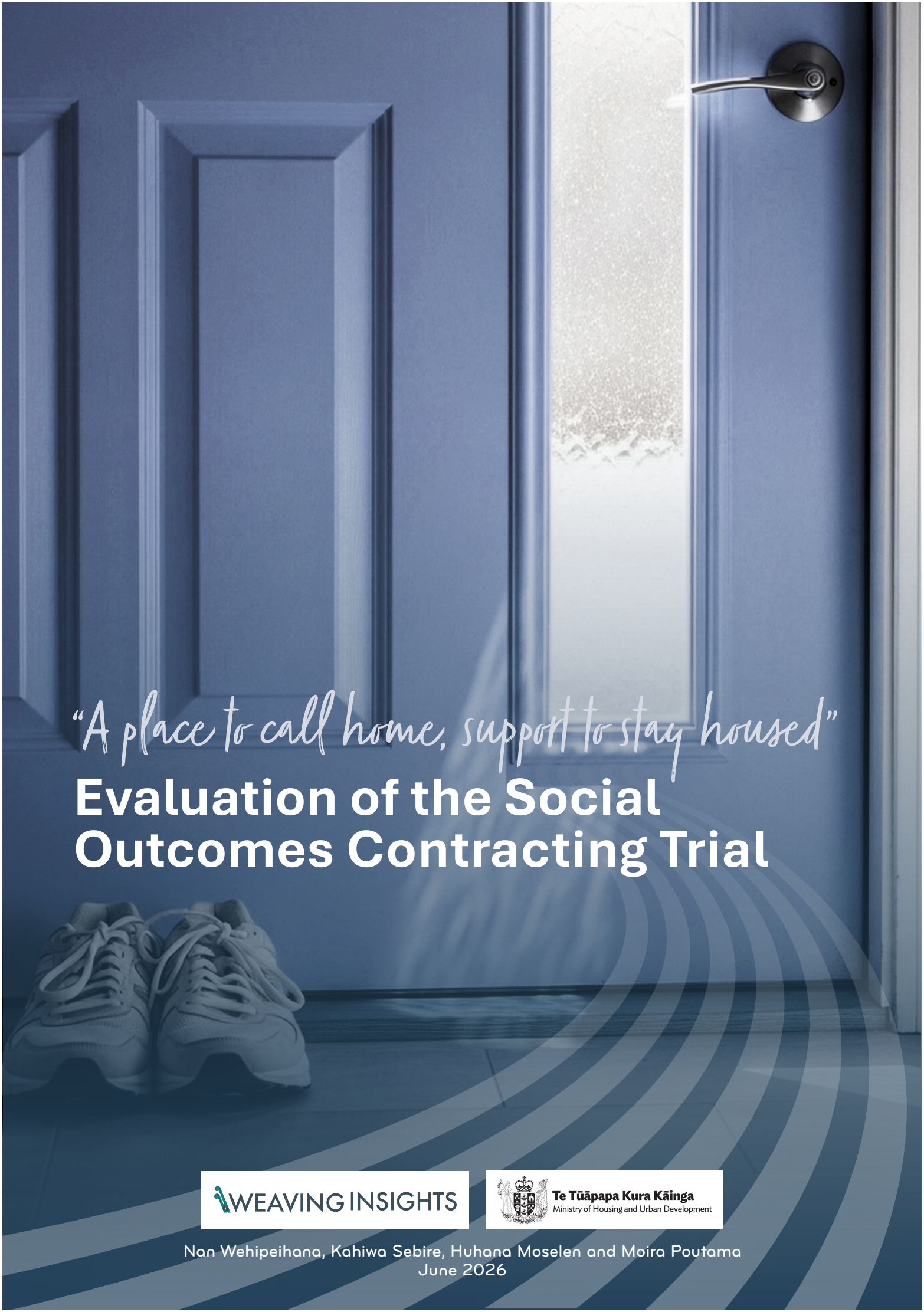


"A place to call home, support to stay housed"

Evaluation of the Social Outcomes Contracting Trial

WEAVING INSIGHTS

Te Tūāpapa Kura Kāinga
Ministry of Housing and Urban Development

Nan Wehipeihana, Kahiwa Sebire, Huhana Moselen and Moira Poutama

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Disclaimer

We developed this report in good faith using the information available to us at the time. We provide it on the basis that the authors of the report are not liable to any person or organisation for any damage or loss that may occur from acting or not acting with respect to any information or advice within this report.

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Table of contents

Executive Summary 4
1. Introduction and programme background 7
   1.1 Background and context 8
2. Outcomes 12
   2.1 Trial participants are moving from emergency housing into stable housing, with support from providers 13
   2.2 Trial participants are experiencing positive holistic wellbeing outcomes 18
   2.3 Interdependency between housing and wellbeing outcomes 21
3. SOC model contribution to outcomes 22
   3.1 Commissioning 24
   3.2 Service design 26
   3.3 Provider engagement and support of participants 28
   3.4 Implementation enablers and constraints 29
   3.5 How value is created 31
4. Participant experiences of SOC-enabled support 33
   4.1 How the model showed up in participants' lives 35
   4.2 Services and supports wrapped around participants 35
   4.3 Participant experiences of provider support 36
5. Future implications 42
   5.1 The emergency housing rationale has changed 44
   5.2 Future decisions should focus on transferable features, not the SOC label 44
   5.3 Outcomes-based payments reinforced the focus on sustainment 44
   5.4 Value for investment: promising, but not yet definitive 45
   5.5 Implications for future decisions 45
6. Conclusion 46
Appendix 1: Evaluation methodology 49
Appendix 2: Evaluative Rubric 52
Appendix 3: Data results 54
Appendix 4: The MSD Emergency Housing Support Services evaluation 56
Appendix 5: SOC Trial Intervention Logic 57
Appendix 6: Kaupapa Māori Research – a brief explanation 58
Appendix 7: References 59

List of tables

Table 1: Key elements of the SOC trial 8
Table 2: Commissioning design settings and implications for delivery 24
Table 3: Flexi-fund allocation and expenditure by provider, as at 31 March 2026 25
Table 4: Common service features 27
Table 5: Provider variation within the SOC service model 28
Table 6: How provider engagement supported housing progress 28
Table 7: Implementation enablers 29
Table 8: Structural and system constraints 30
Table 9: Implementation tensions and future design issues 30
Table 10: Service and organisation types engaged to support SOC participants 35
Table 11: Performance scale used for evaluative rubric 52
Table 12: Evaluative rubric – KEQ1 (Outcomes) 52
Table 13: Evaluative rubric – KEQ 2 (Service design and delivery) 53
Table 14: Evaluative rubric – KEQ3 (Future application) 53

List of figures

Figure 1: Housing status of total participating households, as at March 2026. 14
Figure 2: Housing type of stably housed households, as at March 2026. 14
Figure 3: Housing status of households that exited the trial, as at April 2026. 14
Figure 4: Duration in stable housing of housed participating households, as at March 2026. 15
Figure 5: Timeline of referrals to providers over trial period, as at March 2026 16
Figure 6: Time to be stably housed of participating households, as at March 2026. 16
Figure 7: Time in service for households that exited vs are housed, as at April 2026. 16
Figure 8: Reasons for households exiting program, as at March 2026. 16
Figure 9: How the SOC model and services create value. 32

Executive Summary



The Emergency Housing Social Outcomes Contracting trial (SOC trial) was designed for a small but persistent group of people who had remained in emergency housing for extended periods and were not being well served by existing housing pathways. The trial commenced in October 2024 and concludes in November 2026. It tested whether a more flexible, outcomes-focused contracting model could support people into stable, appropriate and sustained housing, and contribute to wider wellbeing outcomes.

The trial was implemented by Wellington City Mission and Emerge Aotearoa Waikato. It was deliberately small, time-limited and implemented at pace. It tested selected elements of social outcomes contracting, rather than a fully developed social investment model. Key features included core service funding, flexible funding, provider discretion over delivery, milestone payments linked to sustained housing outcomes, and active stewardship by HUD.

The model did not include additional housing supply. Instead, it tested whether flexible commissioning, relationship-based support and stronger accountability for sustained outcomes could improve housing access and sustainment within existing housing pathways, including social housing and private rentals.

The evaluation used mixed methods and assessed evidence against the KEQs and evaluative rubrics. Findings should be interpreted as early evidence of contribution within system constraints, rather than definitive evidence of impact. This reflects the trial design and context: SOC did not include a comparator or counterfactual, including a kaupapa Māori provider model, and operated within existing housing supply and MSD system settings.

Recent MSD evidence[9] provides a useful contextual benchmark for emergency housing support services, but it is not a direct comparator for SOC because it does not use matched cohorts or equivalent measures of stable, appropriate and sustained housing.

KEQ 1: What changed for participants?

The SOC model is showing strong early results for participants. Participants are moving into stable housing, most housed participants are sustaining housing, and there are promising signs of longer-term sustainment. The strongest evidence is currently at three and six months, with emerging evidence at 13 months.

Participants reported wider wellbeing gains. These included improved mental and emotional wellbeing, physical wellbeing, confidence, independence, connection, identity, whānau or family relationships, and sense of belonging.

Housing and wellbeing outcomes were closely connected. Stable housing created the conditions for safety, rest and reconnection, while wider wellbeing support helped people access and sustain housing. The evidence shows that housing was not simply an endpoint; it was a foundation for broader stability and wellbeing.

KEQ 2: What helped outcomes happen?

The SOC model achieved outcomes by combining flexible commissioning with skilled, relational, and sustained support. Providers had sufficient discretion to respond to participant needs while remaining accountable for sustained housing outcomes.

Provider capability, service design, and service delivery were assessed as strong. Providers used relationship-based practice, local housing knowledge, and established service connections, alongside practical approaches to build trust, address barriers, support access to appropriate housing, and remain connected after placement.

The model was effective because support extended beyond securing housing. Providers supported participants to prepare for housing, assess suitability, address practical and wellbeing barriers, and sustain tenancies over time.

System and enabling conditions were assessed as moderate, although commissioning settings were strong. The model enabled flexible, ongoing support; however, broader system constraints limited what could be achieved. These included a limited, affordable, and functional housing supply, changing referral conditions, and differing agency views about how SOC aligned with existing services.

The value of the SOC approach lies in the flexibility, time, and accountability it provides. This enables providers to work with the relationship between housing and wellbeing, rather than treating housing placement as a standalone transaction.

KEQ 3: What does this mean for future decisions?

The SOC trial provides useful evidence for future housing and commissioning decisions. Continuation in its original emergency housing form is not supported because the emergency housing context and target cohort have changed. However, the trial shows which model features helped providers support people with persistent housing instability and complex needs.

The most transferable features are provider discretion, relational practice, practical support, post-placement support, flexible funding, and accountability for sustained housing outcomes. These features are relevant to future housing responses for high-need cohorts and should be deliberately retained, adapted or built into existing services where they are not already consistently available.

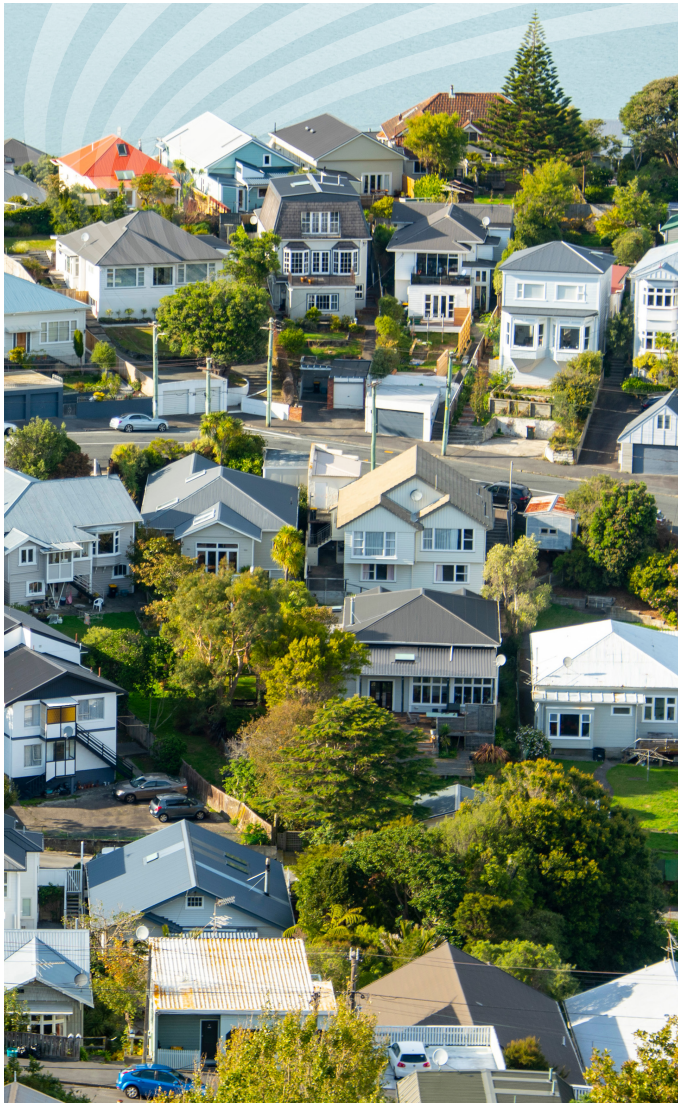
Future use of a SOC-style model would need clearer implementation discipline around agreed policy settings. This includes maintaining the model's approved intent, clarifying agency roles and decision rights, and ensuring operational practice remains aligned with the trial design as implementation conditions change.

What is the value of the SOC model?

The value of the SOC model lies in how its core elements work together. Provider discretion, sustained relational support, flexible funding, milestone payments, and active stewardship gave providers the time, flexibility, and accountability to respond to participants' needs as they changed.

The trial also shows that getting housed and staying housed require different kinds of support. Housing access depended on navigation, advocacy, practical help and matching people with appropriate housing options. Housing sustainment depended on continued support after placement, including help with tenancy responsibilities, wellbeing needs, isolation, confidence and connection.

Value for investment was assessed as moderate, with promising early indications. The trial is producing positive housing and wellbeing outcomes, and providers reported that SOC enabled support that would otherwise have been difficult to deliver. However, the evaluation cannot make a definitive value-for-investment judgement without fuller financial data, clearer comparator evidence, and outcomes data for similar cohorts receiving other services.



1. Introduction and programme background



1.1 Background and context

The Social Outcomes Contracting (SOC) trial was initiated as part of the Emergency Housing Target Delivery Plan (July 2024). It was designed to address a persistent system gap: a cohort of people, predominantly single adults and couples without children, who remained in emergency housing for extended periods, often exceeding 12 months, despite the availability of housing and support programmes.[1,2]

In simple terms, the SOC trial had two purposes. First, it aimed to support a defined group of people, move out of emergency housing, and sustain stable housing. Second, it tested whether a more flexible and outcomes-focused contracting approach could work better than more prescriptive service models for this cohort.

1.1.1 The SOC trial at a glance

	Purpose: To support long-stay emergency housing households into stable housing and test an outcomes-focused contracting approach.
	Target group: Singles and couples without children in their care, in emergency housing for an extended period, starting with those over 12 months.
	Locations: Waikato and Wellington.
	Providers: Emerge Aotearoa and Wellington City Mission.
	Housing supply: No additional housing supply was provided. Providers used existing private rental or social housing pathways.
	Contract model: Core service funding, flexible, tailored initiative funding, and outcomes payments linked to sustained housing at three, six, and 13 months. A "tight-loose-tight" approach: tight on the target cohort, locations, and outcomes sought; loose (flexible) on how providers achieved those outcomes; and tight on reporting and accountability.
	Design limitation: A fast, minimum viable test of selected SOC elements, not a fully developed social investment model.

Table 1: Key elements of the SOC trial

1.1.2 Why the SOC trial was developed

The July 2024 advice shows the trial was developed in response to Ministerial interest in testing different contracting models to support people out of emergency housing and contribute to the Government's target of reducing emergency housing households by 75 per cent by 2030. The trial was therefore both a targeted service response for a cohort likely to remain in emergency housing and an early test of outcomes-focused contracting within the housing context.[2]

While overall emergency housing numbers had begun to decline, policy documents indicate that Ministers were concerned about a residual group who were effectively "stuck" in the system. This signalled that existing, largely prescriptive service models were insufficient to support this cohort in achieving stable housing outcomes.[2]

1.1.3 What the trial was designed to test

In July 2024, Ministers were presented with two options: a faster trial with contracts in place by October 2024, or a more fully developed social outcomes contracting model that would require an estimated six to nine months. Ministers agreed to proceed at pace, recognising that the October option would test elements of social outcomes contracting rather than deliver a fully developed model.[2,3]

The July advice described the proposed trial as a minimum viable product: a small, time-limited trial intended to test outcome payments, provider flexibility, and housing sustainment outcomes within existing system constraints.[2]

The advice was also explicit about the trade-offs associated with proceeding quickly. The compressed timeframe meant the trial would not support multiple Government targets, would not provide comprehensive impact analysis at the outset, and would not allow sufficient time to develop the model fully in partnership with community providers.[2] These trade-offs are an important context for interpreting the trial: it was designed to generate early learning about selected elements of social outcomes contracting, rather than to test a fully developed social investment or outcomes contracting model.

1.1.4 Who the trial was for

The trial targeted households without children in their care, reflecting evidence that this group was over-represented among people with the longest stays in emergency housing and was less well served by existing prioritisation settings.[1,2]

The original design specifications for eligible participants were those who:

	Were located in Waikato (Hamilton City) or Wellington (Wellington, Porirua, and Lower Hutt)
	Had experienced the longest durations in emergency housing, with initial referrals prioritised for those exceeding 12 months[1,3]
	Were not already receiving support through Housing Navigation, Housing First, Rapid Rehousing, or Transitional Housing programmes.[3]

Geographic targeting was informed by MSD data, which identified high numbers of long-stay emergency housing households in Wellington, Porirua, Lower Hutt, and Hamilton. This supported a targeted trial approach focused on areas with the greatest identified need.[3]

Using the length of time in emergency housing as the main eligibility criterion provided a simple and transparent way to identify people whose needs had not been met by existing services. It also reduced discretion in referrals and lowered the risk of prioritising people seen as easier to house.[3]

1.1.5 Housing pathways and supply assumptions

A critical design parameter was that the SOC trial did not include additional housing supply. Instead, participants were expected to access housing through existing system pathways, supported by providers operating within current policy and funding settings.[3]

No limits were placed on housing pathways available to participants, as long as the housing was sustainable. Options considered sustainable included private rental housing, supported by the Accommodation Supplement where eligible, and social housing, accessed through the Social Housing Register, typically receiving an Income-Related Rent Subsidy.[3,4]

This design reflected practical constraints, including limited housing supply. It also intentionally tested whether greater service flexibility and stronger accountability for outcomes could improve results within current housing and service settings.[6] The model, therefore, tested how providers could support access to, and sustainment of, housing within the existing housing system, rather than through new housing stock.

1.1.6 How the SOC model worked

The SOC trial was designed around a non-prescriptive contracting approach. It emphasised provider flexibility and accountability for outcomes rather than outputs.[3] Contract design and delivery expectations were intentionally high-level, allowing providers to tailor support to participant needs within an outcomes-focused framework.[3,4]

The July advice framed the proposed approach as "tight-loose-tight": tight on the target cohort, locations, and outcomes sought; loose on how providers achieved those outcomes; and tight on reporting and accountability.[2] This framing helps explain why the contract was deliberately non-prescriptive while still retaining milestone payments and reporting requirements.

The finalised Intervention Logic articulated a theory of change centred on relationship-based engagement, participant-led planning, and sustained post-placement support.[5] Housing sustainment at three, six, and 13 months was identified as a lead indicator of longer-term outcomes, rather than an endpoint in itself.[6]

1.1.7 How providers were selected

The SOC trial was procured through a rapid, targeted process driven by the need to design, procure, and contract with providers within an eight-week timeframe. Design, procurement, and implementation activities were undertaken in parallel, supported by a cross-functional team spanning policy, procurement, contracting, and operational functions.

