chp
council
to homeless
persons

Ending chronic homelessness: A permanent supportive housing solution

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Problem

Street homelessness, or rough sleeping, in Victoria has increased significantly in recent years. This has had devastating consequences on the health and wellbeing of those sleeping rough, and has created alarm in the broader community.

In June 2016, 247 people were counted sleeping rough in Central Melbourne – a 74 per cent increase from the count in 2014.[i] Many more are rough sleeping in other parts of metropolitan Melbourne and regional Victoria.

People sleeping rough include 'new arrivals' on the street and those who are chronically homeless, who typically cycle between the streets, institutions and poor quality accommodation over a long period of time.[ii] Two thirds of people surveyed for the 2016 Street Count reported that they had been transient for over 12 months.[iii]

This increase in rough sleeping is a result of both a crisis in availability of affordable housing[iv], particularly for single people on low incomes, and a lack of effective support for people with more complex needs.

Providing access to housing that is safe and affordable would resolve the homelessness experienced by many people, including most of those who are newly sleeping rough. In order to prevent homelessness for people at risk of street homelessness, and to enable people who do become homeless to be rapidly rehoused, CHP estimates that around 10,000 new units of public housing for singles are needed over the next five years, alongside expansion in housing suitable to other household types.

However, people who are long-term rough sleepers with more complex needs, including mental illness, substance use, disability and histories of trauma, commonly require both housing *and support* to gain and sustain that housing – an approach called Housing First or permanent supportive housing.

Without this housing and support chronically homeless rough sleepers typically cycle in and out of tertiary services. These include hospital emergency departments, acute mental health care, and the justice system, without achieving any sustained improvement in their health and wellbeing. For example:

- 25 per cent of inpatients of one major hospital psychiatric inpatient unit in Melbourne are 'of no fixed address'[v]. This proportion is likely to be similar across Victoria's acute mental health care system. Many are discharged without safe and appropriate housing being secured.
- 40 per cent of people exiting prison do so into homelessness[vi].

In Victoria, almost no support services are funded to provide the ongoing support people require. Services providing community-based mental health support (MHCSS), that were previously accessible to this group, underwent reform in 2015 and are now more difficult to access for people with more complex needs. These resources are in transition to be part of the NDIS funding pool.

Solution

The evidence

International evidence is clear that Housing First or permanent supportive housing approaches are the most effective way to end homelessness for people who are chronically homeless rough sleepers.

- In **New York:** 75 per cent of people who participated in the New York Pathways Program spent an average of four years stably housed, compared to 48 per cent per cent receiving a standard response.[vii]
- **In Canada:** In a five-site study with over 2,000 participants, Housing First Program participants spent an average of 73 per cent of their time in stable housing over 24 months compared to 32 per cent in the control group.[viii]
- **In Europe:** four Housing First projects in Europe achieved housing retention rates of between 80 per cent to 90 per cent (over variable time frames).[ix]
- **In Melbourne:** After two years, 70 per cent of people in the Street to Home program were in independent secure accommodation.[x] After four years 75 per cent of Journey to Social Inclusion participants remained in stable housing.
- **In Brisbane:** 92 per cent of Street to Home participants had sustained housing for 12 months.[xi]
- **In Scotland:** 86 per cent of participants in a Housing First program for people experiencing homelessness with severe and long-term substance misuse problems had sustained their tenancy by the end of the pilot project[xii].

Housing First/ permanent supportive housing principles

The Housing First/ permanent supportive housing approach has now been rigorously trialled and evaluated in the USA, Canada, Europe, and Australia. These evaluations have demonstrated that program models demonstrating fidelity to the following eight key principles achieve the most effective results:[xiii] [xiv]

1. **Housing is a human right** – Housing First models provide access to permanent housing as a starting point rather than an end goal, without conditions other than abiding by standard tenancy obligations. This is critical to effective outreach and engagement with people who are chronically homeless. While recognising that people may have diverse needs in relation to housing types, research indicates that most prefer ordinary scattered site houses and units.
2. **Choice and control for service users** – This recognises that people using the service should be listened to and their opinions respected, and acknowledges that the same support or housing options won't meet the needs of all service users. Importantly, support staff must build up trusting relationships, show respect, warmth and compassion for service users and put their preferences and choices at the core of their support work.

