Evaluation of the
Melbourne Street to Home Program:
Final Report

Guy Johnson
Chris Chamberlain

RMIT University

A report prepared for HomeGround Services,
Salvation Army Crisis Services, Salvation Army Adult Services and the
Royal District Nursing Service Homeless Persons' Program
.

March 2015

Acknowledgments

About the authors

Dr Guy Johnson, Senior Research Fellow, Centre for Applied Social Research, RMIT University.

Professor Chris Chamberlain, Centre for Applied Social Research, RMIT University.

Suggested citation

Executive summary

The Melbourne Street to Home project was funded for three years as part of the National Partnership Agreement on Homelessness. This is the final evaluation report and it updates the information presented in two previous reports (Johnson and Chamberlain 2012, 2013).

Policy

1 The ability to secure positive outcomes with the long-term homeless is closely tied to the resources available to a service and how these resources are used. A clear strength of the Street to Home model is the capacity of case workers to provide intensive support both before and after the participants have secured housing.

2 The integration of community health nurses is an important strength of the Street to Home approach. Not only does this provide rapid access to health assistance, but it has also broken down the barriers that commonly exist between health and specialist homelessness services. The findings confirm that the provision of health care does not resolve chronic medical conditions, but it does enable people to manage them more effectively.

3 The most pressing problem for Street to Home is finding suitable housing for the clients. Housing options in the inner city are limited and the failure to integrate the provision of housing into the model is a major policy oversight. It is imperative that future policy discussions take into account the need for 'housing first' services to have access to good-quality housing. If this could be achieved it would be a major step forward.

Research findings

Chapter 1 outlines the policy context and **Chapter 2** explains how the evaluation was undertaken.

Chapter 3 develops two arguments. First, it points out those on a youth pathway have less cultural capital than those on an adult pathway. The mean age of those on a youth pathway was 13.1 years when they first became homeless compared with 34.8 years for those on an adult pathway. Fifty-seven per cent of those on a youth pathway had left school before year 10 compared with 25 per cent on an adult pathway. Many people on an adult pathway had some employment experience before becoming homeless, as well as stable housing and, in some cases, marriage and children. Hence they had more cultural capital than those on a youth pathway.

The second argument in Chapter 3 is that when people become chronically homeless their experiences tend to converge. Seventy per cent of Street of Home participants had stayed in crisis accommodation, 86 per cent had lived in a boarding house, 85 per cent had slept rough for three years or longer, and no-one was

employed when they joined the program. Judgments about the effectiveness of Street to Home must take into account the disadvantaged background of the participants.

Chapter 4 shows that after 24 months, 70 per cent of Street to Home clients were housed and 80 per cent of them had been housed for one year or longer. Amongst those on an adult pathway the success rate was 79 per cent, whereas the success rate was 62 per cent amongst those on a youth pathway. Overall, there was a marked improvement in the participants' housing circumstances, but it was more difficult to help clients who first became homeless as teenagers.

Chapter 5 shows that there was a significant improvement in the participants' physical and mental health in the first 12 months, but in the second 12 months the rate of improvement slowed. However, at the final interview, the number admitted to hospital in the preceding three months had declined from 32 per cent at the first interview to 11 per cent at the final interview; and the number of people using an emergency department in the preceding three months fell from 42 per cent at the first interview to 18 per cent at the final interview. These findings are positive.

Chapter 6 shows that the proportion using alcohol and other drugs did not change markedly over the 24 months. At the final interview, 77 per cent had not injected drugs in the preceding four weeks, 18 per cent had injected them occasionally, and five per cent had injected them regularly (every day or every second day). Half (46 per cent) had not consumed alcohol in the preceding four weeks, 44 per cent were occasional drinkers, and 10 per cent were daily drinkers. The provision of housing and ongoing support appears to have done much to defuse those feelings of hopelessness that make excessive drug and alcohol use attractive.

Chapter 7 found a significant reduction in the participants' use of homeless services. At the baseline interview, 59 per cent of clients had used them in the preceding six months, but this had dropped to seven per cent at the final interview. However, about half (56 per cent) continued to use meals programs and drop-in centres, although this had dropped from 80 per cent at the baseline interview.

Chapter 8 shows that many clients had begun to improve their relationships with family and friends. We found that most people re-assessed their relationship with other homeless people once they were re-housed. Many severed their ties with former friends and we refer to this strategy as 'disengagement'. About two-thirds were rebuilding their relationship with their family and this was an important goal for many people. Overall, the participants' social networks had improved significantly.

Chapter 9 summarises what has been learnt from the evaluation and draws attention to those characteristics of the Street to Home model that make it effective. Finally, three policy points are explained.

Table of contents

1 Introduction

1.1 Assisting rough sleepers

In December 2008, the Australian Government released its White Paper on homelessness, *The Road Home*, which adopted two headline goals (FaHCSIA 2008). The first goal was to halve the rate of homelessness by 2020 and the second was to offer supported accommodation to all rough sleepers who need it (FaHCSIA 2008, p.viii). The Government called for 'bold', 'new', 'evidence based' approaches that could reduce rough sleeping.

The Street to Home approach was singled out in the National Partnership Agreement on Homelessness as the principal programmatic response to ending rough sleeping (Council of Australian Governments 2009, p.5). Federal and state governments have made significant investments in the Street to Home program and there are now services operating in every State and Territory (Council of Australian Governments 2009, p.5).

In 2010, the Commonwealth Department of Families, Housing, Community Services and Indigenous Affairs (now the Department of Social Services) funded a consortium of agencies in Melbourne to deliver a Street to Home service for three years. The agencies were HomeGround Services, the Salvation Army Adult Services, the Salvation Army Crisis Services and the Royal District Nursing Service (RDNS) Homeless Persons' Program. This is the final evaluation of that initiative.

