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Housing First

Permanent Supportive Housing

Ending chronic homelessness

Council to Homeless Persons, 2018

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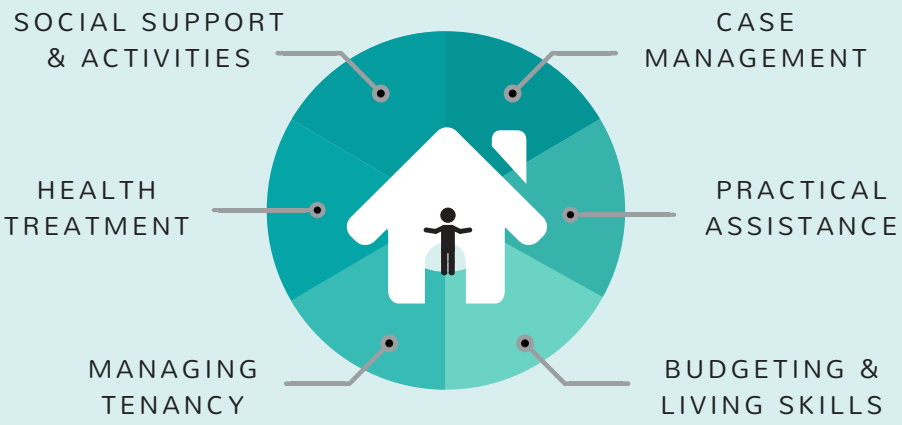
What is Housing First?

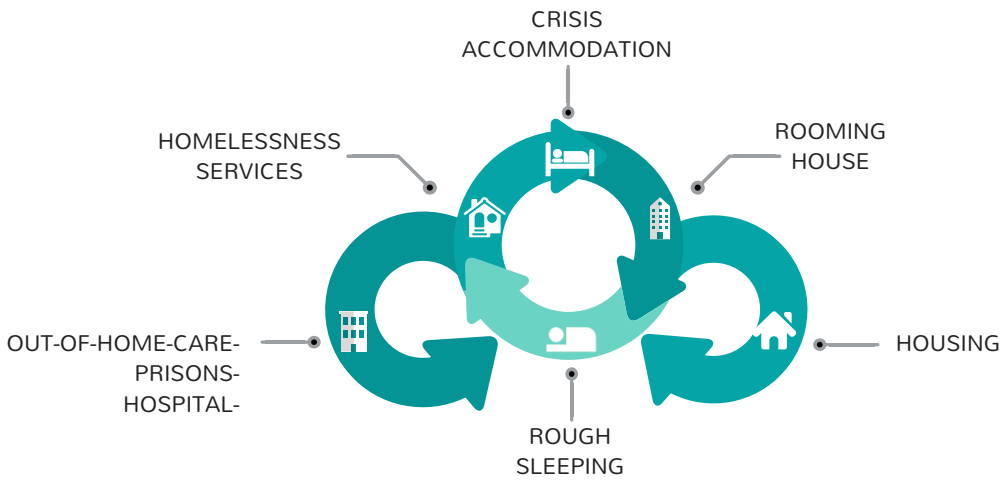
Housing First permanant supportive housing programs quickly move people with complex needs experiencing chronic homelessness into permanent housing with flexible and individual support for as long as needed.

Australian and international evidence strongly supports Housing First Programs as the most effective way of addressing chronic homelessness, including rough sleeping.

Housing First Model



Chronic Homelessness



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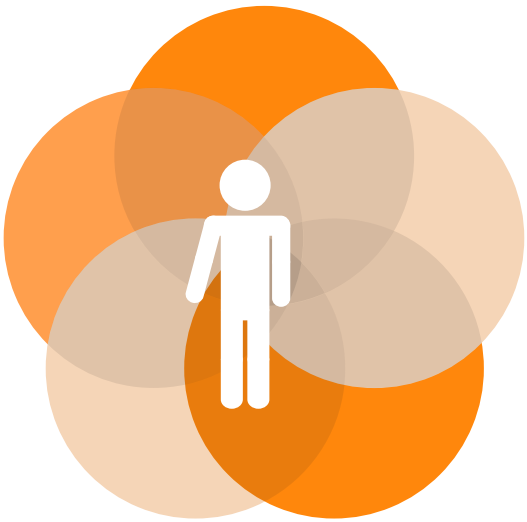
Who is Housing First for?

Housing First permanent supportive housing programs are for adults (without accompanying children) who have experienced chronic homelessness (including rough sleeping) and who have complex needs.



These complex needs may include:

- SUBSTANCE USE
- HISTORIES OF TRAUMA
- INCARCERATION
- SERIOUS MENTAL ILLNESS
- INTELLECTUAL DISABILITY
- ACQUIRED BRAIN INJURY
- CHRONIC HEALTH ISSUES

Evidence for Housing First

Australian and international evidence strongly supports Housing First programs as the most effective way of achieving housing stability and improved well-being for people with histories of chronic homelessness.