3. **Separation of housing and treatment** – Service users are actively encouraged to minimise harm from drugs and alcohol and to utilise treatment options; but they are not required to do so.
4. **Recovery orientation** – Services with a recovery orientation focus on the overall wellbeing of an individual, not only supporting engagement with treatment and housing. This encompasses broader social inclusion and can include enabling access to education, finding a rewarding leisure activity, or supporting people to reconnect with family. It focusses on an individual gaining a sense of hope and purpose with the prospect of a better and more secure life.
5. **Harm reduction** – Harm reduction recognises that services requiring abstinence, or detoxification, do not work well for many people experiencing homelessness. Harm reduction is already mainstream practice in most Victorian services.
6. **Active engagement without coercion** – This can be described as an assertive, but not aggressive, way of working. Importantly, people utilising Housing First services are not threatened with or given sanctions for behaving in certain ways.
7. **Person-centred planning** – this involves organising support and treatment around people and their needs, with Housing First adapting and organising around service users, rather than expecting people to adjust and adapt themselves to the Housing First service.
8. **Multi-dimensional and flexible support for as long as required** – Housing First approaches stay connected with people if they are evicted from or leave their housing and seek to house them again. Support intensity can rise and fall with individual need, so that Housing First services can respond positively when someone needs more, or less, help on a day-to-day basis. Test sites in Europe demonstrated that multidimensional support can be organized in different ways, but need to enable access to support from mental and physical health and addiction services, as well as more general case management support.

Housing First/ permanent supportive housing service elements

Program evaluations have also identified the service elements necessary to end homelessness for people sleeping rough including[xv]:

Assertive outreach

Assertive outreach is an evidence-based approach to working with people including those who are sleeping rough. In a Housing First/ permanent supportive housing context, this combines traditional street outreach to locate and engage people, with immediate access to housing, within a practice framework aimed at ending homelessness.

Engagement

Purposeful and persistent outreach is required to locate, engage and follow up people experiencing long-term homelessness including people sleeping rough. Trauma informed care and harm minimisation are important underpinnings of practice. Consistency and boundaries are critical for people with trauma histories. Fragmented, short-term interventions can mirror and compound chaotic lives. Support needs to be able to follow the person in order to build trust and develop the necessary relationship that, in turn, can provide safety, consistency and boundaries.

People sleeping rough do not, almost by definition, fit well into service systems requiring high levels of compliance and conformity. Being client-centred and respectful of the right to self-determination is both an important principle and an effective practice.

Engaging people into services can happen quickly or over a very long period of time. Consistent with Housing First principles is the need to be able to respond quickly to consumers' priorities with a quick housing offer and the provision of practical assistance to meet other needs as they are identified or arise.

Pathway into housing

Practical assistance to quickly obtain housing, health, and other services is important and valued by consumers. Advocacy addressing barriers to housing such as debts and evictions for anti-social behavior is an important component of this work. Behaviour support will be required for some to regain access to housing.

Assessment, care planning and integrated service provision

Assessment of consumers' housing, health and wellbeing, is important given the range of needs and vulnerabilities. Once consumers are engaged in a case management response, formal assessment and case planning is critical.

The integration of dedicated health services within Housing First Program teams, reflects the prevalence of mental illness, drug and alcohol dependence, disability and chronic health conditions within this population group. For example, the Melbourne Street to Home Program includes a community nurse in each assertive outreach team. The community nurse directly case manages clients with the most complex health presentations, undertakes health assessments across the team, and acts as a resource to other team members about health issues.

Linkage or integration with clinical mental health services and drug and alcohol service responses is also required. This can occur either within teams, through outposting, joint outreach or via the provision of systemic government driven policy requirements.

Some people experiencing chronic homelessness would also be eligible for supports provided under the National Disability Insurance Scheme (NDIS) though experience to date indicates they are likely to need significant assistance to access the scheme and gain supports that meet their needs.

Establishing housing

Both practical and emotional support is required during the transition into housing. This includes practical assistance with moving, furniture, bedding and connecting utilities. The transition into housing can be very difficult for some people with long histories of rough sleeping. Emotional support to manage the responsibility of tenancy and potential loneliness is important. Workers provide assistance with orientation to the new community, identifying interests, accessing aged and disability supports and services, and linking into local health and community services. Once moved into housing, people may need assistance with living skills such as cleaning, shopping, cooking, budgeting and paying bills. Understanding their rights and responsibilities as tenants, and assistance with managing tenancy issues is also important.