The Melbourne Street to Home service operates from two locations in inner Melbourne. One part of the service is managed by HomeGround and operates in the Inner South and the Central Business District. The other part is managed by the Salvation Army Adult Services and covers the Inner West and the Inner North. A Royal District Nursing Service (RDNS) Homeless Persons' Program nurse is a member of each team. In addition, HomeGround and Adult Services both fund a housing options worker.

In all states where Street to Home is operating, there have been evaluations of the program using various longitudinal approaches. Some evaluations have collected data retrospectively (Button and Baulderstone 2013), whereas others – including this evaluation - have followed participants over time (Parsell, Tomaszewski and Jones 2013). These are known as 'panel studies', and in the

international literature on evaluation this is recognised to be a more rigorous approach (Soisin, Pilavan and Westerfelt 1990; Culhane and Homburg 1997).

Nonetheless, in the Australian research on Street to Home, most participants have only been followed for 12 months. This makes it difficult to know whether improvements in their housing are sustained once the intervention has ended. It is important to try to establish this, because chronically homeless people often cycle in and out of homelessness (Culhane and Metraux 2008).

In this study, Street to Home participants were followed for 24 months, by which time many of them were no longer receiving assistance from Street to Home staff. Thus, this research provides a stronger evidence base to assess the effectiveness of the program in the longer term.

This chapter begins by outlining the key theoretical ideas underpinning the Street to Home approach. Then it summarises the main findings of the first and second evaluation reports. Finally, it explains the aims of this report.

1.2 Housing First and Street to Home

The key theoretical ideas underpinning Street to Home are drawn from the Housing First approach which was developed in the US in the 1990s. Up until the early 1990s, the dominant assumption underpinning program design in the U.S was that most long-term homeless people had mental health and/or substance abuse issues and they needed treatment before they could be offered permanent accommodation. However, by the early 1990s there was increasing evidence that this approach was failing (Cohen and Thompson 1992; Tsemberis 1999; Tsemberis and Eisenberg 2000). The Housing First approach emerged in response to this lack of success and it turned the conventional wisdom on its head, arguing that it was more effective to provide people with permanent housing and then to tackle their mental health and/or drug and alcohol issues.

The Housing First model has gained widespread attention around the world because a number of evaluation studies have found that it produces better results than traditional 'continuum of care' approaches. For example, a longitudinal study of 225 people in the United States compared the housing outcomes of 126 people using the 'continuum of care' model and 99 people using a Housing First service. The research found that 88 per cent of those housed through the Housing First program

retained their housing after two years compared to 47 per cent in the continuum of care model (Gulcur *et al.,* 2003).

Other studies have compared housing retention among Housing First service users to people participating continuum of care programs (for example: O'Connell, Kasprow and Rosenheck 2009; Pearson, Montgomery and Locke 2009; Tsai, Mares and Rosenheck 2010). Housing retention rates in these studies have varied from 66 per cent to 85 per cent, but Housing First programs have always achieved higher levels of housing retention than traditional approaches. These findings challenge the assumption that chronically homeless people are unable to maintain conventional housing.

Although Housing First has gained widespread attention, there is variation in how the model has been implemented (Johnson, Parkinson and Parsell 2012). On the one hand, Housing First is presented as a service response based on a common set of operational principles such as those embodied in the original 'Pathways to Housing' model developed in New York (Rosenheck 2010, p.19). On the other hand, there is a view that Housing First should be treated as a broader philosophical approach that embraces a diverse range of service delivery models. European researchers have promoted this approach as a way of extending the basic ideas underpinning Housing First into a more enduring, system-wide set of principles (Busch-Geertsema, Edgar, O'Sullivan and Pleace 2010).

The Melbourne Street to Home model is based on Housing First approach developed in the United States, but it has some distinctive characteristics of its own. First, it explicitly targets the most vulnerable rough sleepers which means those 'at risk of premature death'. Second it uses an assertive outreach approach to engage with rough sleepers. Third, like all Housing First approaches it focuses on the provision of permanent housing. However, some Housing First services favour congregate living arrangements, whereas Melbourne Street to Home uses a range of housing options dispersed across the community. Finally, the Melbourne Street to Home model provides clients with intensive support before they access housing and for up to 12 months after permanent housing has been secured.

The fact that Housing First has been implemented in different ways in different countries means that it is essential to establish an evidence base that identifies which Housing First models work best in particular contexts. Most of the research that endorses the Housing First approach has been undertaken in the United States

which has a quite different housing and welfare system from that which operates in Australia.

1.3 What has been established so far?

The purpose of the first evaluation report (Johnson and Chamberlain 2012) was to investigate whether Melbourne's Street to Home project had engaged with its target group. Thus, it focused on the first 45 people recruited into the program (Cohort 1).

The report found that: eight per cent of the participants in Melbourne Street to Home had slept rough for between six and 11 months; 13 per cent had slept rough for one to two years; and 79 per cent had slept rough on and off for three years or longer. Most (78 per cent) clients had a chronic physical health condition and 69 per cent had been treated for a mental health disorder. The first evaluation report established that Melbourne Street to Home had engaged with its target group.

The second evaluation report had two aims (Johnson and Chamberlain 2013). The first aim was to compare the characteristics of the clients who came into the program in the first year (Cohort 1) with those who entered in the second year (Cohort 2, 26 people).

