# Evaluation of the COMPASS Program

*Summative Report*

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# Acronyms

| Acronyms | Meaning |
|---|---|
| CPC | Child Protection Champion |
| CRIS | Client Relationship Information System |
| CRISSP | Client Relationship Information System for Service Providers |
| CVDL | Centre for Victorian Data Linkage |
| DFFH | Department of Families, Fairness and Housing |
| DGS | Department of Government Services |
| DH | Department of Health |
| DJCS | Department of Justice and Community Safety |
| DP | Victoria Police |
| DTF | Department of Treasury and Finance |
| GCM | Government Contract Manager |
| VSIIDR | Victorian Social Investment Integrated Data Resource |
| JDP | Joint Development Phase |
| LEAP | Law Enforcement Assistance Program |
| MHCSS | Mental Health Community Support Services Data Collection |
| NDIS | National Disability Insurance Scheme |
| OoHC | Out-of-home care |
| PAD | Partnerships Addressing Disadvantage (formerly called Social Impact Bonds, SIB) |
| RTA | Residential Tenancies Act |
| SIB | Social Impact Bond (now called Partnerships Addressing Disadvantage, PAD) |
| VAED | Victorian Admitted Episodes Dataset |
| VEMD | Victorian Emergency Minimum Dataset |
| VADC | Victorian Alcohol and Drug Collection |
| VM | Virtual Machine |

# Definition of key terms

| Term | Definition |
|---|---|
| **Better Futures** | A Victorian government initiative which provides case work support, information and advice and flexible funding to young people transitioning from care services to adulthood. Young people living in care services on a Secretary Order, a Long-Term Care Order, Permanent Care Order, or a Family Reunification Order are referred to Better Futures at 15 years and 9 months. From July 2021, young people on permanent care orders can access Better Futures from 15 years and 9 months. Eligible young people can access support through Better Futures until they are 21 years of age. COMPASS participants can access Better Futures, with support being put on 'active hold' while a young person is participating in COMPASS. |
| **COMPASS control group** | The COMPASS control group was established under the payment arrangements between COMPASS Leaving Care and the State. Outcome payments to COMPASS Leaving Care were informed by how the young people who participated in COMPASS tracked against specific measures when compared to the COMPASS control group. The COMPASS control group left care several years prior to the COMPASS program, and so are not a contemporaneous control group. This meant that social, economic and policy changes and the COVID-19 pandemic affected them differently to the participants in the COMPASS program. |
| **COMPASS Leaving Care** | COMPASS Leaving Care Limited is a special purpose entity (COMPASS SPE, or issuer) and company limited by guarantee. The COMPASS SPE was established to provide a standalone legal entity, through which Anglicare Victoria and VincentCare Victoria can deliver the COMPASS program on a joint venture basis. |
| **COMPASS participant** | A young person who was enrolled in the COMPASS program. 184 young people were enrolled over the duration of the program. This report may refer to 182 participants in some instances, because 2 participants passed away. Within the data-linkage process, a record duplication issue meant that one additional record was excluded from some analyses – analyses in these cases refer to 181 young people. |
| **COMPASS program** | Also known as 'the program' or 'COMPASS'. |
| **COMPASS program staff** | Also referred to as 'program staff' to describe Anglicare and VincentCare Victoria who are working on program delivery. |
| **Home Stretch** | Through Home Stretch, young people and their kinship, foster and permanent carers have the option of the young person remaining with their carer up to the age of 21 years, supported by an allowance. Young people leaving residential care (including lead tenant), kinship care, foster care, permanent care or in some cases leaving another care or living arrangement can access an allowance to support them with housing costs up to 21 years of age. |
| **In-care** | Young people still living in out-of-home care. |
| **Key Worker** | Anglicare staff who support young people in the engagement and participation phases of the COMPASS program. |

| | |
|---|---|
| **Participant** | A young person who has signed up to the COMPASS program. |
| **Participation rate** | The percentage of eligible referrals who go on to participate in the program. Those who were withdrawn are excluded for this calculation. |
| **Post-care** | Young people who have left out-of-home care. |
| **Program staff** | Anglicare and VincentCare Victoria staff contracted by COMPASS Leaving Care to deliver COMPASS Leaving Care. |
| **Service providers** | Providers of specialist support such a mental health, drug and alcohol, education, employment, and housing services. |
| **Partnership Addressing Disadvantage (PAD)** | PADs (formerly Social Impact Bonds (SIBs) and also known social impact investments) bring together capital and expertise from public, private, and not-for-profit sectors to achieve improved social outcomes.<br>PADs aim to improve outcomes for disadvantaged groups in society and avoid government costs through reducing the use of acute and expensive government services. Payments to service providers and investors are, in part, based on achieving agreed social outcomes rather than focusing on inputs or activities. |
| **Stratification tool** | A predictive tool developed by KPMG specifically for COMPASS which estimates the future utilisation of services. It draws on analysis of historical data on services usage for other young people who have been in care.<br>At the referral stage, prospective participants are stratified into high, medium, and low categories. |
| **Tenancy Worker** | VincentCare Victoria staff who manage the COMPASS tenancies and properties. |
| **Urbis control group** | The Urbis control group was constructed for this evaluation and consists of Victorian out-of-home care leavers who turned 18 between 1 January 2019 and 31 December 2021, and who did not participate in the COMPASS program. This group was selected to be a contemporaneous control group, meaning they are expected to have been affected by Covid-19 and policy changes in similar ways to the COMPASS participants. |
| **Young person** | Describes a young person who is an out-of-home care leaver and who is being referred to the program or in the engagement phase. |

# Executive Summary

Young people who are transitioning from the out-of-home care (OoHC) system have significantly poorer outcomes than their contemporaries. This includes a higher likelihood of homelessness, unemployment and justice system involvement, and worse health and mental health outcomes. The COMPASS Leaving Care Program (COMPASS, or 'the program') supports young people as they transition from OoHC to adulthood. It aims to improve their life outcomes by providing personalised case management, assertive outreach, and access to wrap around support and services for up to two years, alongside stable housing where this is needed.

The program commenced services in October 2018. Service delivery phased out towards the end of 2023. The program was delivered by two sub-contractors: Anglicare Victoria and VincentCare Victoria. Anglicare employed Key Workers who engaged with participants and provided case management support, while VincentCare Victoria managed the housing component by providing tenancy and property management, as well as being contracted to manage COMPASS finances. All eligible young people leaving OoHC in the program's catchments were referred, with an initial engagement period of up to six months (eight weeks for post-care referrals and no time stamp for Aboriginal care leavers), during which time young people could elect to 'sign up' to the program.

Once they agreed to participate in the program, COMPASS' goal-directed case management approach linked young people leaving foster care, kinship care, and residential care with education, training, and job opportunities while also providing financial, practical, independent living skills and psychosocial support and connecting them to health and wellbeing services. The program's highly flexible model also enabled tailored supports and referrals that addressed particular needs – for example, support for young parents or linking to cultural strengthening programs for Aboriginal and Torres Strait Islander young people.

For those young people who needed housing support, COMPASS provided accommodation. A key feature of the model is the direct provision of subsidised housing for participants who need it through COMPASS-owned or head-leased properties.

The COMPASS program was funded through an innovative social financing approach based on the social impact bond (SIB) model. In Victoria, SIBs are referred to as Partnership Addressing Disadvantage (PADs), and COMPASS was one of Victoria's first such arrangements. COMPASS was funded by a combination of government and investor funding. Government contributed $6.2 million in fixed funding, and additional variable funding based on agreed acute service use reduction relative to a control group. $14.2 million was contributed from 55 investors, who provide operating capital for the program and the purchase of COMPASS-owned housing. The funding mechanism underpinning COMPASS aims to provide financial returns to investors over a 7.5-year period, enabling investors to share in some of the value created for the state that follows from improving life outcomes for young people leaving the OoHC system. In the case of COMPASS, attainment of specific performance levels among selected outcome measures resulted in performance payments to COMPASS, which flow back to investors.

The funding mechanism is still relatively new, and the COMPASS program model also represents an innovative and flexible approach to supporting the target cohort. In this context, a robust and independent evaluation is a government priority to understand both how well the COMPASS funding mechanism has operated and how well the COMPASS program itself is working. The Victorian Department of Treasury and Finance (DTF), working closely with the Department of Families, Fairness, and Housing (DFFH), commissioned Urbis to undertake an independent evaluation.

This is the report of the Summative Evaluation of COMPASS.

*I talk to people about young people who haven't trusted anyone since they were five, suddenly trusting COMPASS and… allowing COMPASS workers to advise them and support them and on the whole listen [to them].*
*– Anglicare stakeholder*

## This evaluation

The evaluation has taken place over three stages, aligned to key points in the lifecycle of the COMPASS program. In the first stage, the Establishment Evaluation was completed in September 2020. This stage focused on the initial design and early operations of both the COMPASS funding model and COMPASS program. The second stage, in June 2022 with the Interim Evaluation, focused on capturing mid-term outcomes three years post implementation of the program and aimed to generate insights to strengthen the program's overall effectiveness. The Interim Evaluation Report was completed in July 2022.

The third and final stage of the evaluation (Final Evaluation) is the focus of this document. The Final Evaluation stage commenced in October 2023, when all participants had completed the program and medium-term, post-program outcomes were emerging. This stage is focused on delivering a summative evaluation of the appropriateness and effectiveness of the COMPASS PAD model and insights into the broader effectiveness of the COMPASS program beyond the payable outcomes.

This report examines four key evaluation domains spanning the funding model and the COMPASS program:

- Outcomes – the intended and unintended outcomes for participants and stakeholders.
- Implementation – the effectiveness of the design and implementation of the COMPASS program.
- Governance – the role and effectiveness of partnerships and governance arrangements
- Funding model – lessons learnt in the design and development of the funding model.

The evaluation employed a mixed methods approach to collect and triangulate evidence in these key domains. The key sources of data that have informed this report include consultations with key stakeholders, data linkage and quantitative analysis of administrative data. In addition to these new data sources, earlier data collections were utilised when relevant (e.g. participant insights in this report draw on earlier research).

**Consultations with 10 key stakeholders, including n=3 staff members from Anglicare; n=5 staff from DFFH; n=1 staff member from VincentCare Victoria; and n=1 central office staff member from DTF.**

**Data linkage combining multiple data sources from various government services to show the COMPASS participants group's service engagement before, during and after COMPASS participation compared to control groups.**

**Quantitative analysis of COMPASS client management record data including participant demographic information and outcomes.**

## Limitations

This is a summative evaluation, and there are several important limitations to the available data which constrain our findings. These include:

- **Interview sample size:** It was not possible to conduct interviews with all stakeholders within the timeframe and resource envelope for this evaluation. For this stage of research, we spoke to ten stakeholders. The insights provided reflect stakeholders' personal perceptions, and we cannot guarantee the accuracy of all statements.
- **Data linkage sample size**: The relatively small size of the COMPASS program and correspondingly low sample size of cohorts of young people for whom we were able to analyse data decreased the likelihood of finding statistically significant results.

- **Data accuracy:** We cannot guarantee the accuracy and completeness of the program and data linkage data. We recognise there are many extraneous factors that we cannot control for may affect the results shown in the data.
- **Impact of COVID-19:** We recognise the ongoing impact that the COVID-19 pandemic has had on program administration and delivery. The implementation context may have been disrupted by the pandemic and six 'lockdowns' (impacting young person's access to services, education, and employment opportunities). The extent to which implementation and outcomes are replicable in different contexts is unknown. All evaluation findings should be considered in light of this context.
- **Impact of policy changes:** We recognise changes to the youth diversion policy, the universal roll out of the Home Stretch, and the introduction of Better Futures impacted the context in which COMPASS operated and may also impact on specific outcome areas in ways we are not able to identify within our analysis.

# Key Findings

This section presents high-level key findings and insights for the four domains of the evaluation. Overall, the COMPASS program was well established and rolled out effectively. At July 2024, 182 program participants had completed the COMPASS program.

## Outcomes for young people

We considered outcomes for young people both in terms of their experiences of the program, and the changes in their lives that they attribute to COMPASS.

**COMPASS provided participants with support to reach a range of 'practical' outcomes,** including access to housing, improved financial security, and engagement in educational and vocational pathways. COMPASS program data shows that over half (55%) of participants were employed during their participation, 78 per cent of participants were engaged in education or training, 79 per cent of young people had positive relationships with family and of the COMPASS participants that had children in the program (n=17), 82 per cent of children remained in the young person's care at July 2024.

**Family preservation and connection was reaffirmed** as an important outcome with stakeholders noting that reconnecting participants with family, culture, and community had significant, sustainable benefits. There were several reports of family reunification as a result of COMPASS and at program completion, 10 per cent of COMPASS participants who were not at program referral reported that they were now living with their biological parent(s).

**Key enablers of client outcomes included the housing first model and elements of the practice model, such as a flexible and adaptive approach,** allowing Key Workers to creatively meet participants' needs, and a therapeutic approach that builds trust through authentic relationships. Smaller caseloads also enable more personalised and consistent support, which is particularly beneficial for participants with a history of complex trauma. However, there was some evidence that the model of support was not consistently implemented for at least some young people.

**The therapeutic approach of case workers, characterised by relationship-based support and the presence of a dependable Key Worker, was reported as crucial** for positive participant outcomes. COMPASS' genuine engagement, trust-building, and emotional support was described as a unique advantage when compared to similar programs.

**While qualitative feedback and program data demonstrated positive outcomes for COMPASS young people, a commensurate reduction in service use was not consistently identified in the data linkage exercise when compared to the control groups.** This is likely due to the very complex nature of the OOHC cohort creating 'noise' in the dataset, which makes it difficult to isolate the specific impacts of the COMPASS program. Additionally, some literature suggested that those receiving increased support were more likely to access services. The OoHC control groups also received various supports, and the low COMPASS participant sample sizes made it more challenging to observe significant differences.

*The significant difference, the housing experience made for young people… it gave them that real experience in a safe, protected way before they embarked [into] the real world to understand what their responsibilities were as a tenant and rights and getting that rental reference… – Anglicare stakeholder*

We also compared service utilisation data in six categories in the four years immediately prior to the year in which young people commenced COMPASS, with their utilisation patterns in the years following (Table 1, overleaf). We also examined the same data for control groups of young people who turned 18 in the same year as the COMPASS participants (2019, 2020 or 2021). The control groups were selected to have no statistically significant difference in pre-compass service usage patterns, to be similar on gender, Aboriginal, and proportion born in Australia, and similar levels of participation in Homestretch and Better Futures.

When comparing the service utilisation patterns in the post-COMPASS commencement period, we found no significant differences between the three COMPASS by intake year, and the corresponding control groups, with three exceptions, highlighted with a * overleaf and summarised below:

- COMPASS participants commencing in 2019 had significantly more days in receipt of all funded specialist homelessness services (an additional 40.59 per year) in the four years following commencement of the program than did their matched control group (equivalent to an additional 4.57 days per year).
- COMPASS participants commencing in 2020 had significantly fewer police incidents as offenders (-2.43 fewer incidents per annum vs -0.85 fewer per annum in the control group), but smaller decline in the number of police incidents as victims (0.29 fewer per annum compared to 0.35 fewer per annum in the control group).

More broadly, when comparing historic rate of service utilisation prior to the COMPASS commencement year, there were decreases observed in the number of days in receipt of clinical mental health care for the 2020 and 2021 cohorts, but an increase for the 2019 cohort. Rates of presentation to ED increased in all COMPASS cohorts. The mean number of days admitted to hospital increased for COMPASS 2019 and 2020 cohorts but remained steady for the 2021 intake.

*Table 1 Change four years prior to COMPASS start date compared to post COMPASS period*

| Cohort 1 (2019) | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | Change in annualised rate | |
|---|---|---|---|---|
| **Total mental health days of care** | | | | |
| COMPASS (n=44, commenced 2019) | 92.00 | 100.07 | 2.02 | ↑ |
| Control group (n=55, born in 2001) | 65.39 | 73.65 | 2.06 | ↑ |
| **Total emergency department presentations** | | | | |
| COMPASS (n=44, commenced 2019) | 4.89 | 6.27 | 0.35 | ↑ |
| Control group (n=55, born in 2001) | 3.50 | 4.28 | 0.19 | ↑ |
| **Total homelessness service days*** | | | | |
| COMPASS (n=43, commenced 2019) | 185.95 | 348.33 | 40.59 | ↑ |
| Control group (n=55, born in 2001) | 132.39 | 150.67 | 4.57 | ↑ |
| **Total admitted hospital days** | | | | |
| COMPASS (n=43, commenced 2019) | 1.79 | 9.77 | 1.99 | ↑ |
| Control group (n=54, born in 2001) | 2.44 | 2.82 | 0.09 | ↑ |
| **Total police incidents (as offender)** | | | | |
| COMPASS (n=44, commenced 2019) | 8.59 | 3.89 | -1.18 | ↓ |
| Control group (n=55, born in 2001) | 8.55 | 9.24 | 0.17 | ↑ |
| **Total police incidents (as victim)** | | | | |
| COMPASS (n=44, commenced 2019) | 1.58 | 1.67 | 0.02 | ↑ |
| Control group (n=54, born in 2001) | 1.35 | 2.07 | 0.18 | ↑ |

| Cohort 2 (2020) | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | Change in annualised rate | |
|---|---|---|---|---|
| **Total mental health days of care** | | | | |
| COMPASS (n=77, commenced 2020) | 133.12 | 65.55 | -16.18 | ↓ |
| Control group (n=87, born in 2002) | 110.08 | 65.99 | -10.31 | ↓ |
| **Total emergency department presentations** | | | | |
| COMPASS (n=76, commenced 2020) | 6.63 | 7.45 | 0.28 | ↑ |
| Control group (n=87, born in 2002) | 6.24 | 5.26 | -0.19 | ↓ |
| **Total homelessness service days** | | | | |
| COMPASS (n=76, commenced 2020) | 87.91 | 232.43 | 38.66 | ↑ |
| Control group (n=87, born in 2002) | 130.48 | 227.35 | 26.69 | ↑ |
| **Total admitted hospital days** | | | | |
| COMPASS (n=76, commenced 2020) | 5.03 | 9.88 | 1.32 | ↑ |
| Control group (n=87, born in 2002) | 5.64 | 4.77 | -0.17 | ↓ |
| **Total police incidents (as offender)*** | | | | |
| COMPASS (n=77, commenced 2020) | 11.96 | 2.13 | -2.43 | ↓ |
| Control group (n=86, born in 2002) | 8.31 | 4.72 | -0.85 | ↓ |
| **Total police incidents (as victim)*** | | | | |
| COMPASS (n=77, commenced 2020) | 2.44 | 1.25 | -0.29 | ↓ |
| Control group (n=86, born in 2002) | 2.14 | 0.72 | -0.35 | ↓ |

| Cohort 3 (2021) | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | Change in annualised rate | |
|---|---|---|---|---|
| **Total mental health days of care** | | | | |
| COMPASS (n=59, commenced 2021) | 82.61 | 16.98 | -14.66 | ↓ |
| Control group (n=70, born in 2003) | 74.13 | 15.33 | -13.12 | ↓ |
| **Total emergency department presentations** | | | | |
| COMPASS (n=60, commenced 2021) | 3.60 | 3.00 | 0.16 | ↑ |
| Control group (n=70, born in 2003) | 2.58 | 2.32 | 0.17 | ↑ |
| **Total homelessness service days** | | | | |
| COMPASS (n=59, commenced 2021) | 40.76 | 153.05 | 43.83 | ↑ |
| Control group (n=66, born in 2003) | 41.91 | 120.01 | 31.88 | ↑ |
| **Total admitted hospital days** | | | | |
| COMPASS (n=59, commenced 2021) | 2.76 | 1.85 | -0.04 | ↓ |
| Control group (n=70, born in 2003) | 3.23 | 2.23 | -0.02 | ↓ |
| **Total police incidents (as offender)** | | | | |
| COMPASS (n=59, commenced 2021) | 2.78 | 0.48 | -0.53 | ↓ |
| Control group (n=68, born in 2003) | 2.47 | 1.16 | -0.21 | ↓ |
| **Total police incidents (as victim)** | | | | |
| COMPASS (n=59, commenced 2021) | 1.29 | 0.37 | -0.19 | ↓ |
| Control group (n=65, born in 2003) | 0.94 | 0.42 | -0.09 | ↓ |

## Compass program implementation

Our summative evaluation focused on implementation and operation of the program over the total life of the COMPASS program.

We found that Key Workers **effectively implemented COMPASS'** practice model. The COMPASS practice model included key factors such as autonomy of practice and team-based collaboration, empowering workers to creatively support young people. This person-centred approach placed young people's needs at the forefront, fostering trust and mutual respect, which participants valued as it allowed them to have control over their decisions.

There **were some key barriers to securing housing**. These included the changes in the housing market and the lack of a physical presence in Bendigo, which hindered relationship building with local real estate agents. Despite challenges, COMPASS managed to secure 13 properties and 35 head leases, though this fell short of the initial target due to the inability to find suitable properties and market volatility in part driven by the COVID-19 pandemic.

The **interface between COMPASS and Home Stretch created challenges** in managing some cases. A small proportion of young people opted for Home Stretch over COMPASS due to the financial benefits, such as an accommodation allowance and flexible funding, which were put on hold if they joined COMPASS. This created confusion and disruption, with participants moving between programs and not understanding the transitions. Stakeholders suggested that in retrospect, allowing access to both programs or increasing the amount of flexible brokerage available in COMPASS could have mitigated these issues.

**During the program's "wind down" period, some participants experienced a change in their Key Worker as the** Key Workers reached the end of their contracts or departed ahead of their contracts ending. However, the ratio between participants and Key Workers remained relatively low. As participants completed their two-year COMPASS program, they were referred to the Better Futures program.

We also observed that the **management of housing stock at program wind down proceeded generally without difficulty**. Stakeholders reported that good market conditions facilitated the quick movement of housing back into the market, but significant repair work was needed for some properties. While the budgeted expenditure and insurance were adequate for repairs, stakeholders suggested that future iterations of the model should address property damage risks to minimise repair costs.

We found **co-living arrangements may not be appropriate** for this cohort as identified in our Stage 1 and 2 research, due to the complexities of tenant behaviour and the challenges of matching participants with suitable housemates. Stakeholders from both Anglicare and VincentCare acknowledged these difficulties, particularly for participants with complex needs or trauma histories, which often led to conflicts and property damage. More early investment in understanding housing stock and better matching participants could have minimised these issues. Standalone properties and single-bedroom dwellings were suggested as more suitable options to meet the needs of participants and reduce disruptions.

*There were some instances where young people chose not to go down the COMPASS path because they would miss out on the access to Home Stretch funding… [be]cause they're worried about how they're going to pay their rent into the future. – Government stakeholder*

## Governance

**While the governance arrangements for COMPASS continue to be effective, the PAD model requires strong governance** to provide accountability given the higher levels of autonomy and operational risk implementing new ways of working with a complex cohort.

**COMPASS has several layers of governance and program management interface; future PADS could be streamlined** to ensure they are more efficient.

While **Board and Management meetings** did not raise concerns, **Joint Working Group meetings** were seen as more about information provision than decision-making, and **Operations meetings** were generally productive.

## Funding model and design

Features of **the PAD model offer specific strengths in terms of effective service delivery/achieving outcomes**, however from a government point of view, there are **trade-offs in terms of how and who manages accountability** for performance, and transparency of individual outcomes.

In addition, **the COMPASS program has significantly developed government capability in the PAD space**, serving as a model for future initiatives by providing valuable internal learnings and expertise. Stakeholders noted that insights gained from COMPASS, particularly in stakeholder collaboration, outcome measurement, and risk management, can enhance the design and implementation of subsequent PAD projects.

We also observed that **the COMPASS program has successfully leveraged existing stakeholder relationships and experience**, particularly through Anglicare's established rapport with government and other service providers. Stakeholders highlighted that Anglicare's knowledge of department contracts and an experienced government program manager were invaluable in managing the program's complexities and ensuring its successful delivery.

We reported **changes in policy and departmental structures led to some inefficiencies in creating the COMPASS control group**, requiring a year's worth of work to be redone and highlighting the need for better communication and stable organisational structures.

In addition, **small sample sizes and covariates made constructing a robust control group challenging**, leading to statistical issues and inaccurate assessments due to unobserved covariates (i.e. factors influencing outcomes that we do not have data on – and example is primary and preventive health service utilisation (known to impact acute health service utilisation); education and employment status (known to impact housing status and justice outcomes), local availability and suitability of specific services (which would influence access to them) and data quality problems. The lack of comprehensive research specific to the Victorian context further compounded these challenges, highlighting the need for better methodologies such as a Randomised Control Trial.

# 1 Introduction

The Department of Treasury and Finance (DTF), working closely with the Department of Families, Fairness, and Housing (DFFH) and COMPASS management, commissioned Urbis to undertake an independent evaluation of the COMPASS program.

This document is the report of the summative stage of the evaluation.

