility criteria.
Funds are deployed in a way that attracts additional resources and/or builds on existing infrastructure.	• Number of services where additional resources are input to eligible services.	• Services auspiced by NGO's or government health services that provide in kind support and attract additional resources relevant to client group from other programs.	• Funds are deployed in a way that attracts additional resources and/or builds on existing infrastructure.
Program is being monitored effectively by the States.	• Meaningful reports provided to States & DoHA. • Program evaluations undertaken at health jurisdiction levels.	• 98% of service providers provided annual reports in 2005/06. • The quantitative data collected by state/territory health jurisdictions is insufficient to report the types of services provided; data is inadequately defined; there are data gaps and the data is of questionable quality. • Data is not systematically analysed in five jurisdictions. • No program evaluation has been undertaken. • No evaluations have been undertaken at the service provider level	• There are opportunities to improve the effectiveness of program monitoring at the health jurisdictional levels.
Funding allocation process is efficiently managed.	• Transparent and equitable approach to allocation of funds.	• All service providers received rolled over funding allocations. • The budget allocation process well understood.	• Funding allocation process is efficiently managed.
Administrative and compliance arrangements reasonable given the size & nature of the program.	• Compliance costs reasonable. • Sufficient communication between DoHA, states/territories and service providers.	• Satisfactory at service provider level - when compared to other programs. • At the state/territory health jurisdictional level, the costs are high relative to the size of the Program	• Administrative and compliance arrangements are not reasonable given the size & nature of the Program.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   42

4.3   PROGRAM IMPLEMENTATION

An assessment of the effectiveness and efficiency of program implementation was undertaken to determine whether the Program was meeting the needs of clients through the provision of quality, direct, indirect and other services in a coordinated manner.

4.3.1   ASSESSMENT OF PROGRAM IMPLEMENTATION

Service providers are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in a coordinated manner.

A wide range of services are being provided utilising a range of successful service models. Gaps and barriers to effective services and emerging issues are identified at service provider level and reported in their annual reports. They are addressed at service provider level where practical. Service providers have adopted evidence-based practices and aim to provide quality services. Non-government stakeholders are involved in the planning and development of services and services have the appropriate level of staff (to match funds) who are appropriately trained and experienced.

The Review identified that there is little evidence of a policy response at the health jurisdiction or national level to address service gaps, barriers to provision of effective services and emerging issues.

Table 4.3 below presents a summary of the assessment of the Program Implementation to identify the extent program objectives are being met.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   43

Table 4.3: Program Implementation Assessment

Key Result Area: Service providers are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in a coordinated manner			
Objectives	**Performance Indicator**	**Review Findings**	**Conclusion**
Implementation of evidence-based service models.	• Type of service models adopted and identification of successful approaches.	• A wide range of services utilising a range of service models and approaches have been adopted. Clear themes identified into what makes a successful service.	• Approaches and services adopted are successful.
A range of services are being provided.	• Direct outputs provided (eg number of clients, group sessions etc). • Indirect and other outputs.	• Available service output data for the IHSHY program is presented at 2.4. • As envisaged in the Agreement a wide rage of services are being provided.	• A wide range of services are being provided.
Service gaps and/or barriers to effective services are identified and acted upon.	• Service gaps identified. • Barriers to effective services identified.	• Gaps and barriers to effective services are identified at service provider level and reported in their annual reports. They are addressed at service provider level where practical. • There is little evidence of a policy response at the health jurisdiction or national level to address gaps and barriers.	• There are opportunities to address the service gaps and/or barriers at the health jurisdiction and national levels.
Emerging issues are identified and responses developed.	• Evidence of identification of emerging needs	• Emerging issues are identified at service provider level and reported in their annual reports. • There is little evidence of a policy response at the health jurisdiction or national levels to address emerging issues.	• There are opportunities to develop strategies to address emerging issues at the health jurisdiction and national levels.
Service providers adopt evidence-based practices and provide quality services.	• Compliance with evidence-based/quality principles.	• 27 service provider organisations are accredited or have adopted a quality framework. • All service providers indicated that they complied with the best practice principles identified the 2002 IHSHY program evaluation.	• Service providers have adopted evidence-based practices and aim to provide quality services. • There is an opportunity to formally develop and adopt best practice principles as part of service provider agreements However there is no formal framework.
Non-government stakeholders are involved in the service planning, development and	• Evidence client feedback is sought and acted upon. • Evidence of non-government agency involvement in planning,	• Evidence is not provided in annual reports. • Service providers conduct pre- and post-evaluations of group sessions and periodic service feedback questionnaires.	• Non-government stakeholders are involved in the planning and development of services.

Key Result Area: Service providers are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in a coordinated manner			
evaluation of services.	development and evaluation of the service.	• Stakeholders involved in project planning. • Where applicable, service providers are involved in regional youth planning forums. • Some NGO's have stakeholder representation from agencies on management committees. • Evaluation discussed under Impact and Outcomes	
Services have appropriate staffing levels (commensurate to funding) and are appropriately trained and experienced.	• Staff vacancy levels. • Appropriately trained & experienced staff employed.	• No vacant IHSHY program funded positions were identified. • Service providers employ professional (not generalist) staff. • Turnover rates are not high.	• Services have the appropriate level of staff (to match funds) and staff appropriately trained and experienced.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
  Final Report – December 2007

45

4.4   PROGRAM IMPACT AND OUTCOMES

The IHSHY program impact and outcomes of the IHSHY program were examined to identify whether the Program goal and the benefits achieved are sustainable.