Sustaining housing

People who have experienced long-term homelessness are more likely to have difficulties sustaining tenancies. A myriad of challenges can arise ranging from conflicts with neighbours, property damage, legal issues, abandoning housing due to isolation or mental ill health, rent arrears, property damage, hoarding and deteriorating mental or physical health. This support will range from ongoing intensive support, low level monitoring and intermittent case management, to permanent exit from the program after an initial episode of support. This latter group includes people who live independently in the community or access mental health, NDIS, aged care or other community supports).

Broader success factors

Recent Australian research into assertive outreach to end rough sleeping identified further critical factors for success.[xvi] Many of these reaffirm the core Housing First/ permanent supportive housing principles.

Policy settings that support the service delivery model provide:

- Adequate resources for both street outreach and post housing assertive outreach support.
- Availability of dedicated health services integrated with both street outreach and post housing support.
- Availability of ongoing health services for those with chronic health issues, especially mental health.
- Availability of ongoing personal support services for those who require assisted living, especially for those with diminished decision-making capacity.

- Dedicated, flexible supply options and clear access pathways to enable timely provision of appropriate long-term housing.
- Access to interim accommodation and residential rehabilitation services for those who prefer such options, before making decisions about their permanent housing preferences.

Service delivery settings that are aligned to policy intent feature:

- Practice that is client-centred and maximises self-determination.
- Persistent engagement with rough sleepers at times and in locations that enable relationship building and the provision of information about housing and other service options.
- Practical strategies that aim to address barriers faced by people sleeping rough in accessing housing, particularly in terms of enabling the social housing application process.
- Assessment of client needs and vulnerabilities with a specific focus on health and emotional well-being.
- Assertive case management with clients that supports them to identify their goals and the steps needed to achieve them.
- Practical assistance to rough sleepers to obtain permanent housing, health and other services identified as a client's priority.
- Support during the transition into housing including both practical assistance with things like furniture, connecting utilities, and maintaining or establishing new social connections.
- Post housing support for as long as necessary to ensure tenancy establishment and sustainability as well as formal and informal supports and services that facilitate social well-being and opportunities to participate in community, education, training and or employment.
- Exit planning that balances the need for service continuity but avoids overdependence.

Client's motivations, perceptions and actions that align with the assertive outreach service model:

- Are prepared to accept contact and information from workers.
- Are motivated to end their homelessness.
- Come to trust the workers to follow through.
- Are able to recognise the barriers they face and the actions needed to exit homelessness.
- Are prepared to engage in actions that overcome barriers (including attend any appointments, making applications for housing, and attending interviews).
- Reach a point where they believe that housing is an obtainable goal.
- Achieve enough self-confidence to believe that they can change how they live and sustain their housing.

Victorian context

Victoria has a small number of Housing First type programs providing access to permanent housing with ongoing support, including Melbourne Street to Home (MS2H), Journey to Social Inclusion, Homeless Outreach Mental Health Service and Common Ground. Each have achieved positive outcomes in both housing retention and improved wellbeing.

However, these programs focus effort on the CBD and inner Melbourne suburbs, and even in these locations are unable to meet the volume of need.

Evaluations of these programs have also identified that the lack of dedicated housing for these clients has resulted in delays in accessing housing that compromises these programs' effectiveness. For example, many clients of Melbourne Street to Home face wait times of several months for transitional housing, and can wait over a year for permanent housing. Being unable to offer a rapid pathway to permanent housing compromises the effectiveness of outreach to people experiencing chronic homelessness. It also compromises the wellbeing of clients who must move through different accommodation and housing while they wait for a permanent home.

Additional resources allocated to rough sleeping projects over 2016 and 2017 have increased assertive outreach capacity to people sleeping rough in inner Melbourne and provided targeted access to housing for a small proportion of those who are chronically homeless. These resources have also enabled some additional capacity for ongoing case management for people who are long-term rough sleepers with more complex needs in inner Melbourne.

However, a significant gap remains both in the CBD and in locations outside inner Melbourne with large numbers of people sleeping rough. People whose needs are unable to be met outside of inner Melbourne often gravitate to the CBD where there is a greater concentration of services and support.

Further, much of the additional resourcing allocated has been for packages of individualized funding. This fragmented approach drives service responses that lack fidelity to the Housing First principles, and consequently creates risks of not achieving the best possible outcomes from the funding that is available.