Given the timeframe, procurement did not involve a broad market process. The July advice anticipated that HUD would need to opt out of open procurement and select providers in Wellington and/or Waikato based on capability, capacity, and willingness to take part.[2] It also noted that HUD had trusted providers in both regions and a good understanding of provider capability.[2]

Provider selection was capability-led, prioritising organisations with:

- Established experience in housing and wraparound support
- Existing infrastructure and workforce capability
- Strong connections across housing, health, and social services.

This approach helped reduce the risk that early implementation challenges would primarily reflect provider readiness, rather than the contracting model itself.

The July advice also noted that, given the likely Māori profile of the target cohort, HUD would consider whether existing relationships with iwi and Māori providers could be leveraged.[2] While there was early engagement with a kaupapa Māori provider and Māori perspectives informed aspects of the design process, the final contracted provider group did not include a kaupapa Māori provider. Policy documents suggest this outcome reflected the compressed timeframe, delivery-readiness requirements, and narrow procurement approach, rather than an explicit design intention.

Overall, the procurement approach prioritised speed, certainty, and model testing, with trade-offs in the breadth of provider participation.

1.1.8 Early implementation and adaptation

Implementation commenced in late 2024, with MSD responsible for identifying eligible households and referring participants into the trial, starting with those longest in emergency housing.[4] Progress reporting indicates that early implementation occurred against a backdrop of rapidly declining emergency housing numbers, which reduced the eligible pool and required operational adjustments.[6]

Eligibility settings were refined in early 2025 to respond to these conditions, while remaining within the scope of the original Ministerial decisions.[6]

The operational referral criteria were adjusted as follows:

- The Wellington area was widened to include Kāpiti and Upper Hutt
- The emergency housing stay threshold was reduced from six to three months
- Households who have had multiple stays in emergency housing were considered for referral into SOC, if their needs aligned with providers' services
- HUD worked with MSD to determine whether some households could move from the MSD Navigator Service into SOC.

1.1.9 Contract and funding model

The SOC trial was designed as a hybrid contracting model, rather than a pure payment-by-results approach.[3] This structure was intended to balance accountability for outcomes with provider viability, while recognising that providers were operating within wider housing and system constraints that sat largely outside their control.

Key features of the contract included:

- A core service fee forming the majority of funding, ensuring providers could deliver support regardless of the timing or sequence of outcomes achieved
- Outcomes-based payments, representing approximately 20 per cent of total contract value[3]
- Milestone payments linked to sustained housing at three, six, and 13 months[3]
- A 13-month milestone set deliberately beyond a standard 12-month tenancy to reduce the risk of short-term placements followed by tenancy churn.[3]

A flexible 'tailored initiative' component (later referred to as the 'Flexi Fund') was included to enable providers to respond to complex or non-standard barriers, particularly in situations where traditional approaches had not been effective.[4] Consistent with policy intent, providers were given discretion over how support was sequenced and delivered, provided it was directed toward achieving sustained outcomes over time.[4]



1.2 Evaluation

The evaluation used a mixed-method, utilisation-focused approach to assess the implementation and early outcomes of the SOC trial.

It examined the trial through two connected lenses:



To evaluate the housing, housing sustainability and wider wellbeing outcomes for participants.



To test selected elements of the outcomes-focused commissioning and contracting approach.

1.2.1 Key evaluation questions

The evaluation was guided by three overarching key evaluation questions (KEQs):

- **KEQ1:** To what extent does the SOC trial support meaningful and sustained outcomes?
- **KEQ2:** How and why are outcomes being achieved?
- **KEQ3:** What does this mean for future decisions?

1.2.2 Methods

The main methods included:



Interviews with trial participants, providers, MSD and HUD staff



Review of policy, contracting, implementation and operational documents



Analysis of provider reporting, including quarterly hui material and progress updates



Review of available monitoring and administrative data relating to referrals, housing placements and housing sustainment.

1.2.3 Interviews with SOC trial participants, providers and HUD and MSD staff.

The evaluators interviewed 10 SOC participants.

Participants in the Wellington City Mission (WCM) trial (n = 6)

Ethnicity: Māori (3), NZ European (2), Pacific (1)
Gender: Male (4), Female (2)
Housing: 5 housed, 1 in emergency housing

Participants in the Emerge (Waikato) trial (n = 4)

Ethnicity: Māori (1), NZ European (3)
Gender: Male (4)
Housing: 4 housed

A total of 11 provider interviews were completed, involving a mix of managers, key workers, and directors: six with Wellington City Mission (WCM) and five with Emerge Waikato. We conducted 12 interviews with policy and operational personnel from HUD (n=6) and MSD (n=6).

1.2.4 Making evaluative judgements

Interview data were analysed against the KEQs. Evaluative rubrics were used to support transparent and consistent evaluative judgment across the evidence. The performance scale within the rubric provides a consistent way to summarise the strength of the evidence, level of progress, and confidence in each judgement. It also recognises the trial context, where evidence of emerging progress and future potential is relevant alongside evidence of realised outcomes.

1.2.5 Limitations

The evaluation provides early evidence of implementation, outcomes and potential. Its findings should be read as evidence of contribution within system constraints, rather than definitive evidence of impact. This reflects the trial design and operating context. The trial did not include a comparator or counterfactual, and was not designed to test SOC against other models, including a kaupapa Māori provider model. It also operated within existing housing supply constraints and MSD system settings. As a result, the evaluation can show what SOC contributed, but it cannot isolate what would have happened without SOC or under a different model. Findings should be considered in light of the following:

- The SOC trial was ongoing at the time of evaluation, so findings do not fully reflect long-term outcomes or housing sustainment.
- Participant interviews were limited in number (n=10) and may not reflect the full range of participant experiences.
- Monitoring and administrative data varied in completeness and did not consistently capture the full participant journey, support intensity, or wider wellbeing outcomes.
- The absence of a kaupapa Māori provider within the trial limits the ability to assess how Māori outcomes may differ under kaupapa Māori delivery approaches.
- The evaluation timeframe (10 weeks from contract commencement to initial reporting) influenced the scope and sequencing of data collection, analysis, and reporting.

2. Outcomes



Overall, the SOC model supports meaningful and sustained outcomes to a **strong** extent. Trial participants are **consistently moving into, and sustaining, stable housing that is appropriate.** Most participants are experiencing **strong positive shifts in wellbeing,** across broad dimensions. Providers are generally experiencing strengthened relationships, increased engagement, and meaningful progress towards their organisational goals.

Domain 1: Outcomes

KEQ 1: To what extent does the SOC model support meaningful and sustained outcomes?

Sub-domain	Not yet evident	Minimal	Moderate	Strong	Transformative
Participant outcomes – housing	No clear evidence of improved housing for most participants.	Some participants show early signs of improved housing stability, but gains are inconsistent, partial, or not yet sustained.	Improvement in housing stability and appropriateness is evident for a meaningful proportion of participants, though overall results are mixed.	Consistently strong outcomes in stable, appropriate, and sustained housing across most participants, with few gaps.	Embedded and sustained housing outcomes for participants – significant, lasting improvements that set a benchmark for what is achievable.
Participant outcomes – wellbeing	No demonstrable improvement in participant wellbeing.	Early or limited improvements in some wellbeing dimensions are present, but gains are inconsistent, isolated, or not yet stable.	Some improvements in wellbeing are evident for some participants, though overall outcomes are mixed, uneven, or short-term.	Strong positive shifts in wellbeing for most participants.	Significant and sustained improvements for most participants in wellbeing, independence, and connection

This section describes the overall outcomes observed by providers and participants. We provide an evaluative judgement against the KEQs using the evaluative rubric. We also assess the achievement of short-term (ST), intermediate (MT), and long-term (LT) outcomes as noted in the program logic.[5]

2.1 Trial participants are moving from emergency housing into stable housing, with support from providers

Overall, many trial participants are consistently moving into stable housing. Most participants who are housed are sustaining their housing. Participants are engaging with support services from providers, and providers are delivering flexible services tailored to participants' needs.

Provider feedback indicates a positive response to the number of participants housed and the nature of those housing placements over the trial period; however, limited data were available at the time of this evaluation to directly compare SOC trial housing outcomes with EH households in other programmes.

Providers also noted the additional challenges trial participants already face in accessing and maintaining stable housing, including their pre-existing complex needs and other compounding factors. Participants identified as eligible for the SOC trial were more likely to require wraparound services; providers considered being stably housed a 'bigger win' due to the additional barriers they faced.

2.1.1 Participants are moving into stable housing[1]

As of March 2026

79 households have participated in the trial.

53% (42/79) of total households are housed.

16% (13/79) of total households are still participating in the trial and have not yet been housed.

30% (24/79) of total households have exited the trial.

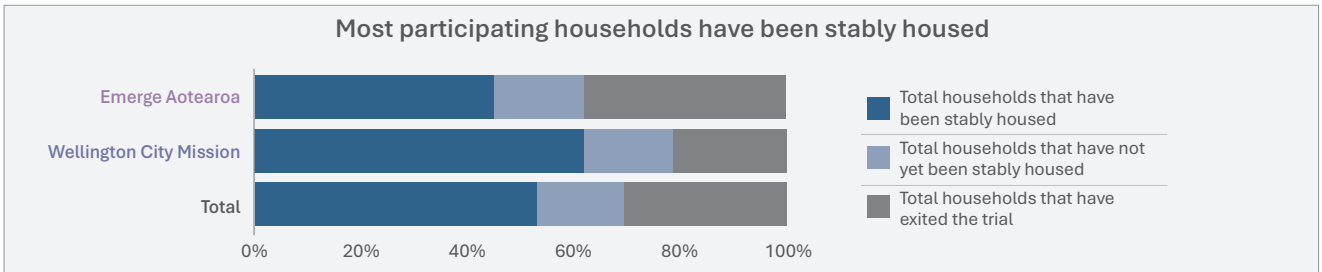


Figure 1: Housing status of total participating households, as at March 2026.

The vast majority of stably housed households, 83% (35/42), are in social housing, including Kāinga Ora and CHP homes. A small number, 6 (14%), are in the private rental market.

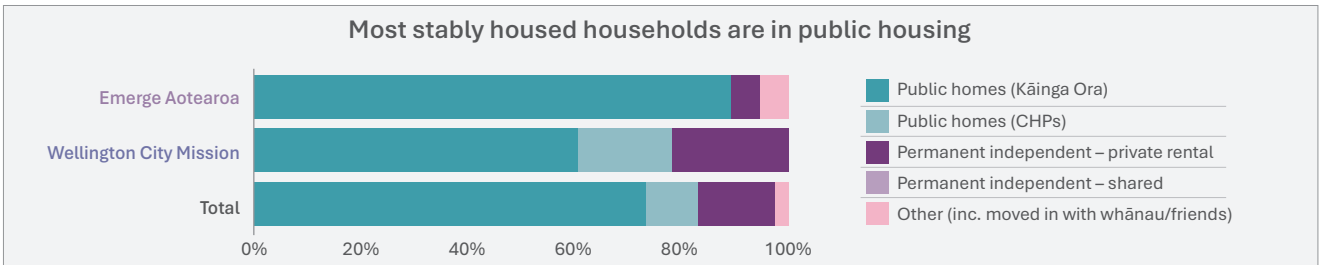


Figure 2: Housing type of stably housed households, as at March 2026.

As at end April 2026, provider data indicates the majority, 61% (17/28), of households that exited the trial have not yet secured stable housing. A small number, 14% (4/28), have since secured stable public or independent housing.

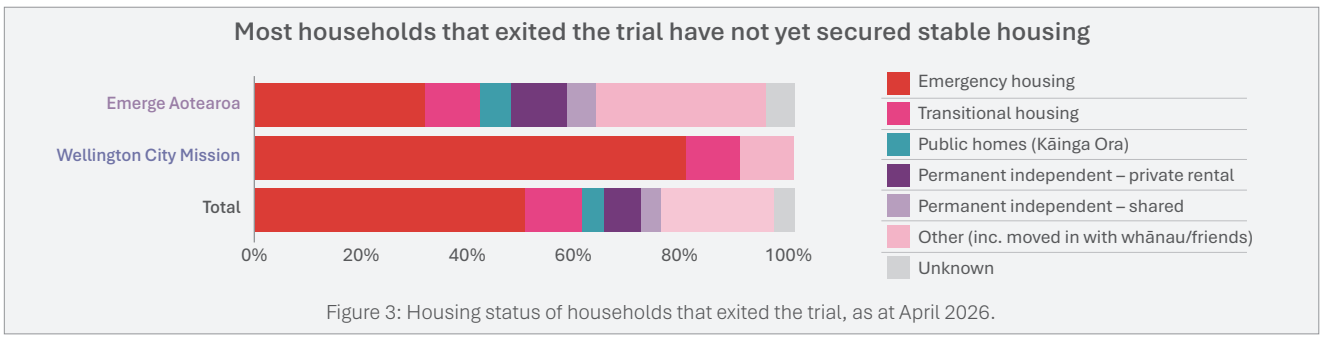


Figure 3: Housing status of households that exited the trial, as at April 2026.

2.1.2 Participants are accessing support they need to maintain stable housing

Providers reported positive engagement with support services among participants, both before and after housing placement. In particular, providers noted instances of participants shifting from a reluctance to engage at all, to proactively engaging with provider staff.

Participants valued being able to access a broad variety of supports, including mental health and WINZ support, through the one provider relationship.

Providers shared that over the period of supporting a household, many participants were more likely to ask questions of staff, seek referrals to and access other services.

Participants are building strong, trusting relationships with providers and, in some cases, this trust extends to other agencies. The SOC trial enabled providers to work flexibly and responsively, allowing participants to engage at their own pace, make informed choices, and feel confident their needs were heard and taken seriously.

1 *We report data as at the end of March 2026, and the end of April 2026.*

2.1.3 The support from providers is contributing positively to these outcomes

Many participants shared that the provider staff, support services, and range of support provided made a difference to their placement in appropriate housing and overall wellbeing.

Providers and participants shared that the trusted relationships built through the service have positively contributed to participants' ongoing engagement, or, in some cases, re-engagement, with support services.

Providers shared examples of participants wanting to give back to staff, reciprocating the support they had received and acknowledging the positive impact of the service and experience.

Providers shared that, in some instances, participants were often more open to accessing external supports when a trusted staff member, such as a peer support worker, accompanied them.

One way providers tailored the support services to meet the needs of participants was by hiring staff with a breadth of expertise and experience. Providers shared that having a combination of peer support, navigation, and other specialist support, such as mental health or dental, in the staff team has made it easier to connect participants with people and services. Notably, participants are more likely to trust unfamiliar support services recommended by the provider because of the trust established between the participant and the provider.

Participants and providers shared that participants were more likely to feel they were in a house that is appropriate for them in comparison to households in other programmes. Participants felt they were supported to describe what an appropriate house looked like for them and supported to choose whether a house that was offered would meet their needs.

Participants and providers highlighted that support post-placement had a positive impact on participants remaining housed. Providers noted instances where low-stakes check-ins after placement allowed them to address potential issues, mitigating the potential for crises for housing providers or other agencies to deal with.

Participants and providers also highlighted the positive impact of reduced obligations to continue to receive support. Providers valued being able to focus on what was needed, at the time and pace of participants, rather than having to complete checks or activities whether they were relevant or not. They noted that this supported building trusting relationships that resulted in overall engagement, as participants were less stressed and suspicious.

Providers acknowledged that some participants may have progressed into housing through existing pathways. However, they also shared that they felt better able to connect participants with more appropriate housing and address broader wellbeing needs, which contributes positively to sustaining housing.

2.1.4 There are positive housing outcomes achieved at three and six months, and promising signs for 13 months

Of the **42** households that were stably housed as at March 2026:

50% (21/42) have been in stable housing for at least three months but less than nine months

21% (9/42) have been in stable housing for at least nine months but less than 13 months

14% (6/42) have been in stable housing for 13 months or more.

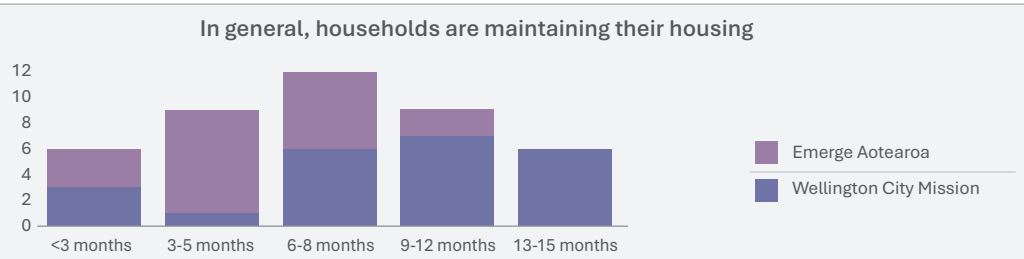


Figure 4: Duration in stable housing of housed participating households, as at March 2026.

All of the households in stable housing for at least 13 months were supported by WCM (6/6). However, it is noted that WCM received referrals earlier in the trial than Emerge. Emerge received the majority of their referrals in June 2025.[2] The timing of referrals impacted the ability of Emerge to achieve sustainable housing targets within the limited timespan of the evaluation of the trial. However, as at March 2026, staff members from Emerge noted that at least one participant was on track to successfully complete 13 months of stable housing by June 2026.

2 *During contract negotiations, it was agreed that Emerge would receive most of their referrals from March 2025 onwards.*

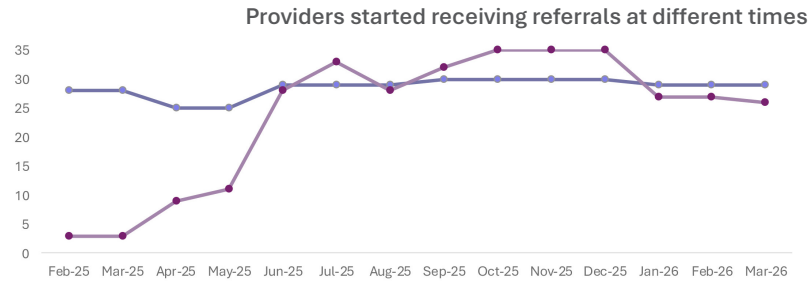


Figure 5: Timeline of referrals to providers over trial period, as at March 2026.

Providers noted that it can take time to support participants into stable housing. This is seen in the time between households entering the trial and being stably housed. Most households, 62% (26/42), took up to six months to be stably housed, while it took up to nine months to house over 80% of households.

Given the timing of referrals into the trial (starting 3–4 months in) and the timing of this evaluation (approximately 13 months in), it is too early to make an overall judgement about longer-term housing sustainability based on the 13+ months stably housed indicator.

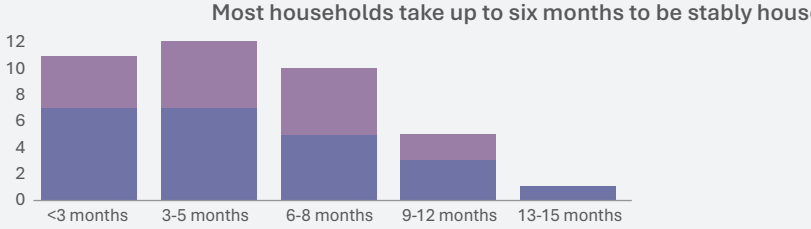


Figure 6: Time to be stably housed of participating households, as at March 2026.

As at April 2026, most households that exited the trial, 50% (14/28), left after having been in the trial for five or more months. A small number, 18% (5/28), left within four weeks of entering the service.

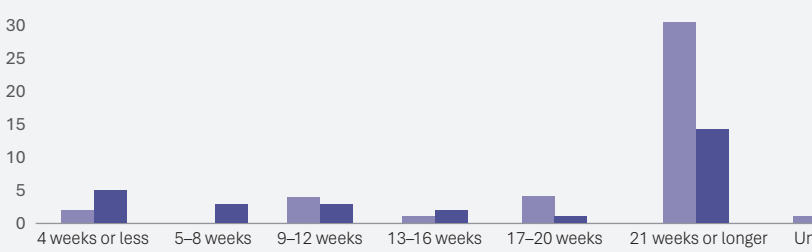


Figure 7: Time in service for households that exited vs are housed, as at April 2026.