## 1.1 Partnerships addressing disadvantage

The 2016-17 Victorian State Budget announced support for a pilot of social impact bonds (SIB) (now referred to in Victoria as Partnerships Addressing Disadvantage or PADs) to address two priority areas: providing assistance to young people leaving out-of-home care (OoHC) and ameliorating the impact of drug and alcohol abuse. The COMPASS Leaving Care Program (COMPASS, the program) began delivering services in 2018. It was one of two PADs announced in 2016-17; since then, a further two PADs commenced, funding for a fifth was announced in the 2021-22 State Budget, and funding for an additional two was announced in the 2023-24 Victorian State Budget.[1] (Victoria State Government, 2023)

COMPASS Leaving Care Ltd was the vehicle established to operate the PAD. VincentCare Victoria and Anglicare Victoria were contracted to deliver aspects of the COMPASS program. The company's governance structure consists of an Executive Manager overseen by a Board of four Directors. COMPASS attracted more than $14.2 million from investors, making it Australia's largest PAD at the time of capital raising. It aimed to provide positive financial returns to investors over a 7.5-year period, through fixed coupon payments of 3.5 per cent during the first two years of operation, transitioning to variable outcome payments and returns from property sales in the latter stages of the investment period.

Social impact bonds have been growing in popularity over the past ten years in Australia as a means of financing innovative approaches to resolving complex social problems. There are advantages and disadvantages they offer as a policy and funding mechanism. Table 1 highlights some of the expected benefits and downsides of PADs.

*Table 2 Hypothesised benefits and downsides of PADs*

| Expected benefits | Potential downsides |
|---|---|
| ▪ Social service providers can **attract private capital to solve social problems** that might not otherwise be available from traditional government and philanthropic sources.<br>▪ PADs provide a **mechanism for government to reward effective innovation**, with program design being market led by service delivery agencies and experts.<br>▪ **Innovation often drives avoided costs to government**, through reducing the use of other acute and expensive government services (e.g., hospitals, correction facilities etc). | ▪ There are **high transaction costs** associated with the design of PAD financial models.<br>▪ **Selecting the right outcomes can be very complex**, particularly in the case of social problems. Choosing the appropriate indicators to measure these outcomes is also challenging.<br>▪ Outcomes-based payment structures have the potential to **create perverse incentives** that influence provider behaviour in ways that may be contrary to the best interests of the intended beneficiaries/participants. |

[1] Victoria State Government. (2023). *Victorian Budget 2023/24 Doing What Matters Service Delivery Budget Paper No.3*. Department of Treasury and Finance. https://s3.ap-southeast-2.amazonaws.com/budgetfiles202324.budget.vic.gov.au/2023-24+State+Budget+-+Service+Delivery.pdf

| Expected benefits | Potential downsides |
|---|---|
| Avoided costs enable government to share the value created with bond holders.<br>▪ The outcomes-driven approach is expected to **increase flexibility and innovation** in service delivery in contrast to input or output funded models.<br>▪ PADs provide a **mechanism for risk transfer** by government where payments are linked to the performance of the underlying COMPASS participants.<br>▪ The PAD structure **increases transparency of outcome performance and productivity** for social service providers. Collection and consideration of outcome information is limited under traditional service funding contracts, which focus on outputs.<br>▪ PADs provide a structure for **facilitating a risk-adjusted return** for impact investors seeking to create a social impact in addition to a financial return.<br>▪ PADs in the Victorian context are innovative pilot programs and require independent evaluation to test their implementation, outcomes, and applicability of the PAD model. Evaluations are not always prepared for standard service agreements. | ▪ The transaction focus on payment for outcomes within a market mechanism **does not create incentives for knowledge capture, transfer, or sharing** as a public good.<br>▪ The PAD structure is explicitly intended to drive profitable returns to bond holders in addition to creating impact; some critics have argued this results in a **commodification of service users**.[2]<br>▪ While (some) financial risk is transferred to investors, the **moral/reputational risk remains government**, at least in part.[3]<br>▪ The PAD model relies on the **availability of fit for purpose data.** |

## 1.2 The Compass Program

COMPASS' service delivery commenced in October 2018. Through its duration, the program supported young people as they transitioned from OoHC to adulthood by providing participants with stable housing (if required), personalised case management, and access to wrap around support and services for up to two years. It aimed to mitigate the significantly poorer outcomes young people leaving care experience in contrast to their peers, including a higher likelihood of homelessness, unemployment, and justice system involvement.

The program was delivered by sub-contractors, Anglicare Victoria and VincentCare Victoria. Anglicare provided young people participating in the program with practical support and case management through Key Workers. Case management included linking young people leaving foster care, kinship care, lead tenant and residential care with education, training, and job opportunities, supporting them to health and wellbeing services. VincentCare Victoria managed the housing component by providing tenancy and property

[2] Hugh, N and Roy, MJ. (2019). Social Innovation, Financialisation, and Commodification: A Critique of Social Impact Bonds. *Journal of Economic Policy Reform. 24:1,* 11-27, DOI: 10.1080/17487870.2019.1571415.

[3] Organisation for Economic Co-operation and Development [OECD]. (2016). Social Impact Bonds. State of play and lessons learnt. Retrieved from https://www.oecd.org/cfe/leed/SIBs-State-Play-Lessons-Final.pdf. (p.17)

management. The last COMPASS participant completed the program at the end of 2023 and service delivery ceased

## The COMPASS model

To support young people in their transition from OoHC to independence, COMPASS incorporated the concept of 'shared obligation'. This is where COMPASS and the young person work in partnership to achieve goals. The program was driven by several guiding principles, including:

- working with each other respectfully, honestly, and collaboratively
- taking a person-centred approach, which supports the young person to make, and be responsible for, their own informed life choices
- proactively engaging with each other and maintaining regular contact, particularly when there is a change in circumstance, or emerging issue to be resolved
- meeting reasonable requirements and norms in relation to the management of tenancy and housing arrangements
- participating in good faith and delivering on commitments and undertakings made
- complying with relevant laws, regulations, and standards of professional practice at all times.[4]
- According to the COMPASS Operations Manual (2022), the program also takes a culturally sensitive approach, which includes being conscious of the young person's family, community, and cultural connections.

## The COMPASS model includes:

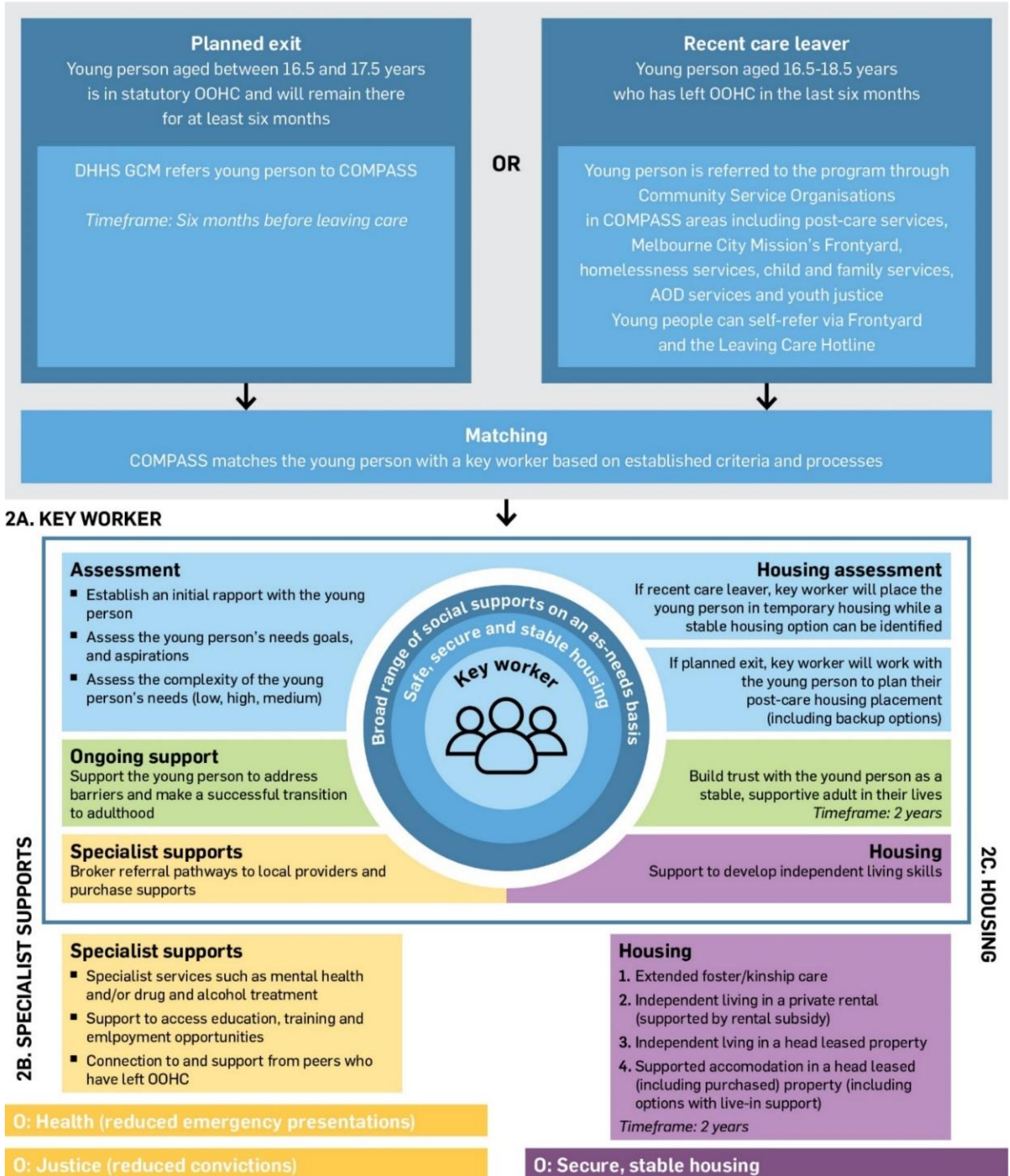
- supporting the young person to continue to reside with their foster family, or with their kinship family. Or alternatively, if required, providing access to housing.
- assigning a Key Worker to help the young person navigate support, education, and employment services. This includes assistance from Aboriginal Community Controlled Organisations to ensure culturally sensitive support is provided.
- access to brokerage .[5] from other services, including those funded by Victorian governments (e.g., Better Futures).

Figure 1 illustrates the COMPASS Service Model by articulating the intake and referral process and the three core program elements: Key Worker, access to specialist support, and housing.

[4] COMPASS Leaving Care Ltd. (2022). *Social Impact Bonds COMPASS Operations Manual.* Victoria, Australia. (p.9).

[5] Brokerage funds are used to purchase additional services or to meet other costs associated (e.g., transport, furniture, laptop etc).

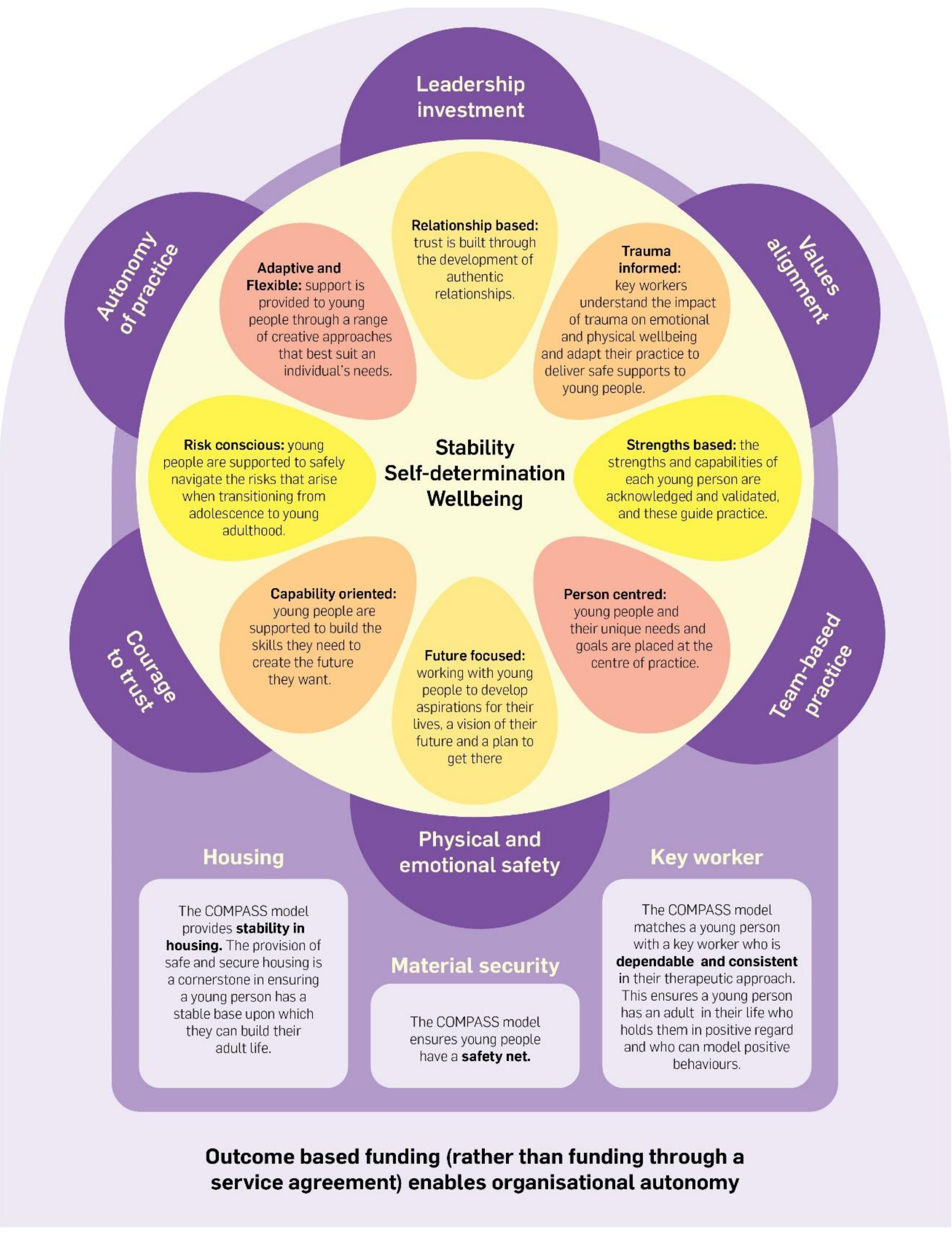
*Figure 1 COMPASS Service Model*




*Source: Adapted from COMPASS Leaving Care Ltd. (2022). Social Impact Bonds COMPASS Operations Manual. Victoria, Australia.*

Additional and complementary to the COMPASS Service Model, the COMPASS Practice Model was developed to guide case management. Figure 2 below shows the COMPASS Practice Model.

*Figure 2 COMPASS Practice Model*




*Source: COMPASS Leaving Care (2024)*

## Program intake, eligibility and referral

The program referral was governed by the following processes:

- **Forecasting:** The Government Contract Manager (GCM) provided the program with a forecast number of in-care young people who were expected to meet the eligibility criteria. This forecast was provided every three months and annually.
- **Minimum number of referrals:** To ensure sufficient flow, the program had a minimum referral target of 202 young people by the end of the referral period in October 2021. This was a government contractual requirement, rather than a COMPASS engagement target. It was assumed all those referred would participate in COMPASS, but this did not end up being the case.

There have been three referral pathways into the COMPASS program:

- **Young people leaving care, known as in-care referrals (aged 16.5-17.5 years):** the GCM can identify and refer eligible young people using the Client Relationship Information System (CRIS). Most care orders cease on the young person's 18th birthday.
- **Young people post-care (up to 18.5 years):** staff from Community Service Organisations (such as Better Futures providers) can identify and refer young people as they are leaving care. GCM then confirms their eligibility.
- **Self-referrals (up to 18.5 years):** young people who have left care can refer themselves to the program through the Melbourne City Mission Front Yard. GCM then confirms their eligibility.

The GCM uses the following criteria to confirm eligibility:

- **Location:** [6] young people located in West Melbourne, North Eastern Melbourne Area, Brimbank Melton, and Greater Bendigo. In late 2019, this was expanded to include Campaspe and Central Goldfields; and in May 2020, to include Hume-Moreland.
- **Type of child protection order**: family reunification, Care by Secretary, and Long-Term Care as set out in the Children, Youth, and Families Act 2005 (s.16).

The Government set the eligibility criteria to ensure that the COMPASS program did not exclude young people due to any of the following characteristics: parenthood or impending parenthood; cultural background or ethnicity (unless the young person is not a permanent resident of Australia); gender identity or sexual orientation; pre-existing medical condition or disability (except for those eligible for accommodation under the National Disability Insurance Scheme (NDIS); prior criminal history or being subject to a community-based order; independent living readiness; or not receiving income support and rental assistance from Centrelink but is entitled to and/or has access to stable alternative income. However, a young person was not eligible for COMPASS if they were supported by a Targeted Care Package[7] or Home Stretch; assessed as eligible to access Specialist Disability Accommodation under the NDIS; or on a temporary of Special Category Visa.

Once the GCM confirmed a young person's eligibility, the Centre for Victorian Data Linkage (CVDL) used the stratification tool developed for this program to determine whether they had 'low', 'medium,' or 'high' projected future service use. As outlined in the Implementation Agreement, COMPASS had to accept all referrals on a 'first come first served basis', unless compliance with that obligation would result in the proportion of participants stratified as high exceeding 20 per cent of all participants.[8]

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[6] DFFH Areas.

[7] Targeted Care Package that will continue beyond their 18th birthday and primarily supports access to accommodation.

[8] DFFH & Compass Leaving Care Ltd (2022). *Implementation Agreement*.

The total Referral Period ran for three years, from October 2018 to October 2021. The last in-care referrals were received on 31 March 2021, with the last post-care referrals received on the 31 August 2021.

## Engagement period and program participation

All young people that were referred to COMPASS had an engagement period. This period provided the opportunity to establish a relationship between the young person and their Key Worker, develop goals, ensure the young person understood the expectations of participating in the program, assess housing needs and gain their signed consent and agreement to participate forms.

For in-care referrals, the engagement period was six months leading up to their expiry of their order. For post-care referrals, the period was eight weeks. Appropriately halfway through the engagement period, an assessment would be made by COMPASS and the young person's care team about the likelihood of the young person proceeding to participation. If it was unlikely, the care team would look for an alternative pathway (e.g., Home Stretch).

After the engagement period, the young person moved into the program participation phase, where they received individualised support for two years. This support was based on an individualised plan tailored to the young person's circumstances and goals and developed jointly with their Key Worker.

The Key Worker was also responsible for assessing the nature and complexity of the young person's individual needs and developing a good understanding of their aspirations. Support could include helping the young person to develop skills in independent living (including through modelling positive behaviours), providing information, advice, and assisting the young person to navigate the service system, and facilitating and supporting them in developing financial independence, including accessing entitlements and pursuing and securing appropriate employment and education. The Key Workers also drew on locally established relationships across the service system to broker referral pathways and connect the young person to appropriate specialist supports to address their needs.

## Program completion

All young people leaving care are eligible for the Victorian Government's Better Futures program, including those participating in the COMPASS program. During their two years with COMPASS, they were put on 'active hold' with Better Futures.[9] If they were under 21 years of age[10] when they exited COMPASS, they transitioned back to Better Futures for further support.

COMPASS defines success as the young person being able to live independently at the conclusion of the program. Living independently is indicated by factors such as:

- they have ongoing accommodation in a place that is safe and secure
- their accommodation arrangements are financially sustainable, and appropriate to their income and financial position in both the short and the long term
- they are engaged in education, training, and/or employment
- they are engaged with, and know how to seek support from, the key health and social services that they are entitled to, including primary healthcare, employment, and education services
- they have developed the life skills and knowledge to independently maintain and manage their own home environment (including, for example, understanding and fulfilling the terms of a residential lease)
- they feel connected to their peers and community and have established positive social connections.

[9] While on 'active hold', the young person is still able to access Better Futures flexible funding.

[10] As Better Futures supports young people that are aged 15 years and 9 months to 21 years of age.

If a young person disengaged from COMPASS before completing the program, they were placed on 'active hold'. This means they were welcome to return within the two-year window.

## Measuring performance

Performance is measured against a matched historical control group of young people. It includes the following measures:

- **Housing Payable Outcome:** average number of times over the measurement period[11] that a young person presented to a specialist homelessness service and were listed as homeless at the end of the data collection period. This measure excludes crisis accommodation due to family violence.
- **Health Payable Outcome:** average number of times that a young person presented to an emergency department during the measurement period.[12]
- **Justice Payable Outcome:** average number of convictions recorded per person during the measurement period.[13] It was found that this outcome wasn't measurable or reliable, and instead a pragmatic solution was agreed and COMPASS investors were paid out at 'very good' for all cohorts for the justice payable outcome..

These certified outcomes payments are paid to COMPASS annually from 2021 until 2026.

# 1.3 The evaluation

DTF has taken a staged approach to evaluating the COMPASS funding mechanism and the COMPASS program:

- **Stage 1 - Establishment (February-July 2020):** considered program design, early implementation, and preliminary outcomes. This took place mid-program intake.
- **Stage 2 - Interim (October 2021-June 2022):** considered progress, preliminary outcomes, opportunities for improvement and the appropriateness of the funding model. This stage took place mid-service delivery.
- **Stage 3 - Summative (October 2023 – October 2024):** undertakes a deeper exploration of the outcomes achieved for clients and the community, the overall appropriateness and scalability of the PAD model, as well as the economic impacts of the program and model more broadly. This stage takes place one-year after the completion of service delivery.

This staged approach allows program delivery, outcomes, and funding model performance to be regularly reviewed. In 2019, Urbis was commissioned to undertake Stage 1 of the evaluation. In 2021, Urbis was commissioned to undertake Stage 2 of the evaluation and in 2022 were commissioned to deliver Stage 3.

The primary audiences for this evaluation are the stakeholders who will make decisions based on the findings of the evaluation reports. This includes DTF, DFFH, Ministers, COMPASS Leaving Care, Anglicare and VincentCare.

[11] 24 and 48-months following commencement of the program.

[12] 24 months following commencement and 24 months from completion from the program.

[13] 48 months following commencement of the program.

## 1.4 This document

This is the report of the summative stage of the COMPASS evaluation. The remainder of this document is structured as follows:

- **Section 2:** Methodology outlines the evaluation overview, purpose, scope, key evaluation questions, and the methodology used. It also outlines the methodological limitations that should be acknowledged when considering the findings.
- **Section 3:** Outcomes answers the key evaluation questions relating to program outcomes for young people and other key stakeholders.
- **Section 4:** Implementation answers the key evaluation questions that relate to implementation. It looks at the strengths of the COMPASS program and key lessons for future delivery.
- **Section 5**: Governance answers the governance related key evaluation questions by examining the governance structure of the COMPASS program.
- **Section 6:** Funding model answers the key evaluation questions related to the appropriateness of the model for social programs, including lessons learnt.

# 2 Evaluation approach

## 2.1 Aims and objectives

The Victorian Government is piloting PADs (formerly SIBs) to test how effective these innovative programs can be in addressing complex social disadvantage. Evidence-based evaluation is integral to assessing whether private investment in non-government community-service programs can achieve improved social outcomes for vulnerable Victorians.

The comprehensive, three-stage COMPASS evaluation will deliver a thorough assessment of the establishment and appropriateness of the program to support OoHC leavers with as they transition to adulthood. In addition, it will offer recommendations to strengthen the COMPASS participants, embed monitoring, and assess the economic impact that the model has on public resources.

The overarching purpose of the COMPASS evaluation is to inform future policy and program directions for adolescents and young adults leaving OoHC services. The evaluation not only informs practice and care, but also aims to build an evidence base of effective strategies to improve outcomes for OoHC leavers.

The achievement of payable outcomes is not in the scope of the evaluation. This evaluation examines the COMPASS program (model of COMPASS participants) and the COMPASS funding model (the design of the PAD approach).

### Stage 1: Establishment (mid-program intake)

Stage 1 of the COMPASS evaluation spanned February to July 2020 (with the report delivered in September 2020). It considered program design, early implementation, and preliminary outcomes and had three key objectives:

- Identify enablers and barriers to the efficient design and implementation of the PAD model and capture key lessons for the design of future bonds in Victoria.
- Review the extent and effectiveness of program implementation, with a focus on enablers and barriers that have arisen in the operating and strategic environment.
- Assess any preliminary outcomes and how they relate to the COMPASS service delivery model (excluding the evaluation of payable outcomes).

The key findings for this stage were:

- The COMPASS program was well established and effectively managed in the early phases of program delivery. It established effective governance arrangements that support operational and strategic decision-making regarding program delivery and the funding arrangement. At the time the Establishment Report (2020) was completed, there were 87 program participants.
- There were some challenges noted with program intake. In particular, a higher-than-expected proportion of young people that were referred into the program had been stratified as 'high', and relatively fewer fell into the 'low' category. This was later identified to be incorrect because the stratification tool included permanent care orders.[14]
- The complexity and support needs of COMPASS participants was not readily understood on referral and was generally higher than assumed. This resulted in Key Workers reporting heavier caseloads than anticipated and a need for the program to manage staff stress and risks of burnout.