The literature suggests that services working with challenging people sometimes maintain the rhetoric of working with those 'most in need', but over time start to work with people who have less challenging problems (Evans, Neale, Buultjens and Davies 2011). However, the evidence indicated that Street to Home had maintained its focus on chronically homeless people in poor health. Seventy-nine per cent in Cohort 1 and 88 per cent in Cohort 2 had slept rough for three years or more, and most people in both cohorts had either physical and/or mental health issues.

The second evaluation report's other goal was to establish how people in Cohort 1 were travelling 12 months after joining the program. We found that three-quarters (77 per cent) of the participants were in good quality housing 12 months after joining the program. Nearly two-thirds (63 per cent) said their general health was better than a year ago and the number who reported moderate to extreme bodily pain had declined from 54 per cent to 24 per cent. We found no change in participants' substance use behaviour. However, many clients had begun to improve

their relationships with family and friends. The report concluded that the early signs were promising.

1.4 Purpose of this report

This report provides an overall evaluation of Street to Home by combining the information on both intakes, focusing on all respondents after 12 and 24 months. The baseline sample was 71 people. The tables in the second evaluation report are now updated in this report. The new data has enabled us to refine our interpretation on a number of important issues, and we have illustrated these arguments using qualitative data.

We also have an important new finding. After 24 months in Street to Home, those chronically homeless people who first became homeless as adults were doing better at maintaining their housing than those who first became homeless as teenagers. Seventy-nine per cent of those on an adult pathway had maintained their housing, compared with 62 per cent on a youth pathway. The report explains why this is the case and points to various policy implications of this finding.

Chapter 2 outlines the methodology for the research and Chapter 3 describes 'life on the streets'. Chapter 4 examines people's housing circumstances and Chapter 5 comments on their physical and mental health. Chapter 6 reviews the clients' use of alcohol and other drugs. Chapter 7 shows some changes in patterns of service and Chapter 8 focuses on people's social networks. Chapter 9 summarises the overall findings and explains why Street to Home is effective.

2 Methodology

This chapter describes how participants were recruited into Street to Home. Then we explain how we interviewed them three times over two years. In the report, these are referred to as the baseline, 12 month and 24 month interviews. After that, we outline the definition of homelessness used in the study.

2.1 Recruiting participants

The first task for the Melbourne Street to Home team was how to identify suitable participants for the program. This was undertaken using an approach developed in the United States known as 'registry week'. Registry week happens once a year when workers and volunteers go out between 3am and 7am over a five day period to locate rough sleepers. People work in teams and systematically search areas where homeless people are known to sleep, such as inner city parks, laneways and other public places. When a rough sleeper is identified they are invited to complete a short survey known as the Vulnerability Index (VI). Although the purpose of the VI is to identify those most likely to 'die within the next five years if they do not find housing and support' (HomeGround Services 2011), it is not possible to verify this claim without a matched control group.

The vulnerability index generated a score from zero to eight. A positive answer to any of the following eight questions scored one point:

- More than three hospitalizations or ER visits in a year
- More than three ER visits in the previous three months
- Aged 60 or over
- Cirrhosis of the liver
- End stage renal disease
- History of frostbite, immersion foot or hypothermia
- HIV+/AIDS
- Tri-morbidity: co-occurring psychiatric illness, substance abuse and a chronic medical condition.

Melbourne's first Registry Week took place in October 2010, and a total of 166 rough sleepers were identified. Of the 51 people who were subsequently accepted

into the program in the first year, we interviewed 45, a response rate of 88 per cent.[1] A second registry week took place in October 2011. However, some people from the first intake were still being supported by Street to Home. Thus, the number of new clients taken into the program in the second year was lower than in the first year. Of the 31 who were accepted into the program, 26 were interviewed, a response rate of 84 per cent.

The second evaluation report examined the two intakes separately to investigate whether there had been any changes in the characteristics of people recruited into Street to Home (Johnson and Chamberlain 2013, Ch.3). This report combines the information on both intakes, focusing on participants after 12 months and 24 months. The baseline sample size was 71 people.

2.2 Retaining participants

The intention was to interview participants as soon as possible after joining Street to Home. However, it took Street to Home staff considerable time to engage some clients in the first cohort, and their baseline interviews took place over eight months.

Table 2.1 shows that 71 people completed the baseline interview; 67 people completed a follow-up interview after 12 months, and 57 completed a follow-up interview after 24 months. The retention rate was 97 per cent after 12 months, and 84 per cent after 24 months. A retention rate of 84 per cent after 24 months is creditable given the high levels of mobility in the homeless population.

We have information on six out of the 11 people who did not complete a final interview: three were housed and three were homeless. There is no information on the other five.

Table 2.1: Retentions rates

	Baseline	12 months	24 months
	N	N	N
Completed interview	71	67	57
Deceased	-	2	1
Revised sample size	-	69	68
Retention rate (%)	**-**	**97**	**84**

---

[1] See Johnson and Chamberlain (2012, Ch.2) for details about the recruitment process.

The baseline interview included a structured set of questions that gathered demographic data as well as information about each participant's housing history, their physical and mental health, their patterns of service use, and their sense of social connectedness. The 12 and 24 month interviews elicited similar information to the baseline interview, except that basic demographic information was not collected.

At the 12 month interview some new questions were asked about people's experiences of trauma. In the 24 month interview some new questions were asked about people's satisfaction with the Melbourne Street to Home service, and also their satisfaction with various aspects of their lives. Participants were paid an honorarium of $30 for completing each interview.

Participants were also asked if they would answer some in-depth questions. Responses to these questions were tape recorded and transcribed. Participants were paid an additional $30 for answering the in-depth questions. At the baseline interview, 54 people answered the in-depth questions; at the 12 month interview 57 did; and at the 24 month interview 50 people did. In total, we undertook 161 in-depth interviews with 69 of people over the 24 month period. Most people undertook either two or three in-depth interviews.