4.4.1   ASSESSMENT OF PROGRAM IMPACT AND OUTCOMES

The Program is achieving positive short-term impacts for the client group. There is no systematic evidence to demonstrate longer-term outcomes associated with the IHSHY program. Anecdotal evidence is suggestive of positive and sustainable long-term benefits.

With the exception of output data provided with respect to the provision of direct services there was no quantitative data available to support an analysis of whether the impacts or outcomes identified in the Review Framework have been achieved. The qualitative information provided in the annual reports and the information gathered during the stakeholders consultations have been used to determine the findings in this Key Result Area.

Direct outputs met immediate client need. Young people's knowledge has improved in relation to appropriate behaviours that will improve health outcomes and they are engaging with service providers and with peers where applicable. Mainstream service providers are increasing their knowledge of client group needs and IHSHY program funded service often receive referrals from these services. Significant innovations are occurring in some state/territory health jurisdictions and service providers are generally trialling innovative approaches within the confines of their existing services and budgets.

Whilst there is no systematic evidence to demonstrate longer term outcomes associated with the IHSHY program, anecdotal evidence and the program logic is suggestive of positive and sustainable long-term benefits. It is likely that personal health is improving, that there is less risk-taking behaviour, that self-esteem and client connectedness is improving and that service providers are modifying services within service models and budgetary confines to meet young people's needs. It would be difficult to state conclusively that client access to mainstream health providers was improving.

No program evaluations had been undertaken by seven state/territory health jurisdictions or at the service provider level.

Table 4.4 below presents a summary of the assessment of the Program Impact and Outcomes to identify the extent program objectives are being met.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – 18 May 2007   46

Table 4.4: Program Impact and Outcomes Assessment

Key Result Area: IHSHY program contributes to the achievement of the program goal and the benefits achieved are sustainable.			
Objectives	**Performance indicator**	**Review Findings**[1]	**Conclusion**
Services have been reviewed or evaluated and results reported.	• Number of services reviewed or evaluated.	• The Review found no evidence of program evaluations being undertaken by seven States. • There was no evidence of program evaluation being undertaken at the service provider level.	• There is a need to undertake formal Program evaluation on an ongoing basis.
IHSHY program is achieving the short-term impacts identified in the Review Framework (presented in Appendix A).	• Immediate client need met by provision of direct services. • Improved client knowledge regarding positive health behaviours. • Level client engagement with service providers. • Level of client peer engagement. • Service providers aware of health needs of client group. • Innovative service models developed.	• Direct outputs met immediate client need. • Client knowledge has improved (no evidence available to indicate whether behaviour changes have occurred except in isolated cases). • Clients engage with service providers. • Clients are engaging with peers where applicable. • Mainstream service providers are increasing their knowledge of client group needs. • Innovation is occurring within existing services.	• IHSHY program is achieving positive short-term impacts for the client group.
IHSHY program is achieving medium- and long-term outcomes identified in the Review Framework (presented in Appendix A).	• Personal health improvements for client group. • Less risk-taking behaviour by client group. • Enhanced client self-esteem. • Improved client connectedness. • Improved client access to mainstream service providers. • Service providers modify service to meet client group needs. • Innovative services implemented and evaluated.	• Strong program logic and anecdotal evidence suggests that longer-term outcomes are being achieved, at least to some extent i.e. that personal health is improving, that there is less risk-taking behaviour and that self-esteem and client connectedness is improving • It would be difficult to state conclusively that client access to mainstream health providers was improving. • No evidence of evaluation at local level.	• There is no systematic evidence to demonstrate longer-term outcomes associated with the IHSHY program

Note [1]: With the exception of output data provided on direct services there was no quantitative data available to support a systematic analysis of whether the impacts or outcomes identified in the Review Framework have been achieved. The qualitative information provided in the annual reports and gathered during the stakeholders consultations have been used to determine the findings in this Key Result Area

4.4.2 SUMMARY OF FINDINGS

Based on the evidence gathered in the conduct of this evaluation, the Review has concluded that the IHSHY program is contributing to improving health outcomes for homeless and at-risk youth. The Program is doing this by:

1. Providing access to specialised health services for homeless and at-risk youth who would otherwise be unlikely to receive similar services in mainstream health systems (and if they did present to mainstream health services, would do so at a later date with additional complications and at increased costs).

2. Providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth. The level of service innovation (where it is occurring) is at the service provider level.

3. Improving access to mainstream health services (to a limited extent) as well as to other related welfare programs. Often mainstream services will refer to IHSHY program due to their inability to respond appropriately to the client group.

The Review has identified there are a number of opportunities for the DoHA, state/territory health jurisdictions and service providers to improve the operation of the IHSHY program. This will ensure that the IHSHY program is able to effectively respond to the increasing demands being placed on the Program. These opportunities are further explored in the next Chapter of this report.

5

FUTURE POLICY DIRECTIONS

This Chapter seeks to draw on the analysis and findings of the Review to discuss a range of opportunities to improve the future policy directions for the IHSHY program. The opportunities are categorised from the perspective of:

- Commonwealth and state/territory Agreements;
- Funding options; and
- Opportunities to improve IHSHY program access and service delivery.

This Chapter also provides a number of Program improvement opportunities that have been identified together with the implications on future policy directions.