Of the households that provided a reason for exiting (25),[3] most households that exited the trial, 72% (18/25), did so voluntarily and 44% (8/18) indicated they were transferring to another service provider. A small number exited involuntarily, 28% (7/25), due to their health or incarceration.

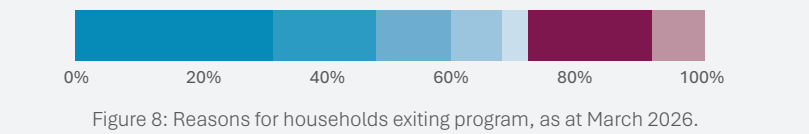


Figure 8: Reasons for households exiting program, as at March 2026.

2.1.5 Housing outcomes were likely also impacted by other factors

These outcomes have been achieved within a constrained housing system and are influenced by changes in the policy and legislative landscape during the trial period, as well as by the characteristics of the target group eligible to participate in the trial.

System

On the one hand, providers highlighted from the outset that a significant barrier to housing outcomes is the existing limited supply of affordable housing and of housing overall. Addressing that barrier was not in scope for this trial. However, providers noted that it remains challenging to support people into appropriate housing when there are few options available.

3 As at March 2026, monitoring data indicated 24 households had exited the programme, however, the total number of reasons noted by providers was 25. Exit reasons provided to the evaluation team were not connected to provider or any other identifying data to be able to determine a potential duplicate to remove. As a result, the numbers are included to indicate the overall trend of exit reasons.

On the other hand, policy and legislation changes during the design and implementation of this trial affected the qualification criteria for EH in general. The reduced total pool of people in EH, those referred to SOC generally, had shorter emergency housing histories than the original target cohort and have had less challenging barriers to securing stable housing.

Target participants

The SOC trial was initially intended to support providers to improve housing outcomes for people and households who are typically underserved by existing alternatives, particularly:

- Men, especially Māori men
- Partnered and single people with no children or who do not have custody of their children
- People with complex housing and wellbeing needs.

Providers shared that a higher proportion of participants in this trial had specific housing requirements than in other cohorts they typically support, which impacted their ability to identify appropriate housing for participants. For example, people with experience of the criminal justice system may face restrictions on being housed near schools and playgrounds, shopping centres, certain housing complexes, or the homes of other people known to the justice system. Some participants did not have custody of their children at the time of entering the service and, therefore, may have only been offered 1-bedroom or studio properties; however, support to provide a 2-bedroom property enables reconnection with children. For other households with physical disability or mobility needs, an appropriate house may need to be on a single level or close to public transport.

> "A lot of the messages we've been getting is there's just no suitability (suitable housing) for someone with mobility needs." (Provider)

At the same time, the changes in policy and legislation led to revisions of the eligibility criteria for referral. While initial trial participant referrals also focused on people who had been in EH for longer periods, households referred later in the trial were less likely to have identified complex needs and were not required to have been in EH for as long.

Some provider staff referred to households participating in the trial as people who were 'left behind' by other services, and, as a result, supporting them into stable housing represented a stronger positive outcome compared with other households with lower support needs or those able to access existing services. However, no data were made available to compare housing outcomes of trial participants with similar people in other programmes or areas.

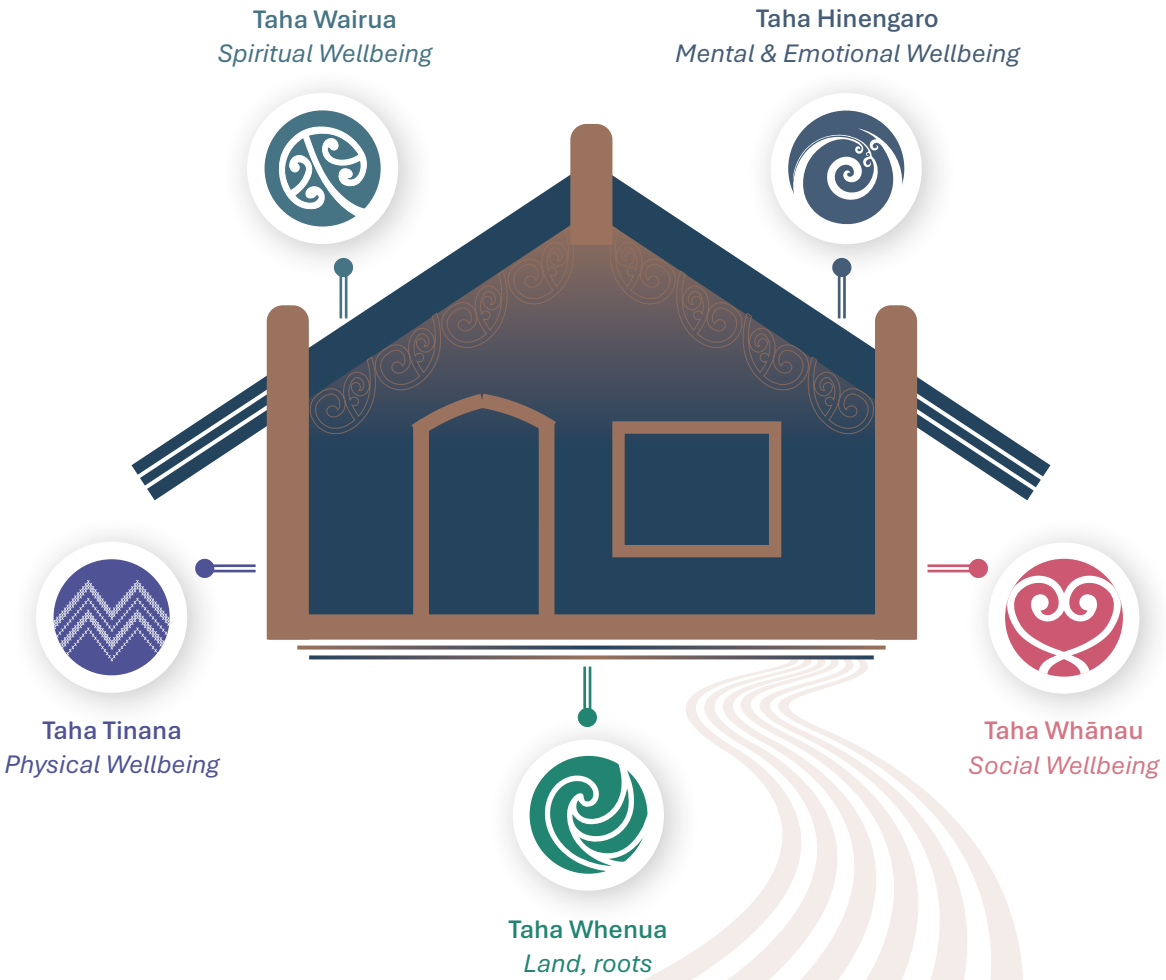
2.1.6 Short-term and intermediate housing outcomes in Intervention Logic are, on balance, being met

ST1	Participants are strengthening their relationship with providers: On balance, met.	Providers and participants described improved and positive relationships between participants and providers, especially compared to when participants entered the trial, and in some cases, improved relationships with other agencies and support providers.
ST2	Participants are accessing tailored approaches to enable stable housing: On balance, met.	Overall, providers are delivering tailored approaches to enable housing and describe positive participant uptake; they also note positive participant engagement with support services and feedback.
ST3	Participants are receiving support that meets their specific needs: On balance, met.	Overall, providers are delivering tailored, responsive approaches that support housing access and improve wellbeing, and they describe positive participant engagement and feedback
ST4	Providers are working with participants and housing providers, to support participants to move into a tenancy: On balance, met.	Overall, providers describe working closely with participants to understand their needs and leverage strong relationships with housing providers, and participants are moving into stable housing.
MT1	Participants are accessing support they need to maintain stable housing: On balance, met.	Overall, providers are delivering support services that appear to address barriers to accessing and maintaining housing, and participants describe the positive impact of providers' support; providers also report positive participant engagement and feedback.
MT2	Tailored approach enables whānau to be stably housed: On balance, met.	Overall, providers are delivering tailored, responsive support services that help participants access and maintain housing, and participants describe the positive impact of providers' support.
MT3	Participants have moved into stable housing with support from providers: On balance, met.	Participants are moving into stable housing at higher rates than those who exited the trial; however, data to compare housing outcomes with existing programmes and approaches were not available for this evaluation.
LT1	Trial participants require no support to maintain stable housing: Unclear.	Service design includes access to ongoing support. Data to compare participant engagement with specific support services or approaches, or with housing outcomes from existing programmes, were not available for this evaluation.
LT3	Trial participants maintain stable and secure housing for three, six, 13 months: On balance, partially met.	Overall, participants are sustaining their housing for the target indicators of three and six months, but it is too early to reasonably assess the 13-month sustained housing outcome. Limited data available to compare housing outcomes with existing programmes and approaches.

2.2 Trial participants are experiencing positive holistic wellbeing outcomes

In this section, we use Te Whare Tapa Whā, a hauora (wellbeing) framework developed by Sir Mason Durie (1985).[7] Te Whare Tapa Whā, and its evolutions, illustrate a multi-dimensional and holistic view of wellbeing, where each dimension needs to be in balance for an individual to experience strong and stable wellbeing, and be resilient. The broad wellbeing outcomes experienced by all participants align with the Te Whare Tapa Whā model.

Overall, most participants are experiencing **strong positive shifts in wellbeing.** Individual participants' experiences differ, including the dimensions of wellbeing affected. This reflects the individual circumstances and context that each participant brings to the services. Providers delivered tailored approaches to meet the wellbeing needs and goals relevant to individual participants.



2.2.1 Hinengaro: Participants experienced improved mental and emotional wellbeing



The Hinengaro dimension relates to mental and emotional wellbeing. It includes the ability to embrace positive thinking, problem-solve, self-regulate, make constructive decisions, communicate openly, and demonstrate compassion and resilience.

Providers and participants shared stories of improved mental and emotional wellbeing because of the support services provided. Participants who were connected to mental health services were more likely to follow through and attend. Providers highlighted instances of participants being better able to manage their own mental health.

> "... probably saved a life here, to be honest." (Emerge participant)

Participants were supported to make decisions about their support and housing needs. The reduced focus on obligations meant providers could take their time to ensure participants were heard and had agency. As a result, providers noted participants were less stressed and took more ownership of their decisions.

> "They said that I didn't have to take it. They said take your time; you don't [have to] give us an answer right then and there – sleep on it and like there was no pressure." (Emerge participant)

Participants demonstrated increased independence, sense of agency, and self-reflection. They changed behaviours and made decisions that helped maintain housing and sustain wellbeing.

> "Having the home is good, but who you invite and what type of people, you know, [it's a] responsibility. So, it's not an easy task, but [it's about] safety ... just putting together a safety plan and connecting the dots for me, how to respond and be a better person." (Emerge participant)

2.2.2 Tinana: Participants experienced improved physical wellbeing



The Tinana dimension relates to physical wellbeing. It includes mobility, nutrition, conscious caring for the body, energy and vitality, and physical growth and development.

Participants and providers shared stories of improved physical health. This included support for accessing information and devices to improve healthy eating and nutrition, direct access to dentists, and support for increasing engagement with primary health providers to avoid hospital stays.

> "I've lost kilos since I've had my teeth out. Emerge have helped me a lot, taking me to appointments, understanding when I don't want to talk on the phone or just understanding how much of a struggle it has been. [They helped me be] able to eat properly, they bought me a blender thing ... stuff like that." (Emerge participant)

Providers noted instances in which participants were better able to access medication and other support services because they were supported in navigating the processes. In turn, helping to build their independence and physical wellbeing.

> And especially with my teeth, the [Emerge staff member] talked to me about going through ACC sensitive claims, yeah, never judgmental, just always on my terms. (Emerge participant)

2.2.3 Wairua: Participants experienced improved outlook, sense of purpose, and identity



The Wairua dimension relates to spiritual wellbeing. It includes identity, values, outlook, a sense of purpose, meaning, and belonging, and faith and belief.

Providers and participants described increased trust and hope, particularly in providers. Participants felt they could trust providers to respond to their needs, as individuals, rather than being driven by "tick-box accountability" activities that may or may not be relevant to the participant.

> "They're there to give us advice, they are there to help us, they are there to encourage us. They always reassure us that they are there for us, anytime we need them, they are just there, just a phone call away." (WCM participant)

> "You always had to have a certain amount of meetings, a certain amount of contact with [previous service provider]. They'd say 'look, if you don't keep communicating with us, we're going to take you off'. I just felt like a number. And that's the luxury I've had with Emerge, there's no pressure." (Emerge participant)

Participants are developing a stronger sense of purpose and meaning. They have been able to focus on their own goals and aspirations, because they are no longer in "survival mode" (Provider staff member), including planning education and employment pathways. Providers described supporting some participants in building foundational life skills, such as cooking, budgeting, and looking after a property.

Providers shared that practical support to access entitlements and everyday resources helped participants feel more secure, hopeful, and able to enjoy life beyond immediate housing stress. Participants were also supported in accessing resources that strengthen their connection to their identity.

> "The staff advised me that because I'm 65, I'm entitled to superannuation. And I said, what is that? I didn't know what that was. And then he explained, that's if you want to retire. Oh, yeah, I want to retire … so they helped me." (WCM participant)

2.2.4 Whānau



The Whānau dimension relates to social connectedness and relationships. It includes the ability to connect with and care for others, to show reciprocity and empathy, to collaborate with others, to contribute to broader social systems, and to build and nurture relationships through mutual support.

Participants are improving their relationships with whānau, friends, and providers. Appropriate housing has enabled some participants to regain access to or rekindle connections with their children.

> "I definitely wouldn't be in this situation. I wouldn't be seeing my babies in the weekend." (Emerge participant)

> "There was a situation [about] me getting access back to my children again. I wanted to have a stable home but that wasn't going nowhere, then Emerge jumped in there, and I couldn't see it, I didn't believe them, then I started viewing these homes. And the first one, I couldn't believe it, I just thought, no, it's not happening, right? But when I got offered the home, man, my anxieties … I've gone so long without any of that. So, [Emerge] were really good, just letting me know that I deserve it. It's okay, we're here to help you." (Emerge participant)

Participants are building trust in providers and, in some cases, this flows on to rebuilding trust and re-engaging with other agencies and support services.

> "If it wasn't for them in the service, anything could have happened. Not that I need much or want much, but, I mean, I've got no sort of family to fall back on." (Emerge participant)

Providers shared stories of participants improving their social cohesion, establishing bonds and collaborating with others in the community, and demonstrating empathy and reciprocity toward provider staff and other community members.

> "They are so reassuring … like they are part of us, they care, and so we are so thankful." (WCM participant)

2.2.5 Whenua



The Whenua dimension relates to connection to land, places, and spaces. It includes connection to the environment, a sense of belonging to a place or space, and a safe, comfortable place to express oneself and one's identity.

Participants are improving their sense of independence, enabled by appropriate housing and providers' services. Providers shared stories of participants feeling pride in and a sense of belonging to their house. In some instances, that meant participants were excited to host provider staff, whānau, and friends; in others, it meant seeing their house as a safe place to retreat to and meeting with provider staff away from home.

> "Like, you know, some people get stuck for housing, and they'll just call up their cuz and ask to stay at their place or something. But I can't do that because I haven't got any family to fall back on. So, it's always been an insecurity, not having my own accommodation." (Emerge participant)

Participants are also connecting to their local community. In some instances, being housed in appropriate locations, that facilitate connections. In other instances, providers' services connect participants to the community and, in some cases, each other.

> "We got a shock when they called us ... and they said they are willing to look for a house for us, and they gave us options. We got what we want and where we want to be." (WCM participant)

2.3 Interdependency between housing and wellbeing outcomes

Housing and wellbeing outcomes are interdependent. This also reflects the Te Whare Tapa Whā model – imbalance in any of the dimensions of wellbeing, or walls of the whare, impacts the other dimensions; it also impacts the whare itself.

> "It's not just about the house... it's about the house and the person and all of the other things." (Provider)

> "For most other programmes, the outcome is housing, and nothing is really measured beyond that. In SOC's case, housing is the gateway to make sustainable long-term improvements. This helps prevent the risk of needing emergency housing or being homeless in the future." (Provider)

Providers and participants highlighted that stable housing enables improvements in health, connection, and confidence, while addressing broader wellbeing needs and supporting access to and the sustainment of housing.

> "There is a clear intersection between housing and mental health and health in general... these two roles... are critical to the outcomes we're achieving." (Provider)

Stable housing supported improvements in health, connection and confidence, while addressing wider wellbeing needs, making it easier for participants to access and sustain housing.

> "Housing contributes to broader life stability." (Provider)

> "Once they've got housing sorted... they're getting better connections with their whānau and their health supports." (Provider)

For others, providers needed to address wellbeing needs first, by connecting to mental health supports, improving physical health, or building trusted relationships. Providers were able to support participants who had not previously had a tenancy in building the necessary skills to budget and care for a property. Some participants require time and support to overcome insecurities and low self-confidence, in order to engage with providers or to apply for housing. Only then were participants ready to access stable housing.

> "[The] majority [of our people] have never had a tenancy. That's what scares them the most straight away. They're thinking no one wants us." (Provider)

The value of the SOC approach was that it gave providers enough flexibility and time to work with the relationship between housing and wellbeing, rather than treating housing placement as a standalone transaction.

> "Reaching hard to engage people and re-engaging, rebuilding trust where trust in the system has been lost." (Provider)

> "Connecting with other services makes [wellbeing] more of a possibility." (Provider)

3. SOC model contribution to outcomes



Overall, the SOC model contributed to outcomes to a **strong** extent. Outcomes were supported by strong provider capability and moderately enabling system conditions, with some strong commissioning features. System and enabling conditions are assessed as **moderate, with strong commissioning features.** The model enabled flexible and sustained support services, but operated within wider system constraints, including limited housing supply, changing referral conditions and differing agency interpretations. These constraints meant the system environment was supportive in some important ways, but not consistently well-aligned.

Domain 2: Service

KEQ 2: How and why are outcomes occurring?

Sub-domain	Not yet evident	Minimal	Moderate	Strong	Transformative
Provider capability	No demonstrable workforce or organisational capability to deliver services effectively; partnerships are absent or non-functional.	Minimal or limited capability is present – some workforce capacity, emerging partnerships – but these are inconsistent, partial, or not yet stable.	Organisational capability is evident in some areas – competent workforce, active partnerships, coordinated delivery – though performance is mixed or uneven across capability dimensions.	Consistently strong organisational capability – skilled and supported workforce, effective organisational systems, well-integrated partnerships, and coordinated delivery across most areas.	Excellent organisational capability – a highly capable, resilient workforce, strong organisational systems, and deeply integrated partnerships that drive sustained, high-quality outcomes.
System and enabling conditions	Funding, contracting, and policy settings are misaligned or create significant barriers to effective delivery and outcomes.	Some enabling conditions are present, but funding, contracting, or policy settings are inconsistently aligned or only partially supportive of effective delivery.	Funding, contracting, and policy settings are broadly enabling in some areas, with evidence of alignment and support for delivery, though gaps or misalignments remain.	Funding, contracting, and policy settings are consistently well-aligned and actively support effective delivery and outcomes, with few systemic barriers.	Very strong alignment across funding, contracting, and policy settings – a fully enabling environment that actively drives effective delivery, innovation, and sustained outcomes.

This section examines how and why outcomes from the SOC trial are occurring. It focuses on two connected domains: provider capability and system enablers. Provider capability matters because the model depended on providers having the skills, relationships, judgement, and organisational capacity to deliver flexible, participant-centred support. System enablers matter because the SOC trial also depended on commissioning, contracting, referral, monitoring, and cross-agency working conditions that supported provider delivery.

3.1 Commissioning

This section describes how the SOC trial was commissioned and implemented in practice. It outlines the commissioning approach, key design settings, and the roles of HUD, MSD and providers.

Table 2 summarises the main commissioning design settings, including what was fixed, what was flexible, and how these settings shaped delivery.