We also conducted a focus group with 10 Street to Home staff. We wanted to know what they thought were the main strengths and weaknesses of the program. The focus group was tape recorded and it lasted for approximately 90 minutes.

Approval for the study was obtained from RMIT University's Ethics Committee.[2] People's names and various personal details have been changed to ensure confidentiality.

2.3 Defining homelessness

Throughout the evaluation we use the well-known cultural definition of homelessness which identifies three groups in the homeless population (Australian Government 2008, p.3). Primary homelessness refers to people living on the streets, sleeping in parks, or squatting in derelict buildings for temporary shelter. Secondary homelessness includes people emergency accommodation (refuges, hostels etc.) and people staying temporarily with other households because they have no accommodation of their own. Tertiary homeless covers people living in boarding

---

[2] Register number CHEAN A – 2000407-09/10.

houses on a long-term and a short-term basis, as well as marginal residents of caravan parks. The strength of the cultural definition is that it is an objective accommodation based approach. Thus, it can be operationalized consistently when comparing outcomes in different observation periods.

3   Life on the streets

The aim of the Melbourne Street to Home program is to engage with chronically homeless people who have slept rough for significant periods of time. This chapter begins by describing the age and gender characteristics of the population. Then it outlines their pathways into homelessness. After that it describes people's experiences 'living on the streets'. Finally, it examines the data on their physical and mental health.

The chapter concludes that all of the Melbourne Street to Home clients were long-term rough sleepers. Judgments about Street to Home must take into account the disadvantaged background of the participants.

3.1 Age and gender

Of the 71 people interviewed, 63 were male (89%) and eight were female. The focus of Street to Home on people sleeping rough means that chronically homeless men are more likely to be recruited into the program than women. Chronically homeless women are less likely to sleep rough because of the risk of physical and sexual assault and they usually develop different survival strategies to get by (Liebow 1993; Casey 2001; Hopper 2003).

Table 3.1: Age of participants (%)

	N=71	
Under 30	3	
30 - 39	32	
40 - 49	31	
50 - 59	23	65%
60 or older	11	
	100	

The mean age of the sample was 45.5 years, which is 14 years older than the mean age for people accessing specialist homelessness services across Australia (Australian Institute of Health and Welfare 2009). Table 3.1 shows that one-third (32 per cent) of the participants were aged 30 to 39, but two-thirds (65 per cent) were

over 40. This is consistent with the literature which reports that rough sleepers in the poorest health tend to be older (Sadowski et al., 2009).

Table 3.2: Age first homeless (%)

	Journey to Social Inclusion* (N=83)	Street to Home (N=71)
Aged 18 or younger	53	49
Aged 19 or older	47	51
	100	100

*Source:** Johnson, Parkinson, Tseng and Kuehnle, 2011

Half of the participants (49 per cent) had their first experience of homelessness when they were 18 or younger (Table 3.2). This is consistent with the findings from another program for chronically homeless people which found that 53 per cent of its participants first became homeless when they were 18 or younger.

We refer to those who were aged 18 or younger when they first became homeless as being on a 'youth pathway' into homelessness. Conversely, we refer to those who were aged 19 or older as travelling on an 'adult pathway' into homelessness.

3.2 Pathways into homelessness

Table 3.3 shows that the mean age for those on a youth pathway was 42.2 years, but their mean age when first homeless was 13.1. In contrast, the mean age for those on an adult pathway was 48.7 years, but their mean age when they first became homeless was 34.8 years.

On average it was now 13.9 years since those on an adult pathway had first become homeless, compared with 29.1 years for those on a youth to adult pathway (Table 3.3). Most people on both pathways had moved in and out of the homeless population a number of times, but their returns to conventional accommodation had always broken down. Table 3.3 shows that, on average, it was 10.6 years since those on a youth pathway had last had a stable home, compared with 8.0 years for those on an adult pathway.

Table 3.3: Age first homeless and current age

	Youth pathway (N=35)	Adult pathway (N=36)	Total (N=71)
Current mean age	42.2	48.7	45.5
Mean age when first homeless	13.1	34.8	24.1
Mean number of years since first homeless	29.1	13.9	21.4
Mean number of years since last had a home	10.6	8.0	9.2

Those who first become homeless on a youth pathway generally have less cultural capital (including education, social skills, knowledge, self-confidence and other non-material assets) than those who first become homeless as adults.[3] There are two reasons for this.

First, those on a youth pathway often receive minimal cultural capital from their family. Table 3.4 shows that 40 per cent of those on a youth pathway had been in state out-of-home care, compared with 19 per cent of those on an adult pathway. People who have been in the child protection system have usually come from seriously dysfunctional families and are likely to have experienced sexual abuse, physical abuse or neglect, and to have grown up in poverty (Calsyn and Morse 1991; Buhrich, Hodder and Teesson 2000; Zugazaga 2004).

Table 3.4: Experience of out of home care

	Youth pathway (N=35)	Adult pathway (N=36)	Total (N=71)
Been in out of home care	40	19	30

The second reason why the cultural capital of those on a youth pathway is likely to be low is because many of them left school early. Table 3.5 compares the educational attainment of Street to Home participants with a large, national, longitudinal study of homeless and 'at risk' individuals, known as *Journeys Home*. Overall, it can be seen that only three per cent of those in Street to Home had gained a tertiary qualification compared to 28 per cent of those in *Journeys Home*. Conversely, 41 per cent in Street to Home did not complete Year 10, compared with 20 per cent in *Journeys Home*.