As highlighted in Chapter 4, the Review findings demonstrate that the IHSHY program is achieving its goal of contributing to improving health outcomes for homeless and at-risk youth. Notwithstanding this positive assessment, there are significant opportunities to improve the operation of the IHSHY program. The Review advocates consideration of these initiatives to ensure the Program is able to:

- Effectively respond to the needs of the target group and the corresponding demands on service providers; and
- Facilitate ongoing evaluation of Program performance in line with evidence-based best practice principles.

5.1 NEXT COMMONWEALTH/STATE SERVICE AND FUNDING AGREEMENTS

This section provides a discussion of the issues that need to be considered by the DoHA, state/territory health jurisdictions and service providers relating to the formulation of the next IHSHY program Service and Funding Agreements

5.1.1 INCREASED FOCUS ON SERVICE INNOVATION

Service providers funded under the Program have generally continued to receive funds for many years, with the services now being regarded as mainstream. The objective of service innovation has to a large extent not been pursued due to service demand pressures and resourcing constraints.

The Review considers it is important that the Program maintains the focus on service innovation. The Program should seek to reinforce its aim to harness and build upon the many innovative service delivery projects currently being undertaken by both public and private agencies across Australia.

To ensure this is achieved, it is suggested that the next Funding Agreements include the provision for pilots to improve service delivery for homeless youth and youth at-risk. These pilot projects should be undertaken within an agreed framework which will ensure all stakeholders are clear as to the intent of the innovative focus of the Program. In addition this framework will provide an opportunity for state/territory health jurisdictions and collaborative partnerships to showcase service delivery improvements. The key components of the innovation framework include:

- Identify need;
- Develop service model;
- Pilot and evaluate service model;

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007
49

- Fine tune model as necessary;
- Ongoing evaluation networking and information sharing;
- Identifying further need;
- Develop new or extended models; and
- Attract interest and funding from IHSHY program or other sources for new service models.

5.1.2 IMPROVE COMMUNICATION PROCESSES

The Review has highlighted there are opportunities to improve communication processes relating to the operations of the Program. We have found that most service providers are operating in isolation from each other and that health jurisdictions are operating in isolation from each and in some cases their IHSHY service providers. Accordingly stakeholders are not able to learn from the experience of others. In addition the Review has identified that there are opportunities to strengthen communication regarding strategic issues and program performance. To improve communication at all levels within the Program, the following initiatives and associated responsibilities have been identified and could be considered in the formulation of the next Agreements.

1. **Establish national website:** There was strong support for the establishment of a national IHSHY Program web site to assist with communication and promulgating relevant information, research and types of services being provided. The website could include the list of services by jurisdiction together with a brief description of their service models, relevant items of research or other items of interest that any stakeholder considers should be shared, other important youth related policy work and the maintenance of an email list to notify IHSHY program workers when new items are posted. The website could be maintained by DoHA. A clear editorial policy should be established to ensure readers are aware of the source of the information, whether it has been reviewed etc. The number of hits and downloads from the website could be monitored and reported on annually.

2. **National meetings to be held during an Agreement period**. The Commonwealth could convene two meetings during the period of the Agreement. The first meeting could focus on discussing the Program operational issues and the future directions for the forthcoming Agreement period. A second meeting could be held at the midpoint of the Agreement period, to focus on new developments, developing responses to emerging issues and addressing barriers to providing or improving services. Guest speakers presenting on topical issues (such as progress of pilot projects funded under the innovative services funding pool) could be invited to this meeting. The meetings could be attended by DoHA, state/territory health jurisdiction representatives and a selection of service providers from each jurisdiction. Information gained from the meeting could be shared with service providers who do not attend the meeting by jurisdiction representatives and could be placed on the proposed national web site.

3. **Development of a Program communication strategy**. The Review considers that it is important for DoHA to develop a communication strategy in association with state/territory health jurisdictions and nominated IHSHY program service providers. The objective of the communication strategy would be to promote the ongoing value of the IHSHY Program to key stakeholders so that there is ongoing commitment to and support for all aspects of the implementation of the Commonwealth and health jurisdictional policy for providing innovative health services to homeless and at-risk youth. The communication strategy could be developed by conducting a stakeholder workshop to determine the issues relating to IHSHY program communication including:

    – Messages to be conveyed to stakeholders;
    – Information needed by stakeholders; and
    – Strategies and objectives for ensuring the attainment of improved ongoing Program communication.

    In the light of these initiatives state/territory health jurisdictions will need to consider how they can improve communication within their jurisdictions.

5.1.3 IMPROVE ANNUAL PROGRAM MONITORING

The Review has identified opportunities to improve the annual Program monitoring processes to assess the degree to which the objectives outlined in the Agreements have been achieved.

As previously discussed, one of the most significant issues encountered by the Review was the inconsistencies in the collection and reporting of quantitative data collection across most state/territory health jurisdictions. In addition we found little evidence of any systematic analysis of data (quantitative or qualitative) that could be used to inform decision-making regarding service delivery or improvement. There is an opportunity to streamline and improve the data collection and reporting processes which should be articulated in the next Agreement.

1. **Improve collection and reporting of quantitative data.** To improve the quality of the quantitative data collection, a review of data items is suggested to ensure they are more reflective of the activity being undertaken in the Program. It is proposed that standardised data definitions be developed and circulated to stakeholders to ensure consistency in data collection and reporting.

2. **Improve collection and reporting of qualitative data.** Based on the feedback received from a number of stakeholders, we suggest that a review be undertaken of the current data items that are reported to the DoHA with a view to reducing the reporting burden on service providers. From this perspective we consider that it is important that wherever possible, the richness of the information that is currently provided should be maintained.