Commissioning design setting	Fixed or flexible?	What this meant for delivery	Link to implementation issues
Target cohort, locations and outcomes	Fixed	HUD set the target cohort and trial locations. Providers were expected to work with eligible long-stay emergency housing participants in Wellington and Waikato.	Clear targeting supported focus, but later changes in the emergency housing context affected referral flow and participant profile.
Intended housing outcomes	Fixed	The trial focused on supporting participants to access and sustain stable housing, with sustainment measured at three, six and 13 months.	The clear outcome focus supported accountability, but achievement depended on factors partly outside provider control, including housing supply, participant complexity and referral flow.
Tight-loose-tight approach	Both	The model was tight on the cohort, locations, outcomes, reporting and accountability; loose on how providers achieved those outcomes.	This design feature encouraged adaptation to participant need, but required shared understanding about what could vary and what remained fixed.
Provider discretion over delivery	Flexible	Providers could decide how to engage participants, sequence support, use their practice knowledge, and draw on local housing, health and social service relationships.	Discretion supported tailored delivery, but also created variation between providers and made direct comparison of delivery approaches harder.
No additional housing supply	Fixed	Participants were expected to access housing through existing pathways, including social housing and private rental where available.	This was a critical boundary on the trial. It limited what provider flexibility could achieve where suitable, affordable or accessible housing was unavailable.
Use of existing housing pathways	Fixed	The trial worked through current housing pathways rather than creating a separate housing pipeline. Providers supported participants through access, advocacy, matching, landlord engagement, transition planning and sustainment within those settings.	Reliance on existing pathways shaped housing options and contributed to later tensions around private rental, social housing and transitional housing (which was never defined in the policy as stable housing).
Core service funding	Fixed	Core funding supported provider viability and enabled providers to deliver sustained support while housing outcomes unfolded over time.	This made the model a hybrid funding approach, rather than a pure payment-by-results model. It also helped balance provider risk where outcomes depended on factors partly outside provider control.
Outcomes-based payments	Fixed	Milestone payments were linked to sustained housing at three, six and 13 months, reinforcing the focus on sustainment rather than short-term placement.	Housing outcomes were influenced by factors outside provider control, including housing supply, referral flow and participant complexity. This made core funding important for balancing provider risk.
Tailored initiative funding/flexi-fund	Flexible within purpose	The flexi-fund allowed providers to respond to practical or wellbeing-related barriers that standard funding might not cover.	In practice, use was selective and relatively low. Different expectations about its purpose became an implementation tension.
Monitoring, reporting and accountability	Fixed	Providers were required to report on progress, participant movement and housing outcomes, while HUD maintained oversight of implementation.	Reporting supported accountability and learning, but future models may need clearer shared expectations about data quality, comparison, attribution and how outcomes are interpreted.
HUD stewardship	Fixed role, adaptive practice	HUD remained actively involved after contract set-up through regular contact, quarterly meetings, progress review and issue resolution with providers and MSD.	Active stewardship helped maintain focus and respond to issues as they emerged, but also required ongoing agency alignment and clarity about roles.
MSD referral and operational role	Fixed role, adaptive practice	MSD identified eligible participants, supported referrals, and remained connected to emergency housing, income support and operational settings.	MSD involvement was essential, but implementation was affected by changing referral flow, different understandings of service distinctiveness, and the need for clear transition planning.

Table 2: Commissioning design settings and implications for delivery.

These design settings are important because they shaped both what the model enabled and what it could not resolve. The implementation consequences of these settings, including where they became enablers, constraints or tensions, are discussed in section 3.4.

3.1.1 Summary

The SOC commissioning approach created enabling conditions for relational, integrated and sustained support through provider discretion, core funding, flexible funding, targeted milestone payments and active stewardship. Its primary strength was that providers had sufficient flexibility to adapt support to participants' needs while remaining accountable for sustained housing outcomes.

At the same time, the model operated within fixed boundaries. It could support access to housing, improve matching, address practical and well-being-related barriers, and help sustain housing after placement. It could not, on its own, create additional housing supply or remove wider system constraints.

3.1.2 Commissioning approach in practice

The SOC trial used a high-trust, outcomes-focused commissioning approach. Rather than prescribing a detailed service model, HUD set the target cohort, outcome expectations, funding structure and reporting requirements, while giving providers discretion over how support was delivered. This reflected the intended tight-loose-tight approach: tight on who the trial was for and the outcomes sought; loose on how providers achieved those outcomes; and tight on monitoring, reporting and accountability.

In practice, this meant providers were not required to deliver a fixed programme or follow a standardised pathway. Instead, they could design and sequence support in ways that responded to individual circumstances, using their own practice knowledge, organisational capability and values[8], and relationships across housing, health and social services. This discretion operated across all aspects of delivery, including how participants were engaged, how support was prioritised, and how housing pathways were navigated and sustained.

As one HUD stakeholder described, the intent was to move away from standardised approaches:

> "We wanted sustainable housing solutions in a way that wasn't pre-determined by existing processes and thinking that everyone was going to fit in the same box."

This flexibility was important given the variation in participant needs, readiness and available housing pathways. As one HUD stakeholder observed:

> "[Providers were] working with social housing providers, making connections and helping people navigate private rental housing."

A key design parameter was that the SOC model did not include any additional housing supply. Participants were expected to access housing through existing system pathways, including social housing, Kāinga Ora placements, community housing providers and private rental options where available. The trial therefore tested whether more flexible commissioning, relational support and stronger outcome accountability could improve housing access and sustainment within existing system constraints, rather than through new housing stock.

In practice, these settings enabled providers to deliver integrated and participant-centred support focused on sustained housing outcomes. However, they also set clear boundaries on what the trial could achieve. Provider flexibility could improve engagement, advocacy, housing matching and sustainment support, but it could not resolve structural housing supply constraints.

3.1.3 Tailored initiative funding/flexi-fund

Tailored initiative funding was a further component of the commissioning model. Referred to by providers as the flexi-fund, it enabled providers to address participant needs that fell outside standard funding arrangements and affected housing access or sustainment, such as transport, household items, specialist food, social reconnection, or the maintenance of cultural and community connections. Providers reported using MSD funding and other available supports first, with the flexi-fund acting as a supplementary mechanism where greater speed or flexibility was required.

Provider	Allocation	Expenditure	% used	Unspent balance
WCM	$20,000	$2,690.57	13.45%	$17,309.43
Emerge	$20,000	$6,231.20	31.16%	$13,768.80
Total	$40,000	$8,921.77	22.30%	$31,078.23

Table 3: Flexi-fund allocation and expenditure by provider, as at 31 March 2026.

Use of the fund was relatively low overall. This suggests the fund was a useful but selective enabling mechanism, rather than a major driver of delivery. Its value sat less in the amount spent and more in the discretion it gave providers to respond to specific practical or wellbeing-related barriers that may not have been covered by standard contracts or funding pathways.

The low use of the fund also highlights an implementation consideration for future models. Where flexible funding is included, providers and agencies need a shared understanding of its purpose, appropriate uses, approval requirements, and relationship to other funding sources.

3.1.4 HUD stewardship and system support

From HUD's perspective, commissioning did not end with contract set-up. HUD remained actively engaged throughout implementation, maintaining regular contact with providers, convening quarterly meetings with providers and MSD, reviewing progress, and supporting operational learning as the trial unfolded.

This active stewardship helped maintain focus on sustained housing and wellbeing outcomes, while enabling issues to be identified and addressed as they arose. It also reflected the adaptive nature of the trial, which was being tested in a changing emergency housing context, with declining emergency housing numbers, evolving referral conditions, and constrained housing supply.

MSD's participation in implementation forums helped connect provider delivery to the emergency housing system and wider operational context. This created a shared space to review progress, address issues, and maintain alignment as the model was implemented. MSD's involvement was particularly important because referrals, emergency housing administration, income support, and many practical barriers sat within or alongside MSD processes.

At the same time, active stewardship required ongoing cross-agency engagement and a shared understanding of the trial's purpose. Differences in perspective remained, including how SOC differed from existing services, how outcomes should be interpreted, and how transition pathways should be managed as the contract period progressed. These issues are taken up in section 3.4.

3.1.5 Summary

The SOC commissioning approach combined an outcomes-focused contract model with provider discretion, core funding, flexible funding, targeted milestone payments, and active stewardship. It operated within existing housing system constraints, without additional housing supply.

Together, these settings created the conditions for providers to deliver relational, integrated, and sustained support. The primary enabling mechanism was provider discretion: providers had enough flexibility to adapt support to participants' needs, while remaining accountable for sustained housing outcomes.

At the same time, the commissioning design established important boundaries. The model could support access to housing, improve matching, address practical and well-being-related barriers, and help sustain housing after placement. It could not, on its own, create additional housing supply or remove wider system constraints. The following sections examine how these commissioning settings were translated into service design and delivery, and where they became enablers, constraints, or sources of tension in practice.

3.2 Service design

This section describes how the SOC model was translated into service design and delivery across the two providers.

3.2.1 Operating model and roles

The SOC model was implemented through a clearly defined structure with distinct yet interdependent roles among MSD, HUD, and providers.

MSD held the front-end role. This included identifying eligible participants through the Emergency Housing Grant system, explaining the trial, gaining consent, and making referrals to providers. MSD also maintained an ongoing role in income assistance and housing pathways.

HUD held the commissioning and stewardship role. This included managing contracts, maintaining the outcomes focus, convening regular engagement with providers and MSD, and supporting implementation as issues emerged.

Providers held the delivery role. They were responsible for engaging participants, assessing needs, and providing support to access and sustain stable housing. Providers were expected to accept referrals unless there were significant health and safety concerns, and had discretion to shape support in response to participant needs.

These roles were interdependent. Delivery relied on coordination across agencies, not a linear referral process. The model therefore functioned as an active system in which commissioning, referral and service delivery were connected through ongoing engagement and adjustment.

3.2.2 Key features of service design

Across both providers, the SOC trial was understood as a relational, sustained support model. While Emerge Aotearoa and Wellington City Mission operated in different local contexts, and drew on different organisational strengths, their approaches shared a common foundation. Both providers understood that stable housing was the immediate goal, but not the whole story. Housing was treated as the base from which participants could rebuild stability, wellbeing, independence and connection.

Providers also recognised that participants were not simply waiting for housing. Many had experienced periods of instability, repeated contact with systems, low trust in agencies, and complex practical or wellbeing needs. Support, therefore, needed to be consistent, relational and sustained. Across both providers, staff worked alongside participants over time, helping them navigate systems, address practical barriers, and maintain engagement after housing placement.

These similarities are important. They suggest that, within a deliberately non-prescriptive contract, a coherent SOC practice model emerged. This model was not defined by a standard set of activities, but by a shared way of working: relational engagement, practical advocacy, and a sustained focus on appropriate housing and longer-term stability.

Table 4 summarises the common service features that emerged across both providers. These include both practice principles and delivery features, as well as the outcomes logic underpinning the model. Together, they show that SOC delivery was not defined by a fixed set of activities, but by a shared way of working focused on relational engagement, practical support, participant choice, appropriate housing, and longer-term stability.

Service design features		What this looked like in practice
Practice principles	Relational and trust-based engagement	Support was grounded in building trust over time. Providers prioritised continuity, regular contact and low-pressure engagement, recognising that participants often had prior experiences of disengagement or unmet need.
	Participant agency and choice	Participants were supported to make decisions about housing and support at their own pace, including whether housing options were appropriate for them.
Delivery features	Holistic and integrated support	Support addressed housing alongside broader wellbeing needs, including health, financial, social and practical factors that influenced housing stability.
	Integrated provider capability	Providers drew on a range of skills, roles and relationships to respond to the complexity of participant needs.
	Focus on appropriate housing	Housing options were considered in terms of suitability for long-term stability, including affordability, safety, location, accessibility, and connection to services and whānau.
	Sustained support across the housing journey	Support extended before and after placement, helping participants access housing and maintain it over time.
Outcomes logic	Housing as a platform for change	Housing created the conditions for wider outcomes, including safety, confidence, reconnection, independence and future planning.

Table 4: Common service features.

Taken together, these features show that the SOC model was not delivered as a fixed service package. Instead, providers translated the commissioning settings into a shared practice approach: relational, flexible, participant-led and focused on sustaining appropriate housing over time. The consistency across providers suggests the non-prescriptive design enabled local adaptation while still supporting a coherent delivery model.

3.2.3 How the model was operationalised

Providers translated the service design features into practice by drawing on their existing organisational capability, local relationships, and knowledge of housing and social support systems. Support was not delivered through a fixed programme or standard sequence. It was shaped over time in response to participant circumstances, readiness, changing needs, and available housing options.

In practice, support included housing navigation and advocacy; help with applications and documentation; connection to MSD, Kāinga Ora, community housing providers, and landlords; coordination across health, budgeting, and social services; practical assistance such as transport, food, and household setup; and ongoing support after placement.

These activities relied on relationships across the housing and social service system. Providers used these relationships to coordinate support around participants, rather than expecting participants to navigate multiple services independently. This contributed to more integrated and responsive support, particularly for participants facing multiple barriers simultaneously.

A consistent feature of delivery was the ability to address practical, day-to-day barriers that affected housing access or stability. These supports were often small in scale, but important for maintaining engagement and helping participants follow through on housing opportunities. The flexi-fund supported this work in specific cases where standard funding was insufficient or unavailable within the required timeframe.

3.2.4 Cultural responsiveness and connection

Cultural responsiveness was embedded within service delivery rather than structured as a separate service component. This was reflected in how providers engaged with participants, worked with whānau, and drew on local relationships and community infrastructure.

In Kirikiriroa, Emerge Aotearoa's relationship with Waikato-Tainui supported connection with mana whenua and strengthened the service's local grounding. In Pōneke, Wellington City Mission's relationship with Ora Toa, a Māori primary health service owned and operated by Te Rūnanga o Toa Rangatira, provided access to Māori-led health support within the wider service model.

These examples show that cultural responsiveness was enacted through practice, relationships, and local connection, rather than through a formalised or standalone kaupapa Māori service model.

3.2.5 Provider variation and delivery capability

The differences between providers are best understood as different expressions of the same SOC model, shaped by organisational history, workforce mix, local relationships, and implementation context. These differences are useful because they show how a non-prescriptive, high-trust contract can be implemented in more than one way.

Area	Emerge Aotearoa	Wellington City Mission	Interpretation
Practice orientation	Greater emphasis on relational engagement, lived experience, and participant agency.	Greater emphasis on mana-enhancing practice, trust-building, and power-sharing.	Both approaches were relational and participant-led, with different language and emphasis.
Workforce model	Mix of local delivery staff, peer support, and organisational housing expertise.	Broad in-house capability, including social work, financial mentoring, health, and practical support.	Different workforce configurations enabled similarly flexible and multidisciplinary support.
Housing approach	Strong focus on access, system navigation, and landlord engagement.	Strong focus on housing suitability, including location, safety, and long-term fit.	Emerge leaned toward enabling access; WCM toward ensuring fit; both contribute to sustainment.
Understanding of complexity	Framed through readiness, tenancy sustainment, and service engagement.	Framed through mistrust, trauma, system barriers, and disconnection.	Complementary perspectives on participant need.
Outcome emphasis	Self-determination, confidence, identity, progression.	Stability, independence, restored mana, reconnection.	Shared view of housing as a platform for broader wellbeing.

Table 5: Provider variation within the SOC service model.

These differences reflect the deliberate flexibility of the SOC contract, not inconsistency or implementation drift. The comparison highlights an important condition for future SOC-style models: flexibility needs to be matched by clear expectations about delivery capability, including relational engagement, housing navigation, tenancy sustainment, system coordination and access to specialist support.

3.2.6 Summary

The SOC service design combined relational engagement, integrated support and sustained involvement over time. A shared model was evident across providers, but expressed differently in practice, reflecting local context and organisational capability.

This variation shows that the model does not rely on a single standardised approach. Its effectiveness depends on providers' ability to translate broad design settings into delivery that supports housing access, sustainment, stability, connection and wellbeing.

3.3 Provider engagement and support of participants

This section describes how providers engaged with participants and supported them through housing pathways.

Engagement function	What this looked like in practice	What this enabled
Building trust and participation	Maintaining regular contact, allowing time, reducing pressure, and responding when participants were ready to engage.	Participants were more able to share information, identify housing preferences, and consider housing options.
Working alongside participants	Supporting decision-making, adapting the pace of support, responding to setbacks, and maintaining connection during periods of low engagement.	Participants had greater agency and could continue moving forward even when progress was uneven.
Identifying and resolving barriers	Navigating administrative processes, advocating with agencies, coordinating health and social support, and addressing practical issues.	Barriers were addressed as they emerged, reducing the risk that participants would disengage or lose housing opportunities.
Supporting access to appropriate housing	Supporting applications, engaging with Kāinga Ora, community housing providers and landlords, and assessing whether options were suitable.	Participants were better supported to access housing that was affordable, safe and appropriate to their circumstances.
Sustaining support after placement	Helping with household set-up, tenancy responsibilities, early risks, and connection to wider supports.	Housing placement was supported as part of a longer process of stabilisation, rather than treated as the endpoint.

Table 6: How provider engagement supported housing progress.

3.3.1 Summary

Provider engagement was central to how SOC contributed to outcomes. It helped create the conditions for participants to access and sustain housing through support that was sustained, adaptive and relationship-based. A defining feature was continuity: providers stayed connected throughout the housing journey, including when engagement was intermittent. This reduced the need for participants to repeatedly re-engage with new services or restart the process when their circumstances changed.

3.4 Implementation enablers and constraints

3.4.1 The SOC trial in practice

This section examines the conditions that enabled and constrained delivery of the SOC trial. It distinguishes between three types of implementation learning:

- Enablers that helped the model work
- Structural and system constraints that limited what could be achieved
- Implementation tensions that have implications for future design.

HUD held the lead role for policy decisions, contracting and overall implementation of SOC. This included designing the model, contracting providers, defining acceptable outcomes, maintaining oversight and stewarding implementation. MSD's role was more operationally defined. MSD drafted the referral process, based on existing emergency housing mechanisms, and front-line MSD staff worked with providers to refer eligible households to the trial. Providers were responsible for engaging participants, delivering support and working toward sustained housing outcomes within the agreed model.

The tables below distinguish between what helped implementation, what constrained delivery, and where future models would benefit from clearer operational alignment, escalation pathways or decision rights.

Enabler	How it worked in practice	Evaluation interpretation
Provider flexibility	The SOC model gave providers discretion to decide how to engage participants, sequence support, use their practice knowledge, and respond to changing participant needs and housing options.	Flexibility was a core implementation enabler. Its value lay in allowing providers to respond to participant complexity and readiness, while remaining focused on sustained housing outcomes. Flexibility alone was not the mechanism; flexibility connected to outcome accountability was the key design feature.
Relationship-based support	Providers prioritised trust-building, continuity and low-pressure engagement, particularly for participants who were wary of services, had disengaged previously, or had experienced repeated system contact without progress.	Relationship-based engagement enabled re-engagement, more honest assessment of need, and stronger participation in housing pathways. It was central to how the model worked for this cohort, because many participants needed trust and consistency before housing progress was possible.
Integrated provider capability	Providers drew on internal and external capability to respond to housing, health, mental health, addiction, budgeting, food, practical support, social connection and whānau or family needs.	Integrated provider capability enabled providers to address the wider drivers of housing instability. Sustained housing depended not only on securing a property, but on whether participants had the practical, social and wellbeing supports needed to remain well and housed.
Sustained post-placement support	Providers continued to work with participants after housing placement, including support with household set-up, tenancy responsibilities, confidence, isolation, health, wellbeing and early risks to tenancy stability.	Post-placement support was a key mechanism for housing sustainment. It helped participants adjust to independent living, manage practical issues and address risks before they became tenancy crises. This reinforced that getting housed and staying housed require different kinds of support.
Active stewardship and implementation support	HUD remained actively involved after contract set-up through regular contact with providers, quarterly meetings with providers and MSD, progress review and issue resolution. MSD participation connected the trial to emergency housing processes and wider operational settings.	Active stewardship helped maintain focus on sustained housing and wellbeing outcomes. It also created a forum for surfacing implementation issues as they emerged. This was important because the trial was implemented in a changing emergency housing context and required ongoing coordination across HUD, MSD and providers.
Flexible funding	The tailored initiative fund, referred to by providers as the flexi-fund, enabled providers to respond to practical or wellbeing-related barriers where standard funding was unavailable, too slow or did not fit participant circumstances. Providers generally used MSD or other available funding first.	The fund was useful but selective. Its value sat in availability and responsiveness rather than the amount spent. Low expenditure does not mean the fund lacked value; it suggests it operated as a targeted enabling mechanism rather than a major driver of delivery.