---

[3] The term 'cultural capital' was first used by Bourdieu and Passeron (1973).

Table 3.5: Educational attainment (%)

	Youth pathway (N=35)	Adult pathway (N=36)	Total (N=71)	Journeys Home (N=1682)
Tertiary qualification	0	5	3	28
Completed Year 12	9	28	18	11
Completed Year 10 or 11	34	42	38	40
Did not complete Year 10	57	25	41	20
No information	0	0	0	1
	100	100	100	100

There is a second pattern: people on a youth homeless pathway were less successful at school than those on an adult homeless pathway. Only nine per cent on a youth pathway completed Year 12, compared to 28 per cent on an adult pathway. Conversely, 57 per cent on a youth pathway did not complete Year 10, compared to 25 per cent on an adult pathway.

The cultural capital of those on a youth pathway is generally lower than the cultural capital of those on an adult pathway for three reasons: their mean age was 13 when they first became homeless; 40 per cent had been in the state care and protection system; and 57 per cent had left school before year 10.

Low education levels puts people at significant disadvantage in a highly competitive labour market. None of the participants in Street to Home were employed when they joined the program and all but one was receiving a Centrelink payment. Most (69 per cent) were on Disability Support Pensions, and most (85 per cent) had been on a government support payment for three years or longer. The participants in Street to Home were chronically disengaged from the labour market.

Nonetheless, the cultural capital of those on an adult pathway into homelessness was still higher than those on a youth pathway. Their average age was 34 when they first became homeless, and many of them had experienced stability in their early adult lives, including employment, stable housing and, in some cases, marriage and children. This can be understood more easily if we examine four typical pathways into adult homelessness, using the approach outlined in Chamberlain and Johnson (2013).

The first pathway is where people lose their accommodation following some form of *housing crisis*. This is always precipitated by a loss of income although the reasons for this vary. Ed's world changed after he was injured in a car accident:

> The injuries I sustained from the car accident prevented me from working as a chef which led to financial hardship … that was the start of my homelessness.

People on a housing crisis pathway have usually been employed and had stable housing.

The second pathway into homelessness is because of *substance misuse.* Tom had a good job as a mechanic, but he was also a recreational heroin user. Gradually, his heroin use escalated and he ended up losing his job:

> I had to start stealing stuff from work and I got caught … The boss said, 'Look, I know you've got a drug problem. Instead of sacking you, I'll let you resign. But if you ever need a reference, you've got to prove to me you've been through detox and you're clean'.

People on a substance abuse pathway have often been employed prior to becoming homeless and sometimes they have had stable housing.

The third adult pathway is where people become homeless following *family breakdown.* Maurice had been married for 22 years and had two children:

> After my marriage broke up I just didn't know where I was … I ended up on the streets … It took me years to get myself back together.

Most of the men on a family breakdown pathway had lived 'conventional' lives before becoming homeless, usually having a job, a home and a family.

The final route into homelessness is a *mental health* pathway. People on a mental health pathway are less likely to have had employment, stable housing or marriage and children. However, there are exceptions if their mental health issues developed later in life.

3.3 Chronic homelessness

People entered the homeless the population on different pathways, but when they become chronically homeless their experiences start to converge. Table 3.6 shows that 70 per cent of the Street to Home participants had stayed in crisis accommodation and 86 per cent had lived in a boarding house. Amongst those who

entered on an adult pathway, 61 per cent of had been in crisis accommodation compared with 80 per cent of those on a youth pathway. This reflects the fact that there are more emergency accommodation options for young men and women, than there are for males over the age of 18. There was little difference in the number who had been in a boarding house (83 per cent and 89 per cent).

Table 3.6: Selected experiences, baseline data (%)

	Youth pathway (N=35)	Adult pathway (N=36)	Total (N=71)
Been in crisis accommodation	80	61	70
Been in a boarding house	89	83	86
Victim of physical violence while homeless	69	83	76

Boarding houses are part of the system of emergency accommodation in the capital cities and many of them are in poor condition. Most of the respondents had stayed in boarding houses at the bottom end of the private rental market. These boarding houses are often in poor condition and the rooms are small. Mandy commented:

> It's a fucking dog box … Most days I go to a meals program in Fitzroy … It beats sitting at home in that depressing little room.

According to Eddie:

> The last time I stayed at *The Circle* they gave me a room that was infested with bed bugs …

Table 3.6 shows that three-quarters (76 per cent) of Street to Home participants had been victims of physical violence when homeless. Many reported that violence was common in boarding houses. Jayden had been watching TV when:

> … a neighbour (started) making a lot of noise so I knocked on his door and asked him to be quiet … Then he started kicking the wall between our rooms. I knocked on his door again and told him to stop banging … then he stabbed me in the lower abdomen.

Violence was also common when people slept rough.

Sleeping rough

When the participants undertook the vulnerability index, everyone reported that they had been sleeping rough. At the baseline interview, six per cent said they had slept rough for between six and 11 months, nine per cent had slept rough for between one and two years, and 85 per cent had slept rough for three years or longer (Table 3.7). However, there were significant differences by pathway. Ninety-one per cent on a youth pathway had slept rough for three years or longer, compared with 79 per cent on an adult pathway. Moreover, half (53 per cent) on a youth pathway had slept rough for 10 years or longer.

People on a youth pathway had usually slept rough in their teenage years. For example, Josh said:

> When I was 16 my father kicked me out … I slept in a bus stop and the police pulled up. They took me back home and made me sneak into the house. I fell asleep on the couch in the lounge room. When Dad woke up, he kicked me out again … After that, I slept on the streets.