3. **Guidelines for annual Program reporting.** The Review proposes that guidelines for annual Program reporting be reviewed in association with state/territory health jurisdictions and service providers. Key reporting areas could include:

   – The background of the projects undertaken under the auspices of the IHSHY program;
   – Analysis of projects in terms of strengths, weaknesses, opportunities and threats; and
   – The actions proposed to improve the Program.

   These guidelines could then be included in the Agreement as part of the performance measurement requirements.

4. **Frequency of data reporting.** Currently Program data is reported by state/territory health jurisdictions to the DoHA on an annual basis. In the interests of improving the effectiveness and efficiency of Program monitoring and to facilitate a timely follow-up of relevant issues, the Review proposes that data reporting be on a six-monthly basis. Jurisdictions could provide a consolidated report to the Commonwealth (as apposed to just forwarding the service provider reports) including an analysis of trends, emerging issues, barriers and other matters of importance as well as highlighting responses to the issues raised. The reports could be posted on the proposed web site to assist service providers in understanding IHSHY program issues from a broader perspective.

5.1.4 PROGRAM EVALUATION

The Review has noted that that the current Agreement specifies that *"services and organisations applying for IHSHY Program funding are required to include an evaluation component in their funding proposals, in order to meet the requirements set out in Attachment A of the Schedule, including maintaining data on clients and service operations, and participating as required in State and Commonwealth evaluation processes"*. We were unable to find evidence to demonstrate that a formal or systematic review or evaluation of the IHSHY Program at health jurisdictional or service provider level existed during the period of the current Agreement with the exception of Western Australia. In addition the Review has identified there is a lack of empirical evidence to demonstrate the impacts, outcomes and benefits of the Program. To support the need to measure the impacts and outcomes for IHSHY program the following opportunities have been identified.

1. **Reinforcement of the conduct of Program evaluations by state/territory health jurisdictions.** The Agreements could reinforce the need for state/territory health

jurisdictions and other recipients of IHSHY program funding to undertake an evaluation of specific projects aimed at demonstrating the appropriateness, effectiveness and efficiency of these projects in meeting specified objectives. It is proposed that the timing of such evaluations be specified in the Agreement and could include a mandatory evaluation report to be submitted by each jurisdiction prior to the end of the Agreement.

2. **Measuring client outcomes.** A generic tool to measure health and social functioning in the client group could be developed and tested in a small number of service providers (so that changes in individual clients can be evaluated over time). This tool could then be made available for all IHSHY program service providers who wish to evaluate client outcomes. It is recognized that there will be difficulties in administering any tool to the target group due to their mobility. However, if supported, investment in such a tool would provide some evidence of client outcomes.

3. **Develop Program evaluation guidelines.** In order to provide support to state/territory health jurisdictions and service providers who will be involved in undertaking Program evaluations, the Review proposes that program evaluation objectives/ guidelines/ principles be included in the Agreement. These could include:

    –   Process being timely and responsive to changing circumstances;
    –   Need to draw upon performance indicators;
    –   Process to be sustainable at relatively low costs in funding and effort;
    –   Need for the findings of the evaluation to facilitate strategic planning, monitoring and decision-making; and
    –   Need to draw on evidence-based practices as appropriate.

5.1.5   OTHER

1. **Estimate number of homeless and at-risk youth.** The Review identified that there was a paucity of data relating to trends in the number of homeless and at-risk youth since the 2001 census data was analysed. To assist in understanding trends in the size of the target group, the adequacy of the overall level of program funding and distribution of those funds across jurisdictions, the estimate of the numbers of homeless and at-risk youth will need to be updated. This could be done in conjunction with FaHCSIA.

2. **Review the eligible funding criteria to include research and needs assessment.** There is a need to review the eligibility criteria to include projects aimed primarily on research and needs assessment (currently excluded by the Agreement). This would assist to identify service gaps and assess the applicability of various service models and strategies that best meet the needs of the client group.

5.2   INITIATIVES TO IMPROVE SERVICE DELIVERY AND ACCESS

Many of the initiatives recommended above are designed to improve service delivery and access. The following additional initiatives are recommended.

1. **Develop and adopt best practice principles.** Service providers are committed to the provision of quality services. Whilst there have been several initiatives in relation to identifying best practice service delivery guidelines across Australia, there has been no attempt to adopt best practice principles for the Program. As part of a commitment to best practice and quality, the IHSHY program could formally develop and adopt best practice principles for service providers and these could be included in service provider service agreements.

2. **Service priorities for funding.** If additional resources are allocated to the Program, funding priorities could include improving geographical coverage of the program, expanding on existing successful models and services, increasing access to GPs and targeted service provision (e.g. Aboriginal and Torres Strait Islander clients).