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[14] The stratification tool was not developed as an indicator of complexity, but of future service use. It was used to determine allocation of staff resources.

- While COMPASS facilitated a range of housing options for young people, securing head leases and purchased properties was challenging. At the time of the report, the program was behind schedule for the number of purchased properties (but was on track for leased properties). This was reportedly due to a lack of appropriate stock on the market, market competitiveness, and difficulties finding housing that met the needs of the participants (such as close to public transport, free standing dwellings to allow for noise, and equal sized bedrooms).
- Stable housing was identified as critical to achieving other positive outcomes for young people. Other positive outcomes noted were engaging young people with education and employment, supporting improved mental health and living skills. A small number of negative outcomes were identified as the result of young people co-tenanting with a disruptive housemate and delays in property sign-up processes.
- A key strength of this program was the tailored and individualised approach to working with young people that are trauma-informed, highly adaptive, and long-term. The commitment, persistence and collaborative working style of program staff was regarded as a key enabler and strength of the program.
- In the establishment phase of the program, COMPASS had been adapting program delivery to adjust for early design assumptions that have not fully held up in the implementation phase. Participation in the program has been slightly lower than expected (likely due to some young people being burnt out from their experience in statutory care) and required DFFH to refer more young people to reach the target of 202 participants, because the number of referrals translating into actual participants was lower than had been forecast. In the housing domain, higher than expected numbers of young people required their own accommodation, rather than being able to cohabit with other participants. Further, there had been more movement between housing types than originally anticipated. This created additional work for housing staff in finding appropriate properties, moving tenants, and completing associated administration. This had cost implications as it reduces the program's capacity to maximise all bedrooms and charge rent accordingly.

## Stage 2: Interim evaluation (mid-program delivery)

Stage 2 built upon the previous stage and the associated key findings. It had six objectives:

- Review the progress of the COMPASS program against the intended trajectory, taking into consideration any refinements or changes to the program, the COMPASS funding mechanism, or any shifts in the strategic or operational environment.
- Identify the preliminary outcomes being achieved (extending beyond the payable outcomes). This includes the impacts on clients, service providers, and the community, with regionally disaggregated analyses that are sensitive to the socio-economic and service-sector context in each region. Explore what aspects of the program have been most effective in achieving outcomes, including analysis of what works for whom, why, and how effectively.
- Identify any lessons or opportunities to improve the COMPASS program.
- Review the appropriateness of the COMPASS funding mechanism for generating beneficial social outcomes for young people transitioning from out-of-home care. This includes both intended and unintended outcomes at the client, service provider, and system level.
- Identify enablers and barriers to the efficient design and implementation of the COMPASS funding mechanism and capture key lessons for the design of future PADs in Victoria.

The key findings for this stage were:

- At the close of intake in October 2021, COMPASS had engaged a diverse cohort of 184 young people from 319 referrals; 90 per cent of the initial referral target.
- Overall, the young people we spoke with were highly satisfied with their experiences in COMPASS. The drivers for satisfaction included the provision of housing, the friendly and committed nature of their Key

Workers, and the flexible range of support provided. Most young people would recommend COMPASS to others leaving OoHC. The program provided all participants needing housing support with access to affordable, stable accommodation. Direct provision of housing was highly valued by young people. The program also supported young people to improve their independent living skills, supported greater engagement in employment and education, and enabled them to access services supporting mental and physical wellbeing.

- There was emerging evidence that reconnection with families was important to young people and was a feature of Key Workers' practice.
- The proportion of COMPASS participants who are Aboriginal or Torres Strait Islander is comparable to the proportion in OoHC. We did not observe differences in reported experience or outcomes among Aboriginal young people, and we observed examples of COMPASS connecting young people to Aboriginal organisations for health, social and emotional and cultural supports
- There were significant changes to the program's strategic and operating environment over the implementation period, including COVID-19, the roll out of Home Stretch, and changes to the Residential Tenancies Act, which affected the program in various ways. In response, there were some adjustments to the program model and operational approach, however the program largely maintained fidelity to its core design elements.
- Anglicare and VincentCare brought specific strengths to the implementation. However, they had very different implementation and delivery experiences, influenced by both internal factors (e.g., staff and leadership) the external environment, and their different roles in the program.
- Caseloads fluctuated as intake and staffing evolved over the program. It was predicted that as the program began to wind down, high and complex caseloads would become less of a challenge.
- Housing and tenancy faced headwinds during implementation. This included the incorrect design assumption that all young people could live in shared spaces, resulting in inefficiencies. Managing participant movement between properties, maintenance issues were considered a more substantial part of the tenancy management role than anticipated, possibly impacting on VincentCare Victoria's responsiveness.
- At the date of the interim report, COMPASS owned 13 properties out of the envisaged 16, and did not expect to meet this initial goal. This was due to issues such as the availability of suitable houses due to market volatility driven by COVID-19.
- Due to the roll out of Home Stretch, there was no longer a 'nil COMPASS participants' contemporary control group readily identifiable. A historical control group was adopted made up of comparable young people in the period 2015-2017.

### Stage 3: Summative (final) evaluation (one year after program completion)

The final stage of the evaluation runs over 2024 and is the focus of this report. It addresses similar objectives as Stage 2, but with a sharper focus on the outcomes of the program as well as an examination of the economic impact of the COMPASS funding mechanism (e.g., potential for downstream avoided service use to government of PADs, not limited to the payable outcomes, including consideration of value for money and broader economic benefits).

## 2.2 Program logic

A program logic is a diagrammatic representation of a program's intended outcomes, including the various activities and outputs which are expected to lead to these intended outcomes. It makes the assumptions on which the program is grounded explicit in a visual way; that is, if A is undertaken then B will take place. A program logic for COMPASS was developed in 2018. It reflects the rationale for COMPASS participants, describes the key inputs intended to create change, and summarises the key outputs and impacts, linked to the three payable outcomes. Appendix A sets out the COMPASS program logic.

## 2.3 Evaluation domains

The summative stage of the evaluation (Stage 3) delivers findings across four key domains. Table 2 below describes these domains, and the key evaluation questions used in the evaluation. Appendix B outlines the evaluation framework for all three stages.

*Table 3 Overview of the four key evaluation domains*

| Domain | Description | Key evaluation questions |
|---|---|---|
| **Implementation** | The design and effectiveness of the implementation of the COMPASS program. | ▪ To what extent has the COMPASS program been implemented as planned (program activities and outputs delivered)?<br>▪ How iterative and responsive has COMPASS been in adapting the program? What modifications have been made?<br>▪ What has been the reach of program, and what factors influenced client engagement participation? How effectively and efficiently has the program been implemented?<br>▪ Do staff have enough support and are they adequately equipped to deliver the program?<br>▪ How has the strategic and operational environment impacted on the program implementation?<br>▪ What were the barriers and enablers for program implementation?<br>▪ What are the key lessons and improvements for program implementation and how can they be applied to other initiatives?<br>▪ Can and should the same model be scaled up to be state-wide?<br>▪ What are the benefits and risks in scaling up the model state-wide? |
| **Outcomes** | Intended and unintended outcomes for both program participants (young people) and stakeholders. | ▪ What outcomes have been achieved in each region for clients (Program Logic impacts), service providers and the community?<br>▪ How enduring are client outcomes after exiting the program?<br>▪ What unintended outcomes have resulted from the program?<br>▪ How have partnerships between different stakeholders contributed to the outcomes?<br>▪ What are the key aspects of the program responsible for creating client outcomes?<br>▪ Are clients satisfied with the program and what is their experience of it?<br>▪ What would have happened to clients in the absence of the COMPASS participants?<br>▪ How can COMPASS be improved based on client feedback?<br>▪ What are community sector perceptions of the program? |
| **Governance** | The role and effectiveness of partnerships and governance arrangements in | ▪ How effective have project governance mechanisms (Government, COMPASS partners, Investors, Operational teams) been, and why?<br>▪ Have governance arrangements facilitated timely resolution of issues? |

| | | |
|---|---|---|
| | delivering the COMPASS funding mechanism and program. | ▪ Are changes to project governance mechanisms required? |
| **Funding model**[15] **(or PAD model, formally known as SIB model)** | Lessons learnt in the design and development of the funding model and assessing avoided government service usage and total cost to administer this type of funding model. | ▪ To what extent is the funding model an appropriate mechanism for generating positive outcomes at client service provider and system levels?<br>▪ How can the COMPASS funding mechanism be improved?<br>▪ What lessons can be applied to other PAD models?<br>▪ What are the economic impacts of the COMPASS SIB in terms of potential downstream avoided government service usage (not limited to the payable outcomes), including consideration of value for money and broader economic benefits?<br>▪ What is the total cost of the SIB transaction, including administration? |

## 2.4 Methodology

This evaluation used a mixed methods approach, summarised in Table 4 below.

*Table 4 Summary of the methodology for Stage 3*

| | |
|---|---|
| | Analysis of linked service use datasets obtained from The Centre for Victorian Data Linkage (CVDL). This included analysis of hospital admissions, emergency department presentations, homeless episodes, mental health episodes and police incidents (offender and victim) for the young people that participated in the COMPASS program (COMPASS participants group), compared to the COMPASS control constructed by the Department and a control group constructed by Urbis. |
| | Quantitative analysis of client management program data. Urbis was provided program data collected for participants including participant demographic details and information on participant housing arrangements, education, employment and support over the period of program participation.<br>Analysis was undertaken to provide quantitative description of the three COMPASS cohorts, as well as all participants as an aggregate group. |
| | Semi-structured interviews with ten program stakeholders about the administration and operation of the program. These interviews were conducted online using Microsoft Teams. The project's Evaluation Working Group (which includes members from the Project's Joint Working Group) assisted with identifying who should be interviewed.<br>The ten interviewees consisted of: three staff members from Anglicare, five central office staff from DFFH, one staff member from VincentCare Victoria, and one staff member from DTF.<br>With consent, the interviews were electronically recorded and transcribed. These documents were then analysed in a qualitative coding program using thematic and content analysis techniques. |

[15] Also referred to as the funding model or mechanism in this summative report.

## 2.5 Ethical considerations

The linked data contained sensitive information including identifying information, health records, service usage information and information regarding individuals' interactions with corrective services. To ensure privacy, only aggregated high level data was downloaded to inform reporting. Data could only be accessed by approved staff via the Virtual Machine (VM) within a secure cloud environment. Data on the virtual machine did not contain names, addresses or complete date of births.

## 2.6 Limitations

The findings from this evaluation have been made on the data that were available. The following methodological limitations should be noted:

- **Interview sample size:** It was not possible to conduct interviews with all stakeholders within the timeframe and resource envelope for this evaluation. For this stage of research, we spoke to ten stakeholders. The insights provided reflect stakeholders' personal perceptions, and we cannot guarantee the accuracy of all statements.
- **Data linkage sample size:** The low sample size of the COMPASS participants cohorts decreased the likelihood of finding statistically significant results.
- **Data accuracy**: We cannot guarantee the accuracy and completeness of the program and data linkage data. Additionally, we recognise there are many extraneous factors that we cannot control for may affect the data results. In particular, the availability of other supports via Better Futures / Homestretch that are likely to mimic some of the effects we might expect to see in the COMPASS program.
- **Impact of COVID-19:** we recognise the ongoing impact that the COVID-19 pandemic has had on program administration and delivery. The implementation context may have been disrupted by the pandemic and six 'lockdowns' (impacting justice approaches, and the young person's access to services, education, and employment opportunities). The extent to which implementation and outcomes are replicable in different contexts is unknown. All evaluation findings should be considered in light of this context.
- **Impact of policy changes:** We recognise changes to the youth diversion policy, the universal roll out of the Home Stretch and the introduction of Better Futures may have impacted findings.

# 3 Experiences and outcomes for young people

This section presents findings on the experiences and outcomes for young people. Findings are based primarily on consultations with program stakeholders (n=10), and a review of program documentation and program data and data linkage activities. The first section outlines perspectives from stakeholders and the program data, and the second section outlines the data linkage findings.

Key messages

- **COMPASS provided participants with support to reach a range of 'practical' outcomes,** including access to housing, improved financial security, and engagement in educational and vocational pathways. Family preservation and connection was reaffirmed as an important outcome.
- Key enablers of client outcomes included **the housing first model and elements of the practice model**, such as a flexible and adaptive approach, allowing Key Workers to creatively meet participants' needs, and a therapeutic approach that builds trust through authentic relationships. Smaller caseloads also enable more personalized and consistent support, which is particularly beneficial for participants with a history of complex trauma.
- The **therapeutic approach of case workers**, characterised by relationship-based support and the presence of a dependable Key Worker, was reported as crucial for positive participant outcomes. COMPASS' genuine engagement, trust-building, and emotional support was described as a unique advantage when compared to similar programs.
- While overall reports are generally very positive about program experiences, there is evidence to suggest the COMPASS model was **inconsistently implemented for at least some COMPASS participants.**
- Linked data analysis undertaken by COMPASS intake year (2019, 2020, and 2021) shows that, relative to the four years prior to the intake year, there were:
  - **reductions in police incidents as offenders** across all three COMPASS intake years.
  - **reductions in police incidents as victims** for COMPASS 2020 and 2021 intake groups
  - **large reductions in the number of days in receipt of mental health care** for the 2020 and 2021 intake groups, and a small increase for the 2019 intake group.
  - **Increases in days spent in hospital** for the 2019 and 2020 intake groups, remained steady for 2021 group.
  - Large **increases in homelessness service days** for all three COMPASS intake years.
  - **Increases in ED presentations** for all three COMPASS intake years.
- Because these changes observed may be driven by external factors, we constructed well-matched control groups to test for significance - although this was ultimately limited by small sample sizes. **Three statistically significant outcomes for COMPASS participants were identified**, when compared to their Urbis control group:
  - COMPASS participants who started the program in 2019 had more homelessness support service days than the control group.
  - COMPASS participants who started the program in 2020 had fewer police incidents as an offender than the control group.
  - COMPASS participants who started the program in 2020 had more police incidents as a victim than the control group.
- Our ability to detect effects attributable to COMPASS is limited by the policy changes which introduced extended intervention (opportunities to remain with carers and financial supports) for all care-leavers. This would be expected to **create some similar effects in our control groups, which makes it harder to detect discrete effects from COMPASS.**

## 3.1 Stakeholder perspectives

### 3.1.1 COMPASS provided participants with support to reach a range of 'practical' outcomes

As identified in our Stage 2 research, the ability of COMPASS to provide housing to participants was understood by COMPASS and government stakeholders to be a key benefit of the program. A key element of the COMPASS model was a 'housing first' approach which involves ensuring accommodation as a first priority to then enable participants to have a stable base from which to address other aspects of their life. The 'housing first' model, which emerged in adult mental health and alcohol and other drug programs, has been shown to have a positive impact in these contexts on mental health, substance abuse, emergency department presentations and housing status.[16]

Stakeholders maintained that COMPASS addresses a gap in the service landscape through its ability to provide the 'bricks and mortar' as other programs tend not to directly provide housing to their clients.

*The significant difference, the housing experience made for young people… it gave them that real experience in a safe, protected way before they embarked [into] the real world to understand what their responsibilities were as a tenant and rights and getting that rental reference… ¬– Anglicare stakeholder*

This was reflected by stakeholders in our Stage 2 research who suggested there are no other programs that offer a comparable level of housing support for this cohort. They highlighted the uniqueness of COMPASS in that its housing first approach does not require participants to meet eligibility criteria such as engagement with employment, education or health services.

One Anglicare stakeholder noted the significant proportion of participants who had been supported to access private rentals post COMPASS, or, where this was not possible, Transitional Housing Management or Aboriginal housing. According to COMPASS' annual report, 63 participants were living in private rentals at the completion of their participation of the program.[17] and in the July 2024 program data (Appendix C) only seven COMPASS participants were in transient housing at COMPASS program closure (couch surfing or homeless). Direct access to housing was understood to be an important enabler of positive outcomes for young people because it provided a secure, stable base from which young people could then address their other needs.

*You know Maslow's hierarchy, that if you can provide young people that stability, that then they have an opportunity to… start to work out from their goals and engage in independent living skills. – Anglicare stakeholder*

Similarly, another stakeholder identified that the provision of this stable home base through housing provided participants the opportunity to establish or maintain place-based supportive factors, such as family connections.

*I think having stable housing, [a client] was able to explore different options, going to other study programs… [COMPASS] could also find a property in the location that was close to her family supports and her family networks and build that community safety around her as well. – Government stakeholder*

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[16] Baxter, A. J., Tweed, E. J., Katikireddi, S. V., & Thomson, H. (2019). Effects of Housing First approaches on health and well-being of adults who are homeless or at risk of homelessness: Systematic review and meta-analysis of randomised controlled trials. *Journal of Epidemiology and Community Health, 73*(5), 379–387. https://doi.org/10.1136/jech-2018-210981

[17] COMPASS Leaving Care. (2023). *COMPASS Annual Report 2023*. https://compassleavingcare.org.au/

Not only did COMPASS provide housing access to participants, but our Stage 2 research also heard from participants that they were supported with household management. They reported they received such support as assistance in connecting gas and electricity, obtaining insurance, and cleaning and cooking skills. The participants we spoke to in our Stage 2 research noted that this support helped them feel more confident regarding their own future rentals following COMPASS participation.

Additionally, COMPASS assisted participants to improve their financial security. One stakeholder highlighted how participants had been supported to access Centrelink, resulting in a level of financial security that might have been difficult to achieve otherwise. This was supported by COMPASS program data (Appendix C) which reported 92% of COMPASS participants had received Centrelink payments.

*The fact that all the COMPASS [participants] who were eligible were getting single Centrelink payments is an amazing outcome… I don't think people understand that bit that, you know, I talk about them getting Centrelink and they go yeah, yeah, of course. Well, no, not of course. – Anglicare stakeholder*

Our Stage 2 research found that other areas of financial support provided to participants included support with budgeting and accessing other government services.

Stakeholders recognised that many participants were supported to engage in education and training, with one stakeholder reporting many participants had started and finished courses. This aligns with our Stage 2 research which found that Key Workers supported participants to engage in employment and education by connecting them to employment providers, assisting with applications and facilitating funding for course fees and materials.

According to COMPASS' program data (Appendix C), over the course of the program, 55 per cent of participants were employed during their participation, 78 per cent of participants were engaged in education or training, and 55 per cent of participants completed or were still enrolled in the study and/or training they had commenced. Of those that had in engaged in education, eight per cent were with a university and 25 per cent were with a TAFE.

We also heard from a program stakeholder that the COMPASS program had helped children of participants to remain in their care. According to the program data (Appendix C), of the COMPASS participants that had children (n=17), 82 per cent of children remained in the young person's care, which is on par with a recent large study of the proportion of children born to mothers in Western Australia with an OoHC history..[18]

### 3.1.2 Family preservation and connection was reaffirmed as an important outcome

In addition to these practical outcomes, COMPASS has assisted participants to reconnect with family, culture and community. Family reconciliation and preservation in particular emerged through stakeholder interviews as a significant outcome for participants. This finding aligns with our Stage 2 research which found that although it was not featured as a key outcome in the program model and documentation, there was emerging evidence that reconnection with families was important to young people and a feature of Key Workers' practice. For example, one Anglicare stakeholder spoke to the impact of engaging participant's family members in the therapeutic process, noting that it enabled the young person to maintain positive family relationships going into the future.

*It's really important and really valuable because… there's young people (who are) going to be adults and (it's important) they remain connected to their family that they were taken away from… Lots of young people who… reconnected who went on to have… positive relationships… with a family member. – Anglicare stakeholder*

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[18] Chloe Bryant, Donna Bayliss, Melissa O'Donnell, Renée Usher, Miriam Maclean, "Young mothers with experience of out-of-home care and intergenerational risk of child removal", Child Abuse & Neglect, Volume 167, 2025.

Similarly, the stakeholders we spoke to for this stage of the evaluation highlighted that where participants were supported to maintain positive relationships with their families, this was understood to be a supportive factor that would have sustainable benefit into their futures. This family connection was further demonstrated in program data (Appendix C), with 10 per cent of COMPASS participants reporting that they were living with biological parents at program completion who were not at program referral and stakeholders reporting instances of family reunification as a result of COMPASS. One stakeholder suggested that family preservation could be incorporated into COMPASS as a payable outcome.

### 3.1.3 Key enablers of client outcomes included the housing first model and elements of the practice model

Certain elements of the COMPASS delivery model were considered by stakeholders to be key enablers of positive participant outcomes. This includes the 'housing first' approach (addressed above), and elements of the practice model. Refer to the implementation and operation section of this report for detail on how the practice model was implemented. Particularly, the practice of a flexible and adaptive approach was referred to as an enabler. COMPASS participants in Our Stage 2 research described creative ways in which support was provided to align with their needs. For example, one young person described how their key worker had taken L2P training, enabling them to support the young person to progress toward gaining their driver licence.

*She's done heaps actually for me… I was trying to figure out how to get some hours up on my L's and she already did the L2P training so she's already an L2P teacher type of thing so if it wasn't for her, I wouldn't have no licence or nothing like I wouldn't be doing my hours. – COMPASS participant*

Second, the therapeutic approach taken by case workers was understood by Anglicare stakeholders to be key in achieving positive outcomes for participants. Elements of the practice model, such as 'relationship based' support that requires trust to be built through the development of authentic relationships, and the requirement of a Key Worker who is 'dependable and consistent' underline Key Workers' therapeutic approach. These stakeholders often spoke to the genuine and meaningful engagement workers undertook with participants.

*We could provide that emotional support, not just transactional… they really I think benefited from… it was a genuine, meaningful interaction and support where you were really alongside them on their journey. – Anglicare stakeholder*

They also spoke to the trust enabled by such an approach; a valuable outcome given the trauma experienced by many young people in their relationships.

*I talk… about young people who haven't trusted anyone since they were five, suddenly trusting… COMPASS workers and allowing… COMPASS workers to advise them and support them… I think that trust stuff is really important because remember, most of these kids have been in the system for a long time and haven't been respected and… so don't trust the worker. – Anglicare stakeholder*

They suggested the therapeutic approach was a unique benefit of COMPASS. It was considered uniquely beneficial when compared to other similar programs such as Better Futures, enabled by small caseloads which allowed workers the capacity to provide these meaningful interactions.

*Because we had smaller caseloads, you know, and we could provide that emotional support, not just transactional – Anglicare stakeholder*

### 3.1.4 Support did not meet expectations for a small number of young people

As described earlier, a component of the program was working with participants to address goals that support "sustainability of [participant's] housing, such as… employment, financial counselling and address

any barriers to maintaining housing such as mental health”..[19] Overall, stakeholders across Anglicare, VincentCare and government recognised the positive outcomes experienced by the majority of COMPASS participants. Participants Urbis engaged with over the course of the evaluation were generally very positive about their experiences with COMPASS.

However, some stakeholders (including government, VincentCare and COMPASS participants) observed that that support was not always well implemented for every participant. This was reported by a small number of stakeholders only and represents a minority view.

One stakeholder we spoke with provided an example of a young person with complex needs allegedly received no assistance to set up MyGov or Centrelink, nor access to therapeutic support such as counselling, or budgeting support. They asserted that the young person was left with debt due to the lack of adequate support around support payments and financial management. While noting the flexible model and partnership arrangement between workers and participants, another stakeholder close to the program suggested that support was not always provided to the extent they thought it should have been to every participant across the program.

A small number of COMPASS participants in our Stage 2 research observed that their key workers were at times unresponsive or slow to respond to requests for assistance in reaching goals or did not provide some forms of support that participants desired, such as support with getting a job, mental health support or support with housemate conflict.

*I'd say they didn't really help me get a job until near the end of my housing which was good don't get me wrong, they helped me get a lot, but they could have done it a bit sooner maybe. – COMPASS participant*

A couple of participants suggested their key workers did not connect with them in a way that made them feel supported.

*No effort was made to have a good relationship. [My key worker] was quite hard to talk to, closed off process, likely feeling useless with me because she couldn't help. [There was a need for her to] Reach out more. – COMPASS participant*

These observations are isolated data points; however, they do indicate some variation in how well the program was implemented for some individuals.

## 3.2 Data linkage and integration process

This section presents the data linkage process and the associated outcomes.

### 3.2.1 Background

The data linkage process aims at integrating information from various government services, combining multiple data sources to provide a detailed view of individual's interactions across these services. For the purposes of the COMPASS evaluation, data linkage brings together records of young people in child protection with services such as education, health, police and homelessness services. By analysing interactions prior to, during and following program participation, a comprehensive understanding is gained of how these young people engage with services and the impact of the program on their well-being.