Craig left home when he was 16:

> Yeah, I pretty much went straight to the streets … right in the centre of Adelaide … Sometimes I slept with other people, sometimes by myself … there were a lot of fights … but there was always someone to talk to.

Table 3.7: Length of time sleeping rough (%)

	Youth pathway (N=32)		Adult pathway (N=32)		Total (N=64)	
Between 6-11 mths	0		12		6	
1 – 2 years	9		9		9	
3 – 4 years	6		25		16	
5 – 6 years	19	91%	16	79%	17	85%
7 – 9 years	13		22		17	
10 years or longer	53		16		35	
Total	100		100		100	

Most people had experienced violence living on the streets. Ziggy said: 'I was living in an old factory and a couple of guys came in … and they just started kicking me'. According to Damien:

> I have been on the streets since I came out of gaol … I was attacked by a group of young guys who were drunk … I suppose I was an easy target … fancy being robbed for a blanket.

Kevin said it was better to sleep rough with two or three other people to avoid being attacked. After being assaulted Ziggy became:

> …more selective on where I stayed. I made sure I found places that were more secure … Yeah, I became very security conscious after that happened.

Cookie had seen a knife fight when he was sleeping in a park. After that: 'I didn't sleep anywhere where people could see me'. Most people did not normatively endorse street homelessness as a way of life, but they had few options when they found boarding houses intolerable.

3.4 Health

Epidemiological, clinical and social studies have all documented that the homeless have a higher incidence of acute and chronic health conditions compared with the general population (Winkleby et al 1992; Toro et al 1995; Kermode et al 1998), and this has long been a concern for policy makers and service providers. Studies also indicate that the physical health of the long-term homeless is poorer than those whose experience short-term homelessness (Culhane and Metraux 2008).

Table 3.8: Selected health characteristics, baseline data (%)

	Youth pathway (N=35)	Adult pathway (N=36)	Total (N=71)
Ever been treated for a mental health disorder	77	72	75
Report chronic physical health condition	86	86	86
Three or more chronic physical health conditions	63	44	54
Currently takes prescribed medication	58	82	70

The Melbourne Street to Home program has a particular focus on health. Table 3.8 shows that 75 per cent of the sample reported that they had been treated

for a mental health disorder and there was little difference by pathway. Similarly, 86 per cent on both pathways reported a chronic physical health condition. Moreover, 63 per cent on a youth pathway reported three or more chronic health conditions, as did 44 per cent on an adult pathway.

The most common diseases were those of the digestive system such as hepatitis C and cirrhosis of the liver (67 per cent); diseases of the musculoskeletal system such as chronic back and neck pain (31 per cent); diseases of the respiratory system such as emphysema and bronchitis (28 per cent); and various physical disabilities (21 per cent). Overall, 70 per cent were currently taking prescribed medication.

Most (90 per cent) of the participants currently smoked cigarettes and over a third (39 per cent) reported they had, at some point in their lives, sustained a serious head or brain injury. Overall, their health was poor and three participants died before completing the program

3.5 Conclusion

This chapter has demonstrated that all of the Melbourne Street to Home clients were long-term rough sleepers, and most of them were in poor health when they started with Street to Home. They were chronically disengaged from the labour market and they had been on the margins of the housing market for a considerable amount of time. Eighty-five per cent had spent three or more years on the streets and 76 per cent had been victims of violence while homeless. Judgments about the overall effectiveness of Street to Home should take into account the disadvantaged background of the participants.

The chapter has also shown that half (49 per cent) of the clients had their first experience of homelessness when they were 18 or younger and, on average, it was 29 years since they had first become homeless. The average age of those on a youth pathway was 13.1 years when they first became homeless. In contrast, 51 per cent of the participants were on an adult pathway, and their average age was 34.8 years when they lost their accommodation. It was 13.9 years since those on an adult pathway had become homeless, compared with 29.1 years for those on a youth pathway.

The cultural capital of those who first became homeless as adults is generally greater than the cultural capital of those on a youth pathway. The younger cohort is more likely to have come from 'unstable' families and to have had traumatic childhoods. Conversely, those on an adult pathway are more likely to have had periods of stability - including employment, stable housing and, in some cases, marriage and children. In the next chapter, we will see how this affects their housing outcomes.

4 Housing Outcomes

This chapter begins by examining the housing outcomes for Street to Home participants. Then it describes the challenges that are faced by chronic rough sleepers once they are re-housed. This is followed by a discussion of how quality, location, safety and affordability influence housing outcomes. Finally, the chapter discusses how those who were successfully re-housed felt about having a 'home'.

In the past, many services working with rough sleepers have focused on resolving people's health problems, with little or no attention directed towards their housing issues. In contrast, Street to Home prioritises access to permanent housing before other challenges like mental health and substance abuse issues are tackled (HomeGround 2010, p.1).

4.1 How many were housed?

Street to Home has an explicit focus on rapidly getting participants into permanent housing and keeping them housed. However, one of the biggest challenges facing services such as Street to Home is that rapid access to affordable housing in inner city Melbourne is difficult. It is hard to find private rental accommodation that is affordable for low income people. The lack of options in the private rental market means that public and social housing are the only realistic alternatives, but waiting lists are long.

The lack of affordable housing meant that Street to Home participants had to wait, on average, nine months before they secured permanent, independent accommodation. A consequence of the tight housing market was that Street to Home had to provide many participants with temporary accommodation arrangements (boarding houses, transitional accommodation etc.), before they were found permanent accommodation.

The use of temporary accommodation is counter to the Housing First philosophy, but Street to Home took the view that providing people with temporary accommodation was better than allowing them to remain on the streets. In many cases this view appeared to be justified. However, a number of participants also reported that the accommodation was far from satisfactory. As Josh put it, 'I was in

one of those rooming houses where all the bloody smack heads are'. Street to Home provided clients with ongoing support while they searched for appropriate housing.