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APPENDIX A – REVIEW FRAMEWORK

The Review Framework for the IHSHY Program as endorsed by DoHA and circulated to all relevant stakeholders. The framework outlined:

- Aim of the review;
- Review approach;
- Program logic
- Key review questions
- Key indicators (and associated questions and data sources);
- Questions to be asked of each stakeholder group: and
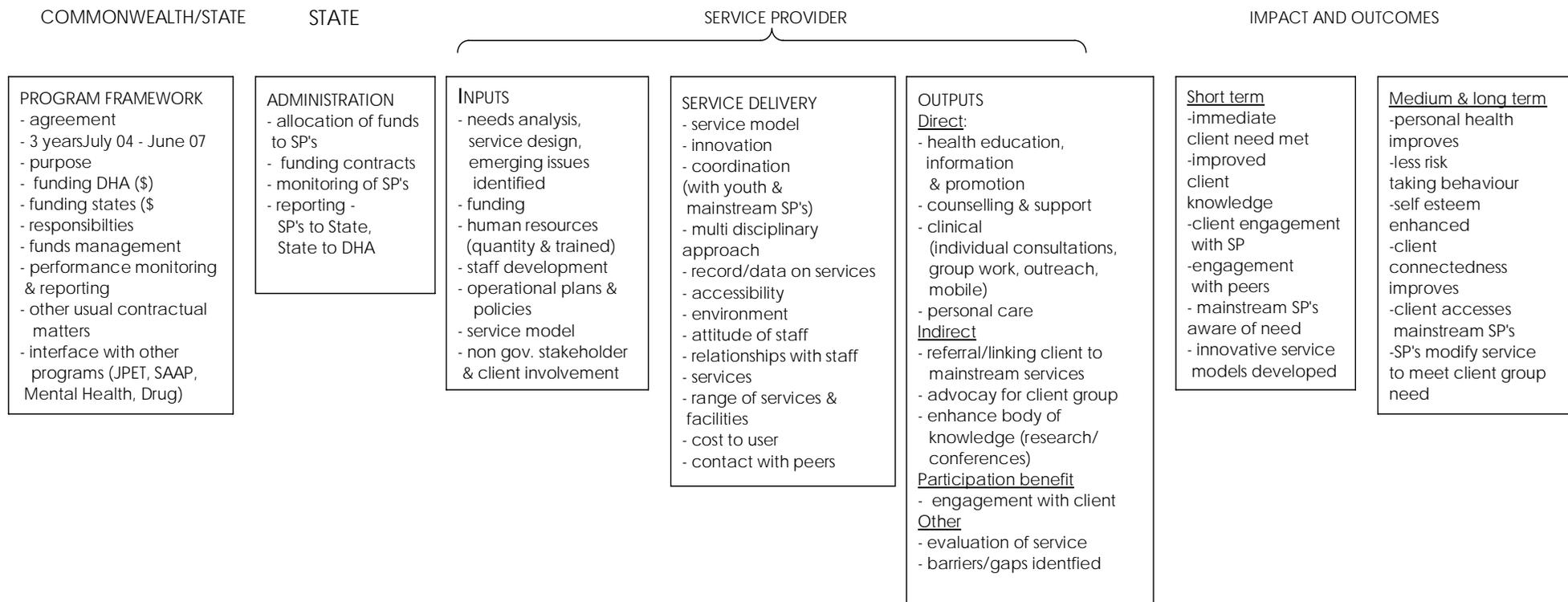- Next steps.

PROGRAM LOGIC

The following diagram provides depicts the program logic including the program goals as per the Commonwealth State Agreements; the program hierarchy; program components and key result areas (KRA) for each program component.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007

53

PROGRAM GOAL: To contrbute to improving health outcomes for homeless and at-risk youth by:
- improving access to mainstream health services or providing access to specialised health services for homeless and at-risk youth: and/or
- providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth.

PROGRAM LOGIC

Program Hierarchy

COMMONWEALTH/STATE	STATE	SERVICE PROVIDER	IMPACT AND OUTCOMES

PROGRAM FRAMEWORK
- agreement
- 3 yearsJuly 04 - June 07
- purpose
- funding DHA ($)
- funding states ($
- responsibilties
- funds management
- performance monitoring & reporting
- other usual contractual matters
- interface with other programs (JPET, SAAP, Mental Health, Drug)

ADMINISTRATION
- allocation of funds to SP's
- funding contracts
- monitoring of SP's
- reporting - SP's to State, State to DHA

INPUTS
- needs analysis, service design, emerging issues identified
- funding
- human resources (quantity & trained)
- staff development
- operational plans & policies
- service model
- non gov. stakeholder & client involvement

SERVICE DELIVERY
- service model
- innovation
- coordination (with youth & mainstream SP's)
- multi disciplinary approach
- record/data on services
- accessibility
- environment
- attitude of staff
- relationships with staff
- services
- range of services & facilities
- cost to user
- contact with peers

OUTPUTS
Direct:
- health education, information & promotion
- counselling & support
- clinical (individual consultations, group work, outreach, mobile)
- personal care
Indirect
- referral/linking client to mainstream services
- advocay for client group
- enhance body of knowledge (research/ conferences)
Participation benefit
- engagement with client
Other
- evaluation of service
- barriers/gaps identfied

Short term
-immediate client need met
-improved client knowledge
-client engagement with SP
-engagement with peers
- mainstream SP's aware of need
- innovative service models developed

Medium & long term
-personal health improves
-less risk taking behaviour
-self esteem enhanced
-client connectedness improves
-client accesses mainstream SP's
-SP's modify service to meet client group need

Program Component and Key Result Area

Policy & Structure

IHSHYP designed and structured appropriately to ensure the Program goal is achieved

Administration

Funds are efficiently and effectively managed and deployed by the States and allocations are consistent with the agreement

Implementation

SP's are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in coordinated manner

Impact and Outcomes

IHSHYP contributes to the achievement of the program goal and benefits achieved are sustainable

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   54

Review Questions

The framework included a range of questions that were discussed with nominated stakeholders relating to the current performance of the IHSHY program and policy directions to be considered in developing the next set of Commonwealth/state and territory agreements governing the program. All Review questions were considered from the perspective of effectiveness, efficiency and appropriateness.