NEW YORK — 75% of people who participated in the New York Pathways Program spent an average of four years stably housed, compared to 48% receiving a standard response.[1]

CANADA — In a five-site study with over 2,000 participants, Housing First Program participants spent an average of 73% of their time in stable housing over 24 months compared to 32% in the control group.[2]

Evidence for Housing First

EUROPE — Four Housing First projects in Europe achieved housing retention rates of between 80% to 90% (over varying time frames).[3]

MELBOURNE — After two years, 70% of people in the Street to Home program were in independent secure accommodation.[4] After four years 75% of Journey to Social Inclusion participants remained in stable housing.[5]

BRISBANE — 92% of Street to Home participants had sustained housing for 12 months.[6]

SCOTLAND — 86% 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.[7]

Housing First Principles ✓

People have a right to a home

- Quickly provide a permanent, self-contained home
- No treatment or behavioural eligibility conditions
- Follow tenancy conditions like other renters
- Meet regularly with the support worker
- Keep their housing if no longer want or need support

Flexible support for as long as it is needed

- No fixed end date (some people receive ongoing support)
- Intensive case management or assertive community treatment
- Scale between high and low intensity support
- Quickly re-engage former consumers
- Onus on workers to maintain relationship

Housing and support are separated

- Support services assist to maintain tenancies
- Support stays with the person
- If the tenancy fails, assist to find another home

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Active engagement

- Be flexible about time and place
- Persist without intruding
- Support fits the individual not the service
- A "whatever it takes" approach
- Support continues if housing is lost or left

Individuals have choice and control

- Housing type
- Where they live
- Where, when and how support is provided
- What they want to achieve or 'person centred planning'

The service is based on people's strengths & aspirations

- Choose own path to a better life
- Offer sense of hope
- Work with strengths
- Identify goals or aspirations

A harm reduction approach is used

- Reduce the risks and effects of substance use and addiction
- No substance use behavioural requirements
- Harm reduction does not preclude drug treatment

Assertive Outreach

In Australia, assertive outreach has been combined with Housing First to engage, house and support vulnerable, long-term rough sleepers. Assertive outreach is a form of persistent and purposeful street outreach that aims to end homelessness for people sleeping rough.* Building rapport and trust are the foundation of this approach.

> Some of the guys that I have known have had traumatic lives, dealt with family violence and abuse from 6, 7, 8, 9, 10 years old. Like they are handing over a piece of themselves every time they tell their story. Their resistance becomes rock hard and solidified [8]
>
> - consumer consultation

Phillips and Parsell identify the policy, service and client 'settings' required for assertive outreach programs to end rough sleeping. . Policy settings include: housing pathways and supply; adequate resources for street outreach and post housing support and, the availability of health services (including mental health).

*Assertive outreach is also used in health and mental health where it may have a health treatment related aim.

Assertive Outreach

Service delivery settings or features identified by Phillips and Parsell are:

- Practice that is client-centred and maximises self-determination.
- Persistent engagement with rough sleepers at times and in location that enable relationship building and the provision of information about housing and other service options.
- Practical strategies that aim to address barriers that people sleeping rough face 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.
- Practical assistance to rough sleepers in obtaining permanent housing, health and other services that clients identify as a priority.
- Support during the transition into housing including both practical assistance with furniture etc., 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 over-dependency.

The above service delivery settings also influence people sleeping rough to: accept contact from services; trust workers to follow through; become motivated to act to end their homelessness and, have confidence to believe that their lives can be better.

Implementing Housing First

In Victoria, many of the principles of Housing First are widely accepted. Separating provision of housing from support, harm reduction, and strengths-based recovery approaches are well-understood and common practice.

The reality in Australia, and elsewhere, is that Housing First programs must adapt to local conditions and constraints. While housing markets may be less constrained in rural and regional Victoria there are few services specifically targeting people who have experienced chronic homelessness and services typically cover large geographical areas.

In Victoria, the very low levels of social housing for single people under 55 years of age constrains the ability of Housing First programs to provide timely access to affordable housing. Time-limited support periods and time-limited funding also constrain the capacity to provide long-term or ongoing support where it is needed.

One of the biggest challenges for Housing First services in Australia is accessing disability and aged care supports. Additionally, services need to be able to respond to the needs and vulnerabilities of particular populations including women, LGBTIQ people, Aboriginal Victorians and people from culturally and linguistically diverse backgrounds.

Providing Support

A key element of Housing First Programs is the provision of intensive, flexible and long-term support. Low initial staff to client ratios enable services to work effectively with people who have had difficulties sustaining tenancies.

In the UK and Australia, intensive support is generally around one worker to seven clients. This enables services to be highly responsive and develop positive long-term relationships with clients.