### 3.2.2 Method

Urbis made an application to the Governing Council of the Victorian Social Investment Integrated Data Resource (VSIIDR) to request data from relevant government departments of all child protection participants between 2010 to October 2023, for the purposes of data linkage. Upon approval, Urbis accessed the data in a

[19] *COMPASS Roles and Responsibilities*. (n.d.). Client supplied document.

secure VM environment hosted by the Centre for Victorian Data Linkage (CVDL) to ensure data privacy and integrity. The data was stored in an SQL database, with each department's dataset linked to form a comprehensive view of an individual's engagement across services.

The data linkage process involved the following steps:

1. **Accessing the Data in the VM:** After being granted access, we connected to the VM to work with the data in the SQL Server, adhering to data privacy and security standards throughout the analysis.
2. **Data Exploration and Validation:** Initial exploration was conducted to understand the data fields and their relationships. We consulted with subject matter experts from the respective departments to ensure that the data fields were correctly interpreted and to confirm data accuracy to the best of their ability. These consultations were crucial for understanding the linkage of different fields and the representation of specific aspects of service interaction.
3. **Creation of Functions and Views:** Using SQL, a combination of functions and views was created to extract relevant insights from the data. This allowed for a more efficient analysis, enabling us to transform and aggregate the data according to the research needs. For example, views were created to link data on child protection with health and education outcomes.
4. **Analysis and Reporting:** Once data processing was complete, data quality checks were conducted to ensure accuracy and consistency. Analysis was conducted using SQL to derive preliminary insights for the COMPASS participants and control groups (control group construction is described below). These insights were further visualised and expanded upon in PowerBI to generate interactive dashboards that captured key trends and metrics. PowerBI was particularly useful for collaborating with the team and ensuring a shared understanding of the findings.
5. **Final Outputs in Excel:** For final reporting requirements, summary tables and visualisations were exported to Excel. This was done to allow for the migration outside of the VM upon approval by CVDL, ensuring that key findings were accessible and shareable for stakeholders.

The table overleaf outlines the datasets leveraged for analysis.

*Table 5 Data*

| Owning Organisation | Dataset | Description |
|---|---|---|
| **COMPASS program** | COMPASS Program Participants | Data on participants in the COMPASS program, including demographic details. This data set also included the COMPASS control participants. |
| **Better Futures program** | Better Futures Program Participants | Records of individuals participating in the Better Futures program. |
| **Home Stretch program** | Home Stretch Program Participants | Records of individuals participating in the Home Stretch program. |
| **Department of Families Fairness and Housing (DFFH)** | Child Protection - Case Management | Case management records for children and young people under child protection. |
| | Homelessness Data Collection | Data on individuals accessing homelessness services. |
| **Department of Justice and Community Safety (DJCS)** | Community Correction Services | Records of individuals in community corrections (not used in analysis). |
| | Youth Custodial Services Data Collection | Data on individuals in youth custodial services (not used in analysis). |
| **Department of Health (DH)** | Victorian Admitted Episodes Dataset (VAED) | Data on hospital admissions, including dates and types of services. |
| | Victorian Emergency Minimum Dataset (VEMD) | Records of emergency department presentations and outcomes. |
| | Victorian Alcohol and Drug Collection (VADC) | Data on alcohol and drug treatment services accessed by individuals. |
| | Client Management Interface/Operational Data Store (CMI/ODS) | Information on mental health services provided by Victorian mental health services. |
| **Victoria Police (DP)** | Law Enforcement Assistance Program (LEAP) extract | Law enforcement records linked to the offender and victim of each incident |

## Measure creates

The following key measures were developed to track outcomes across linked datasets:

- **Hospital Admission Days:** Tracks the total number of hospital admissions.
- **Emergency Department Presentations**: Measures the frequency of emergency visits in the hospital.
- **Homelessness Service Days:** Tracks the total number of days in receipt of homeless support services to evaluate housing stability.
- **Mental Health Service Days:** Captures the total number of days in receipt of mental health services.
- **Police Incidents (Offender/Victim):** Tracks involvement in crime either as an offender or victim.

### Data points and datasets excluded

Some datasets or specific data points were excluded due to data quality or relevance:

- **Youth Justice Data**: Only available up to 18 years of age, while analysis required post-18 data.
- **Corrections Data:** No relevant records for COMPASS participants in this dataset.
- **Drug and Alcohol Treatment Data:** The working group and stakeholders advised concerns over data accuracy and underreporting; reliability concerns led to exclusion from analysis.

## The COMPASS control group

The list of COMPASS participants provided by Department program areas also included details of the COMPASS control group participants, the unique identifiers, and assigned cohort. It is important to note that the COMPASS control group participants were assigned a COMPASS start date of 2015 to mitigate the effects of completing the program. These participants were matched to COMPASS participants cohorts based on similar characteristics as using propensity score matching. This is the control group that was used to calculate program performance for the purpose of outcome payments.

Initial analysis of the COMPASS control group suggested minimal meaningful differences compared to the COMPASS participants group. Stakeholders highlighted several challenges for the COMPASS control group. One stakeholder noted that small sample sizes could lead to statistical issues. Another mentioned that unobserved covariates and data quality affect the result accuracy, emphasising the need for qualitative data to address these issues.

A key concern for several stakeholders was the impact of policy changes and COVID-19 on certain data points, potentially leading to inaccurate results. The Joint Working Group Paper from December 2022 highlighted data limitations/feasibility issues with the justice measures including issues with data availability and privacy, small sample sizes, COVID-19 and the introduction of the youth diversion policy.[20]

The new Urbis control group aims to address some of these challenges by aligning the control period with that of the COMPASS participant group.

## Grouping COMPASS participants into new cohorts

Urbis received a list from COMPASS containing all COMPASS participants, their cohort, COMPASS start date, and their Unique Identifier which was used to link participants to the other datasets. For analysis with control groups, COMPASS participants were divided into three new cohorts based on their program start year. The reason for this was to support the selection of a contemporaneous control group at a similar stage of life and who would be impacted in similar ways by the broader externalities occurring around the COMPASS program implementation (e.g., COVID, changes to youth justice policy, macroeconomic conditions, and policy changes).

- Cohort 1: late 2018 and 2019 start date (referred to hereafter as the 2019 intake)
- Cohort 2: 2020 start date.
- Cohort 3: 2021 start date.

The cohort specific analysis can be found in Appendix D. In the body of the report, participants are grouped by their COMPASS start year.

## Construction of the Urbis control groups

The original COMPASS control group comprised matched records with data points that were not contemporaneous with COMPASS participants. The Urbis control group cohorts were specifically created to align with the same time periods as the COMPASS participant cohort groups. This was done to ensure that both groups experienced the same policy changes and COVID-19 effects.

[20] Out of Session – COMPASS JWG Paper – Justice Outcome Measure – December 2022

The steps for creating the Urbis control group were as follows:

1. **Identify Potential Control Participants:** We selected potential control participants by identifying individuals under Child Protection and out-of-home care who turned 18 in 2019, 2020 or 2021, the three years in which COMPASS had intakes of participants. Individuals with a permanent care placement were excluded.
2. Assign Cohort**s:** Each record in the pool was assigned Cohort 1 (2019), 2 (2020), or 3 (2021) based on their birthdate. Since they had no COMPASS start date, we assumed their 'start date' was the point they turned 18 years of age.
3. **Calculate Mean Scores:** For each COMPASS cohort, we calculated the mean total service utilisation values across six key measures for the four years prior to COMPASS intake year:
   i. Total days in receipt of mental health services
   ii. Total ED presentations
   iii. Total number of days admitted to hospital
   iv. Total days in receipt of homelessness services
   v. Total police incidents as offender
   vi. Total police incidents as victim
   vii. We also compared on three demographic factors: the proportion who were female, Indigenous, and born overseas
4. **Randomisation and Matching:** We randomly generated a total of 3000 potential control groups (1000 for each cohort) and calculated the difference from the COMPASS cohorts on their mean scores on the nine data points.
5. **Best match selection:** We selected the control group which had the lowest total difference across the nine data points, and the lowest variance within the 9 difference scores. Selecting for low variance reduced the likelihood of one particular data point among the nine being very different.
6. **Oversampling:** We oversampled each cohort by 10. This was intended to reduce the impact of later removing outliers for a specific calculation on our sample size. Outliers with values more than 5 standard deviations from the mean were excluded from calculations at variable level for both COMPASS and for the control groups.

A detailed comparison of each COMPASS cohort and its corresponding control can be found in Appendix D. In Urbis' view, these cohorts show very good matching at the cohort level, providing us with confidence in their utility as contemporaneous control groups.

### 3.2.3 Limitations and assumptions

Several limitations and assumptions were identified during the data linkage and analysis process:

- **Data Accuracy:** While extensive efforts were made to ensure the accuracy of the data, complete accuracy cannot be guaranteed. For example, not all service usage may have been recorded, potentially leading to underreporting. Additionally, we recognise there are many extraneous factors that we cannot control for may affect the data results.
- **Proxy Indicators:** The indicators used rely on service utilisation as a proxy for the targeted outcome. This can introduce bias due to the availability of services or an individual's desire to access them. For example, in regional areas with limited emergency department services, lower recorded usage may not reflect actual need. Similarly, homeless service usage measures only those who accessed services, not everyone experiencing homelessness.
- **Sample Size:** The very small sample sizes of the COMPASS cohorts increase the likelihood of statistical error and reduce the chance of identifying statistically significant outcomes.

- **Control Group ID and Demographics:** It was assumed that linking COMPASS participants to the Child Protection dataset would provide unique identifiers and demographic data for the control group, meaning the control group began with records from this dataset.
- **Policy changes:** Policy changes around youth justice and the universal expansion of Home Stretch and introduction of Better Futures led to some data limitations.
- **Incident and Admission Dates:** The dates for police incidents and hospital admissions are recorded by the date of the offence and admission, respectively, with no further granularity assumed.
- **Drug and Alcohol Data:** Data collection methods for drug and alcohol services changed in 2018, potentially affecting the consistency and accuracy of the information. Although we implemented measures to mitigate this risk, such as handling data from different periods separately (different source tables), some inconsistencies remained, and we elected to exclude this data from analysis.
- **Data matching error:** Two records in the COMPASS participant dataset supplied to Urbis appeared to be matched to a duplicate record in the Child Protection data table and were removed from our analysis.

### 3.2.4 Data linkage learnings

While undertaking the data linkage exercise there were some notable learnings:

- Understanding the data and how it connects takes a significant amount of time. Data owners at different points in the system have specific insight into the meaning of data, their accuracy and completeness, and their relationship with 'real world' outcomes.
- Finding the best variable to analyse takes a lot of exploratory work and testing. In several cases, limitations in the way data is collected or constructed emerged through the analysis, and resulted in re-thinking which data points were most reflective of program impact.
- The Virtual Machine environment placed constraints on the analytical team with some analytical software packages unavailable, restrictions on the number of simultaneous users, restrictions on access to specific hours, and occasional machine performance issues.

### 3.2.5 Findings

The below sections outline the findings for each data measure from the data linkage exercise for the COMPASS participants groups and the Urbis control groups.

While the control groups did not participate in the COMPASS program, the COMPASS start date for this group refers to a hypothetical date in which they would have started the program (when they turned 18 years of age). For the charts, 'Year 0' is the first year of COMPASS and 'Year 2' is generally the year in which the young person exits from COMPASS.

The tables shown include analysis of data with outliers removed from both the COMPASS and control groups. An outlier was defined as a high-side value that was more than five standard deviations from the mean. The removal of outliers is signified by a change in the n value reported for each data point.

Readers should note that we elected to remove outliers at data point level rather than at whole record level to maximise the sample available. This means that an individual whose record is excluded from calculation of one variable (the hospital admitted days) is included in the calculation of another variable (e.g., mental health service days) where their data point does not meet the criteria for an outlier.

Charts in this section showing year by year data do include outliers for COMPASS participants, so may appear slightly inconsistent with the tabulated aggregate data. Where there are material effects on the outcome shown, this is noted in the accompanying commentary.

Of note, there were very few statistically significant findings. This discrepancy is likely due to

- The very complex nature of the OoHC cohort, which creates 'noise' in the dataset and makes it difficult to isolate the specific impacts of the COMPASS program.

- The possibility that the program may have driven some forms of service utilisation that are ultimately positive, further complicating the analysis.
- The various forms of support (e.g., Homestretch, Better Futures) received by the Urbis-constructed control groups, which may have contributed to the relative lack of observable differences between the groups.
- The low overall numbers which make it more challenging to detect statistically significant differences, as smaller samples are less robust in revealing effects.

### Access to clinical mental health care

We examined the number of days in receipt of clinical mental health care recorded within the linked dataset.[21] The table below shows mixed results for the three intake years. The 2019 intake cohort saw a small increase in the number of mental health days recorded per annum, while the 2020 and 2021 intakes had declines. When compared with the changes to the control groups over the same period, none of the changes for the COMPASS groups were statistically significant.

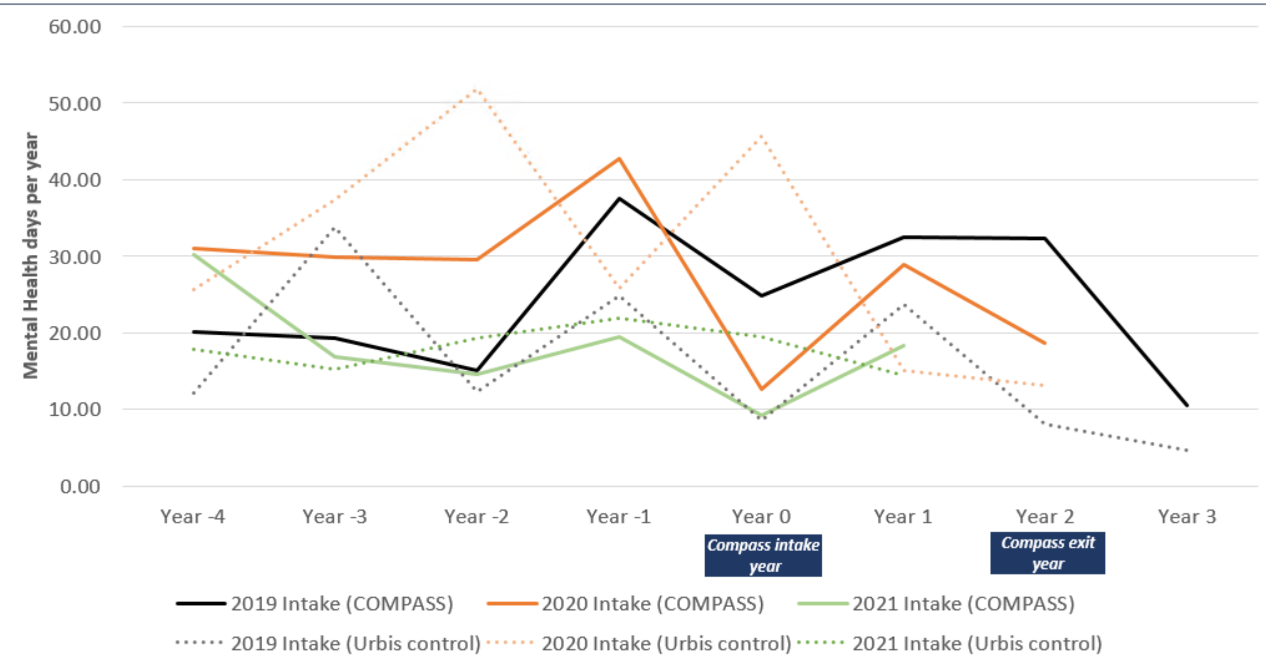
*Table 6 Clinical mental health days in care*

| **Cohort 1 (2019)** | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | **Change in annualised rate** | |
|---|---|---|---|---|
| **Total mental health days of care** | | | | |
| COMPASS (n=44, commenced 2019) | 92.00 | 100.07 | **2.02** | ↑ |
| Control group (n=54, born in 2001) | 65.39 | 73.65 | **2.06** | ↑ |
| **Cohort 2 (2020)** | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | **Change in annualised rate** | |
| **Total mental health days of care** | | | | |
| COMPASS (n=77, commenced 2020) | 133.12 | 65.55 | **-16.18** | ↓ |
| Control group (n=85, born in 2002) | 110.08 | 65.99 | **-10.31** | ↓ |
| **Cohort 3 (2021)** | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | **Change in annualised rate** | |
| **Total mental health days of care** | | | | |
| COMPASS (n=60, commenced 2021) | 82.61 | 16.98 | **-14.66** | ↓ |
| Control group (n=70, born in 2003) | 74.13 | 15.33 | **-13.12** | ↓ |

[21] This data sourced from the MentalHealthEpisode table. Variables used in the table were the StartDate and EndDate. Days in mental health care were calculated by the difference between these two variables for each record in the table. The means were calculated by summing the total number of days for each participant and dividing by total number of individuals in the cohort. The annualised rate was calculated by dividing by the number of months of data and multiplying by twelve.

The chart following shows the mental health days calculated for each year. The number of days in care appeared to decrease in the first year of the program for all COMPASS cohorts and two of the control groups, but these changes are not significant and were generally followed by an uptick in the year after entering COMPASS.

*Chart 1 Average mental health days of care by COMPASS year*



## Emergency department presentations

We examined the number of presentations at Emergency Departments recorded within the linked dataset.[22] The table below shows increased annualised rates of presentations for the three intake years. Increases were also observed for two of the three control groups. When compared with the changes to the control groups over the same period, none of the changes in COMPASS groups were statistically significant.

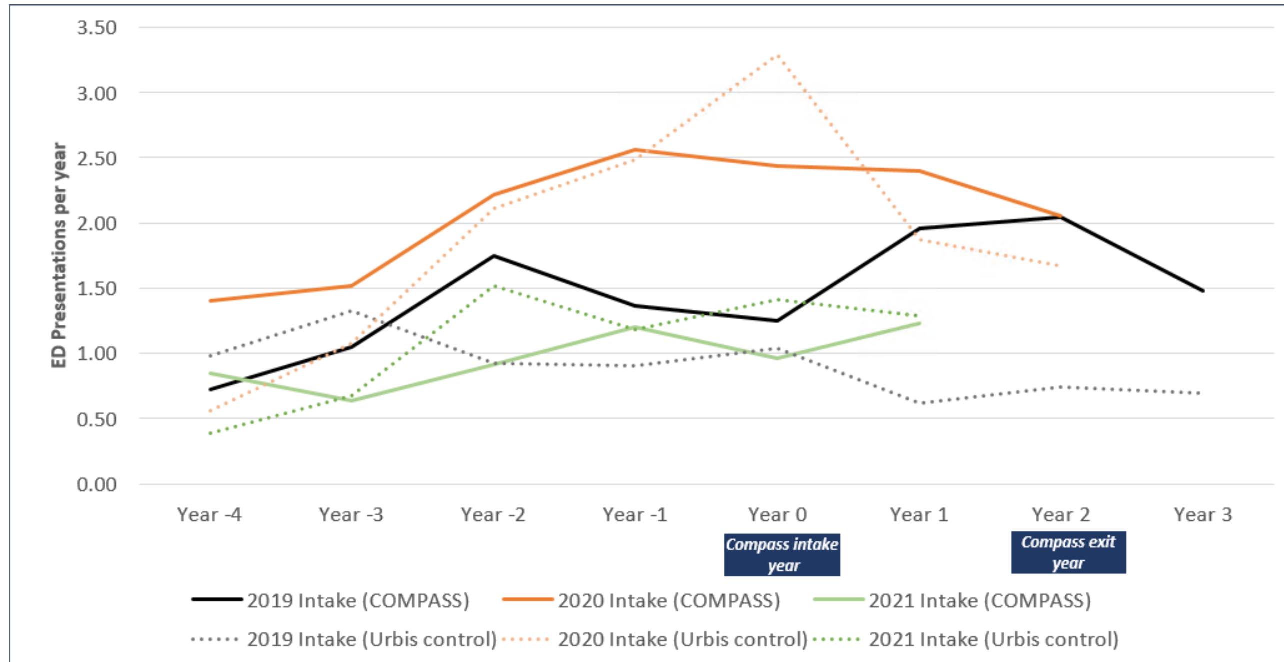
*Table 7 Emergency department presentations*

| **Cohort 1 (2019)** | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | **Change in annualised rate** | |
|---|---|---|---|---|
| **Total emergency department presentations** | | | | |
| COMPASS (n=44, commenced 2019) | 4.89 | 6.27 | **0.35** | ↑ |
| Control group (n=54, born in 2001) | 3.50 | 4.28 | **0.19** | ↑ |
| **Cohort 2 (2020)** | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | **Change in annualised rate** | |
| **Total emergency department presentations** | | | | |
| COMPASS (n=77, commenced 2020) | 6.63 | 7.45 | **0.28** | ↑ |
| Control group (n=87, born in 2002) | 6.24 | 5.26 | **-0.19** | ↓ |
| **Cohort 3 (2021)** | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | **Change in annualised rate** | |
| **Total emergency department presentations** | | | | |
| COMPASS (n=60, commenced 2021) | 3.60 | 3.00 | **0.16** | ↑ |
| Control group (n=67, born in 2003) | 2.58 | 2.32 | **0.17** | ↑ |

[22] This data sourced from the Victorian Emergency Minimum Dataset, and the EmergencyDepartment table. The variables used in the table was the ArrivalDate. Each arrival was counted as an ED Presentation. The means were calculated by summing the total number of ED Presentations for each participant and dividing by total number of individuals in the cohort. The annualised rate was calculated by dividing by the number of months of data and multiplying by twelve.

The chart following shows the average emergency department presentations by year of COMPASS. All groups show increasing emergency department presentations up until they are due to leave foster care at 18 years of age. The trend thereafter is mixed. In Year 1 (the second year post COMPASS intake) decreases are observed in all control groups and one COMPASS intake (2020), and increases in two COMPASS intakes (2019, 2021).

*Chart 2 Average Emergency department presentations by COMPASS year*



## Hospital admissions

We examined the number of days admitted to hospital recorded within the linked dataset.[23] The table below shows increases for two COMPASS intake years (2019, 2020), while the 2021 intake and all control groups largely held steady, with very small changes observed. When compared with the changes to the control groups over the same period, none of the changes for the COMPASS groups were statistically significant.

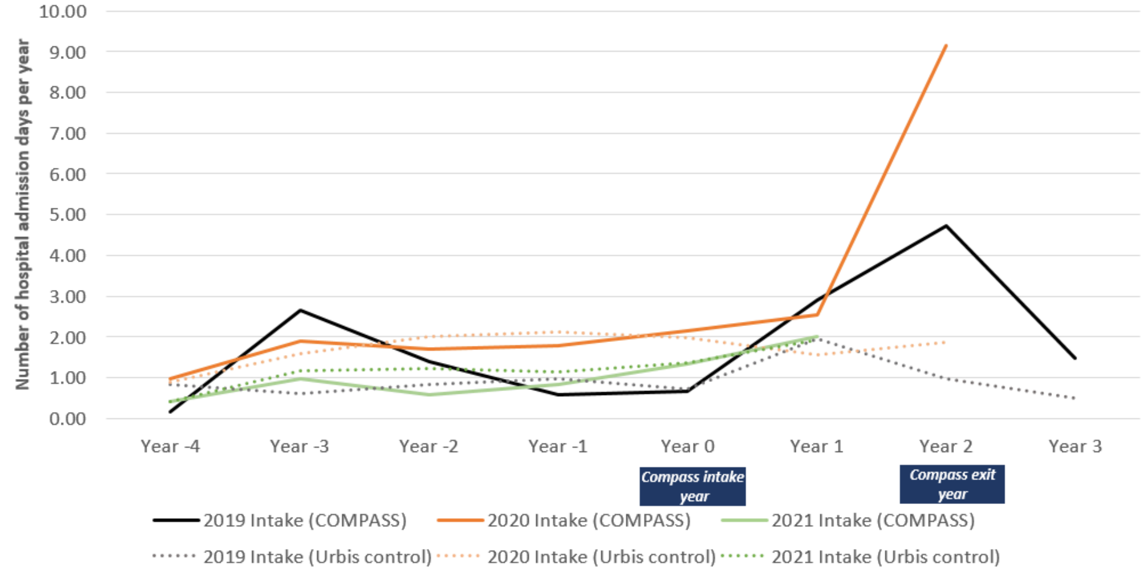
*Table 8 Average admitted hospital days*

| **Cohort 1 (2019)** | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | **Change in annualised rate** | |
|---|---|---|---|---|
| **Total admitted hospital days** | | | | |
| COMPASS (n=44, commenced 2019) | 1.79 | 9.77 | **1.99** | ↑ |
| Control group (n=54, born in 2001) | 2.44 | 2.82 | **0.09** | ↑ |
| **Cohort 2 (2020)** | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | **Change in annualised rate** | |
| **Total admitted hospital days** | | | | |
| COMPASS (n=77, commenced 2020) | 5.03 | 9.88 | **1.32** | ↑ |
| Control group (n=86, born in 2002) | 5.64 | 4.77 | **-0.17** | ↓ |
| **Cohort 3 (2021)** | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | **Change in annualised rate** | |
| **Total admitted hospital days** | | | | |
| COMPASS (n=60, commenced 2021) | 2.76 | 1.85 | **-0.04** | ↓ |
| Control group (n=69, born in 2003) | 3.23 | 2.23 | **-0.02** | ↓ |

[23] This data sourced from the AdmittedEpisode table. Variables used in the table was LengthOfStay The means were calculated by summing the total number of days for each participant and dividing by total number of individuals in the cohort. The annualised rate was calculated by dividing by the number of months of data and multiplying by twelve.