ASSESSMENT OF PROGRAM PERFORMANCE

In assessing the current performance of the Program the key review questions that were discussed with stakeholders were as follows:

1. Is the IHSHY program contributing to improving health outcomes for homeless and at-risk youth?

2. Is the IHSHY program improving access to mainstream health services for homeless and at-risk youth?

3. Is the IHSHY program providing access to specialised health services for homeless and at-risk youth?

4. Is the IHSHY program providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth?

The answers to these questions were used to identify:

- What the program has achieved;
- How well it has contributed to the goal;
- What worked well and what didn't, and why;
- Whether there were any unintended outcomes; and
- What can be learnt from the program to improve practice and inform the next agreement?

To assist with the Review the following key result areas (KRA's) by program component were identified:

1. **Policy and Structure** – IHSHY program designed and structured appropriately to ensure the Program goal is achieved;

2. **Administration** – Funds are efficiently and effectively managed and deployed by the States and allocations are consistent with the agreement;

3. **Implementation** – Service providers are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in coordinated manner; and

4. **Impact and Outcomes** – IHSHY Program has contributed to the achievement of the Program goal and the benefits achieved are sustainable.

KEY INDICATORS

The tables in this section identify by program component, the KRA, the domain, the review question, the associated indicator and the proposed data sources in relation to that indicator. Analysis of these indicators enabled conclusions to be drawn in relation to each KRA with respect to the appropriateness, effectiveness and efficiency.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   55

POLICY AND STRUCTURE

Key Result Area: IHSHY PROGRAM designed and structured appropriately to ensure the Program goals is achieved			
Domain	**Review Questions**	**Indicator**	**Data source**
Appropriateness	Is the funding level adequate?	• Funding trend contrasted to homeless youth trends. • Equitable allocation between States.	• Consultations with DoHA, state/territory health jurisdictions and service providers • Analysis of data provided by ABS, DoHA and state/territory health jurisdictions
Appropriateness	Are eligible services those which best meet the Program goal?	• Number of potential services identified that are not covered by agreement and number that do not meet goal.	• Literature review. • Consultations with DoHA, state/territory health jurisdictions and service providers
Appropriateness. Effectiveness	Do other Commonwealth or State programs overlap with IHSHY Program or are the programs complimentary? Are the programs well coordinated?	• Satisfactory Interface with other programs.	• Consultations with FaCSIA, DEWR, DoHA Mental Health & Drug Branch, DoHA, state/territory health jurisdictions and service providers.
Appropriateness. Effectiveness	Are responsibilities between the States and DoHA clear and appropriate to the program?	• Evidence of responsibilities clear and appropriate.	• Consultations with DoHA, and state/territory health jurisdictions
Appropriateness. Effectiveness Efficiency	What opportunities do you see for improvement in this KRA area and do you have other comments in relation to future directions?	• Options for improving program policy, design and structure.	• Consultations with DoHA, state/territory health jurisdictions and service providers

ADMINISTRATION

Key Result Area: Funds are efficiently and effectively managed and deployed by the States and allocations are consistent with the agreement			
Domain	**Review Questions**	**Indicator**	**Data source**
Effectiveness Efficiency	Are funds being allocated in accordance with eligibility criteria?	• Funded services in accordance with eligibility criteria. • Analysis of funding allocation and expenditure	• Consultations with DoHA, state/territory health jurisdictions and service providers • Program reports
Effectiveness Efficiency	Are funds deployed in a way that attracts additional resources and/or builds on existing infrastructure?	• Number of stand alone services. • Number of services where additional resources are input to eligible services.	• Consultation with state/territory health jurisdictions and service providers. • Program reports.
Effectiveness Efficiency	Is the program being monitored effectively by the States?	• Timely and accurate reports provided to state/territory health jurisdictions and DoHA. • Level of program reporting and monitoring at the health jurisdictional and service provider levels.	• Consultation with state/territory health jurisdictions • Program reports
Efficiency	Is the funding allocation process efficiently managed?	• Transparent and simple approach to allocation of funds.	• Consultation with state/territory health jurisdictions and service providers.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   56

Key Result Area: Funds are efficiently and effectively managed and deployed by the States and allocations are consistent with the agreement			
Domain	**Review Questions**	**Indicator**	**Data source**
Effective Efficiency	Are administrative and compliance arrangements reasonable given the size & nature of the program?	• Compliance costs reasonable. • Effective communication between DoHA & state/territory health jurisdictions	• Consultations with DoHA, state/territory health jurisdictions and service providers
Efficiency Effectiveness	Is there sufficient communication between DoHA & States & SP's to ensure effective & efficient management?	• Number of respondents indicating communication satisfactory.	• Consultations with DoHA, state/territory health jurisdictions and service providers •
Appropriateness Effectiveness Efficiency	What opportunities do you see for improvement in this KRA area and do you have other comments in relation to future directions?	• Options for improving the effectiveness and efficiency funding arrangements.	• Consultations with DoHA, state/territory health jurisdictions and service providers