The two main types of Housing First support models are intensive case management and assertive community treatment. The table below outlines some of the key features of these models. Hybrid support models are also common.

	Intensive Case Management	Assertive Community Treatment
Target population	• Single adults with complex needs who have experienced chronic homelessness	• Single adults with high acuity mental illness who have experienced chronic homelessness
Environment	• Good access to health and community support services	• Limited access to health and community support services

	Intensive Case Management	Assertive Community Treatment
Team	• Individual caseloads (often with back up worker) • 24 hour on call crisis response • Social or welfare and peer support workers • In Victoria, Streets to Home has delivered a hybrid model including community nursing • Peer support is increasingly employed in ICM models	• Team case management approach • 24 hour on call crisis response • Multidisciplinary teams e.g. social worker, peer support, psychiatric nurses, alcohol and drug counsellors providing direct support and treatment, particularly for mental illness and alcohol and drug issues.
Organisation	• Dedicated team manager • Weekly review of all clients • Regular supervision • Case conferencing and care coordination	• Dedicated team manager • Weekly review of all clients • Regular supervision • Case conferencing and care coordination

	Intensive Case Management	Assertive Community Treatment
Staff skills and knowledge	• Motivational interviewing • Harm reduction • Trauma Informed Care • Positive Behaviour Support • Assertive outreach/active engagement • Recovery principles • Case management • Housing Focused Support	• Motivational interviewing • Harm Reduction • Trauma Informed Care • Positive Behaviour Support • Assertive outreach/active engagement • Recovery principles • Case management • Housing focused Support

Providing Housing

	Single Site	Scattered Site
Target population	• Very socially isolated • High support needs • Vulnerable women and men with safety needs • Mixed with other social housing tenants	• Is preferred by most people • People with behaviours of concern, or who use drugs, may be more suited to scattered site
Services	• 24 hour concierge common e.g. Common Ground model • On site social support activities • Case management • On site health service provision common	• Outreach support • Linking to health and social support services
Housing management	• Housing and support management are separate • Tenants have standard lease	• Housing and support management are separate • Tenants have standard lease

Providing Housing

	Single Site	Scattered Site
Housing management	• Housing is permanent • Housing is self-contained (own bathroom and cooking facilities)	• Housing is permanent • Housing is self-contained (own bathroom and cooking facilities)
Housing is affordable	• Ideally, housing costs no more than 30% of income provided through social housing or rental subsidy	• Ideally, housing costs no more than 30% of income provided through social housing or rental subsidy

Planning

Key considerations in planning Housing First permanent supportive housing services include identifying who is most in need, building partnerships and working out how best to provide a flexible and integrated service response.

Housing First for most in need

- Single adults (and couples) without accompanying children
- People with highest needs
- Existing services have not been effective
- Currently rough sleeping
- Histories of chronic homelessness
- Agreement re target group and use of screening tools

Service planning, partnerships & coordination

- Map key formal and informal service system (services providing meals can be important contact points)
- Consult, promote and build relationships with formal and informal services
- Ensure that key health, mental health, housing, aged care, homelessness and disability services are engaged in partnership
- Fill gaps rather than duplicate strength
- Assist with identification of high need and risk people
- Reduce duplication of effort
- Increase consistency of response
- Minimising risks to self and others
- Achieve service system improvements

Integrated service delivery

- Specialist health roles embedded as full team members with a caseload with same manager and using the same systems as other team members
- Peer support role requires training of peer workers, managers and colleagues
- Specialist positions provided through partnerships with health services facilitate access to health services, NDIS and My Aged care supports
- Integrative mechanisms between services for identification, referral and engagement of potential housing first clients; avoiding duplication of effort; and achieving consistent practice approaches.

Flexibility

- Staff rostering and resourcing to provide flexibility in days/hours of work and on-call capacity
- Systems and processes in place to support local housing, health and community support services around managing and responding to risk
- Systems and processes to manage different support needs over time: intensive, low level, monitoring and dormant

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7. Johnsen S 2013, Turning Point Scotland's Housing First Project Evaluation Final Report, Institute for Housing Urban and Real Estate Research, Heriot-Watt University. Retrieved from: https://researchportal.hw.ac.uk/en/publications/

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Resources

- Housing First Europe Hub includes links to Housing First Europe Guide and Housing First Canada Toolkit: http://housingfirsteurope.eu/

- Evaluation of the Melbourne Street to Home Program: Final Report
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• Webinair about Manchester Housing First program for women
Webinar on the Threshold Housing First program for vulnerable women in Greater Manchester
https://www.homeless.org.uk/housing-first-for-women-webinar

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Department of Health and Human Services 2011, Positive Practice Framework a guide for behaviour support practitioners, Victoria
http://providers.dhhs.vic.gov.au/specialist-disability-support

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