The chart below shows the average hospital admissions by year. The COMPASS intake in 2019 is affected in year 2 by one outlier with 100+ days in hospital; excluding this record the mean is around 2.2. The COMPASS intake in 2020 intake is affected by outliers in year 2 who spent 240+ and 300+ days in hospital. Excluding these records results in the mean dropping to around 2.1, broadly consistent with the control. The COMPASS participants group and two of three control groups show an increase in the number of days spent in hospital during the COMPASS program, which is consistent with literature[24] that suggests young people with increased support are more likely to seek out help. Similarly, our Stage 1 research found that as a result of engaging with COMPASS, some young people were more open to engaging with GPs and had increased engagement with programs.

*Chart 3 Average hospital admitted days by COMPASS year*




[24] Savaglio, M., Yap, M., Smith, T. et al. "I literally had no support": barriers and facilitators to supporting the psychosocial wellbeing of young people with mental illness in Tasmania, Australia. *Child Adolescent Psychiatry Ment Health 17*, 67 (2023).

### Specialist Homelessness Services support

We examined the support received from funded Specialist Homelessness Services (SHS) recorded within the linked dataset.[25] Young people who accessed SHS services often accessed multiple services, over multiple and sometimes overlapping periods. The data below captures duration between first support provided and last, inclusive of all supports provided by SHS, not just emergency accommodation. While an over-estimate in terms of periods of no support, it captures concurrent services and should be considered as a proxy for an unmet support need. A slightly higher proportion of COMPASS participants (32% compared to 27%) accessed funded Specialist Housing services at least once in the four years after commencing the COMPASS program.

The table below shows increases in all COMPASS intake years and controls which is expected as the participants were housed (in out-of-home care) prior to COMPASS. When compared with the changes to the control groups over the same period, only the change observed in the COMPASS 2019 intake was statistically significant. This is consistent with qualitative insights from our primary data collection which emphasise the impact of the program's housing first approach in supporting COMPASS participants to enrol in housing supports they might otherwise struggle to access, as well as the impact of practical and financial support in supporting participants to manage and maintain their housing.

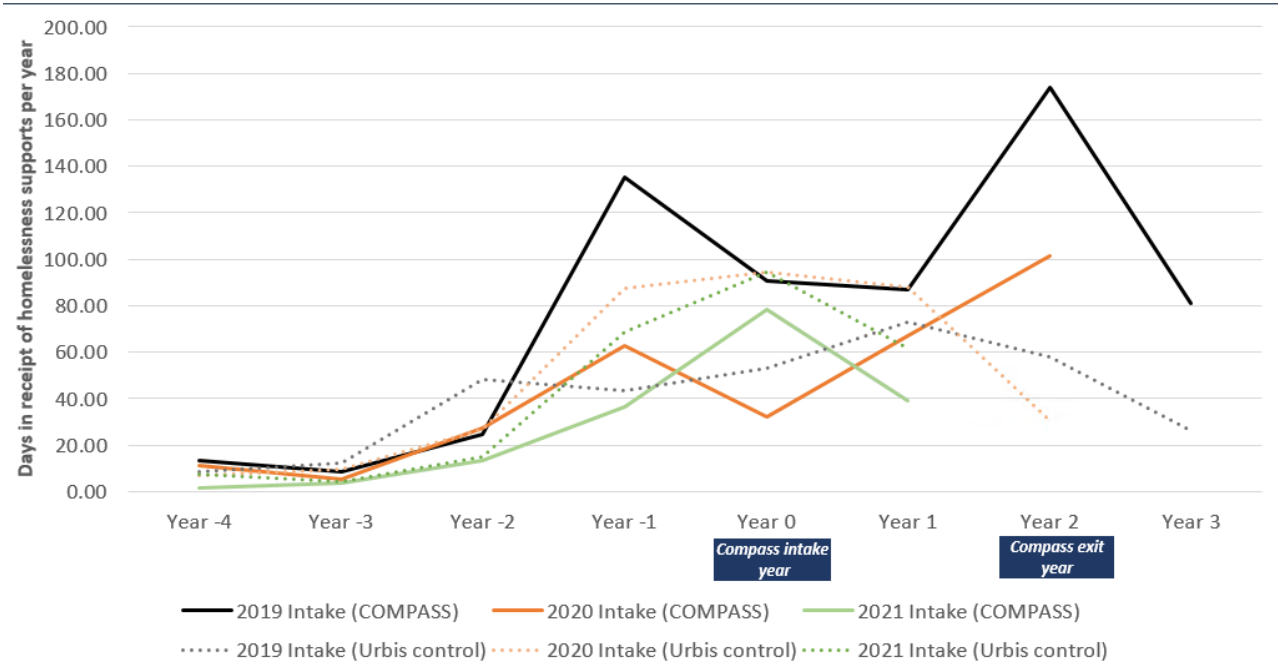
*Table 9 Average days between first and last period of support delivered by Specialist Homelessness Services*

| **Cohort 1 (2019)** | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | **Change in annualised rate** | |
|---|---|---|---|---|
| **Total homelessness service days*** | | | | |
| COMPASS (n=44, commenced 2019) | 185.95 | 348.33 | **40.59** | ↑ |
| Control group (n=54, born in 2001) | 132.39 | 150.67 | **4.57** | ↑ |
| **Cohort 2 (2020)** | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | **Change in annualised rate** | |
| **Total homelessness service days** | | | | |
| COMPASS (n=77, commenced 2020) | 87.91 | 232.43 | **38.66** | ↑ |
| Control group (n=87, born in 2002) | 130.48 | 227.35 | **26.69** | ↑ |
| **Cohort 3 (2021)** | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | **Change in annualised rate** | |
| **Total homelessness service days** | | | | |
| COMPASS (n=60, commenced 2021) | 40.76 | 153.05 | **43.83** | ↑ |
| Control group (n=66, born in 2003) | 41.91 | 120.01 | **31.88** | ↑ |

[25] This data sourced from the HomelessSupportPeriod table. Variables used in the table were the EpisodeStartDate and LastSupportPeriodDate. Days were calculated by the difference between these two variables for each record in the table. The annualised rate was calculated by dividing by the number of months of data and multiplying by twelve.

The chart below shows the average duration between first support accessed and last support closed from SHS by year of COMPASS. All groups have a lower volume of supports when younger, increasing as they approach 18 years of age (roughly the COMPASS intake year). Thereafter the pattern is mixed. Both COMPASS and control groups show relatively high variance within the datasets.

*Chart 4 Average days between first and last support delivered by Specialist Homelessness Services by COMPASS year*



## Police offender incidents

We examined the number of police incidents (as an offender) within the linked dataset.[26] The table below shows decreases in all COMPASS intake years and in two of the three controls. While the rate of incidents recorded for COMPASS participants fell further than each of their control groups, only the change observed in the COMPASS 2020 intake was statistically significant.

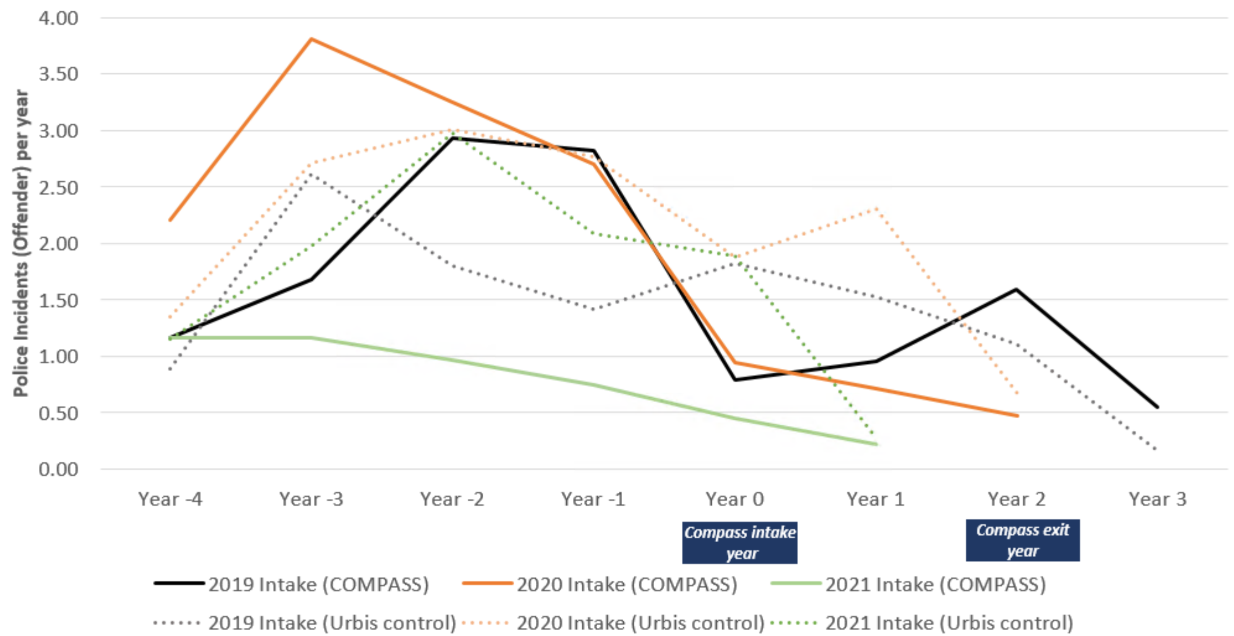
*Table 10 Average police offender incidents*

| **Cohort 1 (2019)** | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | **Change in annualised rate** | |
|---|---|---|---|---|
| **Total police incidents (as offender)** | | | | |
| COMPASS (n=44, commenced 2019) | 8.59 | 3.89 | **-1.18** | ↓ |
| Control group (n=55, born in 2001) | 8.55 | 9.24 | **0.17** | ↑ |
| **Cohort 2 (2020)** | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | **Change in annualised rate** | |
| **Total police incidents (as offender)*** | | | | |
| COMPASS (n=77, commenced 2020) | 11.96 | 2.13 | **-2.43** | ↓ |
| Control group (n=86, born in 2002) | 8.31 | 4.72 | **-0.85** | ↓ |
| **Cohort 3 (2021)** | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | **Change in annualised rate** | |
| **Total police incidents (as offender)** | | | | |
| COMPASS (n=59, commenced 2021) | 2.78 | 0.48 | **-0.53** | ↓ |
| Control group (n=68, born in 2003) | 2.47 | 1.16 | **-0.21** | ↓ |

[26] This data sourced from the PoliceVicPersonOffender table. Variable used in the table was the IncidentCode. The average offender incidents were calculated by summing total number of incidents for each participant and dividing by total number of participants. The annualised rate was calculated by dividing by the number of months of data and multiplying by twelve.

The chart below shows the average police offender incidents by year of COMPASS. With the exception of the control group for the 2019 intake, all groups saw a decrease in police offender incidents around the COMPASS intake year (i.e., coinciding with turning 18), with the sharpest decrease in the first year for the COMPASS participants. While noting that only the 2019 intake was significantly better than its control group, the pattern of out-performance vs control across all cohorts, coupled with qualitative findings around the impacts of provision of stability and support supports a claim that the program has a positive effect in reducing offending behaviour.

*Chart 5 Average number of police recorded offender incidents by COMPASS year*



### Police victim incidents

We examined the number of police incidents (as a victim) within the linked dataset.[27] The table below shows decreases in two of three COMPASS intake years and in two of the three controls. Only the change observed in the COMPASS 2020 intake was statistically significant, where the fall recorded by COMPASS groups was significantly less than that recorded in the corresponding control group – although the marginal difference in effect size was very small.

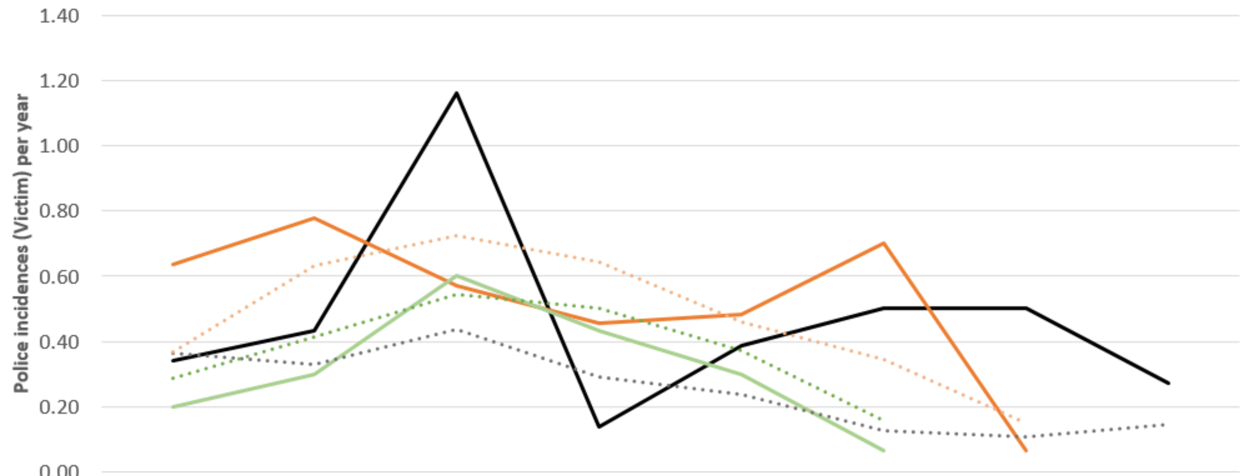
*Table 11 Police victim incidents*

| **Cohort 1 (2019)** | 4 years pre-COMPASS Jan 2015-Dec 2018 (48mths) | Post-COMPASS period Jan 2019-Dec 2022 (48mths) | **Change in annualised rate** | |
|---|---|---|---|---|
| **Total police incidents (as victim)** | | | | |
| COMPASS (n=43, commenced 2019) | 1.58 | 1.67 | **0.02** | ↑ |
| Control group (n=54, born in 2001) | 1.35 | 2.07 | **0.18** | ↑ |
| **Cohort 2 (2020)** | 4 years pre-COMPASS Jan 2016-Dec 2019 (48mths) | Post-COMPASS period Jan 2020-Oct 2023 (46mths) | **Change in annualised rate** | |
| **Total police incidents (as victim)*** | | | | |
| COMPASS (n=77, commenced 2020) | 2.44 | 1.25 | **-0.29** | ↓ |
| Control group (n=86, born in 2002) | 2.14 | 0.72 | **-0.35** | ↓ |
| **Cohort 3 (2021)** | 4 years pre-COMPASS Jan 2017-Dec 2020 (48mths) | Post-COMPASS period Jan 2021-Oct 2023 (34mths) | **Change in annualised rate** | |
| **Total police incidents (as victim)** | | | | |
| COMPASS (n=59, commenced 2021) | 1.29 | 0.37 | **-0.19** | ↓ |
| Control group (n=65, born in 2003) | 0.94 | 0.42 | **-0.09** | ↓ |

[27] Counts the number of victim incidents. This data sourced from the PoliceVicPersonVictim table. Variable used in the table was the IncidentCode. The average victim incidents were calculated by summing total number of incidents for each participant and dividing by total number of participants. The annualised rate was calculated by dividing by the number of months of data and multiplying by twelve.

The chart below shows the police victim incidents by year of COMPASS. The control groups show a generally consistent downward trend, while the COMPASS intake groups appear to exhibit more volatility and variability between cohorts making it difficult to make confident findings. The 2020 COMPASS intake saw a slower overall decrease compared to its control group (statistically significant as noted above) but had a lower number of incidents than the same control in year 2.

*Chart 6 Average number of police recorded victim incidents by COMPASS year*




## Data linkage conclusions

While qualitative feedback and program data demonstrated positive outcomes for COMPASS young people in several categories, these were generally not significantly different to the outcomes observed in the three control groups, with three exceptions.

- COMPASS participants commencing in 2019 had significantly more days of homelessness service (an additional 40.59 per year) in the four years following commencement of the program than did their matched control group (equivalent to an additional 4.57 days per year).
- COMPASS participants commencing in 2020 had significantly fewer police incidents as offenders (-2.43 fewer incidents per annum vs -0.85 fewer per annum in the control group), but smaller decline in the number of police incidents as victims (0.29 fewer per annum compared to 0.35 fewer per annum in the control group).

# 4 Implementation and operation

The section presents findings on the implementation and operation of the program. It answers the key evaluation questions that fall under the implementation domain and is based on the program stakeholder consultations (n=10) and the program documents.

## Key messages

- Key workers **effectively implemented COMPASS'** practice model. The COMPASS practice model included key factors such as autonomy of practice and team-based collaboration, empowering workers to creatively support young people. This person-centred approach places young people's needs at the forefront, fostering trust and mutual respect.
- **Key barriers to securing housing included the changes in the housing market which meant it was more difficult to find appropriate properties and the lack of a physical presence in Bendigo.** VincentCare's lack of presence in Bendigo hindered the ability to build relationships with local real estate agents and their ability to secure head leases was impacted. Despite challenges, COMPASS managed to secure 13 properties and 35 head leases, though this fell short of the initial target due to the inability to find suitable properties and market volatility caused by the COVID-19 pandemic.
- The **unexpected interface between COMPASS and expanded access to Home Stretch, created some challenges** in managing cases. A small number of young people opted for Home Stretch over COMPASS due to the financial benefits which were put on hold if they joined COMPASS. This created some confusion and disruption to the program, with some participants moving between programs and not fully understanding the impacts of the transitions.
- While overall a successful partnership, there are **lessons learned for partnerships and consortia where organisational culture and ways of working differ**. This is important for service delivery and a seamless experience for the young people, with the added complexity of investor returns being dependent on participant outcomes.
- The **program wind down period was impacted by staff departures to new roles, making support to remaining participants more challenging**. The departure of many Anglicare Key Workers before their contracts ended challenged the program's capacity, although caseloads remained manageable.
- The **management of housing stock at program wind down proceeded generally without difficulty**, but there were some challenges experienced in preparing housing for sale due to damage incurred during tenancies. Stakeholders reported that good market conditions facilitated the quick movement of housing back into the market, but significant repair work was needed for some properties. While the budgeted expenditure and insurance were adequate for repairs, stakeholders suggested that future iterations of the model should include consideration of property damage risks.
- **Co-living arrangements may not always be appropriate** for this cohort as identified in our Stage 1 and 2 research, due to the complexities of tenant behaviour and the challenges of matching participants with suitable housemates. Stakeholders from both Anglicare and VincentCare acknowledged these difficulties, particularly for participants with complex needs or trauma histories, which in some cases led to conflicts and property damage. More early investment in understanding housing stock and better matching participants could have minimised these issues. Standalone properties and single-bedroom dwellings were suggested as more suitable options to meet the needs of participants and reduce disruptions.

## 4.1 Key Findings

### 4.1.1 The COMPASS practice model was tested and formalised over the course of implementation

COMPASS' unique practice model was developed by Anglicare throughout the implementation period. The model was tested and formalised over the course of program implementation, with the development of the model and its success evidence of the maturing and bedding down of the program. As depicted in Figure 2 – COMPASS Practice Model on page 14 of this report, the COMPASS practice model is made up of four key factors: the funding environment, unconditional supports, practice elements and enabling organisational factors. Stakeholders described how the practice model was implemented.

There is evidence to suggest that the enabling organisational factors of 'autonomy of practice' and 'team-based practice' were effectively implemented. Under the COMPASS Practice Model, autonomy of practice means Key Workers are empowered to work creatively with young people to support them in ways most appropriate to their needs. Team-based practice emphasises collaborative, agile and non-hierarchical teamwork structures. One Anglicare stakeholder suggested that these organisational factors were effective because they encouraged workers to take bold, creative steps in supporting their clients.

*We just think out of the box, I guess, and we were encouraged to do that… We were encouraged to try everything and anything and not to… be prescriptive or afraid or risk…we just had… an amazing leader and leadership who were all really sort of quite flat (non-hierarchical) in their approach. – Anglicare stakeholder*

An example of this is where COMPASS workers provided 'adaptive and flexible' support. This practice element requires that support is provided to young people through a range of creative practices that best suit an individual's needs. Brokerage was used in creative ways to reach positive outcomes for participants, such as purchasing a pottery wheel for a participant who was struggling with their mental health as described above. One Anglicare stakeholder described the approach of the Key Workers in the context of this case as proactive and creative - it was not a typical solution, rather, it creatively met the client's needs.

*There's a level of willing to try and be innovative. They actually picked people who were brave and were willing to make a decision. – Anglicare stakeholder*

Additionally, stakeholders spoke to the person-centred support provided by Key Workers. A person-centred approach under the COMPASS Practice Model is defined as where 'young people and their unique needs are placed at the centre of practice'. For stakeholders, in practice this looked like empowering young people to have a level of control regarding decisions made about them and their needs.

*I guess often too, because you're in a care team where decisions are made for young people, not with… that's where we can… start to bring them to the table in a meaningful way too. You're in control. You're gonna be in the driver's seat. – Anglicare stakeholder*

These stakeholders described trust toward the young person as a key part of what allowed a person-centred approach:

*It's looking for the good all the time and having faith in these young people that… with a little bit of effort they will develop. – Anglicare stakeholder*

This was similarly highlighted by participants in our Stage 3 research, who saw their Key Worker as an ally, and valued having a relationship based on mutual trust, rather than supervision.

### 4.1.2 Barriers to securing housing included changes in the housing market and lack of a physical presence in Bendigo

There was some difficulty experienced in securing housing for participants. As described in our Stage 2 research, purchasing properties and securing headleases was more challenging than anticipated due to specific criteria of the program that required identifying properties that would meet the needs of participants (see below for housing suitability for this cohort). We also heard that property market volatility (partly driven by the COVID-19) made it harder to find appropriate properties. A few stakeholders in this reporting period

again spoke to these challenges, particularly regarding the difficulty in securing housing due to conditions in the housing market and availability of appropriately located and priced stock. One Anglicare stakeholder we spoke with for this research stage suggested that changes in the market across the period between program design and implementation meant that initial costing was outdated by the time COMPASS was securing housing, potentially limiting the housing options available.

*[At time of program implementation] the market had changed, so… when they looked at the financial sort of side of things, we ended up having to probably spend a little bit more on some of the housing stock because what was budgeted and costed was outdated by the time we went live. – Anglicare stakeholder*

There was recognition that this made it difficult to secure head leases in the areas most appropriate to participant's support needs and most conducive to positive outcomes (refer to Section 3 on Experiences and outcomes for young people within this report, for the importance of housing for participant outcomes).

*Sometimes that was a challenge… getting the stock in the areas that we needed it to… keep kids connected to their community or close to… education and employment. – Anglicare stakeholder*

Anglicare stakeholders also suggested the lack of a physical presence of VincentCare in Bendigo further challenged the ability of COMPASS to secure housing. They identified Bendigo as a 'relational area', where buy in from real estate agents requires the development of trust and relationships. Stakeholders contended that because VincentCare did not have a frequent physical presence in Bendigo, their ability to build relationships and secure head leases was impacted.

*Bendigo is very… relational and reputational… So they were this sort of unknown entity coming into town… trying to spread (and) promote this program… So it took a while for us to get any sort of head lease options happening. – Anglicare stakeholder*

Despite these challenges, COMPASS was able to secure 13 properties over the period of program implementation. This falls short of the anticipated target of 16. The shortfall in purchased properties was managed by securing additional head lease properties of which COMPASS secured 35.[28]

### 4.1.3 The unexpected interface between COMPASS and Home Stretch created some challenges in managing cases

The unexpected interface between COMPASS and Home Stretch/Better Futures, as a result of COVID-19 driven policy changes, was recognised by government and Anglicare stakeholders as a key implementation challenge. As reflected in our Stage 2 research, the roll out of Home Stretch likely impacted on referrals into COMPASS. Stakeholders highlighted that some young people chose to participate in Home Stretch instead of COMPASS – while it was ultimately a positive that young people had a range of options to choose from, this change did affect assumptions underlying the COMPASS model.

Home Stretch documentation states the program provides an accommodation allowance and flexible funding to facilitate the young person's access to housing, education, employment and wellbeing.[29] The allowance and flexible funding provided through Home Stretch is put on 'active hold' when participants enter COMPASS, with stakeholders suggesting this was a disincentive for young people to access COMPASS.