IMPLEMENTATION

Key Result Area: Service providers are effectively and efficiently meeting the needs of clients by provision of quality, agreed direct, indirect and other services in coordinated manner			
Domain	**Review Questions**	**Indicator**	**Data source**
Effectiveness	What approaches & services are successful in meeting client needs?	• Type of service models adopted and identification of successful approaches.	• Consultations with DoHA, state/territory health jurisdictions and service providers.
Efficiency	What services are being provided?	• Quantity of direct outputs provided eg no. of clients, no. of group sessions • Indirect & other outputs.	• Consultations with DoHA, state/territory health jurisdictions and service providers. • Program reports.
Effectiveness	Are there service gaps and/or barriers to effective services?	• Service gaps identified. • Barriers to effective services identified.	• Consultations with DoHA, state/territory health jurisdictions and service providers. • Program reports.
Appropriateness Effectiveness	Are emerging issues identified and what are they?	• Evidence of identification of emerging needs	• Consultations with DoHA, state/territory health jurisdictions and service providers. • Program reports.
Effectiveness	With respect to the list of best practice principles are quality services being provided?	• Compliance with best practice principles (2). .	• Consultations with DoHA, state/territory health jurisdictions and service providers.
Effectiveness	How are non-government stakeholders involved in the planning, development and evaluation of services?	• Evidence client feedback is sought & acted upon. • Evidence of non-government involvement in planning, development & evaluation of the service.	• Consultations with state/territory health jurisdictions and service providers. • Program reports.
Effectiveness Efficiency	Do you have the appropriate level of staff (to match funds) and are they appropriately trained and experienced?	• Staff vacancy levels. • Appropriately trained & experienced staff employed.	• Program reports. SP and State consultations.
Appropriateness.	What opportunities do you see	• Options for improving the	• Consultations with

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   57

Effectiveness Efficiency	for improvement in this KRA area and do you have other comments in relation to future directions?	effectiveness and efficiency of service delivery to meet client needs.	state/territory health jurisdictions and service providers.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   58

IMPACT AND OUTCOMES

Key Result Area: IHSHY Program contributes to the achievement of the program goal and the benefits achieved are sustainable?			
Domain	**Review Questions**	**Indicator**	**Data source**
Appropriateness. Effectiveness Efficiency	Has the Service been reviewed or evaluated and what were the results?	• Number of services reviewed or evaluated	• Consultations with state/territory health jurisdictions and service providers. • Program reports.
Appropriateness. Effectiveness	With reference to the review framework (or other outcome indicators you have) what have been the short term outcome or impacts from the program?	• Immediate client need met by provision of direct services. • Improved client knowledge regarding positive health behaviours. • Level of client engagement with service providers. • Level of client peer engagement. • Mainstream serve providers aware of need of client group. • Innovative service models developed.	• Consultations with state/territory health jurisdictions and service providers. • Program reports. • Analysis of previous indicators.
Appropriateness. Effectiveness	With reference to the review framework (or other outcome indicators you have) what have been the medium and long term outcomes?	• Personal health improves for client group. • Less risk taking behaviour by client group. • Self esteem enhanced. • Client connectedness improves. • Client access to mainstream health services improves. • Service providers modify service to meet client group needs. • Innovative services implemented and evaluated.	• Consultations with state/territory health jurisdictions and service providers. • Program Reports. • Analysis of previous indicators.

QUESTIONS BY STAKEHOLDER GROUP

This section identifies the questions that were asked of each stakeholder group. The questions have been drawn from the tables in section 4.2 above. The Review Framework was emailed to nominated representatives of selected organisations prior to the interview. This enabled interviewees to consider the key issues and be fully prepared. Interviewees were also requested to provide any additional information/reports etc they had collated in relation to IHSHY program that may not have been forwarded to DoHA.

DISCUSSIONS WITH HEALTH JURISDICTION REPRESENTATIVES

Responses from nominated health jurisdiction representations were sought to the following questions:

1. Is the funding level adequate?

2. Are eligible services those which best meet the Program goal?

3. Do other Commonwealth or state programs overlap with IHSHY program or are the programs complimentary? Are the programs well coordinated?

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   59

4.   Are responsibilities between the States and DOHA clear and appropriate to the program?

5.   Are funds being allocated in accordance with eligibility criteria?

6.   Are funds deployed in a way that attracts additional resources and/or builds on existing infrastructure?

7.   Is the program being monitored effectively?

8.   Is the funding allocation process efficiently managed?

9.   Are administrative and compliance arrangements reasonable given the size and nature of the program?

10.   Is there sufficient communication between DoHA & States & SP's to ensure effective & efficient management?

11.   What services are being provided?

12.   What approaches & services are successful?

13.   Are there service gaps and/or barriers to effective services?

14.   Are emerging issues identified and what are they?

15.   With respect to the list of best practice principles are quality services being provided?

16.   How are non-government stakeholders involved in the planning, development and evaluation of services?

17.   Do you have the appropriate level of staff (to match funds) and are they appropriately trained and experienced?

18.   Has the Program been reviewed or evaluated and what were the results?

19.   With reference to the review framework (or other outcome indicators you have) what have been the short term outcome or impacts from the program?

20.   With reference to the review framework (or other outcome indicators you have) what have been the medium and long term outcomes?

21.   What opportunities do you see for improvement in any component of IHSHY program and do you have other comments in relation to future directions?

22.   In your view is the IHSHY program improving access to mainstream health services for homeless and at-risk youth?

23.   In your view is the IHSHY program providing access to specialised health services for homeless and at-risk youth?

24.   In your view is the IHSHY program providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth?

SERVICE PROVIDERS

Responses from nominated IHSHY program service providers were sought to the following questions:

1.   Is the funding level adequate?

2.   Are eligible services those which best meet the Program goal?

3.   Do other Commonwealth or state programs overlap with IHSHY Program or are the programs complimentary? Are the programs well-coordinated?