Table 7: Implementation enablers.

Constraint	How it affected implementation	Evaluation interpretation
Limited housing supply	Providers identified limited suitable, affordable and accessible housing as the most significant barrier to housing outcomes. The trial did not include additional housing supply and relied on existing housing pathways.	This was the clearest structural constraint. SOC could improve engagement, advocacy, matching and sustainment support, but it could not resolve the wider shortage of appropriate housing. This limited what provider flexibility alone could achieve.
Reliance on existing housing pathways	Participants were expected to access housing through existing social housing, community housing and private rental pathways. Providers worked within those pathways rather than through a dedicated SOC housing pipeline.	Reliance on existing pathways was both a fixed design feature and an implementation constraint. It shaped which housing options were realistic and contributed to tensions around private rental, social housing and transitional housing pathways.
Changing emergency housing context	The trial was implemented while emergency housing numbers were declining and eligibility settings were changing. This affected the eligible pool, referral flow and participant profile over time.	The changing context makes outcome interpretation more complex. Later referrals may not have had the same duration in emergency housing or level of complexity as the original target group. This affects conclusions about the model's effectiveness for the intended long-stay cohort.
Referral flow and eligibility	MSD held the operational referral role. Providers relied on referrals from MSD and were expected to accept referrals unless there were significant health and safety concerns. Referral criteria were refined as emergency housing numbers declined and the eligible pool changed.	Referral pathways were central to implementation. Changes to emergency housing eligibility, obligations and flow affected the number and profile of participants referred to SOC. This shaped provider capacity, participant access, and the extent to which the trial continued to reach the originally intended long-stay cohort.
Participant complexity and housing fit	Some participants had specific housing needs linked to health, disability, justice restrictions, whānau or family circumstances, location, accessibility, income, safety or support needs.	Participant complexity affected both time to housing and the range of suitable housing options. The SOC model helped providers work toward appropriate housing, but where housing options were limited, matching people to housing that would support sustainment remained difficult.
Outcome interpretation and comparator evidence	The trial did not include a matched comparator or counterfactual. Data from other services were not available in a way that allowed direct comparison with SOC participants, outcomes or support intensity.	The evaluation can assess contribution and emerging outcomes, but cannot determine whether SOC performed better than existing services without evidence from comparable cohorts and service models. A significant reduction of the emergency housing numbers meant an outcomes evaluation with a matched counterfactual was not possible.

Table 8: Structural and system constraints.

Design or implementation issue	Agreed intent or design setting	What became contested or unclear in practice
Distinctiveness from existing services	SOC was designed as a flexible, outcomes-focused trial with provider discretion, core funding, flexible funding, milestone payments and a focus on sustained housing outcomes.	Providers viewed SOC as distinct because of the combination of flexibility, intensity, duration, post-placement support, wellbeing focus and accountability for sustainment. MSD questioned whether some SOC-type activities were already available through existing services.
Similarities with existing housing services	The trial was not designed as a full system comparison with existing services. It was designed to test selected SOC features for a defined emergency housing cohort.	Similarities with existing services were raised during implementation, particularly in relation to relationship-based practice, housing navigation, brokerage and support after placement,
Flexibility and accountability	The SOC model intentionally combined provider discretion with accountability for sustained housing outcomes. Providers had flexibility over delivery, while HUD maintained the focus on agreed outcomes and reporting.	Some implementation questions arose about what could vary, what needed to remain fixed, and how provider accountability should be interpreted when outcomes were affected by system constraints such as housing supply and referral flow.
Tailored fund purpose	The tailored initiative fund was intended to help providers address practical or wellbeing-related barriers affecting housing access or sustainment, where standard funding was insufficient or unavailable.	Providers used the fund selectively and often used MSD or other funding first. MSD raised questions about whether the fund could or should have been used differently e.g. out-of-the-box innovation to test private rental market options.
Information sharing and visibility of support plans	Providers were responsible for participant engagement and support planning. HUD maintained implementation oversight, while MSD retained operational roles connected to emergency housing and income support.	Providers and agencies had different levels of visibility over participant support, housing pathways and ongoing needs. Greater visibility could support coordination, but too much sharing could undermine participant trust.
The role of transitional housing	The approved SOC outcome focus was stable and sustained housing. Transitional housing was not defined as a SOC stable housing outcome.	Some MSD staff viewed transitional housing as a pragmatic option where long-term housing was not yet available. Providers were cautious where transitional housing did not align with participant needs or the SOC focus on stable, sustained housing.
Maintaining agreed policy intent during implementation	HUD held responsibility for the SOC model design, contract settings and approved outcomes. MSD's role was operational, including referrals through existing emergency housing processes.	Operational pressures and different agency interpretations sometimes created uncertainty about how the model should be applied, particularly around service distinctiveness, referral flow, transitional housing and outcome interpretation.

Table 9: Implementation tensions and future design issues.

3.4.2 Implications for future design

These tensions point to several ways of working that should guide any future SOC-style model. First, flexibility needs to be purposeful. Providers need room to adapt support to participant circumstances, but that flexibility needs to sit within a shared understanding of the model's purpose, outcome intent and non-negotiable settings.

Second, accountability needs to be realistic and relational. Providers can be held accountable for the quality, persistence and responsiveness of support, and for sustained housing outcomes where these are within their influence. However, accountability needs to recognise the wider system conditions that shape outcomes, including housing supply, referral flow and participant complexity.

Third, stewardship needs to be active and disciplined. Where multiple agencies are involved, future models need more than goodwill and regular meetings. They need clear roles, decision rights, escalation pathways and shared processes for resolving differences when operational practice begins to drift from agreed policy intent.

Fourth, participant trust needs to remain central. Information sharing, monitoring and coordination are important, but they should be designed in ways that protect participant relationships and avoid turning flexible, relational support into compliance-driven case management.

Finally, future decisions should focus less on whether individual SOC activities are unique, and more on whether the full set of enabling conditions is present. The key question is whether existing or future services provide the same combination of flexibility, intensity, sustained engagement, post-placement support, outcome accountability and provider capability for a comparable high-need cohort.

3.4.3 Summary

Implementation

Implementation was enabled by provider flexibility, relationship-based engagement, integrated provider capability, sustained post-placement support and active stewardship. These features worked together. They allowed providers to respond to participant complexity, support access to appropriate housing, and stay connected after placement, rather than treating housing placement as a standalone transaction.

Implementation was constrained by structural and system conditions, including limited housing supply, reliance on existing housing pathways, changing referral conditions and limited comparator evidence. These constraints affected what providers could achieve and how confidently outcomes could be attributed to SOC alone.

The main implementation learning is that future SOC-style models need to be designed around clear ways of working, not only specific service features. Flexibility needs to be purposeful, accountability needs to be realistic, stewardship needs to be active and disciplined, and participant trust needs to remain central. These are best understood as design lessons for future SOC-style approaches, rather than evidence that the trial was poorly specified or poorly implemented.

3.5 How value is created

Value within the SOC model is created through the interaction between flexible commissioning, trusted provider capability, relational practice, tailored support, and sustained engagement over time, as outlined in Figure 9. Rather than value being generated solely through housing placement, the evidence indicates that value emerges for SOC participants from the combined effect of these factors, which contribute to reduced stress and instability, increased agency, and stronger social and service connections. As one provider stakeholder commented:

> "Could a model where you look at the outcomes, but you're much less prescriptive about how they're achieved, be more successful?"

A central mechanism for value creation was providers' ability to spend time building relational trust and continuity with participants. Providers repeatedly described the importance of "going back", maintaining engagement, and building credibility with people who had often experienced repeated system failure or disengagement. This relational capital appeared critical in enabling participants to engage with support, sustain housing, reconnect with services, and build confidence over time. As one provider stakeholder commented:

> "[Taking] the whole journey [and] everyone with you – so, you don't have to rebuild relationships."

Another important pathway to value was the model's flexibility. Providers were able to tailor support to participants' circumstances rather than deliver predefined interventions. This enabled highly practical and timely responses to barriers that might otherwise destabilise housing outcomes. The discretionary flexi-fund was particularly important in supporting this adaptability and responsiveness.

The evidence also suggests that value was created through the prioritisation of "the right housing" rather than simply rapid placement into any house. Housing that aligned with participant location preferences, support networks, cultural connections, transport access, health needs, and family relationships contributed to greater stability and wellbeing outcomes over time.

> "Viewing housing as more than a house ... successful housing requires more than just a house." (Provider manager)

The model also generated wider system value. Providers described reduced cycling back into crisis responses, improved engagement with health and social supports, strengthened trust in agencies, and increased independence among participants. Several participants described becoming more willing to engage with wider systems once trust had been established through the provider relationship.

The value of the SOC model lies not only in achieving housing placement, but in creating the relational, practical, and systemic conditions that enable people to sustain housing and improve broader wellbeing over time.



Figure 9: How the SOC model and services create value.

4. Participant experiences of SOC-enabled support



Overall, SOC-enabled service design and delivery supported participant outcomes to a **strong** extent. Services **consistently centred participant needs,** enabled **flexible and holistic support,** and allowed providers to respond to housing, wellbeing, practical, whānau, cultural and post-placement needs. The support services delivered support were **relational, practical, flexible and sustained.** Providers **built trust, addressed practical barriers,** supported access to appropriate housing, and stayed connected after placement.

Domain 2: Service

KEQ 2: How and why are outcomes occurring?

Sub-domain	Not yet evident	Minimal	Moderate	Strong	Transformative
Service design	No demonstrable evidence that service design addresses client needs, is culturally responsive, or takes a holistic approach.	Service design shows early or limited alignment with client needs, with some culturally responsive or holistic elements present but inconsistent or not yet embedded.	Service design clearly addresses client needs in some areas and shows evidence of cultural responsiveness and holistic intent, though application is mixed or uneven.	Service design consistently meets client needs, is culturally responsive, and takes a holistic approach across most areas, with few gaps.	Excellent service design that is deeply client-centred, fully culturally responsive, and genuinely holistic – setting a new benchmark for how services can be designed to meet complex needs.
Service delivery	No demonstrable effectiveness in service delivery, with known barriers unaddressed and little responsiveness to client needs or contexts.	Service delivery shows early or limited effectiveness, with some effort to address barriers and respond to clients, but performance is inconsistent or not yet stable.	Service delivery is clearly effective in some areas, with evidence of barrier reduction and responsiveness to clients, though overall performance is mixed or uneven.	Consistently effective service delivery that actively addresses known barriers to housing and is responsive and flexible to diverse client needs and contexts, with few gaps.	Excellent service delivery – highly effective, actively and proactively addresses known barriers to housing, and highly responsive to client needs and contexts, creating lasting impact and serving as a model for others.

This section centres the experiences of participants who took part in the SOC trial. It follows the participant journey: what life was like before support, how trust was built, what practical help mattered, how housing access was supported, why post-placement support was important, and what changed for participants.

It draws on 10 participant interviews from Wellington City Mission (n=6) and Emerge Aotearoa (n=4), as well as provider interviews and reporting. Participant voice is used to show what the support meant in practice, while provider evidence helps explain the practice behind those experiences.

4.1 How the model showed up in participants' lives

SOC-enabled support showed up in participants' lives as sustained, practical and relationship-based support. Participants did not experience the model as a contract or funding arrangement. They experienced it through how providers stayed connected, helped them navigate systems, responded to practical needs, supported access to housing, and remained available after placement.

Across the interviews, the strongest pattern was that housing and wellbeing outcomes were connected. Stable housing created a base for safety, rest, reconnection and future planning, while practical and wellbeing support helped participants access housing and make it work. These experiences are explored in more detail in section 4.3.6

4.2 Services and supports wrapped around participants

SOC providers worked with a wide range of agencies, services and community supports to help participants access and sustain housing. These relationships mattered because participants' housing stability was often connected to income, health, mental health, addiction, budgeting, justice, whānau or family connections, food, transport, and household setup.

Table 10 summarises the main service and organisation types providers engaged with during delivery.

Service or organisation type	Emerge Aotearoa	Wellington City Mission	Purpose of support
MSD/Work and Income	Worked with MSD for referrals, income support, emergency housing processes, grants, and resolving practical barriers.	Worked with MSD for referrals, emergency housing payments, income support, grants, and pathway coordination.	Referral, income support, emergency housing administration, practical assistance, and system navigation.
Kāinga Ora	Worked closely with Kāinga Ora placement teams to identify suitable housing options and support placements.	Worked with Kāinga Ora and other housing providers to support applications, advocacy, and housing matching.	Access to public housing, matching to suitable properties, and tenancy sustainment.
Community housing providers	Engaged as part of wider housing pathway work.	Engaged as part of wider housing pathway work and suitable placement advocacy.	Alternative social housing pathways and housing options.
Private landlords/ property managers	Engaged where private rental options were possible, including supporting participants to be seen as viable tenants.	Engaged where private rental options were possible; WCM placed five participants into private rentals.	Private rental access, landlord confidence, tenancy applications, and advocacy.
Health services	Drew on health pathways, including mental health and alcohol and drug capability within the SOC team.	Drew on GP, dental, addiction, and wider health supports available through WCM and external networks.	Addressing health needs that affected housing readiness and sustainment.
Mental health and addiction services	Dedicated mental health/alcohol and drug clinician was part of the SOC model.	Accessed addiction support internally and external mental health or addiction pathways where needed.	Mental health, addiction support, recovery, and risk management.
Peer/lived experience support	Peer and lived-experience capability was a distinctive part of the Emerge model, including advisory input.	Lived experience informed practice, particularly through homelessness sector experience and relational support.	Trust-building, engagement, confidence, and support from people with relevant experience.
Budgeting/ financial mentoring	Supported financial capability where needed, including income and practical tenancy costs.	Used WCM financial mentoring and budgeting support.	Rent readiness, debt, budgeting, tenancy costs, and financial stability.
Food and material support	Supported access to food, household items, transport, and practical resources.	Used WCM food, household, transport, and practical assistance supports.	Immediate stability, household set-up, wellbeing, and reducing stress.
Community, cultural, and whānau supports	Connected participants to community groups, cultural supports, whānau, and social networks.	Connected participants to local supports, whānau, churches, community groups, and neighbourhood-based services.	Social connection, cultural connection, belonging, and long-term stability.
Corrections/ justice-related services	Engaged where participants had current justice involvement or restrictions affecting housing options.	Engaged where justice history, bail conditions, or restrictions affected housing options.	Managing housing restrictions, safety, compliance, and suitable placement.
Disability/needs assessment services	Engaged where participants required accessible housing or additional support.	Physical health, disability, accessibility, and (Needs Assessment and Service Coordination) needs affecting housing suitability.	Accessible housing, support needs, and sustainable placement.

Table 10: Service and organisation types engaged to support SOC participants.

4.3 Participant experiences of provider support

This section centres the experiences of participants who took part in the SOC trial. It draws on 10 participant interviews from Wellington City Mission (n=6) and Emerge Aotearoa (n=4), as well as provider interviews and reporting.

This section follows the participant journey from the conditions people were living with before support, through trust-building, practical support, housing access, post-placement support, and the changes participants experienced. It uses participant voice to show how the SOC trial was experienced by the people it was intended to support. Provider evidence is used to help explain the practice behind those experiences, including how providers built trust, addressed practical needs, supported access to housing, and remained connected after housing placement.

The section is structured around shared participant experiences, while retaining a specific Māori lens that makes cultural needs and Māori responses visible. This allows Māori participants' voices to remain clear, while ensuring non-Māori participants' experiences are also treated with care, dignity and respect.

Across the interviews, Māori and non-Māori participants described many of the same things as important: stable housing, practical help, trusted relationships, advocacy, health and wellbeing support, and being able to move at their own pace. The main differences were not in the core needs themselves, but in how those needs were expressed. Māori participants more often spoke about housing and support through whānau, whakapapa, place, kai, manaaki, cultural obligations and Māori provider connections. Non-Māori participants also described family, belonging, peer support, faith, grief, trauma and trusted relationships, but these were generally expressed through personal, family, service or community frames.

4.3.1 Before support: survival, uncertainty and low trust

Participants entered the SOC trial after long periods of housing instability. Some had spent many months, or years, in emergency housing. Others described moving between motels, temporary accommodation, cars, boarding situations, prison release, family homes, or unsafe living arrangements before entering the trial. For many, housing insecurity was tied to wider pressures, including health issues, disability, financial stress, grief, addiction, family breakdown, justice involvement, social anxiety, or previous negative experiences with agencies.

Before support could begin, participants were often managing the daily demands of survival. This included keeping appointments, maintaining contact with agencies, finding food, managing health needs, staying safe, looking after belongings, keeping phones connected, and trying to remain hopeful while living with ongoing uncertainty. For some, emergency housing provided temporary shelter but not stability, privacy, safety, or a clear pathway forward.

Several participants described being worn down by repeated contact with the system. They had told their story many times, followed up with different agencies, and waited for decisions that did not always lead anywhere. In this context, disengagement was not always a sign that people did not want support. Sometimes it was a protective response from people who were tired of being disappointed, judged, or asked to start again with someone new.

> "I just felt like a number."

> "You're scared all the time, like you don't know when the phone call is going to come."

For Māori participants, this experience of being moved through systems could also sit alongside a need to be seen in the fullness of their identity, whānau relationships, health needs, whakapapa responsibilities and connection to place. One Māori participant described the importance of not being treated as "just a name on a piece of paper". This was not only a comment about service quality. It reflected a deeper need for support to recognise the person, their history, their relationships and what mattered to them.

Non-Māori participants described similar experiences of low trust, but often through a different language of grief, trauma, health, addiction, prison release, social anxiety, faith, family disconnection or previous service fatigue. Some had been self-reliant for most of their lives and found it difficult to ask for help. Others had been in systems for so long that they did not believe a different outcome was possible.

This starting point is important for understanding the SOC approach. Participants were not simply waiting for a housing vacancy. Many needed time, trust, practical help and consistent support before they could fully engage with housing options. For some, the first task was not completing a housing plan, but rebuilding enough confidence to believe that support might lead somewhere different this time.

For some participants, stepping back from services was a protective response after repeated disappointment, judgment, or having to retell their story. The early work of providers was therefore to create sufficient safety and consistency to enable engagement.



Disengagement was not always refusal.

For some participants, stepping back from services was a protective response after repeated disappointment, judgment, or having to retell their story.

4.3.2 Support worked when people felt known, not managed

Across participant interviews, trust was built through consistency. Participants noticed when providers kept showing up, checked in regularly, remembered what mattered, and did not withdraw support when engagement was uneven. This mattered because many participants had previous experiences of feeling judged, being let down, or having to repeat their story to different agencies.

Support was strongest when it was low-pressure and reliable. Participants valued being able to engage at their own pace, step back when needed, and reconnect without fear of support being withdrawn. For some, this was different from other service experiences where support felt conditional, compliance-focused, or driven by appointment schedules rather than what was happening in their lives.

> "If I decide I didn't want to see them, I could just message, 'No, not this week.'"

> "They're there if I need them, and they check on my wellbeing. There's no pressure."

These experiences show that trust was not built through a single interaction. It developed over time, as providers demonstrated that they were interested in the person, not only their housing status. Participants valued workers who listened, followed through, advocated when needed, and helped them make sense of systems that were often difficult to navigate.

Participants were more willing to discuss what was really happening in their lives when providers had taken time to build trust. This helped providers identify barriers that were not always visible at first contact, including health issues, anxiety, isolation, whānau disconnection, financial pressure, previous service fatigue, or fear of moving into housing that would not be sustainable.

For Māori participants, this kind of support was closely connected to being recognised in the fullness of their circumstances: as people with whānau relationships, whakapapa obligations, health needs, histories, preferences and connections to place. For non-Māori participants, similar needs were often expressed in terms of trust, respect, non-judgement, independence, and being treated as a person.