*Young people get about 16,000 per year if they're living independently and that's brokered by Better Futures, and it can go towards rent and rent and utilities and kind of maintaining*

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[28] COMPASS Leaving Care. (2023). *COMPASS Annual Report 2023*. https://compassleavingcare.org.au/

[29] Department of Families, Fairness and Housing. (2021). *Home Stretch home-based care (kinship and foster care) practice advice updated December 2021*. https://providers.dffh.vic.gov.au/home-stretch-allowance-home-based-care-practice-advice

*accommodation… there was a big gap in payment … whereas if the young people had access to Home Stretch, that would probably bridge that gap. – Government stakeholder*

This reflects our Stage 2 research which heard from some stakeholders that the difference in overall carer payments was primary reason for young people to choose support through Home Stretch rather than COMPASS. These stakeholders noted that a payment of $70 per week would be available for COMPASS participants' foster or kinship carer, whereas those caring for a participant in Home Stretch could receive a reimbursement up to $15,000-17,000 for costs associated with accommodation.

It was noted by the stakeholders we spoke to in this stage of research that those young people who chose to access Home Stretch rather than COMPASS would have benefitted from the wraparound support COMPASS provides, but they missed out on this due to their need to access the Home Stretch flexible funding. Additionally, the intersection between COMPASS, Home Stretch and Better Futures was considered confusing and disruptive for participants. Young people often began in Better Futures, then were moved to COMPASS support when they turned 18 years of age, and then moved back onto Better Futures when COMPASS closed. Young people often couldn't understand why these changes were occurring and didn't seem to understand COMPASS was not mandatory.

*I've received from agencies that young people have said that they didn't really understand why they moved from service to service… (I) received feedback from an agency supporting an Aboriginal young person… who is really confused about why they didn't have access to Home Stretch, why they couldn't stay with Better Futures… They have friends that have Home Stretch and kind of receive all this monetary support, and they're confused about why they don't. – Government stakeholder*

These stakeholders noted that Better Futures information sheets had been made available to explain the differences between the programs, but that this didn't assist in the confusion. It was suggested that some COMPASS workers were also understandably confused regarding the pathways for young people through these programs and possibilities for participants to access Better Futures funding, especially at beginning of the Home Stretch roll out.

*I think that was confusing for staff… Some feedback we had from COMPASS staff is when they wanted to access Better Futures flexible funding, that… all the services connecting together was a bit clunky. – Government stakeholder*

In recognition of these challenges, government stakeholders suggested COMPASS participants would benefit if the intersection between programs was to be addressed differently. Suggestions included for young people to be able to access both programs or a portion of Home Stretch funding while on COMPASS. There was also suggestion that COMPASS flexible brokerage could be increased so that participants wouldn't need to access Home Stretch funding, and suggestion that referral pathways between the programs be made clearer.

Various government and Anglicare stakeholders identified that COMPASS has unique aspects that distinguish it from Better Futures and Home Stretch, providing needed value (such as the housing first approach and flexible case management). Strengthening the intersection between the programs to allow young people to access this support was considered crucial.

### 4.1.4 Delineation of roles and responsibilities between Anglicare and VincentCare presented some challenges

Our Stage 2 research spoke to some of the challenges the two COMPASS providers, Anglicare and VincentCare, experienced in working together to deliver COMPASS. For example, the difference in the internal cultures of these two providers, and difficulties in managing expectations around roles, responsibilities, and performance, were reported as key challenges to implementing the program in our Stage 2 research. During this period, a Roles and Responsibilities document was created to clarify the obligations of the two organisations, demonstrating their efforts in formalising responsibilities. Throughout program delivery, both organisations participated in the Joint Working Group and various meetings to facilitate communication (these governance structures are further discussed in the section on Governance within this report).

Despite these efforts, stakeholders from both Anglicare and VincentCare we spoke with during this final stage described these inter-organisational differences as continuing to impact on how the organisations worked together. Both organisations made efforts to minimise any impacts to participants. The lack of VincentCare's presence in Bendigo created more work for Anglicare (refer above for the challenges of securing property in Bendigo).

*Given that VincentCare didn't have that presence or investment [in Bendigo], we ended up taking onboard a lot of the property management… being asked to perform lots of duties that were really outside the scope of what was intended for [our] role. – Anglicare stakeholder*

They reported that these additional responsibilities impacted how young people understood the role of their Key Worker.

*We're kind of having to wear all the hats and deliver information and Key Workers often felt like that hindered their rapport with young people as well because they just saw them… as… the person that was supposed to be on top of all of those things as well. – Anglicare stakeholder*

This aligns with our Stage 2 research which highlighted the differences in cultures, operating philosophy and delivery approaches of the two organisations.

Additionally, one Anglicare stakeholder suggested staff and management turnover in VincentCare likely impacted on the organisations' ability to establish an 'agreed approach' to collaborating on program delivery.

### 4.1.5 The program wind down period was initially marked by difficulty in providing support to a small number of participants, largely due to delineation of roles, and the loss of Key Workers as they reached the end of their contracts

COMPASS wound down its activities during 2023, which required transitioning young people out of the COMPASS program and housing. The transition of young people out of COMPASS was characterised broadly by stakeholders as a period of uncertainty in terms of the management of young people's exits from the program although they were referred back to Better Futures six months from COMPASS completion. As described above, the key issue of delineation of responsibility between the organisations was a notable challenge, and this continued during program wind down. VincentCare felt they had to take on increased responsibilities outside the scope of their role during this period, as Anglicare Key Workers stepped back as participant eligibility for supports came to an end.

COMPASS stakeholders provided their insights on the reasons for changes in support to participants during program wind down. Primarily, they highlighted changes to capacity to provide support to participants was impacted where many Key Workers, facing the end of their contracts, left Anglicare often before the end of their contracted period.

*I guess that was another thing was when contracts are coming to an end, I guess Key Workers start to look outward, everybody's got lives or mortgages and things. So some people were jumping, been up to six months before the end of their contracted time and they might still have eight, you know, young people or so, yeah, I had to just kind of take over leftover sort of caseloads of Key Workers as they would move on as well. – Anglicare stakeholder*

Though experiencing these challenges differently, stakeholders across Anglicare and VincentCare similarly highlighted the difficulties in supporting participants over the wind down period. These challenges highlight the risks around having short term contracts for Key Workers and a lack of clarity regarding delineation of roles and responsibilities for the activities required specific to this period.

### 4.1.6 The management of housing stock at program wind down proceeded generally without difficulty

The program wind down period additionally involved preparing housing for sale, including repairing any damage to properties, and working with local agencies to move housing back into the market. Largely, stakeholders reported this process to have gone smoothly, although some properties suffered damage during their tenancies which required significant repair work. This created reputational risk for COMPASS and led to increased hesitation among real estate agents in some areas to lease to COMPASS again.

A key component of the COMPASS model is the direct provision of subsidised housing for participants who need it through COMPASS-owned or head-leased properties. Our Stage 2 research identified market conditions including availability of appropriate stock and market competitiveness as at times making the procurement of housing challenging. For the program wind down period, stakeholders reported that the management of housing generally ran smoothly, enabled by good market conditions which allowed housing stock to move through the market relatively quickly.

As identified in our Stage 1 and 2 research, some properties experienced damage caused by participants. At program wind down, some properties were in poor condition with a few having experienced significant damage. This meant repairs needed to be undertaken to prepare many of the properties for sale. COMPASS' design allows for budgeted expenditure for maintenance and repairs to maintain fixtures and fittings, as well as insurance to cover incidental damage, fire and theft to properties..[30] The budgeted expenditure and insurance process were considered adequate to allow for repairing the damages. However, stakeholders suggested property damage be highlighted as risk for future iterations of the model, where steps should be taken to minimise the level of possible property damage and subsequent investment in repairs. This is particularly important given the changeable nature of the housing market and any impact this might have on the ability of the program to cover costs, as it is likely that the rise in property prices at the time the housing was being brought back into market assisted in covering the cost of repair.

### 4.1.7 Co-living arrangements may not always be appropriate for this cohort

As identified in our Stage 1 and 2 research, the complexities of tenant behaviour contributed to some additional work for program staff, such as dealing with property damage or transferring participants to new leases. In this reporting period, stakeholders from both Anglicare and VincentCare again acknowledged these additional challenges, made difficult due to the limited options to match participants suitably (COMPASS primarily provides two or three-bedroom dwellings, meaning that most participants who reside in COMPASS properties are co-tenants with another program participant). This was evident where participants had complex needs or trauma histories:

*The model talked about all young people sharing and what we found was that obviously some young people because of the level of pain-based behaviour and complexity for a period of time can't share with another young person because it's not safe to do so. – Anglicare stakeholder*

A few stakeholders suggested that these challenges could have been minimised if more work had been done early in the program to establish a better understanding of available housing stock and options to match participants.

*Obviously, you'd like to be able to better match young people… to have options to kind of go, oh well, look, these two young people might get along well, or this particular young person couldn't live with a male because of their trauma history. (Limited housing stock) it made it difficult when you're thinking about matching. – Anglicare stakeholder*

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[30] COMPASS Leaving Care. (2018). *COMPASS Information Memorandum May 2018*. https://compassleavingcare.org.au/wp-content/uploads/2020/06/COMPASS-Information-Memo.pdf

The need for more early investment in suitably matching participants was similarly reflected in our Stage 2 research, where both participants and Key Workers suggested that more work could have been done to foster prospective housemate relationships before young people move in together, and to better allocate young people to houses.

Stakeholders from both this reporting period and our Stage 2 research described the impact of unsuitable matching of participants. Our Stage 2 research found that for some program participants, the behaviours of their housemates made them feel unsafe or threatened, with program staff suggesting this created risk of retraumatising participants. Unresolvable conflict at times resulted in participants being relocated or becoming the sole occupants of three-bedroom dwellings, at significant cost to COMPASS. At the time of our Stage 2 research, data provided by COMPASS showed that of the 115 participants who lived in COMPASS housing, 45 per cent had moved at least once.[31]

Stakeholders also offered retrospective insights into the types of housing most suitable to meet the needs of participants. Standalone properties were considered most suitable due to their ability to reduce disruption to neighbours. This is reflected in our Stage 1 research, where program staff described ideal properties as those that offer some space between neighbours to reduce complaints, have evenly sized bedrooms and are close to public transport to allow the young person to move around freely. Similarly, stakeholders in our Stage 2 research suggested the provision of more single-bedroom dwellings would be beneficial for some program participants – although this type of housing stock is typically available in apartment and attached dwelling configurations.

[31] Thomas, J., Grisdale, J., Burgess, A., Bagot, C., McArthur, M., Milward, K., Newman, G., & Ridgeway, M. (2022). *COMPASS Evaluation—Interim Report*. Urbis, for Victorian Department of Treasury and Finance.

# 5 Governance

This section presents findings on the governance arrangements that support the program and its funding arrangements. It answers the key evaluation questions that fall under the governance domain and is based on program stakeholder consultations (n=10) and interim reporting.

Governance

- **While the governance arrangements for COMPASS continue to be effective, the PAD model requires strong governance** to provide accountability given the higher levels of autonomy and operational risk with the new ways of working.
- Although **COMPASS has a range of governance structures available, these could be streamlined** to ensure they are more efficient.
- While Board and Management meetings did not raise concerns, Joint Working Group meetings were seen as more informational than decision-making, and Operations meetings, though productive, sometimes felt accusatory.

## 5.1 Stakeholders were generally positive about governance arrangements

Governance findings for this round of data collection aligned with those from the interim report, which are outlined in the table below. For this round of data collection, as described above, stakeholders from both Anglicare and VincentCare described some inter-organisational tensions as impacting program implementation.

| Type | Description | Feedback |
|---|---|---|
| **Board Meetings** | ▪ The Board is comprised of four directors, the CEOs of Anglicare Victoria and VincentCare Victoria, and another member from each organisation. | Stakeholders did not raise any issues or concerns about the operation of the Board. |
| **Joint working group** | ▪ The Joint Working Group (JWG) meetings are generally quarterly and are jointly chaired by the CEO of Anglicare and representatives from the State. Membership of the JWG is comprised of representatives from COMPASS Leaving Care Ltd, Anglicare, VincentCare Victoria, DFFH (including the Government Contract Manager (GCM)), DTF, and DH..[32]<br>▪ According to the Operations Manual (2021) the role of the JWG is to:<br>a. provide advice on matters regarding the implementation and performance of the COMPASS funding mechanism<br>b. advise and agree on material changes to project delivery and processes | The GCM and Compass Executive Manager (CEM) continue to be noted as working well together, evidenced by the number of joint papers they have submitted to the group. Papers prepared in advance assist parties in understanding the context and issues at hand (such as changes to the Operations Manual and detailing the COMPASS/Home Stretch interface).<br>Some stakeholders felt that the JWG meetings were not a functional space for government stakeholders to work through potential issues as it was a forum for sharing information rather than making decisions. While this reflects the advisory role of the JWG, it may reflect a need for |

[32] According to the 2019 Terms of Reference and the 2021 Meeting 8, Agenda Item 3 document titled COMPASS Governance.

| | | |
|---|---|---|
| | c. monitor outcomes and broader objectives that are to be delivered or to be achieved<br>d. provide advice on matters of formal Dispute Resolution (see clause 32 of the Implementation Agreement). | further processes within government to monitor PADs.[33]<br>Our review of meeting documents has indicated that the number of meetings has reduced over time (four meetings in 2019 to three meetings in 2020 and 2021).[34] It was unclear if the Terms of Reference/Governance document has been updated since 2021. |
| **Operations meetings** | ▪ Monthly operations meetings with the Anglicare Operations Manager and Team Leaders, and VincentCare Victoria housing staff. There is a rotating chair and note taker. These meetings are a forum for Anglicare and VincentCare Victoria staff to raise and resolve issues, discuss operational matters, and refine roles and responsibilities. | These meetings continue to be regarded by program staff as a productive forum for working through issues and building relationships across organisations Stakeholders in the summative report data collection, reported that these meetings sometimes felt accusatory rather than constructive due to differences in role perceptions and operating philosophies. |
| **Management meetings** | ▪ Fortnightly management team meetings are relatively new and were initiated by the COMPASS Executive Manager and attended by Anglicare and VincentCare Victoria. | Stakeholders did not raise any issues or concerns about these meetings. |
| **Housing meetings** | ▪ Fortnightly or monthly housing meetings, attended by Anglicare and VincentCare Victoria. This is a forum to discuss each of the tenancies, such as updates on any tenancy issues from both a support and tenancy management perspective (e.g., current rent arrears, note any maintenance issues, or highlight issues happening for a participant which may have an impact on their tenancy). The meeting also includes a discussion in relation to current or upcoming vacancies, with a view to forming a plan for these.<br>▪ The meetings are an opportunity for tenancy and support workers to raise any concerns or swap ideas. It also highlights issues that need to be escalated to the management meetings. | Anglicare Victoria told us that the VincentCare Victoria representatives often did not attend these meetings. |

[33] As an advisory body, the JWG has no formal decision-making authority, and its recommendations are not binging on the Parties (Source: Operations Manual 2021).

[34] The minutes supplied to the project included February 2019, May 2019, August 2019, November 2019, April 2020, July 2020, October 2020, March 2021, June 2021, September 2021, and March 2022.

# 6 Funding model and design outcomes

This section presents findings about the COMPASS funding mechanism. It answers the key evaluation questions that fall under the funding model domain and is based on program stakeholder consultations (n=10).

Key messages

- Features of the **PAD model offer specific strengths in terms of effective service delivery/ achieving outcomes**, however there from a government point of view, there are trade-offs in terms of how and who manages accountability for performance, and transparency of individual outcomes.
- **The COMPASS program has significantly developed government capability in the PAD space**, serving as a model for future initiatives by providing valuable internal learnings and expertise. Stakeholders noted that insights gained from COMPASS, particularly in stakeholder collaboration, outcome measurement, and risk management, can enhance the design and implementation of subsequent PAD projects.
- **The COMPASS program has successfully leveraged existing stakeholder relationships and experience**, particularly through Anglicare's established rapport with government and other service providers. Stakeholders highlighted that Anglicare's knowledge of department contracts and an experienced government program manager were invaluable in managing the program's complexities and ultimately ensuring its successful delivery.
- **Changes in policy and departmental structures led to inefficiencies in creating the COMPASS control group**, requiring a year's worth of work to be redone and highlighting the need for better internal communication around emerging policy trajectories that can impact long term programs.
- **Small sample sizes and covariates made constructing a robust COMPASS control group challenging**, leading to statistical issues and inaccurate assessments due to unobserved covariates and data quality problems. The lack of comprehensive research specific to the Victorian context further compounded these challenges, highlighting the opportunities to explore robust methodologies like a Randomised Control Trial.

## 6.1 Key findings

### 6.1.1 The PAD model offers multiple benefits with trade-offs in terms of transparency of operations and individual outcomes

The impact of the PAD model and its contractual requirements on program delivery was highlighted for its benefits, with potential limitations raised. Stakeholders highlighted that the PAD model offers strengths, such as shared risk management, flexibility, and an incentive-based framework. A few stakeholders spoke to the benefits of increased operational flexibility provided by the model's contractual arrangements. One government stakeholder suggested that the emphasis the model placed on outcome measurement, while allowing freedom in service provision, supported a valuable level of discretion and flexibility for Anglicare that was distinct from typical government service delivery arrangements. This was a view supported by Anglicare stakeholders in both our Stage 2 and 3 research, who described the flexibility of the arrangement as supporting a beneficially innovative approach to service delivery.

The PAD model is very different to standard service contracts, with an accountability model focused on delivery of outcomes, and does not have the usual levers in place for government assurance of delivery or process elements. There is relatively greater emphasis placed on accountability to the Board and investors. Some government stakeholders felt that decreased visibility of individual support outcomes to government was problematic, while acknowledging that this was how the PAD was established. One government stakeholder suggested a need to better balance innovation and accountability to government partners. Anglicare stakeholders felt the Board had an important and increased role in accountability and performance monitoring.

Similarly, our Stage 2 research found that the model enabled greater transparency regarding impact through transparency of payable outcomes, though the outcome measures themselves were relatively 'blunt', and often were proxies to reflect the broad outcomes the program intended to promote for participants. This suggests a focus on broad cohort level outcomes, with less focus on measuring individual support outcomes.

Though outcome measures can lack nuance, there is room to consider learnings offered by differing systems of accountability. For example, the Better Futures program collects client input data, including number of contact hours, and the client's subjective assessment at baseline and annually throughout involvement in the program.[35] Outcome data is to be used to inform case management as well as program evaluation, and to enable accountability for any changes made in participants' lives.[36] This differs to COMPASS' PAD outcome measurement, as it involves ongoing qualitative assessment of outcomes and experience from a young person's perspective throughout their involvement in the program. The evaluation of Better Futures has not yet been published but should provide opportunity to reflect on learnings.

### 6.1.2 COMPASS has developed government capability in the PAD space

Urbis found, across all research stages, that the COMPASS program has contributed to developing government capability in the PAD space, serving as a model for future initiatives. In particular, Stage 3 stakeholder interviews noted that the program has provided valuable internal learnings and expertise, which can be leveraged to enhance the design and implementation of subsequent PAD projects.

*COMPASS has been held up as a bit of a poster program, and now you know, for example, there's funding for a new program modelled on the COMPASS practice approach – VincentCare stakeholder*

Stakeholders suggested that future programs can benefit from the insights gained through COMPASS, particularly in areas such as stakeholder collaboration, outcome measurement, and risk management. A stakeholder noted the importance of disseminating these learnings, so that the government can build a robust knowledge base that informs best practices and addresses common challenges encountered in PAD programs going forward.

*I think remembering that it is an innovative different approach and that we're learning more broadly as we go along. It's not just about participant outcomes, which some of them have been very good. I don't mean to downplay them, but it's also about broader learnings. – VincentCare stakeholder*

### 6.1.3 COMPASS has leveraged existing stakeholder relationships and experience to enable successful delivery

Relationships between Anglicare and the government, as well as interdepartmental relationships have enabled successful delivery of the COMPASS program due to their experience with similar contracts and existing rapport with influential contacts. For example, one government stakeholder reported that Anglicare's knowledge of department contracts and established relationships with government were invaluable.

*Anglicare are one of the largest service providers the department contracts… they do hold quite a lot of sway within government – Government stakeholder*

Further, one stakeholder noted Anglicare's relationships with other service providers were helpful in getting the COMPASS program off the ground. Another stakeholder emphasised that having an experienced

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[35] Department of Families, Fairness and Housing. (2024). *Better Futures and Home Stretch outcomes measurement practice advice June 2024.*

[36] Ibid. (2024).

government program manager at the outset of the COMPASS program was beneficial, as she effectively utilised her contacts to seek out the right advice to manage program complexities.

*Given the complexity and implementing it…I think that can be a bit of a difficult thing to manage, but I think given our relationships over the years, I think we've been able to manage that complexity pretty well. – Government stakeholder*

### 6.1.4 Changes in policy and department structures led to some inefficiencies in creating the COMPASS control group

Changes in policy and departmental structures created inefficiencies when the department was creating the COMPASS control. A stakeholder reported that the Out-of-Home-Care policy change (the universal expansion of Home Stretch and introduction of Better Futures) meant that a year's worth of COMPASS control group work had to be re-done. This disruption was further exacerbated by COVID-19 and a lack of communication from higher government levels about the change and they noted that earlier communication about the policy change would have allowed the government team to pivot their work sooner.

*It's really about the government awareness of what everyone else is doing in government and their potential impacts upon everyone else, because I don't think that that awareness exists. – Government stakeholder*

Concurrently, a departmental restructure resulted in added layers of complexity and duplication, which further strained efforts to establish a valid control group. These combined challenges underscored the critical need for better communication channels and more stable organisational structures to ensure the smooth execution of future projects.

### 6.1.5 Small sample sizes and covariates made the construction of the COMPASS control group challenging

The government stakeholder we spoke to noted that small sample sizes and covariates made the construction of a good COMPASS control group somewhat challenging. The stakeholder mentioned issues with small sample sizes led to statistical problems and made propensity score matching of individuals within the control group difficult. Further, issues with unobserved covariates and data quality affected evaluation accuracy. For instance, missing data or variables not captured in the dataset seemed to be systematically biasing the outcomes, leading to inaccurate assessments.

*It's really small cohorts and you know when you try and form subgroups and start digging… you get down to like 7 people. – Government stakeholder*

The stakeholder reported compounding these challenges was a lack of comprehensive research specific to the Victorian context, forcing the team creating the COMPASS control group to rely on general or international studies that may not be fully applicable.

*We've been operating off all these impact bonds without the necessary level of research to understand the Victorian context. – Government stakeholder*

The stakeholder suggested Randomised Control Trials would be a better alternative for creating robust control groups to ensure there is no co-variance. However, there are ethical challenges in applying Randomised Control Trials to Human Services, such as the denial of services to individuals in the control group, which is not feasible when dealing with vulnerable populations who require immediate support.

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# Appendix A Program logic

# Program logic

The program logic for COMPASS was developed in 2018, and reflects the rationale for COMPASS participants, describes the key inputs intended to create change, and summarises the key outputs and impacts, linked to the three payable outcomes. The program logic is set out below.

### Problem Opportunity

Young people are not supported when they exit out of home care by age 18. As a result they experience:

- Higher homelessness rates
- Lower physical and mental wellbeing
- Higher rates of engagement with the justice system
- Lower employment rates
- Lower education attainment

### Inputs

#### Activities

**Funding** from investors and government

**Staff**

- Key workers and supervisors
- Property and tenacy managers
- Program administers
- Purchased and referred specialist services

**Housing** (purchased and rental)

**Brokerage**

**Practice frameworks** and training

#### Participants

Program to be delivered to all young people between 16.5 and 17.5 years due to exit care in the next 6 months

- Inner West & Brimbank/ Melton
- Inner North
- Loddon (Bendigo)

and

- eligible young people who have left care in the selected region in the last 6 months

Intake - 202 over 3 years

### Outputs

Young person is matched with a key worker

Appropriate accommodation is sourced and secured

Individual plan developed to support each Participant to address barriers to effective transitions

Specialist assistance/ support engaged as required

Exit plan developed including planned transition to independence

### Impact

Reduced homelessness

Improved health and wellbeing

Increased engagement in education and employment

Improved life skills (decision making, financial management, household management)

Improved self-care and reduced risk-taking behaviour

Reduced engagement with criminal justice system

Better knowledge of and engagement with social and health services

Reduced interaction with the child proctection system for children born to OOHC leavers

### Measurable Outcomes

Young person does not require emergency housing

Presentations at emergency departments are reduced

Convictions for offences are reduced.

*Source: COMPASS Social Impact Bond Information Memorandum (2018)*

# Appendix B Evaluation framework

# Evaluation framework

This section sets out the objectives, key evaluation questions and data sources for each of the three evaluation stages.

The table below presents the evaluation data framework for Stage 1 of the COMPASS evaluation and includes the Minimum Data Set (MDS). It sets out the key evaluation questions (KEQ), and associated indicators, measures, data sources/owners and collection responsibility and frequency.

The MDS comprises a sub-set of data that COMPASS will be responsible for providing towards Stage 1, 2 and 3 of the evaluation.