4.   Are funds being allocated in accordance with eligibility criteria?

5.   Are funds deployed in a way that attracts additional resources and/or builds on existing infrastructure?

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   60

6. Is the funding allocation process efficiently managed?

7. Are administrative and compliance arrangements reasonable given the size and nature of the program?

8. Is there sufficient communication between DoHA & States & SP's to ensure effective & efficient management?

9. What services are being provided?

10. What approaches & services are successful?

11. Are there service gaps and/or barriers to effective services?

12. Are emerging issues identified and what are they?

13. With respect to the list of best practice principles are quality services being provided?

14. How are non-government stakeholders involved in the planning, development and evaluation of services?

15. Do you have the appropriate level of staff (to match funds) and are they appropriately trained and experienced?

16. Has the Service been reviewed or evaluated and what were the results?

17. With reference to the review framework (or other outcome indicators you have) what have been the short term outcome or impacts from the program?

18. With reference to the review framework (or other outcome indicators you have) what have been the medium and long term outcomes?

19. What opportunities do you see for improvement in any component of IHSHY program and do you have other comments in relation to future directions?

20. In your view is the IHSHY program improving access to mainstream health services for homeless and at-risk youth?

21. In your view is the IHSHY program providing access to specialised health services for homeless and at-risk youth?

22. In your view is the IHSHY program providing a range of innovative health and related services which respond to the complex needs of homeless and at-risk youth?

DEPARTMENT OF HEALTH AND AGEING REPRESENTATIVES

Responses from nominated DoHA representatives were sought to the following questions:

1. Is the funding level adequate?

2. Do other Commonwealth or state programs overlap with the IHSHY program or are the programs complimentary? ? Are the programs well coordinated?

3. Are responsibilities between the States and DoHA clear and appropriate to the program?

4. Are administrative and compliance arrangements reasonable given the size and nature of the program?

5. Is there sufficient communication between DoHA & States & SP's to ensure effective & efficient management?

OTHER COMMONWEALTH AGENCIES -FACSIA AND DEWR

Responses from representatives of FaCSIA and DEWR were sought to the following questions:

1. Please outline the programs you are providing in relation to homeless and at-risk youth.

2. Do you have a clear understanding of the IHSHY program?

3. Is there any overlap or conflicting priorities with the IHSH Y program?

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   61

4. Are the programs (those delivered by your agency and IHSHY Program) well coordinated (at agency and the local level) and seamless to youth where appropriate?

5. Have you had any reviews or evaluations undertaken to support your view?

6. What opportunities do you see for improvement in any component of IHSHY Program and do you have other comments in relation to future directions?

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   62

B

APPENDIX B – ELIGIBLE AND INELIGIBLE SERVICES

The following are the eligible and ineligible services as per Schedule B of the Commonwealth/State Agreement.

Eligible Services

To be funded, service providers must meet the following key requirements:

- Provide, or assist in the provision of, primary health care at no cost to homeless and otherwise at-risk young people between the ages of 12 to 24 years and their dependants;
- Provide for non-government involvement in the planning, development and evaluation of services;
- Co-ordinate their service activities, as far as practicable, with both mainstream health services and with other services for young people; and
- Record and supply appropriate and adequate data for service monitoring purposes.

Service providers should also, as far as practicable:

- Promote the multi-disciplinary approach including, where appropriate, staff of both sexes who are from a mix of ethnic, or other relevant backgrounds;
- Provide individual consultations, group, outreach and/or mobile services and activities focused on health education, information and promotion; and
- Provide counselling and support services, with an emphasis on enhancing self-esteem and connectedness among service clients.

Approved service providers may also use IHSHY program funds for:

- Group activities with a health promotion focus. Eligible activities could include:
- Conflict resolution activities;
- Sexual health information sessions; and
- Cooking and nutrition classes.
- Laundry and showering facilities;
- Supply of pharmaceuticals;
- Supply of food packs and occasional meals;
- Supply of personal hygiene items for which an alternative source of funding is not available to the client. Eligible items could include:
- Toilet bags;
- Soap;
- Shampoo;
- Condoms;
- Tampons and sanitary napkins; and
- Toothbrushes and toothpaste.
- Supply of clothing items essential for maintaining and improving the health of the client, and for which an alternative source of funding is not available to the client. Eligible items could include:
- Footwear for clients with a medical condition affecting their feet;

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   63

- Winter clothing for clients that do not have sufficient clothing to keep warm; and
- Underwear.
- Occasional group activities for service clients;
- Client recruitment work, including the provision of limited recreational activities within the service;
- Referral, brokerage and advocacy work to facilitate access to mainstream health and other relevant services;
- Staff training and development;
- Development, production and/or distribution of health information and health promotion resources;
- Development of protocols, for operating in a multi-disciplinary environment, for consumer rights, confidentiality, complaints mechanisms, etc.; and
- Trialing an innovative aspect of service provision or the provision of seed funding for a new service.

Ineligible Services

IHSHY Program funds are not provided for:

- The purchase, major maintenance, or renovation of premises;
- Projects primarily aimed at research or needs assessment work;
- Client services that do not have a clear health focus; and
- The provision of regular meals.

Eligible services may seek funding from other sources for activities that are not eligible for, or unable to be funded by, the IHSHY Program.

Department of Health and Ageing
Review of the Innovative Health Services for Homeless Youth Program
Final Report – December 2007   64