> "The ball was always in my court."

> "They actually listened. It didn't feel like I was just another number."

Trust also created room for participants to take a more active role in decisions. When people felt heard and not pushed, they were better able to talk about what kind of housing would work for them, what support they needed, and what they were not ready for. This was particularly important for participants who had disengaged from services in the past, or who had lost confidence that systems could help them.

Provider evidence helps explain why this mattered. Providers described relationship-building as core housing work, not an optional extra. Taking time to understand people's circumstances helped providers identify barriers that were not always visible at first contact, including anxiety, addiction, health issues, financial stress, isolation, whānau disconnection, lack of confidence, or fear of moving into housing that would not be sustainable.



Relationship-building is core housing work, not an optional extra.

Trust gave providers access to the real barriers affecting housing stability, including health, anxiety, isolation, whānau disconnection, financial pressure and fear of another failed placement.

Overall, participants' experiences suggest that the SOC model worked best when support was relational, persistent and person-centred. People were more likely to trust support when they felt known, not managed; when they had choices, not instructions; and when providers stayed connected long enough for trust to become possible.

4.3.3 Practical help made housing liveable

Participants did not experience support as only help to find a property. Housing became possible and more sustainable when providers helped with the practical things that made a house liveable and daily life manageable.

Across the interviews, participants described support with food, furniture, whiteware, clothing, bedding, phones, transport, appointments, forms, benefits, medication, GP enrolment, moving, and household set-up. These forms of help were often modest, but they mattered. For people coming from emergency housing, homelessness, prison release, unstable accommodation, or long periods of financial stress, small practical barriers could quickly become the things that delay housing or make a new tenancy harder to sustain.

> "The food support, yeah. Having access to kai."

> "They got all my pots, pans, all that stuff, and took it to my house."

Practical support also reduced the pressure on participants to navigate multiple systems alone. Providers often acted as connectors between participants, MSD, Kāinga Ora, health services, landlords, community agencies and other supports. This was particularly important where participants felt anxious, unwell, overwhelmed, or unsure what help was available. For some, having a worker make a call, explain a process, attend an appointment, or follow up on their behalf made the difference between support being theoretically available and support being usable.

Participants valued this help because it was tied to what was happening in their lives at the time. For some, the immediate need was food or transport. For others, it was medication, health care, furniture, a phone, help with moving, or support to understand forms and appointments. The support worked best when it was responsive and practical, rather than limited to a fixed housing pathway.

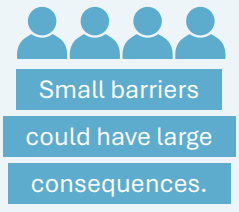
For Māori whānau, practical support was often experienced as more than help with tasks or household items. Kai, health support, transport, clothing, bedding and help setting up a home could also carry a manaaki dimension, helping whānau feel cared for, less pressured, and more able to settle. Where providers were able to connect Māori participants with Māori providers, Māori health services, whānau networks or culturally familiar support, practical help also strengthened access to relationships and services that were more grounded in their identity and circumstances.

For non-Māori participants, similar supports were often described through the language of groceries, essentials, health needs, service navigation, faith, family support, or practical relief. These accounts also showed how important it was for support to be respectful and human. Participants were often grateful not only for what was provided, but for the way help was offered: without judgement, with reassurance, and with a clear sense that someone was trying to make things easier.

Practical support was therefore not separate from housing stability. It helped turn a tenancy into a home. It reduced stress, supported health and wellbeing, helped people meet basic needs, and gave participants greater confidence in managing daily life. Without this kind of support, a housing placement could still leave people without the resources, routines or confidence needed to sustain it.

Once housed, practical needs did not disappear; they changed. Participants then needed support to set up routines, manage bills, connect utilities, access food and health care, and adjust to living independently again. This point is developed further in section 4.3.6.

Provider evidence reinforced this point. Providers described practical help as part of the work of sustaining housing, not simply as short-term crisis support. A participant might need help with a food parcel one week, a GP appointment the next, and furniture or budgeting support after moving. The ability to respond flexibly meant providers could deal with barriers as they arose, rather than waiting until they became tenancy risks.



A missing phone, lack of transport, no furniture, food insecurity, or difficulty completing forms could delay access to housing or make a new tenancy harder to sustain.

Overall, participants' experiences suggest that practical support was central to the SOC model. It helped bridge the gap between being offered housing and being able to live safely and independently in that housing. For many participants, the basics were not small things. They were the conditions that made stability possible.

4.3.4 Whānau, family and connection mattered

For participants, stable housing was not only about having somewhere to live. It created a base for connection, belonging and responsibility. Across the interviews, Māori and non-Māori participants talked about children, partners, siblings, parents, wider whānau, friends, peer networks, faith communities and trusted workers. These relationships shaped what people needed from housing, what support they needed to recognise, and what became possible once they were housed.

For Māori participants, whānau connection was a central part of the housing journey. Housing created a place where whānau could visit, siblings could be supported, relationships could be repaired, and cultural responsibilities could be maintained. In some accounts, a suitable home was one that supported whānau connection, access to local services, connection to familiar places, and the ability to meet whakapapa responsibilities.

> "I'm able to have my family come over every now and again."

> "This place meets my needs. My doctors are here. Everything's close."

These accounts show that housing was not only an individual outcome. For Māori participants, a stable home could also support whānau responsibility, manaaki, connection to place, and cultural obligations. This was visible in practical ways: having space for whānau to visit, being close to doctors and familiar services, being able to support a younger sibling, or needing help to attend a tangi when travel costs were a barrier. Housing also created a base from which whānau responsibility and manaaki could be practised again. This included being able to host whānau, support siblings, stay close to familiar services, maintain connections to place, and meet cultural responsibilities. For some, the shift into housing also restored the ability to give back after long periods of instability where they had been unable to reciprocate in the ways they wanted to.

Non-Māori participants also described the importance of family and connection, although these experiences were generally framed differently. For some, stable housing supported reconnection with children or partners after long periods of instability, addiction, illness, prison release, grief or social isolation. For others, peer networks, friends, faith, or trusted support workers became important sources of connection where family relationships were distant, strained or unavailable.

> "I had lost my family... now I'm still able to connect with my family and move forward."

> "We started to build that trusting relationship."

Several participants also described peer support that had developed through shared experiences of emergency housing or homelessness. These relationships provided understanding, encouragement and practical help. Participants talked about checking in on each other, sharing advice, helping others navigate services, and returning to emergency housing sites to encourage people who were still waiting for housing.

This reciprocity matters. Participants were not only recipients of support; they were people with relationships, responsibilities and something to offer others. Once housed, some were better able to support siblings, children, friends or peers. For some, this was part of the wider wellbeing change associated with housing stability: they were not only safer and more settled but also better able to be present for others.

Provider evidence supports this finding. Providers described the importance of understanding who mattered in a participant's life, what relationships supported stability, and what connections might create stress or risk. In practice, this meant recognising that housing decisions could not be separated from whānau and family circumstances, cultural obligations, peer relationships, safety concerns, health needs or community connection.



Once housed, some participants were better able to support whānau, reconnect with children, contribute to peer networks, and practise manaaki from a more stable base.

Overall, participants' experiences suggest that housing support worked best when it recognised people as relational beings. A sustainable housing outcome was not only a person in a property. It was a person who was able to maintain the relationships, routines, supports, and responsibilities that helped them stay well and remain housed.

4.3.5 Appropriate housing, not just any housing

Participants and providers both emphasised that stable housing needed to be appropriate, not simply available. For people who had spent long periods in emergency housing, homelessness, temporary accommodation, or unsafe living situations, being offered "a place" was significant. However, participants' accounts show that housing was more likely to support stability when it fitted their health needs, whānau or family circumstances, mobility, safety, income, transport, services and sense of belonging.

For some participants, location mattered because it kept them close to doctors, pharmacies, shops, public transport, support workers, whānau, family, friends or familiar communities. For others, the physical features of the house mattered: stairs, accessibility, size, outdoor space, security, heating, or whether there was room for children, siblings or whānau to visit. Some participants needed housing that supported recovery, reduced anxiety, or helped them avoid environments linked to previous instability.

> "It's close to the shops, just a walk away."

> "I'm able to have my family come over every now and again."

These comments show that "suitable housing" was not an abstract service category. It was about whether the home could work in the realities of a person's life. A property that was technically available could still be unsuitable if it isolated someone, increased transport costs, made health care harder to access, created safety concerns, or made whānau and family connections difficult.

Choice also mattered. Participants valued being able to consider whether a house would work for them, rather than feeling pressured to accept the first available option. Some described positive experiences in which they were given time to think, told they did not have to decide immediately, or supported in raising concerns. Others described moves that felt rushed or housing decisions with limited choice.

> "They said I didn't have to take it. Take your time. You don't have to give us an answer right then and there."

> "One minute you think you've got a week or two to get your head around it, and then the next minute, you've got two days to sort yourself."

This difference matters. For participants who had lived with instability for a long time, moving into housing could bring relief, but also anxiety. Having time, information, and choice helped people feel more in control. When decisions felt rushed or when there was little room to discuss what would work, the process could add pressure at the very point where people were trying to settle.

For Māori participants, appropriate housing also needed to support whānau connection, cultural obligations and connection to place. This included being close to services and familiar places such as kohanga, kura or marae, having space for whānau to visit or stay, and being able to meet responsibilities such as attending tangi. These needs were not always separate from practical housing considerations; they were part of what made housing workable and sustaining.

For non-Māori participants, suitability was also strongly relational and practical. Participants talked about reconnecting with children, living with a partner, being near shops or services, managing health needs, rebuilding routines, and feeling safe after long periods of disruption. For some, the right house created a sense of possibility they had not felt for a long time.

Provider evidence reinforces this point. Providers were not only trying to move participants out of emergency housing; they were trying to support sustained housing. This meant understanding what would make a placement workable over time. In practice, that included advocating for housing that matched participants' circumstances, resisting unsuitable options where possible, and helping participants prepare for the responsibilities and routines of living independently again.



Housing fit matters.

The closer housing matched participants' health, whānau or family, location, mobility, and safety needs, the less post-placement support was needed to compensate for a poor fit.

The closer the housing matched participants' lives, the less likely post-placement support had to compensate for a poor fit.

Overall, participants' experiences show that the quality and fit of housing mattered. A successful placement was not just an exit from emergency housing. It was housing that people could realistically live in, afford, access, feel safe in, and connect from. When housing fitted people's lives, it was more likely to become a stable base rather than another temporary stop.

4.3.6 Housing was a turning point, not the finish line

For participants who moved into housing, the shift was significant. Housing created safety, privacy, relief and a sense of possibility after long periods of uncertainty. Participants described feeling calmer, more settled, and better able to manage day-to-day life. For some, it also created space to reconnect with whānau or family, engage with health services, think about work or study, or begin rebuilding routines.

> "I'm a lot more mellow, less stressed, less agitated and more stress-free."

> "I've got my own place now... It's been amazing."

> "I cried when I saw it... I said, 'Oh my God, it's beautiful.'"

At the same time, housing did not resolve everything. Moving into a tenancy after emergency housing, homelessness, prison release, family breakdown, illness, or long periods of instability could bring its own pressures. Participants still needed to manage bills, food, utilities, appointments, furniture, health needs, relationships, tenancy responsibilities and the emotional adjustment of living independently again. For some, the quiet and responsibility of a new home required adjustment after a long period of survival mode.

The support participants needed to get into housing was not always the same as the support they needed to sustain housing. Pre-placement support often focused on access: finding a property, attending viewings, navigating agencies, completing forms, organising bond, transport, furniture and household set-up. Post-placement support focused more on sustainment: managing bills, routines, health needs, food, landlords, utilities, isolation, whānau or family responsibilities, and the emotional adjustment of living independently after a long period of instability.

This is why post-placement support mattered. Participants valued workers who stayed connected after they moved, checked in to see whether they had what they needed, helped with practical issues, and remained available when things became difficult. This support reduced the risk of people becoming isolated, overwhelmed, or disconnected once the immediate housing placement was secured.

> "They're there if I need them."

> "It's not like I need it all the time. It's just like when I fall short."

> "I wouldn't have made it so far if it weren't for [name]."

For Māori participants, post-placement support was important because housing created a base for whānau connection, manaaki and cultural responsibilities. A stable home made it more possible to host whānau, support siblings, stay connected to services, attend tangi, and meet wider whakapapa obligations. It also created the conditions for reciprocity. After long periods in emergency housing or instability, some participants were better able to care for others, contribute to peer networks, and practise manaaki from a place of greater stability. Support with kai, transport, health care, household set-up and service connection helped make the new home workable. In this sense, post-placement support helped make housing a place of stability, responsibility, and contribution, not simply a placement.

For non-Māori participants, post-placement needs were similarly varied. Some needed help with bills, landlords, health appointments, social anxiety, transport or food. Others were ready for support to step back once they felt settled. This shows the importance of support being flexible and responsive over time. The right level of support was not the same for everyone, and it changed as people became more confident and settled.

Some participants also described the need for support to reduce once it was no longer useful. This was not a rejection of the service, but a sign that participants wanted their independence recognised. Others still valued light-touch check-ins, particularly where trust had been built, and the relationship itself remained a source of reassurance.

Provider evidence reinforces this point. Providers described housing placement as one stage in a longer journey. Sustained housing depended on whether participants had the practical resources, confidence, wellbeing support and relationships needed to remain housed. Continued support after placement enabled providers to respond early to issues that could otherwise have become risks to tenancy stability.



Getting housed and staying housed require different kinds of support.

Pre-placement support helped participants access housing. Post-placement support helped them make housing work.

Overall, participants' experiences suggest that the SOC trial was strongest where support continued beyond housing placement and adjusted to each person's changing needs. Housing was the turning point: it created the conditions for safety, rest, connection and future planning. Post-placement support helped ensure that the turning point held, particularly for participants still managing health issues, financial pressure, isolation, whānau or family responsibilities, or the practical and emotional adjustment to living independently again.

4.3.7 What changed for participants

For participants, the most visible change was movement into more stable housing. However, the interviews show that the meaning of that change was wider than having a roof overhead. Housing provided a foundation for safety, privacy, rest, routine, connection, and future planning. It reduced some of the stress and uncertainty that had shaped daily life in emergency housing, homelessness, temporary accommodation or unstable living situations.

Participants described feeling calmer, safer and more settled. Some were able to reconnect with whānau, family, partners or children. Others were able to engage with health services, manage appointments, keep food in the cupboards, look after belongings, make plans, or begin thinking about work, study or other next steps. For some, the most important change was simply having a place where they could close the door and begin to feel secure.

> "I've got myself in a good mindset now."

> "I'm just glad that I'm in a house."

These changes were supported by the combination of housing, practical help and relational support. Participants' accounts suggest that the SOC trial worked best when these elements came together: a suitable housing option, a trusted worker, practical support to make the home liveable, and ongoing contact after placement. Where this happened, housing became more than an exit from emergency housing. It became a foundation for rebuilding stability.

The support also helped some participants regain a sense of control. Being listened to, having choices respected, and receiving practical help over time contributed to participants feeling less like they were being moved through a system and more like they had a say in what happened next. This mattered for participants who had lost trust in agencies, disengaged from services in the past, or felt that earlier support had not recognised their circumstances.

For Māori participants, change was visible in both individual and collective terms. Housing supported safety, rest, and independence, but it also provided a foundation for whanaungatanga (whānau connection and relationships), manaakitanga (ethic of care), haepapa (responsibilities), and tauututu (reciprocity). Some participants were able to host whānau, support siblings, stay connected to familiar places and services, or contribute to peer networks. These changes suggest that housing stability can restore not only personal wellbeing, but also the ability to take part in relationships and responsibilities that matter.

For non-Māori participants, change was also relational and practical. Housing supported reconnection with children or partners, rebuilding confidence after grief, illness, addiction or justice involvement, and relying less on crisis-based support. Some participants described strong peer relationships, faith, trusted workers or friends as important parts of their recovery and stability.

The changes were not always immediate or complete. Some participants were still managing health issues, financial pressure, isolation, anxiety, family strain or the practical demands of settling into a tenancy. For some, housing created relief; for others, it also brought new responsibilities and uncertainty. This reinforces the importance of post-placement support that can adjust as needs change.

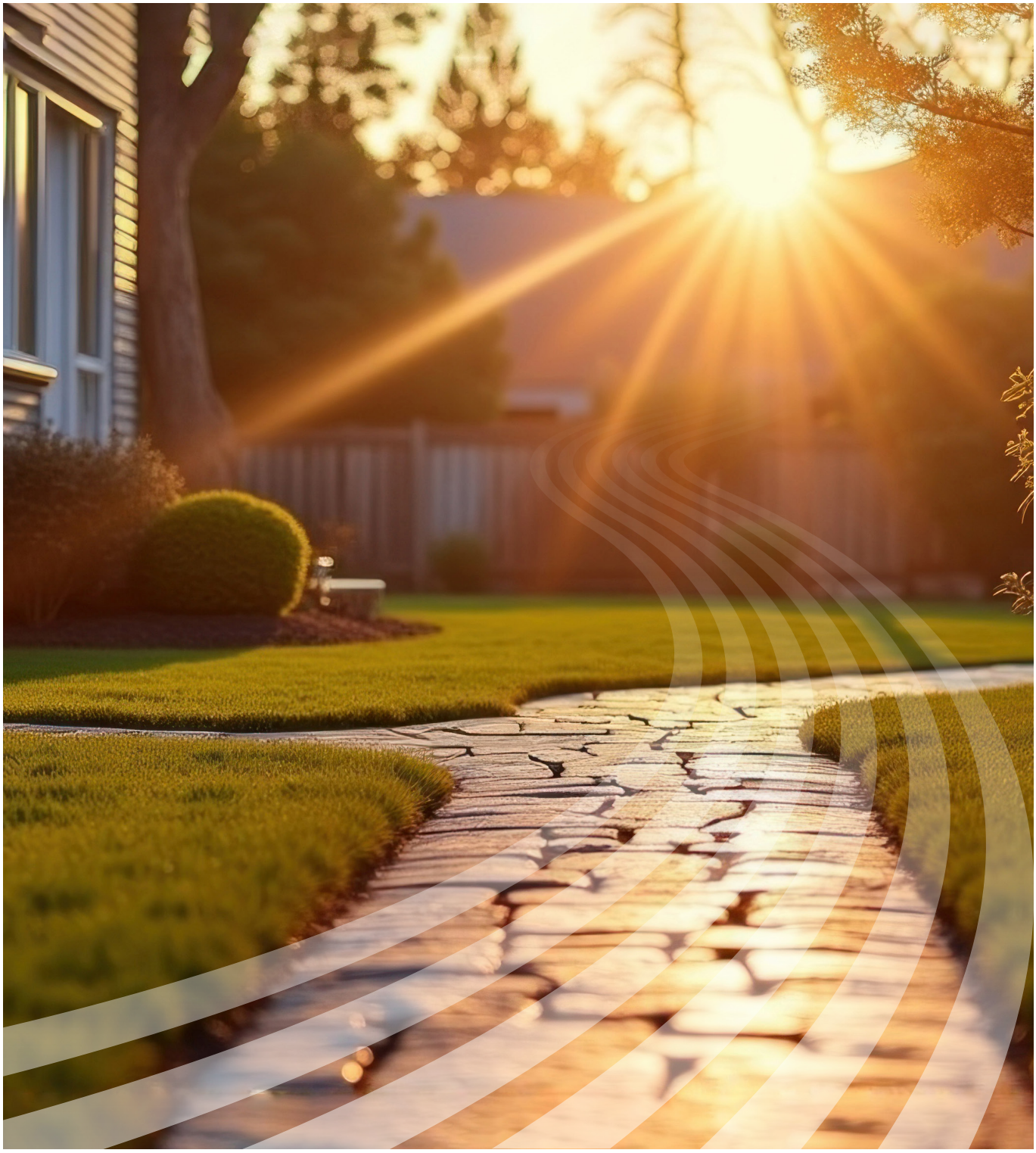
Overall, participant experiences suggest that the SOC trial contributed to more than housing placement. For many, the combination of sustained support, appropriate housing, practical help and ongoing connection helped create the conditions for independence, wellbeing, whānau or family connection, and future planning. The strongest evidence of change was not only that participants moved into housing, but that housing gave them a more stable base from which to live, connect and look ahead.