## Stage 1

Stage 1 of the COMPASS evaluation spans February-July 2020 and considers program design, early implementation and preliminary outcomes

The three objectives for Stage 1 are as follows:

1. Identify enablers and barriers to the efficient design and implementation of the COMPASS SIB model and capture key lessons for the design of future social impact bonds in Victoria.
2. Review the extent and effectiveness of COMPASS program implementation, with a focus on enablers and barriers that have arisen in the operating and strategic environment within which the COMPASS program was situated.
3. Assess any preliminary outcomes and how they relate to the service delivery model of the COMPASS program (excluding the evaluation of payable outcomes).

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| **IMPLEMENTATION KEQs** | | | | | | |
| IM.1 How efficient was the design process for the COMPASS SIB model? | ▪ Extent to which design process aligned to the expected timeframes | ▪ Alignment of design process to anticipated timeframes | Joint Development Phase and design documentation, (DHHS, COMPASS) | DHHS COMPASS | **Once-off; by document review** | |
| | ▪ Extent to which stakeholders perceive the process to have been efficient | ▪ Thematic findings from analysis of stakeholder views.<br>▪ Proportion of stakeholders perceiving an efficient process. | ▪ Consultation with:<br>▪ DHHS - Government Contract Manager (GCM)<br>▪ Anglicare / Vincent Care<br>▪ DTF | Urbis | **Once-off; by stakeholder interview** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | | | ▪ COMPASS Executive Manager<br>▪ KPMG | | | |
| IM.2 How have the design assumptions that underpin the COMPASS program model held up? | ▪ Extent to which the design assumptions of COMPASS have been reflected in program design and implementation | ▪ Thematic findings from analysis of stakeholder views/ assumptions<br>▪ | ▪ Consultation with:<br>▪ COMPASS Executive Manager<br>▪ Anglicare /Vincent Care<br>▪ DHHS GCM<br>▪ DTF | Urbis | **Once-off; by stakeholder consultation** | |
| | ▪ Extent of alignment of the design to the literature/evidence base | ▪ Extent of consistency between evidence base informing program design and program implementation | ▪ Literature review/evidence base informing program design<br>▪ Design documentation (DHHS, COMPASS) | DHHS<br>COMPASS | **Once-off; by document review** | |
| IM.3 To what extent has the COMPASS program been implemented as planned (program activities and outputs delivered)? | ▪ Extent of alignment between planned and actual program activities and outputs | All data sought by period (quarterly), and cumulative.<br>▪ Numbers of referrals made to COMPASS Leaving Care by region, risk level and source/pathway<br>▪ Number of accepted referrals by region, risk level and source/pathway<br>▪ Number of individual plans for YP | ▪ COMPASS ECMS data<br>▪ COMPASS data<br>▪ Government Contract Manager records | DHHS<br>COMPASS | **Periodic; Quarterly** | **MDS** |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | | ▪ Number of YP with an assigned Key Worker<br>▪ Number of YP with housing sourced and secured<br>▪ Number of YP receiving specialist assistance, by assistance type<br>▪ Number of YP with exit/transition plans established<br>▪ Number of YP exiting the program, by exit reason | | | | |
| | | ▪ Thematic analysis from monthly reporting and implementation meetings | ▪ JWG meeting minutes<br>▪ Implementation meeting minutes | DHHS COMPASS | **Periodic; Quarterly** | |
| | ▪ Extent to which stakeholders observe consistency/inconsistency between planned and actual activities and outputs | ▪ Thematic findings from analysis of stakeholder views on program implementation | ▪ Consultation with:<br>▪ COMPASS Executive Manager<br>▪ Anglicare Compass program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS – GCM<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** | |
| IM.4 How iterative and responsive has COMPASS Leaving Care been in | ▪ Extent to which the COMPASS program has | ▪ Thematic analysis of number and nature of program modifications | ▪ Implementation meeting minutes<br>▪ Monthly reporting | DHHS COMPASS | **Periodic; Quarterly** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| adapting the COMPASS program? What modifications have been made? | been adapted/modified and rationale | | | | | |
| | ▪ Extent to which stakeholders consider COMPASS Leaving Care to have been iterative/responsive | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager<br>▪ Anglicare Compass program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions DTF | Urbis | **Once-off; by stakeholder consultation** | |
| IM.5 What has been the reach of program, and what factors influenced client engagement and 'conversion'/participation? | ▪ Extent of program reach | All data sought by period (quarterly), and cumulative.<br>▪ Numbers of referrals made to COMPASS Leaving Care by region, risk level and source/pathway<br>▪ Number of accepted referrals by region, risk level and source/pathway<br>▪ Number of active clients by region, risk level, and demographics (age; gender; CALD; Koori) | ▪ Stratification and referral source data (CVDL and GCM)<br>▪ COMPASS data<br>▪ Monthly reporting | DHHS<br>COMPASS | **Periodic; Quarterly** | **MDS** |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | ▪ Reasons for non-entry/non-continuation | All data sought by period (quarterly), and cumulative.<br>▪ Number of YP exiting the program, by exit reason<br>▪ Number of YP-initiated withdrawals/exits, by exit reason<br>▪ Number of program-initiated exits, by exit reason | ▪ 'Did not proceed' data held by COMPASS | | | **MDS** |
| | ▪ Extent of program reach and extent to which stakeholders identify factors that have influenced client engagement | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Anglicare Compass program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS GCM<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** | |
| IM.6 How effectively and efficiently has the program been implemented? | ▪ Extent to which referral timelines are reasonable | ▪ Clarity, efficiency and timeliness of intake and referral processes (per referral path) | Consultation with:<br>▪ DHHS – GCM<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions<br>▪ Referring agencies | Urbis | Once-off; by stakeholder consultation | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | ▪ Extent to which intake and referral processes meet intended targets for numbers and client complexity | All data sought by period (quarterly), and cumulative.<br>▪ Number and proportion of YP referred to COMPASS in each risk category<br>▪ Number and proportion of YP accepted into COMPASS in each risk category<br>▪ Prescribed and actual number of days associated with the intake and referral processes (per referral pathway) | ▪ CRIS<br>▪ COMPASS ECMS | DHHS<br>COMPASS | | **MDS** |
| | ▪ Extent to the stratification tool has been well developed, consistently applied and useful | ▪ Extent to which the tool was developed in line with intended purpose<br>▪ Extent to which is has been consistently applied<br>▪ Thematic findings from analysis of stakeholder interviews on implementation process and adequacy of stratification tool<br>▪ Extent to which stakeholders perceive stratification tool useful | Consultation with:<br>▪ DHHS – GCM<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions<br>▪ Referring agencies | Urbis | **Once-off; by stakeholder consultation** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | ▪ Extent and appropriateness of housing available to clients against intended targets (including selection of housemates, location of housing)<br>▪ Effectiveness of activities to secure housing | ▪ Number of houses rented and number of houses purchased for client housing needs<br>▪ Thematic findings from analysis of stakeholder interviews | ▪ Vincent Care housing management data<br>▪ Vincent Care housing staff<br>▪ COMPASS Team Leaders | COMPASS<br>Vincent Care | **Data captured once each stage**<br>**Once-off; by stakeholder consultation** | |
| | ▪ Extent to which stakeholders consider the implementation process effective and efficient | ▪ Thematic findings of stakeholder interviews on effectiveness and efficiency of program implementation | ▪ Consultation with:<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ DHHS GCM<br>▪ DHHS Child Protection Champions<br>▪ Referring agencies | Urbis | **Once-off; by stakeholder consultation** | |
| IM.7 Do COMPASS staff have enough support and are they adequately equipped to deliver the program? | ▪ Extent to which COMPASS staff consider support adequate and feel equipped in their roles in terms of training, daily management of caseload | ▪ Staff perception of training and program documentation adequacy | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff) | Urbis | **Once-off; by stakeholder consultation** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | volume and intensity of work, retention and management support | ▪ Staff perception of support provided in daily management<br>▪ Staff perception of adequacy to deliver | ▪ DHHS Child Protection Champions | | | |
| | ▪ Extent to which ratio of caseworkers to young people is consistent with intended targets<br>▪ Extent to which staff training documentation canvasses roles and program delivery | ▪ Review of Operations Manual (amendments)/Training documentation | ▪ Operations Manual (incl amendments)/Training documentation | DHHS COMPASS | **Once-off: historical view** | |
| | | Data sought by period (quarterly)<br>▪ Average caseloads per 1.0 FTE worker, by risk category | ▪ COMPASS case data | COMPASS | **Periodic; quarterly** | **MDS** |
| IM.8 What were the barriers and enablers during the establishment phase? | ▪ Extent to which stakeholders identify enablers and barriers to establishment phase | ▪ Thematic findings of stakeholder interviews on enablers and barriers to program establishment | ▪ Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Executive Manager<br>▪ DHHS GMC<br>▪ DTF<br>▪ Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** | |
| | ▪ Extent to which enablers and barriers are identified and addressed in early stage program documentation | ▪ Thematic analysis of early stage documentation and implementation meeting minutes | ▪ Early stage documentation, COMPASS, DHHS<br>▪ Implementation meeting minutes | DHHS COMPASS | **Once-off; (end of first year documentation)** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| IM.9 What are the key lessons from the establishment phase, and how can they be applied to COMPASS and to other OOHC initiatives? | ▪ Extent to which stakeholders identify lessons from the establishment phase and application beyond COMPASS (e.g. Better Futures, Home Stretch) | ▪ Thematic analysis of lessons from the establishment phase and wider application | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Executive Manager<br>▪ DHHS GCM<br>▪ DTF | Urbis | **Once-off; by stakeholder consultation** | |
| **OUTCOMES** | | | | | | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| O.1 What preliminary outcomes have been achieved to date for clients (Program Logic impacts)? | ▪ Extent to which preliminary outcomes have been achieved for clients/ young people (YP)<br>▪ Proportion of YP experiencing intended outcomes | ▪ YP have improved health and well being<br>▪ YP have increased engagement with education and employment<br>▪ YP have increase life skills decision making, financial management, household management, maintaining tenancy<br>▪ YP have improved self-care and reduced risk-taking behaviour (including support with additional goals including housing stability, education, employment and addressed barriers to housing such as mental health, AOD misuse and trauma)<br>▪ YP have better knowledge of and engagement with social and health service<br>▪ YP have reduced homelessness<br>▪ YP have reduced engagement with the criminal justice system | ▪ Key Workers' perspectives<br>▪ COMPASS ECMS<br>▪ Case studies<br>▪ Annual Report (2018-2019)<br>▪ | DHHS<br>COMPASS | Periodic; Quarterly | MDS |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | ▪ Extent to which stakeholders identify preliminary outcomes for clients and service providers | ▪ Thematic findings of analysis from stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** | |
| O.2 What other outcomes have resulted from COMPASS? | ▪ Extent of other outcomes identified by stakeholders | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** | |
| O.3 How have partnerships between different stakeholders contributed to the outcomes (referral to services, service alignment)? | ▪ Extent to which stakeholders attribute partnerships to client and service delivery outcomes | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Executive Manager<br>▪ DHHS GCM<br>▪ DTF<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | ▪ Extent to which post-care referral pathways have been influenced by partnerships | ▪ Thematic findings from review of stratification and referral source data | ▪ Stratification and referral source data<br>▪ Government Contract Manager records | DHHS<br>COMPASS | **Once-off; by stakeholder consultation** | |
| | | All data sought by period (quarterly), and cumulative.<br>▪ Numbers of referrals made to COMPASS Leaving Care by region, risk level and source/pathway<br>▪ Number of accepted referrals by region, risk level and source/pathway | ▪ COMPASS ECMS data<br>▪ COMPASS data<br>▪ Government Contract Manager records | DHHS<br>COMPASS | **Periodic; Quarterly** | **MDS** |
| O.4 How have other Government initiatives and policies impacted on program implementation and outcomes? | ▪ Extent of impact of other government initiatives on COMPASS program implementation and outcomes | ▪ Thematic findings from review of Better Futures and Home Stretch Evaluation reports<br>▪ Document review and analysis of other government initiatives and policies relevant to care-leaver cohort | ▪ Better Futures evaluation report, DHHS<br>▪ Home Stretch evaluation report, DHHS<br>▪ Other government initiative and policy document as determined relevant | DHHS | **Periodic; six-monthly** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | ▪ Extent to which stakeholders identify government policies and initiatives that have affected program implementation and outcomes | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ COMPASS Operational staff<br>▪ DHHS – GCM<br>▪ DTF | Urbis | **Once-off; by stakeholder consultation** | |
| **GOVERNANCE** | | | | | | |
| G.1 How effective have project governance mechanisms (Government, COMPASS partners, Investors, Operational teams) been, and why? | ▪ Extent to which stakeholders view governance mechanisms to be effective | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** | |
| | ▪ Extent to which governance mechanisms are effectively documented | ▪ Thematic analysis of review of governance documentation | ▪ Operations Manual<br>▪ Implementation Agreement | DHHS<br>COMPASS | **Once-off** | **MDS** |
| G.2 Have governance arrangements facilitated timely resolution of issues? | ▪ Extent to which decision-making and timely resolution is facilitated by | ▪ Number, nature and timing of issues resolved via | ▪ JWG minutes<br>▪ Implementation meeting minutes | DHHS<br>COMPASS | **Once-off** | **MDS** |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | governance arrangements | governance arrangements | | | | |
| | ▪ Extent to which governance stakeholders perceive timely resolution of issues | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ DHHS – GCM<br>▪ DTF Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** | |
| G.3 What changes or improvements to project governance mechanisms would be beneficial? | ▪ Extent to which stakeholders identify improvements to governance mechanisms | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ DTF<br>▪ DHHS – GCM<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** | |
| **SIB MODEL** | | | | | | |
| SIB.1 What role did partnerships play in the design of the SIB model? | ▪ Extent to which stakeholders identify the role partnerships played in SIB model design | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS - GCM<br>▪ Anglicare COMPASS program operational | Urbis | **Once-off; by stakeholder consultation** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| | | | staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ Investors | | | |
| SIB.2 What lessons were learnt in the development of the SIB model? | ▪ Extent to which stakeholders identify lessons learnt from SIB model development | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager<br>▪ Anglicare/Vincent Care program developers | Urbis | **Once-off; by stakeholder consultation** | |
| SIB.3 What challenges did the SIB model development face and how were these overcome? | ▪ Extent to which challenges to the SIB model development are documented | ▪ Nature of challenges in SIB model development<br>▪ Nature of strategies used to overcome challenges | ▪ Implementation meeting minutes<br>▪ Early stage program documentation | DHHS<br>COMPASS | **Once-off** | |
| | ▪ Extent to which stakeholders identify challenges to the SIB model development and how these were overcome | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager<br>▪ Anglicare/Vincent Care program developers | Urbis | **Once-off; by stakeholder consultation** | |

| STAGE 1 – DOMAIN | Indicator | Measure | Data source / owner | Who collects it | Collection frequency and method | MDS |
|---|---|---|---|---|---|---|
| SIB.4 Is the monitoring of COMPASS providing sufficient information to all stakeholders involved in the SIB (e.g. governance boards, investors, special purpose vehicle, service delivery organisations)? | ▪ Extent to which stakeholders consider COMPASS monitoring and information sharing adequate | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** | |

## Stage 2

Stage 2 of the COMPASS evaluation considers the progress of the program, preliminary outcomes, opportunities for improvement and the appropriateness of the SIB model

The six objectives for Stage 2 are as follows:

4. Review the progress of the COMPASS program against intended trajectory, taking into considering any refinements or changes to the program, the COMPASS SIB model, or to the strategic or operational environment of implementation.
5. Identify the preliminary outcomes being achieved by the COMPASS program (extending beyond the payable outcomes), including impacts on clients, service providers and the community, including analyses by region which are sensitive to the socio-economic and service sector context in each region.
6. Explore what aspects of the COMPASS program have been most effective in generating outcomes, including analysis of what works for whom, why, and how effectively.
7. Identify any learnings or opportunities for improvement to the COMPASS program.
8. Review the appropriateness of the COMPASS SIB as a mechanism for generating beneficial social outcomes for young people transitioning from out-of-home care, including consideration of both intended and unintended outcomes at client, service provider and system levels.
9. Identify enablers and barriers to the efficient design and implementation of the COMPASS SIB model and capture key lessons for the design of future social impact bonds in Victoria.

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| **IMPLEMENTATION KEQs** | | | | | |
| IM.1 To what extent has the COMPASS program been implemented as planned (program activities and outputs delivered)? | ▪ Extent of alignment between planned and actual program activities and outputs | ▪ Numbers of referrals by region and risk level<br>▪ Number of YP with a Key Worker<br>▪ Number of YP with housing sourced and secured<br>▪ Number of YP who are living with their Kinship or Foster Carers<br>▪ Number of YP that are being supported in alternative | ▪ COMPASS CRIS (data reports)<br>▪ COMPASS ECMS<br>▪ Program documentation (Monthly reporting, annual reporting) | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | | accommodation (e.g. private rental, student accommodation)<br>▪ Number of individual plans for YP<br>▪ Number / type of specialist assistance<br>▪ Number of exit/ transition plans out of program | | | |
| | | ▪ Thematic analysis from monthly reporting and implementation meetings | ▪ JWG meeting minutes<br>▪ Implementation meeting minutes | DHHS<br>COMPASS | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders observe consistency/inconsistency between planned and actual activities and outputs | ▪ Thematic findings from analysis of stakeholder views on program implementation | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off, by stakeholder consultation** |
| IM.2 How iterative and responsive has COMPASS been in adapting the program? | ▪ Extent to which the COMPASS program has been adapted/modified and rationale | ▪ Thematic analysis of number and nature of program modifications | ▪ Implementation meeting minutes<br>▪ Monthly reporting<br>▪ DHHS Government Contract Manager list of exceptions | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| What modifications have been made? | ▪ Extent to which stakeholders consider COMPASS iterative/responsive | ▪ Thematic findings from analysis of stakeholder interviews | ▪ Consultation with:<br>▪ DHHS - GCM<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DTF | Urbis | **Once-off, by stakeholder consultation** |
| IM.3 What has been the reach of program, and what factors influenced client engagement 'conversion'? | ▪ Extent of program reach | ▪ Numbers of referrals by region and risk level<br>▪ Number of referrals and clients by referral pathway<br>▪ Numbers of clients (by region, demographic, risk level, eligibility)<br>▪ Client reasons for not proceeding | ▪ Stratification and referral source data (CVDL and GCM)<br>▪ Did not proceed data<br>▪ COMPASS CRIS<br>▪ COMPASS ECMS | DHHS<br>COMPASS | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders identify factors that have influenced client engagement | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Clients<br>▪ DHHS - GCM<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| IM.4 How effectively and efficiently has the program been implemented? | ▪ Extent to which intake and referral processes meet intended targets for numbers and client risk profiles<br>▪ Extent to which referral timelines are reasonable | ▪ Clarity and efficiency of intake and referral processes (per referral path)<br>▪ Proportion of YP across the client risk targets<br>▪ Number of days associated with the intake and referral processes (per referral pathway) | ▪ COMPASS CRIS<br>▪ COMPASS ECMS<br>▪ Government Contract Manager records<br>▪ OOHC agencies (referring agencies i.e. Berry Street and others) | DHHS<br>COMPASS | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders perceive stratification tool useful | ▪ Thematic findings from analysis of stakeholder interviews on implementation process and adequacy of stratification tool | Consultation with:<br>▪ DHHS – GCM<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent of housing available to clients against intended targets<br>▪ Effectiveness of activities to secure housing | ▪ Number of houses rented and number of houses purchased for clients housing needs<br>▪ Thematic findings from analysis of stakeholder interviews | ▪ Vincent Care housing management data<br>▪ Vincent Care housing staff | DHHS<br>COMPASS<br>Vincent Care | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders consider program implementation effective and efficient | ▪ Thematic findings of stakeholder interviews on effectiveness and efficiency of program implementation | Consultation with:<br>▪ Anglicare COMPASS program operational | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | | | staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS – GCM<br>▪ DHHS Child Protection Champions | | |
| IM.5 Do staff have enough support and are they adequately equipped to deliver the program? | ▪ Extent to which COMPASS operational staff consider support adequate and feel equipped in their roles in terms of training, daily management of caseload volume and intensity of work, retention and management support | ▪ Staff perception of training and program documentation adequacy<br>▪ Staff perception of support provided in daily management<br>▪ Staff perception of adequacy to deliver | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which ratio of caseworkers to young people is consistent with intended targets<br>▪ Extent to which staff training documentation canvasses roles and program delivery | ▪ Review of Operations Manual (amendments)/Training documentation<br>▪ Ratio of caseworkers to YP | ▪ Operations Manual (incl amendments)/Training documentation<br>▪ COMPASS staffing numbers | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| IM.6 How has the strategic and operational environment impacted on the program implementation? | ▪ Extent to which stakeholders observe operational and environmental impacts on program implementation | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DHHS - GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** |
| IM.7 What were the barriers and enablers for program implementation? | ▪ Extent to which stakeholders identify enablers and barriers to program implementation<br>▪ | ▪ Thematic findings of stakeholder interviews on enablers and barriers to program implementation | Consultation with:<br>▪ DHHS - GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Clients | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which enablers and barriers are identified and addressed in program implementation | ▪ Thematic analysis of JWG minutes | ▪ JWG meeting minutes | DHHS<br>COMPASS | **Once-off** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| IM.8 What are the key lessons and improvements for program implementation and how can they be applied to other initiatives? | ▪ Extent to which stakeholders identify lessons and improvements for program implementation and application beyond COMPASS | ▪ Thematic analysis of lessons from program implementation and wider application | Consultation with:<br>▪ DHHS – GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Clients | Urbis | **Once-off; by stakeholder consultation** |
| **OUTCOMES** | | | | | |
| O.1 What outcomes have been achieved to date for clients (Program Logic impacts) and service providers and the community? | ▪ Extent to which outcomes have been achieved for clients, service providers and the community<br>▪ Proportion of YP experiencing intended outcomes | ▪ YP have improved health and well being<br>▪ YP have increased engagement with education and employment<br>▪ YP have increased life skills decision making, financial management, household management) | ▪ Young people<br>▪ Key Workers<br>▪ COMPASS ECMS<br>▪ Case studies (Detail required)<br>▪ Annual Report (2018-2019)<br>▪ | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | | ▪ YP have improved self-care and reduced risk-taking behaviour<br>▪ YP have better knowledge of and engagement with social and health service<br>▪ YP have reduced homelessness<br>▪ YP have reduced engagement with the criminal justice system<br>▪ YP have reduced interaction with child protection system | | | |
| | ▪ Extent to which stakeholders identify outcomes for clients and service providers | ▪ Thematic findings of analysis from stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions<br>▪ COMPASS Clients<br>▪ Other service providers including Better Futures | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| O.2 What aspects of the COMPASS program have been most effective in generating client outcomes? For whom, how and why? | ▪ Extent to which program elements have influenced effectiveness of client outcomes | ▪ Client outcome data (by demographic, region and supports) | ▪ COMPASS ECMS<br>▪ Monthly reporting<br>▪ Outcomes data from O.1 | DHHS<br>COMPASS | **Periodic; Quarterly** |
| O.3 What other unintended outcomes have resulted from the program? | ▪ Extent of other unintended outcomes identified by stakeholders | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ Other service providers including Better Futures | Urbis | **Once-off; by stakeholder consultation** |
| O.4 How have partnerships between different stakeholders contributed to the outcomes? | ▪ Extent to which stakeholders attribute partnerships to client and service delivery outcomes | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ DHHS – GCM<br>▪ DTF<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which referral pathways have been influenced by partnerships | ▪ Number and origin of referral sources<br>▪ Thematic findings from review of stratification and referral source data | ▪ Stratification and referral source data<br>▪ COMPASS CRIS | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| **GOVERNANCE** | | | | | |
| G.1 How effective have project governance mechanisms (Government, COMPASS partners, Investors, Operational teams) been, and why? | ▪ Extent to which stakeholders view governance mechanisms to be effective | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which governance mechanisms are effectively documented | ▪ Thematic analysis of review of governance documentation | ▪ Operations Manual<br>▪ Implementation Agreement | DHHS<br>COMPASS | **Once-off** |
| G.2 Have governance arrangements facilitated timely resolution of issues? | ▪ Extent to which decision-making and timely resolution is facilitated by governance arrangements | ▪ Number, nature and timing of issues resolved via governance arrangements | ▪ JWG minutes | DHHS | **Once-off** |
| | ▪ Extent to which governance stakeholders perceive timely resolution of issues | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| G.3 Are changes to project governance mechanisms required? | ▪ Extent to which stakeholders identify changes to governance mechanisms | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 2 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| **SIB MODEL** | | | | | |
| SIB.1 To what extent is the SIB model an appropriate mechanism for generating positive outcomes at client service provider and system levels? | ▪ Extent to which stakeholders consider the SIB model appropriate for generating positive client provide and system outcomes | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| SIB.2 How can the COMPASS SIB model be improved? | ▪ Extent to which stakeholders identify improvements to the SIB model | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| SIB.3 What lessons can be applied to other SIB models? | ▪ Extent to which stakeholders identify lessons from the COMPASS SIB model that apply to other/future SIBs | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |

## Stage 3

Stage 3 of the COMPASS evaluation considers a deeper exploration of the outcomes achieved in the program for clients and the community, the overall appropriateness and scalability of the SIB model as well as the economic impacts of the program and model more broadly

The seven objectives for Stage 3 are as follows:

1. Review the progress of the COMPASS program against intended trajectory, taking into considering any refinements or changes to the program, the COMPASS SIB model, or to the strategic or operational environment of implementation.
2. Identify the broader set of outcomes being achieved by the COMPASS program (extending beyond the payable outcomes) including analyses by region which are sensitive to the socio-economic and service sector context in each region.
3. Explore the mechanisms through which the outcomes created by the COMPASS program are generated, including analysis of what works for whom, why, and how effectively (and identify any learnings or opportunities for program improvement).
4. Identify any learnings or opportunities for improvement to the COMPASS program.
5. Assess the overall appropriateness and effectiveness of the COMPASS SIB as a mechanism for generating beneficial social outcomes for young people transitioning from out-of-home care, including consideration of both intended and unintended outcomes at client, service provider and system levels.
6. Analyse the economic impacts of the COMPASS SIB in terms of the potential for downstream avoided government service usage (not limited to the payable outcomes), including consideration of value for money and broader economic benefits where applicable.
7. Identify enablers and barriers to the efficient design and implementation of the COMPASS SIB model and capture key lessons for the design of future social impact bonds in Victoria.