Table 4.1: Housing outcomes after 12 months (%)

	Youth pathway (N=32)	Adult pathway (N=35)	Total (N=67)
Housed	69	86	78
Homeless	12	11	12
Institution (prison, psychiatric hospital etc.)	19	3	10
	100	100	100

All the clients were homeless when they did the vulnerability index. Table 4.1 shows that after 12 months 78 per cent were living in independent housing. However, amongst those who had first become homeless as adults, 86 per cent were housed. In contrast, 69 per cent for those who first became homeless as teenagers were living in independent accommodation. There are many factors that influence how long it takes to find chronically homeless people secure accommodation, but this indicates that it is more difficult to help those on a youth pathway. As we saw in the last chapter, many of those on youth pathways have had traumatic experiences in childhood and limited experience of independent housing as adults

Table 4.2: Housing outcomes after 24 months (%)

	Youth pathway (N=29)	Adult pathway (N=28)	Total (N=57)
Housed	62	79	70
Homeless	35	21	28
Institution (prison, psychiatric hospital etc.)	3	0	2
	100	100	100

Table 4.2 shows that after 24 months the proportion that was housed had declined to 70 per cent and the proportion that was homeless had doubled (from 12 per cent to 28 per cent). However, amongst those on an adult pathway 79 per cent were housed compared with 62 per cent on a youth pathway. This corroborates the point that it is more difficult to help those who first become homeless as teenagers.

Of the 40 people who were housed, 37 (or 93 per cent) were in public or social housing, one person was living in private rental and two people were living with their families.

4.2 Facing new challenges

When people were offered their own accommodation there was an understandable mix of relief and excitement at 'having their own place. Jess (youth pathway) was first homeless in her early teens and has bipolar and schizophrenia. After four months, Jess was offered a Housing Commission property in an outer suburb:

> Interviewer: How did you feel when you got word they had a place for you?
> Jess: Pretty excited!
> Interviewer: Yeah?
> Jess: I started crying.
> Interviewer: How long had you been homeless for?
> Jess: (crying) Seventeen years.

Most of the participants did not have furniture or white goods to put in their new home and Street to Home provided basic furniture and kitchen equipment to get people started. Nonetheless, for many it was still difficult. Sandra (youth pathway) said the first year was 'pretty tough' because 'this was my first home in a long time and everything I owned had been lost or stolen'. According to Tom (substance abuse pathway):

> The first three months were the hardest. I knew the place was mine but it was very bare. I only had my bed, my table and chairs, pots and pans and that was it … I had a crumby old TV. It took me quite a while to get set up.

Anthony (family breakdown pathway) had no possessions and he felt lonely:

> It was very hard at first. I didn't know anybody in the area. Plus I had no furniture, no nothing, until Street to Home bought me some furniture and things.

The transition out of long-term homelessness is often a stressful process, because it involves an abrupt separation from existing roles and routines, combined with the challenge of managing accommodation (Tsemberis 2010; Johnson, Kuehnle, Parkinson and Tseng 2012). Most people told us that that it took time to

adjust to living in independent housing. For example, Alex (family breakdown pathway) said:

> … I've lived on the streets for a while and I never had the responsibility for paying rent and other things … And all of a sudden I got a house and I got stuck paying this and that and it's a shock to the system.

People who have been long-term rough sleepers are confronted by a host of issues they have not had to deal with for many years. Brendan (adult pathway) told us that:

> You've got utilities to pay, buying your own food, you're managing your own affairs, managing your own income, paying your own rental, all those things come into play.

Running a house can be a daunting for those with little experience (or whose experience may have been many years ago). This can increase their anxiety and if they do not have access to post-settlement support the risk of a tenancy breakdown remains high. Most rough sleepers need post-settlement support to assist them through this difficult transition period. Brendan said that moving into a new place was:

> …a challenge … It's a big step from homelessness into a home, especially when you've been in a chronic homeless situation … So it is a big leap and it's not one that's easily managed without support. Fortunately, I've had that support from Street to Home.

Anthony (family breakdown pathway) was:

> … managing okay. At first it was scary because I didn't know anyone and I was very lonely. It didn't feel like home at first, that's all. But once you start getting all material stuff it starts feeling like a home … Yeah, I can handle it now.

With the assistance of Street to Home, many people were able to overcome their initial settlement problems. The provision of ongoing support is crucial as it helps people to adjust to a new way of life and mitigates the risk of them losing their housing. Of the 40 people who were housed at the 24 month interviews, 80 per cent had been housed for one year or longer. Most of these people had got through the difficult transition period.

However, some people on a youth pathway and those who have mental health issues may need more than 12 months' support after they have been re-housed. Earlier, we met Jess (youth pathway) who has bi-polar and schizophrenia. At the 24 month interview, Jess had been housed for over a year.

> Interviewer: How has having a house helped you?
>
> Jess: Well, having a house has made me feel a lot better … I'm also getting better physically … and I don't use heroin anymore.
>
> Interviewer: So how has having a house contributed to how you're feeling?
>
> Jess: Well, I've been learning how to cook again and learning how to make beds. I've also been learning about hygiene and how to clean the place properly.

Currently Street to home provides clients with support for up to 12 months after they have been re-housed. This is sufficient for many clients, but others need longer-term support to remain housed, particularly if they have mental health issues.