Housing gave people a base to live, connect and look ahead.

The most marked change was not only movement into housing, but the wider stability, connection and confidence that housing made possible.

5. Future implications



Overall, the SOC trial provides **moderate to strong evidence for future application.** The evaluation does not support continuing the trial in its original emergency housing form, because the context and target cohort have changed. The trial provides strong insights into features of the SOC model that enabled delivery, including provider discretion, relational practice, practical support, post-placement support, flexible funding, and accountability for sustained housing outcomes. These features are highly relevant to future housing responses for high-need cohorts and should be deliberately retained, adapted, or built into existing services where they are not already consistently available.

Scalability is assessed as **Moderate.** There is useful evidence about the conditions that supported delivery, including provider discretion, relational practice, practical support, post-placement support, flexible funding and accountability for sustained housing outcomes. However, future use would require a implementation discipline as reflective of HUD and MSD set roles and the policy and model intent.

Value for investment is assessed as **Moderate, with promising early indications.** The trial is producing positive housing and wellbeing outcomes, but the evaluation cannot make a definitive value-for-investment judgement without fuller financial data, clearer comparator evidence, and outcomes data for similar cohorts receiving other services.

Domain 3: Future application

KEQ 3: What does this mean for sustainability and future decisions?

Sub-domain	Not yet evident	Minimal	Moderate	Strong	Transformative
Scalability	No demonstrable basis for continuation or scaling – the model is not yet sustainable and conditions required for expansion are unknown or not feasible.	Minimal or limited evidence that the model could be sustained or scaled – some enabling conditions are identified but significant changes needed	Some evidence that the model is sustainable in its current form – some understanding of conditions required for scaling, though feasibility of continuation or expansion is mixed or uncertain.	Generally strong basis for scalability – the model is demonstrably sustainable, conditions for expansion are known and largely feasible, and there is a credible path to scaling with some refinement	Strong evidence for sustainability and scalability – model is well-understood, conditions for continuation or expansion are known and feasible, model can be maintained over time.
Value for investment	No demonstrable value for investment – outcomes do not justify the level of investment and compare unfavourably with business-as-usual alternatives.	Limited value for investment – some positive outcomes are present but these are insufficient or inconsistent relative to investment, and comparison with BAU alternatives is unclear.	Moderate value for investment overall – outcomes are broadly commensurate with investment, with some basis for favourable comparison with BAU alternatives, though the overall picture is mixed, uneven or too resource-intensive.	Good value for investment overall – outcomes clearly justify the investment, with minor inefficiencies, and are at least as good as BAU alternatives across most dimensions.	Excellent value for investment overall – strong outcomes relative to investment, are at least as good as BAU alternatives, demonstrating a compelling case for sustained or expanded funding.

This section addresses the third evaluation question: what the SOC trial means for future decisions. The trial was designed for a specific emergency housing context, and that context has changed. The future question is therefore not simply whether SOC should continue in its original form, but what can be learned from the trial, which features appear transferable, and what further evidence is needed to assess future value for investment.

5.1 The emergency housing rationale has changed

The SOC trial was designed for a specific emergency housing context: people who had remained in emergency housing for extended periods and were not already receiving support through other targeted housing exit pathways. That context has changed. Emergency housing numbers have reduced, and tighter eligibility requirements and obligations have changed the size and nature of the cohort the trial was originally designed to support.

This means the future question is not simply whether the SOC trial should continue in its original emergency housing form. On the current evidence, continuation in that form is not supported. The more useful question is what can be learned from the trial, and whether selected elements of the SOC approach have value for other high-need housing cohorts or should be built into existing services.

5.2 Future decisions should focus on transferable features, not the SOC label

The most transferable features of SOC are not tied only to emergency housing. They relate to how support is commissioned and delivered for people experiencing complex and persistent housing instability.

The strongest transferable features are outlined below:



Provider discretion: Providers had the flexibility to tailor support to participants' needs, readiness, circumstances, and housing options.



Relational engagement: Providers had the time and flexibility to build trust, including with participants who had low confidence in services or had previously disengaged.



Practical barrier removal: Providers could respond to immediate needs affecting engagement, housing access, or sustainment.



Appropriate housing focus: Providers supported housing that fitted participant needs, rather than treating any placement as sufficient.



Post-placement support: Support continued after housing placement, helping participants settle, manage new responsibilities and reduce the risk of tenancy breakdown.



Outcome accountability: The model reinforced a focus on sustained housing outcomes, not only activity or short-term placement.



Provider capability: The model worked because providers had the workforce, relationships, local knowledge and infrastructure to use flexibility well.

These features could be retained through a dedicated SOC-type model or by building them into existing housing contracts and services. The key decision is whether these enabling conditions are already in place and consistently available to high-need cohorts.

5.3 Outcomes-based payments reinforced the focus on sustainment

Outcomes-based payments were a key feature of the SOC model. Milestone payments linked to sustained housing at three, six, and 13 months helped reinforce that the trial focused on housing sustainment, not simply on housing placement.

This feature appears valuable because it aligns provider effort with longer-term outcomes. However, the trial also shows that outcomes-based payments need to sit alongside core funding. Providers were supporting participants with complex needs, within a constrained housing system, and without additional housing supply. A hybrid funding model helped maintain the focus on sustained outcomes without placing unreasonable risk on providers for factors outside their control.

For future models, the key questions are what outcomes should trigger payment, what timeframe is appropriate, and how provider accountability should be balanced against wider system constraints.

5.4 Value for investment: promising, but not yet definitive

Early indications suggest that the SOC trial is creating value. Participants are moving into and sustaining housing, experiencing wider wellbeing gains, and receiving support that providers and participants describe as meaningful. Providers are delivering housing and wellbeing outcomes, and shared that the housing and wellbeing outcomes achieved and the experience of the SOC trial services are at least as good as existing alternatives.

However, the evaluation cannot make a definitive value-for-investment judgement.

Fuller evidence is needed on:

- The full cost of delivery, including the contribution of existing provider infrastructure and capability
- Outcomes for comparable high-need cohorts receiving existing services, especially when measured over longer time frames (e.g. 13+ months post housing placement)
- The intensity, duration and nature of support provided
- Whether SOC reduces future demand for emergency housing or other crisis services
- The relative value of the commissioning model, compared with the provider capability that already existed.

For these reasons, value for investment is best described as promising, but not yet definitive.

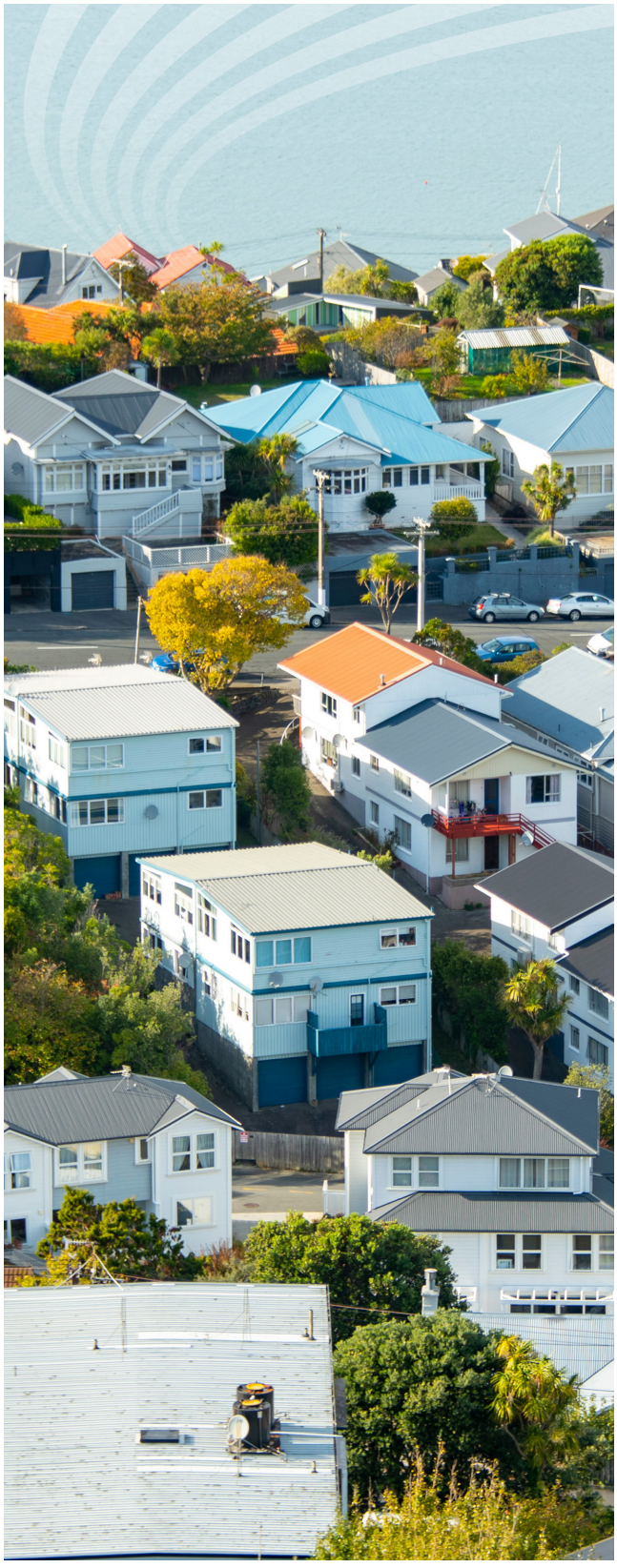
5.5 Implications for future decisions

The future decision is not simply whether to continue SOC. It is whether future housing responses include the enabling conditions that appeared to matter: provider discretion, relational engagement, practical barrier removal, appropriate housing, post-placement support, flexible funding, provider capability and accountability for sustained housing outcomes.

Future decisions should therefore focus on three questions:

1.	Which high-need housing cohorts, if any, require SOC-type support?
2.	Are these enabling conditions already present and consistently available within existing services?
3.	What evidence is needed to assess comparative effectiveness and value for investment?

Overall, the SOC trial suggests that flexible, relational and sustained support can contribute to housing and wellbeing outcomes for people experiencing complex housing instability. Its future value will depend on where service gaps remain, and how deliberately these enabling conditions are built into future housing responses.



6. Conclusion



The SOC trial shows early promise as both a housing intervention and a test of more flexible, outcomes-focused commissioning. The strongest evidence is that participants are moving into and sustaining housing, and that stable housing is contributing to wider wellbeing, connection, confidence and stability.

These outcomes were not produced by housing placement alone. They were supported by the combination of provider discretion, skilled provider capability, practical help, appropriate housing, trusted relationships and continued support after placement. In this sense, the trial reinforces that getting housed and staying housed require different kinds of support.

The contracting approach mattered because it created the conditions for this kind of support. Core funding supported provider viability and sustained engagement. Provider discretion allowed support to be tailored to participant needs and readiness. Flexible funding helped providers respond to practical barriers. Milestone payments reinforced the focus on housing sustainment, not only placement. Active stewardship helped maintain attention to implementation, learning, and outcomes. Together, these features enabled providers to work with the relationship between housing and wellbeing, rather than treating housing as a standalone transaction.

The evaluation cannot determine whether SOC is more effective than existing services, nor can it make a definitive value-for-investment judgement without a stronger comparator and financial evidence. The changed emergency housing context also means the SOC trial cannot be continued as originally designed. SOC-type settings can strengthen support, navigation, matching and sustainment, but they cannot resolve structural housing supply constraints on their own.

A recent MSD evaluation[9] provides a useful contextual benchmark, but it does not resolve the question of SOC's added value. It should not be treated as a direct comparator because its key measure of non-return to emergency housing within 180 days is not equivalent to SOC's measures of stable, appropriate and sustained housing.

The main decision for the future is therefore not whether to replicate SOC exactly. It is a question of whether future housing responses for high-need cohorts include the enabling conditions that appeared to matter: flexible commissioning, provider discretion, relational engagement, practical barrier removal, appropriate housing, post-placement support, provider capability, and accountability for sustained housing outcomes. These features are highly relevant to future housing responses and should be deliberately retained, adapted, or built into existing services where they are not already consistently available.



Appendixes



Appendix 1: Evaluation methodology

Evaluation approach and design

This evaluation used a mixed-methods, outcomes-focused approach to examine the implementation and early outcomes of the Social Outcomes Contracting (SOC) trial in Wellington and Waikato. The evaluation was designed to generate practical, policy-relevant insights to inform future housing and commissioning decisions, and to understand the operation of social outcomes contracting as a funding model.

The approach drew on kaupapa Māori-informed and utilisation-focused evaluation frameworks. This included an emphasis on whānau experience, relational practice, and the wider system and structural factors shaping housing outcomes.

The evaluation approach:

- Emphasised whānau voice and lived experience in data collection and interpretation
- Prioritised relational, strengths-based understandings of outcomes
- Considered the interaction between individual needs, service delivery, and structural housing constraints
- Focused on producing findings that are relevant and usable for policy, commissioning, and service design decisions.

The evaluation was guided by the Key Evaluation Questions (KEQs) outlined in the Request for Proposal, which were lightly refined for flow and coherence. Evaluative rubrics were developed to support structured analysis and synthesis across the evidence base (see Appendix 2).

Evaluation scope and focus

The evaluation examined both implementation and early outcomes of the SOC trial. It focused on:

- How the trial was implemented in practice
- The extent to which intended outcomes were being achieved
- What could be learned about the service model and the social outcomes contracting approach.

Key outcome domains included:

- Housing sustainment
- Wider wellbeing outcomes for participants
- System and commissioning learning.

Data collection methods

Data collection was designed to capture both implementation experience and early outcomes across multiple perspectives. Multiple data sources were used to support triangulation and strengthen the robustness of findings.

The evaluation drew on:

- Document review (see the reference section for a list of policy and other documents cited in this evaluation report)
- Quarterly provider and agency meeting notes:
  - Emerge Waikato: May, September, November 2025 and March 2026
  - Wellington City Mission: May, September, November 2025 and March 2026.
- Monitoring and administrative data
- Semi-structured interviews with participants, providers, HUD, and MSD.

Document review

A review of programme and policy documentation was undertaken to understand the rationale, design, implementation, and intended outcomes of the SOC trial. Documents reviewed included Cabinet papers, briefings, procurement and contracting documentation, intervention logic and trial procurement letters to selected providers (anonymised).

This provided contextual grounding for understanding how the trial was intended to operate and how it evolved over time.

Monitoring and administrative data

The evaluation included analysis of routine monitoring and administrative data collected as part of the SOC trial, including participant engagement, housing placements, sustainment milestones and exit timing and reasons and exits timeframes.

Meeting notes of quarterly conversations between officials and providers from May 2025, September 2025, November 2025, and March 2026 were also analysed to provide insight into implementation experience, emerging challenges, adaptations, and learning.

Given the small cohort and early stage of the trial, quantitative analysis was primarily descriptive.

Interviews and recruitment

Semi-structured interviews were undertaken with SOC participants, providers, and agency staff. Recruitment and interview processes were tailored to each provider context to support participation and minimise burden on participants.

HUD facilitated initial introductions between the evaluation team and provider organisations (Wellington City Mission and Emerge). The evaluation team then worked directly with a key contact in each organisation to coordinate interviews.

Provider interviews were conducted first, with a total of 11 completed. In Wellington, three individual interviews were undertaken with a manager, a key worker, and a director, followed by a paired interview with the manager and key worker (n=5 participants). In Waikato, three paired interviews were conducted with managers, policy staff, and key workers (n=6 participants).

Participant recruitment was supported by providers, using an information sheet and consent form developed by the evaluation team. In Wellington, key workers approached potential participants, including those who were housed and those still in emergency housing. Where participants agreed, their contact details were shared with the evaluation team for follow-up. Eleven participants agreed to be contacted; three declined to be interviewed when contacted, and eight agreed to be interviewed. Six interviews were completed; one person was hospitalised, and one person did not reconfirm on the day or when we followed up later. In Waikato, Emerge coordinated participant interviews. Five participants were confirmed; four attended on the day. One participant declined a follow-up invitation after not attending.

Participants were interviewed in locations that suited them. In Wellington, interviews were held at a place of the participant's choosing (including provider sites and homes). In Waikato, all interviews were held at Emerge premises.

In Wellington, where interviews took place in participants' homes, a small kai basket (fruit, biscuits, tea/coffee, milk; approximately $15) was provided, along with a $50 Prezzy card. In Waikato, shared kai was provided at Emerge premises, along with a $50 Prezzy card for participants.

At the beginning of each interview, evaluators reviewed the information sheet and consent form with participants, including the purpose of the evaluation, confidentiality, and the voluntary nature of participation. Participants were given the opportunity to ask questions and could withdraw at any time. All participants provided informed consent.

Participant profile:
Participants (n=10)

WELLINGTON CITY MISSION (WCM) (n=6)



ETHNICITY:
Māori (3), NZ European (2), Pacific (1)

GENDER:
Male (4), Female (2)



HOUSING:
5 Housed, 1 in EH

EMERGE (WAIKATO) (n=4)



ETHNICITY:
Māori (1), NZ European (3)

GENDER:
Male (4)



HOUSING:
4 Housed

The sample reflects participants available and willing to take part at the time of data collection and is intended to provide depth of insight rather than represent the full SOC cohort.

We also conducted 12 interviews with policy and operational personnel from HUD (n=6) and MSD (n=6).

Analysis

Analysis combined deductive and inductive approaches. Evidence was organised against the KEQs and evaluative rubrics, while allowing for emergent themes across the data. Findings from different sources were triangulated to identify areas of agreement, difference, and uncertainty.

Analysis approach

The analysis was conducted in two phases and combined collaborative team-based sense-making with structured thematic analysis.

In the first phase, the research team analysed interview data collaboratively against the KEQs. All team members had either conducted interviews or acted as note-takers. A Miro board was used to document initial insights, identify themes, and map findings. The team revisited this analysis to refine interpretations, test assumptions, and agree key findings.

Participant interviews were analysed in stages. The six Wellington City Mission interviews were analysed first, followed by the four Emerge interviews. These were then combined and analysed using a compare-and-contrast approach.

Further analysis was undertaken by participant group. Māori participant interviews (n=4) were analysed separately, followed by non-Māori participant interviews (n=6), and then compared to identify similarities and differences.

In the second phase, Claude 4.6 (AI) was used as a secondary analytical tool to support sense-making, identify patterns, and test consistency across the analysis.

Making evaluative judgements

Findings were assessed against the KEQs using evaluative rubrics to support transparent and consistent judgment.

A performance scale was developed to summarise the strength of the evidence, the level of progress, and confidence in the findings (see Appendix 2). Judgements consider both observed outcomes and evidence of emerging progress and potential.

The evaluation does not attribute causal impact. Instead, the findings reflect an assessment of the contribution the SOC trial appears to have made within the constraints of the trial design, the available evidence, and the timeframe.

Limitations

The limitations of this evaluation reflect the trial's design and the system context in which it was implemented, rather than gaps in the evaluation approach. The trial was not designed with a comparator or counterfactual, including a kaupapa Māori provider, and relied on existing housing pathways and MSD processes.

The evaluation was undertaken while the trial was ongoing and within a constrained timeframe. Findings, therefore, reflect early outcomes and do not capture long-term housing sustainment.

The absence of a kaupapa Māori provider is a feature of the trial design that shapes the scope of the evaluation. While the evaluation includes specific analysis of Māori participant experiences, the trial does not include a comparator that would enable assessment of outcomes under kaupapa Māori delivery.

As a result, the evaluation can describe Māori participants' experiences and outcomes within the model but cannot assess how these compare with kaupapa Māori approaches or attribute differences to the service model's design. This limits the ability to assess differential outcomes for Māori and should be considered when interpreting findings.

Additional limitations include:

- A small number of participant interviews, which provide depth rather than representativeness
- Variability in the completeness and detail of monitoring and administrative data
- A changing emergency housing context, including declining numbers, refined eligibility settings, and constrained housing supply.