Team composition and service response

The team composition described below is intended to deliver support across multiple dimensions of need common among chronic rough sleepers along the full spectrum of service elements outlined above from outreach to housing sustainment. The resources described below are intended to both build on and complement existing service capacity.

While some participants will be able to exit the program permanently after an initial period of intensive support, (either to living independently or with other mental health, NDIS or community supports); others will require ongoing support and engagement that may intensify intermittently in anticipation of or in response to crises. Only a small group of people with very complex needs would require ongoing continuous active support.

In addition to assertive outreach and case management workers and community health nurses, psychiatric nursing positions have been included in the composition of the proposed teams. This will provide a specialist mental health input, facilitate access to mental health services and assist in accessing specialist assessments and the evidence required to access NDIS funded support. The mental health and community-nursing component of the service is also vital outside of inner Melbourne, where there are less specialist and accessible general and mental health services for people experiencing homelessness and a greater need for specialist knowledge and skills in navigating health and other service systems.

It is intended that staff in these teams work to develop relationships with people requiring intensive support to end chronic rough sleeping and maintain this relationship beyond housing establishment. The multi-disciplinary teams provide the ability to easily deliver specialist supports, as well as providing case managers with often critical secondary consultation.

Team size and composition

Team size and composition	No	Cost per worker	Total
Assertive outreach and case management workers	6	$120,000	$720,000
Community health nursing	1.6	$130,000	$208,000
Psychiatric nursing	2	$130,000	$260,000
Practice manager	1	$140,000	$140,000
Team	10.6EFT		
Office space			30,000
Brokerage			$70,000
Shift allowance			$60,000
TOTAL			**$1,488,000**

Service response types, staffing and targets

Service response types	No	EFT
1. **Assertive outreach** to engage prospective consumers 1:20 ratio at any given time (not active case management: engagement, responsive assistance and referral pathway into housing and specialist homeless services for low needs consumers and Street to Home like program for high needs)	20	1
2. **Initial intensive case management** for up to 18 months at 1:6 ratio (12 months post housing) to engage client, access and establish housing and health and community support services including NDIS and aged care entitlements.	24	4
3. **Active case management support** at 1:10 ratio (ranging from long-term ongoing support or intermittent support for exited clients.	30	3
4. **Long-term low-level support and monitoring** (for example monthly home visit, liaison with housing provider and phone calls escalating to 3. Active case management episode as required	60	1
Total consumers (at any given time)	134	10
TOTAL		

Scale of response

Determination of the number of teams required to provide an adequate permanent supportive housing response across Victoria, needs to be driven by data around the number of chronically homeless rough sleepers, and continually reviewed as the program scale grows. The necessary scale will be influenced by the effectiveness of responses in other human services systems, such as supports for children leaving care, availability of community mental health services, as well as the investment in, and effectiveness of homelessness prevention programs. These programs reduce the numbers of people who become entrenched in homelessness by preventing people becoming homeless in the first instance, or by rapidly housing people who do become homeless, preventing the harm caused by long-term homelessness.

While resources have increased for assertive outreach in central Melbourne over the past year, there remains a significant gap both in housing options for those needing permanent supportive housing, and in ongoing case management. In addition to addressing these gaps, a full single team is needed in each 'hot spot', including regional cities, and other Melbourne locations, such as Frankston and Dandenong.

Housing to accompany support

Lack of affordable housing, particularly for singles, is both driving an increase in rough sleeping, and is hampering the capacity of support services to assist people out of homelessness. In order to succeed, a permanent supportive housing model requires investment in as many housing opportunities as are provided in support. A much larger number of housing opportunities is needed to prevent the flow of new people into rough sleeping, and other forms of homelessness.

Increasing the stock of single social housing by 10,000 units over five years would enable flexibility in housing people needing support, at the same time as preventing homelessness.

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[iii] City of Melbourne, *StreetCount 2016 Final Report*, Melbourne (2016)

[iv] The most recent DHHS Rental Report reveals that only 29 one-bedroom private rental properties in Melbourne (0.3%) were affordable to people on Newstart.[iv] Data released by the Victorian Government in 2012 revealed that 20,000 households were waiting for a one-bedroom public housing property, when there are only 18,000 already tenanted one-bedroom houses or apartments of public housing stock.[iv] A proportion of these smaller units of public housing are reserved for people over the age of 55. As a consequence, even with the highest priority, single people under 55 can often wait up to four years to be housed.

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