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| **IMPLEMENTATION KEQs** | | | | | |
| IM.1 To what extent has the COMPASS program been implemented as planned (program activities and outputs delivered)? | ▪ Extent of alignment between planned and actual program activities and outputs | ▪ Numbers of referrals by region and risk level<br>▪ Number of YP with a Key Worker<br>▪ Number of YP with housing sourced and secured<br>▪ Number of YP who are living with their Kinship or Foster Carers | ▪ COMPASS CRIS<br>▪ COMPASS ECMS<br>▪ Program documentation (Monthly reporting, annual reporting) | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | | ▪ Number of YP that are being supported in alternative accommodation (e.g. private rental, student accommodation)<br>▪ Number of individual plans for YP<br>▪ Number / type of specialist assistance<br>▪ Number of exit/transition plans out of the program | | | |
| | ▪ | ▪ Thematic analysis from monthly reporting and implementation meetings | ▪ JWG meeting minutes<br>▪ Implementation meeting minutes | DHHS | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders observe consistency/inconsistency between planned and actual activities and outputs | ▪ Thematic findings from analysis of stakeholder views on program implementation | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off, by stakeholder consultation** |
| IM.2 How iterative and responsive has COMPASS been in adapting the | ▪ Extent to which the COMPASS program has been adapted/modified and rationale | ▪ Thematic analysis of number and nature of program modifications | ▪ Implementation meeting minutes<br>▪ Monthly reporting<br>▪ Government Contract Manager records | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| program? What modifications have been made? | ▪ Extent to which stakeholders consider COMPASS iterative/responsive | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DHHS - GCM<br>▪ DTF<br>▪ COMPASS Executive Manager | Urbis | **Once-off, by stakeholder consultation** |
| IM.3 What has been the reach of program, and what factors influenced client engagement 'conversion'? | ▪ Extent of program reach | ▪ Numbers of referrals by region and risk level<br>▪ Numbers of program clients (by region, demographic, risk level, eligibility)<br>▪ Reasons for not proceeding | ▪ Stratification and referral source data (CVDL and GCM)<br>▪ Did not proceed data<br>▪ COMPASS CRIS<br>▪ COMPASS ECMS (incl demographics)<br>▪ Monthly reporting | DHHS<br>COMPASS | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders identify factors that have influenced client engagement | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Clients<br>▪ DHHS - GCM<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |
| IM.4 How effectively and efficiently has the program been implemented? | ▪ Extent to which intake and referral processes meet intended targets for numbers and client risk profiles | ▪ Clarity and efficiency of intake and referral processes (per referral path) | ▪ COMPASS CRIS<br>▪ COMPASS ECMS<br>▪ Government Contract Manager records | DHHS<br>COMPASS | **Periodic; Quarterly** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | ▪ Extent to which referral timelines are reasonable | ▪ Proportion of YP across the client risk targets<br>▪ Number of days associated with the intake and referral processes (per referral pathway) | | | |
| | ▪ Extent to which stakeholders perceive stratification tool useful | ▪ Thematic findings from analysis of stakeholder interviews on implementation process and adequacy of stratification tool | Consultation with:<br>▪ DHHS - GCM<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions/staff | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent of housing available to clients against intended targets<br>▪ Effectiveness of activities to secure housing | ▪ Number of houses rented and number of houses purchased for clients housing needs<br>▪ Thematic findings from analysis of stakeholder interviews | ▪ Vincent Care housing management data<br>▪ Vincent Care housing staff | COMPASS<br>Vincent Care | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders consider program implementation effective and efficient | ▪ Thematic findings of stakeholder interviews on effectiveness and efficiency of program implementation | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS – GCM | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | | | ▪ DHHS Child Protection Champions | | |
| IM.5 Do staff have enough support and are they adequately equipped to deliver the program? | ▪ Extent to which COMPASS operational staff consider support adequate and feel equipped in their roles in terms of training, daily management of caseload volume and intensity of work, retention and management support | ▪ Staff perception of training and program documentation adequacy<br>▪ Staff perception of support provided in daily management<br>▪ Staff perception of adequacy to deliver | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which ratio of caseworkers to young people is consistent with intended targets<br>▪ Extent to which staff training documentation canvasses roles and program delivery | ▪ Review of Operations Manual (amendments)/Training documentation<br>▪ Ratio of caseworkers to YP<br>▪ | ▪ Operations Manual (incl amendments)/Training documentation<br>▪ COMPASS staffing numbers | DHHS<br>COMPASS | **Periodic; Quarterly** |
| IM.6 How has the strategic and operational environment impacted on the program implementation? | ▪ Extent to which stakeholders observe operational and environmental impacts on program implementation | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DHHS – GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| IM.7 What were the barriers and enablers for program implementation? | ▪ Extent to which stakeholders identify enablers and barriers to program implementation<br>▪ | ▪ Thematic findings of stakeholder interviews on enablers and barriers to program implementation | Consultation with:<br>▪ DHHS – GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Clients | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which enablers and barriers are identified and addressed in program implementation | ▪ Thematic analysis of JWG meeting minutes | ▪ JWG meeting minutes | DHHS | **Periodic; Quarterly** |
| IM.8 What are the key lessons and improvements for program implementation and how can they be applied to other initiatives? | ▪ Extent to which stakeholders identify lessons and improvements for program implementation | ▪ Thematic analysis of interview findings on lessons from program implementation and wider application | Consultation with:<br>▪ DHHS – GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Clients | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| IM.9 Can and should the same model be scaled up to be state-wide? | ▪ Extent to which stakeholders view SIB model as scalable across Victoria | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DHHS – GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** |
| IM.10 What are the benefits and risks in scaling up the model state-wide? | ▪ Extent to which stakeholders identify benefits and risks of scaling up the SIB model across Victoria | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DHHS – GCM<br>▪ DTF<br>▪ COMPASS Executive Manager<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| **OUTCOMES** | | | | | |
| O.1 What outcomes have been achieved in each region for clients (Program Logic impacts), service providers and the community? | ▪ Extent to which outcomes have been achieved for clients and service providers and the community | ▪ YP have improved health and well being<br>▪ YP have increased engagement with education and employment<br>▪ YP have increased life skills decision making, financial management, household management)<br>▪ YP have improved self-care and reduced risk-taking behaviour<br>▪ YP have better knowledge of and engagement with social and health service<br>▪ YP have reduced homelessness<br>▪ YP have reduced engagement with the criminal justice system<br>▪ YP have reduced interaction with child protection system | ▪ Young people<br>▪ Key workers<br>▪ COMPASS ECMS<br>▪ Case studies (Detail required)<br>▪ Annual Report (2018-2019)<br>▪ | DHHS<br>COMPASS | **Periodic; Quarterly** |
| | ▪ Extent to which stakeholders identify outcomes for clients and service providers | ▪ Thematic findings of analysis from stakeholder interviews | Consultation with:<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
| --- | --- | --- | --- | --- | --- |
| | | | ▪ DHHS Child Protection Champions<br>▪ COMPASS Clients<br>▪ Other service providers including Better Futures | | |
| O.2 How enduring are client outcomes after exiting the program? | ▪ Extent to which stakeholders consider client outcomes enduring | ▪ Thematic findings of analysis from stakeholder interviews | Consultation with:<br>▪ Young people<br>▪ Key workers<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ COMPASS Executive Manager<br>▪ DHHS Child Protection Champions<br>▪ COMPASS Clients<br>▪ Other service providers including Better Futures | Urbis | **Once-off; by stakeholder consultation** |
| O.3 What unintended outcomes have resulted from the program? | ▪ Extent of other unintended outcomes identified by stakeholders<br>▪ | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Young people<br>▪ Key workers<br>▪ Anglicare COMPASS program operational staff (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| | | | ▪ Other service providers including Better Futures | | |
| O.4 How have partnerships between different stakeholders contributed to the outcomes? | ▪ Extent to which stakeholders attribute partnerships to client and service delivery outcomes | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ COMPASS Executive Manager<br>▪ DHHS – GCM<br>▪ DTF<br>▪ DHHS Child Protection Champions | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which referral pathways have been influenced by partnerships | ▪ Number and origin of referral sources<br>▪ Thematic findings from review of stratification and referral source data | ▪ Stratification and referral source data<br>▪ COMPASS CRIS | DHHS<br>COMPASS | **Periodic; Quarterly** |
| O.5 What are the key aspects of the program responsible for creating client outcomes? | ▪ Extent to which program elements have influenced effectiveness of client outcomes | ▪ Client outcome data (by demographic, region and supports) | ▪ COMPASS CRIS<br>▪ Monthly reporting | COM DHHS<br>COMPASS<br>PASS | **Periodic; Quarterly** |
| O.6 Are clients satisfied with the program and what is their experience of it? | ▪ Extent of client satisfaction with the COMPASS program | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>COMPASS clients | Urbis | **Once-off; by stakeholder consultation** |
| O.7 What would have happened to clients in the absence of the | ▪ Extent to which stakeholders attribute positive/negative outcomes to the COMPASS program | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ COMPASS clients<br>▪ Anglicare COMPASS program operational staff | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| COMPASS participants? | | | (Team Leaders and frontline staff)<br>▪ Vincent Care Compass operational staff<br>▪ DHHS Child Protection Champions<br>▪ Control group data of extent achievement of PL outcomes | | |
| O.8 How can COMPASS be improved based on client feedback? | ▪ Extent of improvements identified by clients | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ COMPASS clients | Urbis | **Once-off; by stakeholder consultation** |
| O.9 What are community sector perceptions of the program? | ▪ Extent of positive/negative community sentiment about the program | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ Other service providers including Better Futures | Urbis | **Once-off; by stakeholder consultation** |
| **GOVERNANCE** | | | | | |
| G.1 How effective have project governance mechanisms (Government, COMPASS partners, Investors, Operational teams) been, and why? | ▪ Extent to which stakeholders view governance mechanisms to be effective | ▪ Thematic findings from analysis of stakeholder interviews | Consultation with:<br>▪ DTF<br>▪ DHHS - GCM<br>▪ Investors<br>▪ COMPASS Executive | Urbis | **Once-off; by stakeholder consultation** |
| | ▪ Extent to which governance mechanisms are effectively documented | ▪ Thematic analysis of review of governance documentation | ▪ Operations Manual<br>▪ Implementation Agreement | DHHS<br>COMPASS | **Once-off** |
| G.2 Have governance arrangements | ▪ Extent to which decision-making and timely resolution is facilitated by | ▪ Number, nature and timing of issues resolved via governance arrangements | ▪ JWG minutes | DHHS<br>COMPASS | **Once-off** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| facilitated timely resolution of issues? | governance arrangements | | | | |
| | ▪ Extent to which governance stakeholders perceive timely resolution of issues | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ Investors<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| G.3 Are changes to project governance required? | ▪ Extent to which stakeholders identify changes to governance mechanisms | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ Investors<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| **SIB MODEL** | | | | | |
| SIB.1 To what extent is the SIB model an appropriate mechanism for generating positive outcomes at client service provider and system levels? | ▪ Extent to which stakeholders consider the SIB model appropriate for generating positive client, service provider and system outcomes | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS – GCM<br>▪ Investors<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| SIB.2 How can the COMPASS SIB model be improved? | ▪ Extent to which stakeholders identify improvements to the SIB model | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS - GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |

| STAGE 3 – DOMAIN | Indicator | Measure | Source | Who collects it | Collection frequency and method |
|---|---|---|---|---|---|
| SIB.3 What lessons can be applied to other SIB models? | ▪ Extent to which stakeholders identify lessons from the COMPASS SIB model that apply to other/future SIBs | ▪ Thematic analysis of interview findings | Consultation with:<br>▪ DTF<br>▪ DHHS - GCM<br>▪ COMPASS Executive Manager | Urbis | **Once-off; by stakeholder consultation** |
| SIB.4 What are the economic impacts of the COMPASS SIB in terms of potential downstream avoided government service usage (not limited to the payable outcomes), including consideration of value for money and broader economic benefits? | ▪ Level of benefit from COMPASS SIB required for break-even with total government costs/payments in a cost-benefit analysis | ▪ Identification of the program economic benefits from downstream avoided government service usage and broader economic benefit<br>▪ Break-even analysis of the COMPASS program | ▪ COMPASS ECMS<br>▪ Urbis data collection<br>▪ DTF government expenditure data (for per unit cost savings)<br>▪ Other economic value literature | Urbis | **Once-off;** |
| SIB.5 What is the total cost of the SIB transaction, including administration? | ▪ Total costs to administer the COMPASS SIB | ▪ Annual administration costs<br>▪ Cost to develop the SIB- including negotiation / contract execution | ▪ COMPASS Financial and contractual documents/data<br>▪ DTF<br>▪ DHHS | DTF<br>DHHS | **Once-off** |

# Appendix C Summary of COMPASS program data (July 2024)

The below table outlines the COMPASS program data provided to Urbis. The data is dated up until July 2024. Urbis analysed the data by cohorts (Cohort 1,2 and 3) to match the cohorts used in the data linkage analysis and as a whole (all COMPASS participants).

| | Cohort 1 (2019 start date) | Cohort 2 (2020 start date) | Cohort 3 (2021 start date) | All COMPASS participants |
|---|---|---|---|---|
| ***Number*** | 25% (n=46) | 42% (n=77) | 33% (n=61) | n=184 |
| ***Sex*** | | | | |
| *Male* | 41% | 43% | 48% | 44% |
| *Female and Other* | 59% | 57% | 52% | 56% |
| ***Birth year*** | | | | |
| *2000* | 20% | 0% | 0% | 5% |
| *2001 and 2002* | 80% | 100% | 5% | 64% |
| *2003 and 2004* | 0% | 0% | 95% | 31% |
| ***Indigenous*** | | | | |
| *Indigenous* | 22% | 25% | 23% | 23% |
| *Not Indigenous* | 78% | 75% | 77% | 77% |
| ***CALD*** | | | | |
| *CALD* | 22% | 13% | 15% | 16% |
| *Not CALD, Unknown or no response* | 78% | 87% | 82% | 85% |
| ***Stratification*** | | | | |
| *High* | 33% | 31% | 13% | 26% |
| *Medium* | 57% | 55% | 59% | 57% |
| *Low* | 11% | 14% | 28% | 18% |
| ***Referral type*** | | | | |
| *In-care* | 50% | 77% | 89% | 74% |
| *Post-care* | 50% | 23% | 11% | 26% |
| ***Referral date*** | | | | |
| *2018* | 22% | 0% | 0% | 5% |
| *2019* | 78% | 34% | 0% | 34% |
| *2020* | 0% | 66% | 72% | 52% |
| *2021* | 0% | 0% | 28% | 9% |
| ***Participation start date*** | | | | |
| *2018/2019* | 100% | 0% | 0% | 25% |
| *2020* | 0% | 100% | 0% | 42% |
| *2021* | 0% | 0% | 100% | 33% |
| ***Housing arrangement at point of referral*** | | | | |
| *Apartment/hotel, couch surfing or homeless* | 14% | 6% | 0% | 6% |
| *Home based care or foster care* | 20% | 17% | 13% | 17% |
| *Kinship care* | 24% | 29% | 44% | 33% |
| *Lead tenant* | 24% | 23% | 13% | 20% |

| | Cohort 1 (2019 start date) | Cohort 2 (2020 start date) | Cohort 3 (2021 start date) | All COMPASS participants |
|---|---|---|---|---|
| *Residential care* | 15% | 21% | 15% | 17% |
| *Supported accommodation, Transition Care Program, public housing, other* | 4% | 5% | 8% | 7% |
| *Unsure or no response* | 0% | 0% | 5% | 2% |
| ***Did they utilise COMPASS housing?*** | | | | |
| *Utilised COMPASS housing* | 74% | 56% | 54% | 60% |
| *Didn't utilise COMPASS housing* | 26% | 44% | 46% | 40% |
| ***Housing arrangement at COMPASS closure*** | | | | |
| *Couch surfing, homeless, transient, supported accommodation, transitional housing management, remand* | 6% | 14% | 18% | 14% |
| *Social housing incl. Aboriginal housing, public housing, Office of Housing, COMPASS housing* | 7% | 6% | 12% | 7% |
| *Home based care or foster care* | 9% | 6% | 5% | 7% |
| *Kinship care or biological parent/s* | 17% | 28% | 34% | 30% |
| *Private rental* | 46% | 32% | 18% | 31% |
| *Other incl. university accommodation, carer of sibling/s* | 15% | 14% | 13% | 12% |
| ***Were they employed during time with COMPASS?*** | | | | |
| *Employed* | 61% | 45% | 62% | 55% |
| *Not employed, unknown or no response* | 39% | 55% | 38% | 45% |
| ***Estimated length of employment over 24 month participation*** | | | | |
| *1 to 10 months* | 37% | 19% | 21% | 24% |
| *11 to 15 months* | 13% | 10% | 13% | 12% |
| *16 to 25 months* | 9% | 16% | 21% | 16% |
| *None or N/A* | 33% | 47% | 31% | 38% |
| *Unknown or no response* | 9% | 8% | 13% | 10% |
| ***Were they engaged in education during time with COMPASS?*** | | | | |
| *Engaged in education* | 80% | 73% | 80% | 77% |
| *Not engaged in education, unknown or no response* | 19% | 27% | 20% | 23% |
| ***Highest education*** | | | | |
| *Flexible learning* | 17% | 19% | 11% | 16% |
| *Secondary school* | 11% | 13% | 16% | 14% |
| *Tafe* | 33% | 23% | 21% | 25% |
| *University* | 7% | 5% | 11% | 8% |
| *Other (including apprenticeship, HoMie Pathway Alliance, Indie School, RSA course, traffic control course)* | 10% | 14% | 19% | 15% |
| *None* | 22% | 25% | 21% | 23% |

| | Cohort 1 (2019 start date) | Cohort 2 (2020 start date) | Cohort 3 (2021 start date) | All COMPASS participants |
|---|---|---|---|---|
| ***Was education completed?*** | | | | |
| *Yes, all education qualification/s completed that were commenced* | 17% | 30% | 28% | 26% |
| *No, none completed that were commenced* | 17% | 16% | 18% | 17% |
| *Still enrolled in all that were commenced* | 24% | 16% | 20% | 19% |
| *One was completed, and still enrolled in or not completed another* | 20% | 8% | 7% | 10% |
| *N/A* | 22% | 31% | 28% | 28% |
| ***Did they have children during time with COMPASS? (n=17)*** | | | | |
| *Yes as at July 2024* | 83% | 79% | 85% | 82% |
| *No or missing data* | 18% | 21% | 15% | 18% |
| ***If yes, did children remain in their care? (n=17)*** | | | | |
| *Yes, remained in their care* | 100% | 88% | 67% | 82% |
| *No, didn't remain in their care* | 0% | 13% | 33% | 18% |
| ***Did the young person have a care team/ professional support network?*** | | | | |
| *Yes* | 76% | 77% | 90% | 81% |
| *No or no response* | 24% | 24% | 10% | 19% |
| ***Did the young person have a positive relationships with family?*** | | | | |
| *Yes* | 74% | 77% | 85% | 79% |
| *No or no response* | 27% | 23% | 15% | 21% |

# Appendix D Urbis control group characteristics

## Selected control groups

The characteristics of the selected control groups are summarised in the table following. The ten highlighted rows were the variables that directly informed control group matching. Matching was undertaken at cohort (not individual) level and the process used involved random generation of 1000 potential combinations before the 'best fit' was selected based on least overall difference and lowest variance among differences from the COMPASS group. None of the differences between COMPASS group and its selected control group was significant at $p<0.05$ for the ten selection variables.

| COHORT 1 | COMPASS Participants | Urbis selected control |
|---|---|---|
| Number of young people[1] | 44 | 55 |
| Average birth year[1] | 2001 | 2001 |
| Period in COMPASS[1] | 2018-2020 | N/A |
| Days in receipt of clinical mental healthcare Jan 2016 - Dec 2019 | 133.12 | 110.08 |
| ED presentations Jan 2016 - Dec 2019 | 7.70 | 6.24 |
| Homelessness service days Jan 2016 – Dec 2019 | 107.05 | 130.48 |
| Admitted days in hospital Jan 2016 – Dec 2019 | 6.35 | 5.64 |
| Total police offender incidents Jan 2016 – Dec 2019 | 11.96 | 8.31 |
| Total police victim incidents Jan 2016 – Dec 2019 | 2.44 | 2.14 |
| Female[2] | 61% | 47% |
| Indigenous[2] | 27% | 24% |
| Born in Australia[2] | 84% | 82% |
| Average number of child protection placements[2] | 6.75 | 3.01 |
| Last placement type: | | |
| Residential care[3] | 18% | 12% |
| Kinship care[3] | 36% | 49% |
| Home based care[3] | 45% | 36% |
| **COHORT 2** | **COMPASS Participants** | **Urbis selected control** |
| Number of young people[1] | 77 | 87 |
| Average birth year[1] | 2002 | 2002 |
| Period in COMPASS[1] | 2019-2021 | N/A |
| Days in receipt of clinical mental healthcare Jan 2017 - Dec 2020 | 133.12 | 110.08 |
| ED presentations Jan 2017 - Dec 2020 | 7.70 | 6.24 |
| Homelessness service days Jan 2017 - Dec 2020 | 107.05 | 130.48 |
| Admitted days in hospital Jan 2017 - Dec 2020 | 6.35 | 5.64 |
| Total police offender incidents Jan 2017 - Dec 2020 | 11.96 | 8.31 |
| Total police victim incidents Jan 2017 - Dec 2020 | 2.44 | 2.14 |
| Female[2] | 60% | 55% |

| | | |
|---|---|---|
| Indigenous[2] | 23% | 23% |
| Born in Australia[2] | 95% | 92% |
| Average number of child protection placements[2] | 5.55 | 6.89 |
| Last placement type: | | |
| Residential care[3] | 25% | 32% |
| Kinship care[3] | 44% | 40% |
| Home based care[3] | 31% | 28% |
| **COHORT 3** | **COMPASS Participants** | **Urbis selected control** |
| Number of young people[1] | 60 | 70 |
| Average birth year[1] | 2003 | 2003 |
| Period in COMPASS[1] | 2020-2022 | N/A |
| Days in receipt of clinical mental healthcare Jan 2018 - Dec 2021 | 81.23 | 74.13 |
| ED presentations Jan 2018 - Dec 2021 | 3.60 | 2.58 |
| Homelessness service days Jan 2018 - Dec 2021 | 55.25 | 41.91 |
| Admitted days in hospital Jan 2018 - Dec 2021 | 2.77 | 3.23 |
| Total police offender incidents Jan 2018 - Dec 2021 | 4.05 | 2.47 |
| Total police victim incidents Jan 2018 - Dec 2021 | 1.53 | 0.94 |
| Female[2] | 50% | 51% |
| Indigenous[2] | 20% | 21% |
| Born in Australia[2] | 85% | 95% |
| Average number of child protection placements[2] | 5.86 | 6.17 |
| Last placement type: | | |
| Residential care[3] | 13% | 16% |
| Kinship care[3] | 52% | 50% |
| Home based care[3] | 30% | 34% |

1 Data from: COMPASS table (match_results_cohorts1to11_Jun23_update). 2 Data from: ChildProtectionPerson_11042024 table. 3 Placement taken from: ChildProtectionPlacement_11042024 table

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