These factors influence outcomes beyond the programme's control.

Taken together, findings should be interpreted as evidence of contribution within system constraints, and as indicative of early outcomes rather than definitive evidence of impact.

AI-assisted analysis

AI-assisted analysis was used as a supplementary step within the evaluation synthesis process. The evaluation team first undertook independent analysis of interview data, including transcript review, collaborative sense-making, and assessment against the KEQs and evaluative rubrics.

De-identified interview data were then analysed using the commercial version of Claude 4.6 to support secondary thematic analysis. This included identifying patterns, similarities and differences, and testing the consistency of emerging findings.

AI outputs were used to refine and validate the evaluation team's analysis, not replace it. Data privacy safeguards were applied, and no identifiable information was used.

Appendix 2: Evaluative Rubric

Key Evaluation Questions (KEQs)

1. **To what extent does the SOC trial support meaningful and sustained outcomes?**
   a. To what extent are whānau accessing stable, appropriate, and sustained housing?
   b. To what extent are whānau experiencing wider wellbeing outcomes?
   c. For whom were the services most or least effective?
   d. What were the experiences of providers?

2. **How and why are outcomes being achieved?**
   a. To what extent were providers able to design a service that met the needs of whānau?
   b. How well did the services address known barriers to whānau and clients accessing stable housing?
   c. To what extent did providers have the capability to deliver their intended service effectively?
   d. What factors of the SOC model enable or constrain delivery?
   e. What factors of the SOC model enable or hinder outcomes for whānau?

3. **What does this mean for future decisions?**
   a. To what extent is the SOC model suitable for continuation or scaling (up, out, deep)?
   b. To what extent does the SOC model represent good value given the investment (current and/or future)?
   c. What learnings have emerged for future policy and/or practice?

Performance Scale

Level	Not yet evident	Minimal	Moderate	Strong	Transformative
Description	Insufficient evidence or no demonstrable performance, progress, or potential.	Minimal or limited performance is present, but inconsistent, partial, isolated, not yet stable.	Good performance, progress, or potential is present in some areas, mixed or uneven performance overall.	Consistently strong performance, progress, or potential overall, some areas to refine.	Embedded and sustained performance that delivers significant impact, sets a new benchmark, or creates lasting change.

Table 11: Performance scale used for evaluative rubric.

Rubric: KEQ 1: To what extent does the SOC model support meaningful and sustained outcomes?

DOMAIN 1: OUTCOMES

Domain / Sub-domain	Not Yet Evident	Minimal	Moderate	Strong	Transformative
Participant outcomes – housing	No clear evidence of improved housing for most participants.	Some participants show early signs of improved housing stability, but gains are inconsistent, partial, or not yet sustained.	Improvement in housing stability and appropriateness is evident for a meaningful proportion of participants, though overall results are mixed.	Consistently strong outcomes in stable, appropriate, and sustained housing across most participants, with few gaps.	Embedded and sustained housing outcomes for participants – significant, lasting improvements that set a benchmark for what is achievable.
Participant outcomes – wellbeing	No demonstrable improvement in participant wellbeing.	Early or limited improvements in some wellbeing dimensions are present, but gains are inconsistent, isolated, or not yet stable.	Some improvements in wellbeing are evident for some participants, though overall outcomes are mixed, uneven, or short-term	Strong positive shifts in wellbeing for most participants	Significant and sustained improvements for most participants in wellbeing, independence, and connection
Provider outcomes	No demonstrable evidence of positive outcomes for providers, or evidence of overall negative outcomes	Minimal or limited positive provider outcomes, but these are inconsistent, partial, or not yet stable.	Generally positive outcomes for providers are evident in some areas – strengthened relationships, positive staff experience, or increased client engagement – though performance is mixed overall.	Consistently strong provider outcomes, with strengthened client and partner relationships, overall positive staff experience, increased client engagement, and meaningful progress toward organisational goals.	Clear evidence of positive provider outcomes – deep, sustained relationships, highly positive staff experience, strong client engagement, and meaningful progress toward of organisational goals

Table 12: Evaluative rubric – KEQ1 (Outcomes).

Rubric: KEQ 2: How and why are outcomes occurring?

DOMAIN 2: SERVICE

Domain / Sub-domain	Not Yet Evident	Minimal	Moderate	Strong	Transformative
Service design	No demonstrable evidence that service design addresses client needs, is culturally responsive, or takes a holistic approach.	Service design shows early or limited alignment with client needs, with some culturally responsive or holistic elements present but inconsistent or not yet embedded.	Service design clearly addresses client needs in some areas and shows evidence of cultural responsiveness and holistic intent, though application is mixed or uneven.	Service design consistently meets client needs, is culturally responsive, and takes a holistic approach across most areas, with few gaps.	Excellent service design that is deeply client-centred, fully culturally responsive, and genuinely holistic – setting a new benchmark for how services can be designed to meet complex needs.
Service delivery	No demonstrable effectiveness in service delivery, with known barriers unaddressed and little responsiveness to client needs or contexts.	Service delivery shows early or limited effectiveness, with some effort to address barriers and respond to clients, but performance is inconsistent or not yet stable.	Service delivery is clearly effective in some areas, with evidence of barrier reduction and responsiveness to clients, though overall performance is mixed or uneven.	Consistently effective service delivery that actively addresses known barriers to housing and is responsive and flexible to diverse client needs and contexts, with few gaps.	Excellent service delivery – highly effective, actively and proactively addresses known barriers to housing, and highly responsive to client needs and contexts, creating lasting impact and serving as a model for others.
Provider capability	No demonstrable workforce or organisational capability to deliver services effectively; partnerships are absent or non-functional.	Minimal or limited capability is present – some workforce capacity, emerging partnerships – but these are inconsistent, partial, or not yet stable.	Organisational capability is evident in some areas – competent workforce, active partnerships, coordinated delivery – though performance is mixed or uneven across capability dimensions.	Consistently strong organisational capability – skilled and supported workforce, effective organisational systems, well-integrated partnerships, and coordinated delivery across most areas.	Excellent organisational capability – a highly capable, resilient workforce, strong organisational systems, and deeply integrated partnerships that drive sustained, high-quality outcomes.
System and enabling conditions	Funding, contracting, and policy settings are misaligned or create significant barriers to effective delivery and outcomes.	Some enabling conditions are present, but funding, contracting, or policy settings are inconsistently aligned or only partially supportive of effective delivery.	Funding, contracting, and policy settings are broadly enabling in some areas, evidence of alignment and support for delivery, though gaps or misalignments remain.	Funding, contracting, and policy settings are consistently well-aligned and actively support effective delivery and outcomes, with few systemic barriers.	Very strong alignment across funding, contracting, and policy settings – a fully enabling environment that actively drives effective delivery, innovation, and sustained outcomes.

Table 13: Evaluative rubric – KEQ 2 (Service design and delivery).

Rubric: KEQ 3: What does this mean for sustainability and future decisions?

DOMAIN 3: FUTURE APPLICATION

Domain / Sub-domain	Not Yet Evident	Minimal	Moderate	Strong	Transformative
Scalability	No demonstrable basis for continuation or scaling – the model is not yet sustainable and conditions required for expansion are unknown or not feasible.	Minimal or limited evidence that the model could be sustained or scaled – some enabling conditions are identified but significant changes needed	Some evidence that the model is sustainable in its current form – some understanding of conditions required for scaling, though feasibility of continuation or expansion is mixed or uncertain.	Generally strong basis for scalability – the model is demonstrably sustainable, conditions for expansion are known and largely feasible, and there is a credible path to scaling with some refinement	Strong evidence for sustainability and scalability – model is well-understood, conditions for continuation or expansion are known and feasible, model can be maintained over time.
Value for Investment	No demonstrable value for investment – outcomes do not justify the level of investment and compare unfavourably with business-as-usual alternatives.	Limited value for investment – some positive outcomes are present but these are insufficient or inconsistent relative to investment, and comparison with BAU alternatives is unclear.	Moderate value for investment overall – outcomes are broadly commensurate with investment, with some basis for favourable comparison with BAU alternatives, though the overall picture is mixed, uneven or too resource-intensive.	Good value for investment overall – outcomes clearly justify the investment, with minor inefficiencies, and are at least as good as BAU alternatives across most dimensions.	Excellent value for investment overall – strong outcomes relative to investment, are at least as good as BAU alternatives, demonstrating a compelling case for sustained or expanded funding.

Table 14: Evaluative rubric – KEQ3 (Future application).

Appendix 3: Data results

This section provides the tables of monitoring data used to inform charts in this report. Data was provided by HUD for the areas of interest in two different time periods: as at March 2026, and as at April 2028.

Figure 1: Total households by participation and housing situation (as at Mar 2026)

	WCM	Emerge	Total
Total households participated	37	42	79
Total households in service	29	26	55
Total households that have been stably housed	23	19	42
Total households that have exited the trial	8	16	24

Figure 2: Housing situation of households in stable housing (as at Mar 2026)

	WCM	Emerge	Total
Public homes (Kāinga Ora)	14	17	31
Public homes (CHPs)	4	0	4
Permanent independent – private rental	5	1	6
Permanent independent – shared	0	0	0
Other (e.g. moved in with whānau/friends)	0	1	1
Total	**23**	**19**	**42**

Figure 3: Housing situation of all households that exited since the programme commenced (as at Apr 2026)

	WCM	Emerge	Total
Emergency housing	8	6	14
Transitional housing	1	2	3
Public homes (Kāinga Ora)		1	1
Permanent independent – private rental		2	2
Permanent independent – shared		1	1
Other (including moved in with whānau/friends)	1	6	6
Unknown		1	1
Total	**10**	**19**	**28**

Figure 4: Duration of maintained housing for households that are stably housed (as at Mar 2026)

	WCM	Emerge	Total
<3 months	3	3	6
3–5 months	1	8	9
6–8 months	6	6	12
9–12 months	7	2	9
13–15 months	6	0	6
Total	**23**	**19**	**42**

Figure 5: Timing of households entering service (as at Mar 2026)

	WCM	Emerge	Total
Feb-25	28	3	31
Mar-25	28	3	31
Apr-25	25	9	34
May-25	25	11	36
Jun-25	29	28	57
Jul-25	29	33	62
Aug-25	29	28	57
Sep-25	30	32	62
Oct-25	30	35	65
Nov-25	30	35	65
Dec-25	30	35	65
Jan-26	29	27	56
Feb-26	29	27	56
Mar-26	29	26	55

Figure 6: Time taken to house households that are stably housed (as at Mar 2026)

	WCM	Emerge	Total
<3 months	7	4	11
3–5 months	7	8	15
6–8 months	5	5	10
9–12 months	3	2	5
13–15 months	1	0	1
Total	**23**	**19**	**42**

Figure 7: Duration in program by household status (as at Apr 2026)

	Total – Exited^	Total – Housed^
4 weeks or less	5	2
5–8 weeks	3	0
9–12 weeks	3	4
13–16 weeks	2	1
17–20 weeks	1	4
21 weeks or longer	14	30
Unknown	0	1
Total	**28**	**42**

Figure 8: Category of exit reason of total households exited the trial (as at Mar 2026)

Note: As at March 2026, monitoring data indicated 24 households had exited the programme, however, the total number of reasons noted by providers was 25. Exit reasons provided to the evaluation team were not connected to provider or any other identifying data to be able to determine a potential duplicate to remove. As a result, the numbers are included to indicate the overall trend of exit reasons.

Summary of Exit Reasons by Code	Count	Percentage
Involuntary	7/25	28%
Justice	5	71%
Health	2	29%
Voluntary	18/25	72%
Transfer	8	44%
Opted out	4	22%
Disengaged	3	17%
Relocated	2	11%
Housed independently	1	6%

Appendix 4: The MSD Emergency Housing Support Services evaluation

This evaluation considered the recent MSD Emergency Housing Support Services evaluation[9] as part of its assessment of SOC distinctiveness, future application and value for investment. The MSD evaluation is relevant because it examines outcomes for people receiving broader emergency housing support services during a period similar to that of the SOC trial.

Both evaluations have limitations regarding causal attribution and counterfactual evidence. The SOC evaluation was not designed as an impact evaluation, given the small trial cohort, a changing participant sample, and the absence of a matched comparison group. The MSD evaluation also does not establish a counterfactual or provide an impact or cost-effectiveness analysis. These limitations reflect the scope, design and available evidence for each evaluation.

The MSD evaluation reports positive outcomes for people receiving Emergency Housing Support Services, including high rates of sustained exits from emergency housing and low rates of return. It also identifies enabling mechanisms that align with SOC findings, including relationship-based support, service integration, flexibility, post-placement support and the ongoing constraint of housing supply.

However, the MSD evaluation does not provide a direct comparator for SOC. One of its key outcome measures is non-return to emergency housing within 180 days. This shows whether people returned to emergency housing during the measured period, but it does not confirm that all people were in stable, appropriate or long-term housing. Some may have moved into social housing or private rental housing; others may have moved into transitional housing, informal arrangements, or housing situations not fully visible in administrative data.

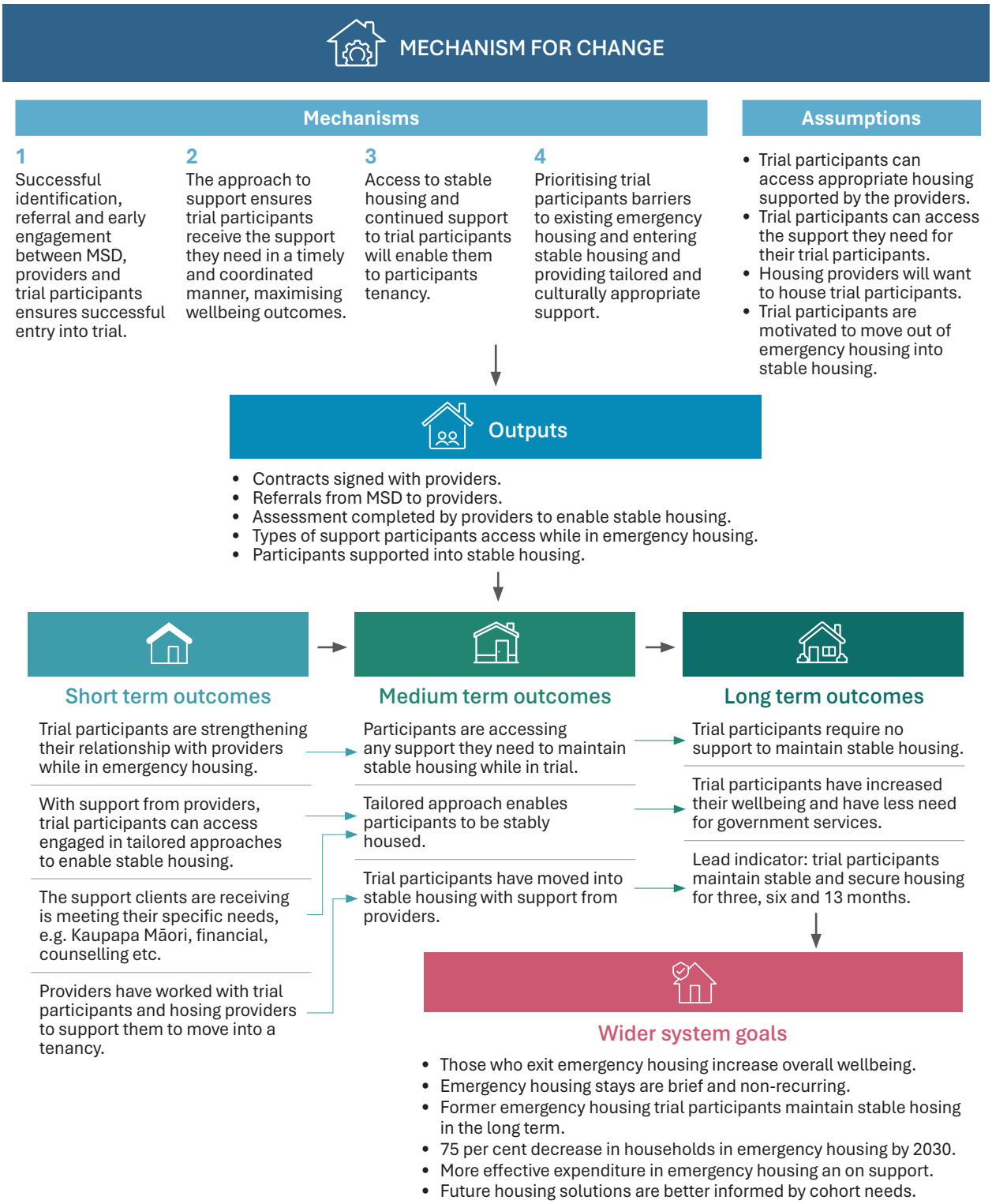
The MSD evaluation also sits within a wider period of emergency housing policy and system change. EH Gateway changes, Priority One changes in eligibility and obligations, changing inflow and exit patterns, and reduced emergency housing volumes shaped the context in which MSD outcomes were observed. These changes also affected the SOC trial, including referral numbers, participant eligibility, participant profile, and the conditions for accessing and sustaining housing. This means the very low return to emergency housing reported in the MSD evaluation cannot be attributed to support services alone, nor treated as equivalent to confirmed stable, appropriate and sustained housing.

If the same administrative measures were collected for SOC participants, they could provide useful supplementary comparator evidence. Relevant measures would include non-return to emergency housing, Social Housing Register status, Housing Support Product use, Accommodation Supplement receipt, transitional housing entry and social housing placement at consistent time points. These measures would not replace SOC's focus on stable, appropriate and sustained housing and broader wellbeing outcomes, but would support clearer comparison with existing services.

For these reasons, the MSD evaluation is best understood as contextual benchmark evidence and convergent evidence about what matters in effective housing support. It should not be treated as a matched comparison group or a direct test of SOC's added value. The more useful comparison is not whether SOC activities were wholly unique, but whether SOC brought together similar enabling features in a more consistent, sustained and accountable way for a cohort not already being well served by existing pathways.

A stronger future comparator would require matched evidence from similar cohorts, including participant profiles, duration in emergency housing, housing pathways, service intensity, post-placement support, housing sustainment, broader wellbeing outcomes and the policy context in place at the time.

Appendix 5: SOC Trial Intervention Logic



Appendix 6: Kaupapa Māori Research – a brief explanation

"Kaupapa Māori literally means a 'Māori way' of doing things, and the concept of kaupapa implies a way of framing and structuring how we think about and do research with Māori. The advent of Kaupapa Māori theory provides a framework for naming, framing, and situating a Māori explanatory theory.[10] It positions Māori worldviews and what Māori value and believe as authoritative, legitimate and valid to guide research with whānau, hapū and iwi.

Kaupapa Māori is concerned with both methodology (the process of enquiry that determines the methods used) and methods (the tools used to produce and analyse data). As such, Kaupapa Māori is a theory and an analysis of the context of research involving Māori, as well as the approaches to research with, by, and/or for Māori.[10] In the context of this research, this means ensuring both the appropriateness of methods for Māori and a critical analysis of the findings with respect to Māori.

A Kaupapa Māori approach is open to a wide range of methods, but it critically interrogates those methods in relation to tikanga Māori (Māori values and practices). Kaupapa Māori research practices guide ethical research with Māori communities.[10,11,12]

These include:

- A respect for people (aroha ki te tangata)
- Being a face that is known in the community (kanohi kitea)
- Looking and listening before speaking (titiro, whakarongo, korero)
- Being humble (ngākau māhaki)
- Being careful in our conduct (kia tūpato)
- Ensuring we uphold the mana of all people (kaua e takahia te mana o te tangata).[13]

This was not a Kaupapa Māori evaluation. However, Kaupapa Māori principles informed how the evaluation was undertaken.

This included:

- Applying tikanga as appropriate, for example, through karakia, mihimihi, and kai as koha
- Upholding the mana of participants, including by analysing Māori and non-Māori interview data as distinct groups
- Being a face known to participants, kanohi kitea, by conducting all interviews in person
- Acting with care, by being guided by providers in how we engaged with participants.

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