4.3 Housing quality

The availability of on-going support is a key element in retaining housing, although housing retention rates are also influenced by a range of factors, some of which are tied directly to housing. It is well understood that the quality, location and safety of housing all influence longer term housing outcomes but it is not entirely clear how these different elements interact (Foster, Gronda, Mallet and Bentley 2011). Participants who were housed were asked to assess the adequacy of their housing across a number of dimensions.

People were particularly impressed with the condition of their accommodation, with 93 per cent rating the condition of their housing as adequate or better (Table 4.3). Anthony said:

> When they told me where it was I thought I don't want to live there … but when I saw the place I couldn't knock it back. It was brand new!

Erik (substance abuse pathway) told us:

> Oh it's a home, it's a beautiful place, I've turned it into a beautiful place and everybody who walks in here says 'wow!' you know, 'this place is great, I love it'.

Location is also important. In a study of 103 people leaving transitional accommodation Johnson, Gronda and Coutts (2008, p.174) found that housing location was just as crucial to the success of maintaining housing as affordability. Among the Street to Home participants 39 of the 40 people who were housed reported that the proximity of their housing to shops and basic amenities was adequate or more than adequate (Table 4.3). This likely reflects the fact Street to

Home is an inner city service where there is a relatively well developed transport, shopping and service infrastructure. While participants were happy with the access they had to basic amenities, four people (10 per cent) reported their housing was too far away from their family and friends (Table 4.3) but this was much lower than reported in the 12 months follow up (36 per cent)

Table 4.3: Housing adequacy, 24 months (%)

	Condition of housing (N=40)	Close to amenities (N=40)	Close family or friends (N=40)	Safe and secure (N=40)	Privacy (N=40)
Adequate or more than adequate	93	98	80	90	85
Less or much less than adequate	7	2	10	10	15
Not stated/refused	0	0	10	0	0
	100	100	100	100	100

While good quality accommodation has been linked to high retention rates among the formerly homeless, research has also found that privacy and security are often identified as important characteristics of a home (Mee 2007). Here the home functions as a safe haven that provides security and protection from the outside world (Dupuis and Thorns 1998; Kearns, Hiscock, Ellaway and Macintyre 2000; Hiscock, Kearns, Macintyre and Ellaway 2001). When people sleep rough they have no control over the space in which they 'live' and most want safe and secure housing.

Table 4.3 shows that 90 per cent of those who were housed after 24 months felt safe and secure where they lived. Erik emphasised how much he enjoyed his place and how he benefitted emotionally and intellectually from feeling safe:

> Yeah, there could be nothing more important for me right now than to have this home … having a place where I know that I'm secure and safe … This place is crucial to my well-being.

According to Mitchell (substance abuse pathway):

> This place is quiet and safe and no-one in the building bothers me, so that's a good thing.

Tran (youth pathway) compared the security of his flat with his life on the streets:

> Now I don't have to worry when I go to sleep. I know my things will be there in the morning. It's not like being on the streets. I lost heaps of stuff, you know, birth certificates and wallets, everything. I just got sick of it.

Eighty-five per cent reported their housing provided them with an adequate or better than adequate sense of privacy (Table 4.3). When Adrian (family breakdown pathway) was asked to identify the most important thing about his housing, he emphasised the importance of privacy as well as the autonomy to do what he liked:

> Oh, privacy, just having my own place … having the time to do what I want to do, when I want to do it … If I want to have a sleep in the morning I can have a sleep in the morning … that's fine.

While privacy, safety and control are all crucial elements of a home, housing affordability stress can also negatively impact on people's health and their capacity to maintain their housing (Wood and Ong 2009). All except one of the participants was in public or social housing. These tenants pay a fixed amount of their income on rent. The amount is around 30 per cent of their income, which is generally considered affordable for low income earners.

Most people (93 per cent) said their place was affordable and nearly everyone paid by direct debit. As Sandra put it: 'I don't mind having $89 taken out of my bank account every week to have a roof over my head'. In the previous report we found that five people were behind in their rent, but at the 24 month survey only one person was in rent arrears.

4.4 The importance of home

Earlier we saw that Anthony (family breakdown pathway) had no furniture when he was re-housed and his new property was in an area where he had no friends. Street to Home provided basic furniture, but as time went by Anthony acquired other things that he needed and began to set up his place as a 'home':

> I have gradually got the things I need and I'm making it into a home … like I've got all my kids' photos on the wall in frames and everything. So that's just great! My mum sent me down the photos of the kids. It's just so good to have their pictures on the wall. It's the first time I've ever had a place like this. This is my castle.

Tom (family breakdown pathway) also had few possession when he was re-housed except for those provided by Street to Home, but unlike Anthony he has no contact with his family and relies on a couple of 'good mates' for emotional support. It also took Tom quite a while to settle in:

> I'm used to it now. I'm more comfortable. I'm getting the place set up the way I like it … putting posters up, things like that. It's good to be able to cook, not just for yourself but for mates when they come over … I can cook up a nice feed because I like cooking …. I'm having a couple of mates over on Christmas day and we're going to cook … I've got a nice stereo so we can play music and have a few drinks.

Many people talked about the importance of being able to keep their clothes clean and safe and the joy they experienced cooking meals. Ilona (youth pathway) had rarely had stable accommodation:

> Having a place of my own – it's just so amazing! A simple thing like having a place of you own makes such a difference. You can shower, you can keep clean, you can wash your clothes. … Being in a house you can actually cook. I love cooking. Cooking makes me happy … It's just so much better when I cook for myself, even if it's only pasta or something … When I was on the street I could never do that.

Like Ilona, Sandra (youth pathway) had spent many years on the streets. Sandra also appreciated the 'simple things'.

> I appreciate the simple things. Yeah, I appreciate having to cook a meal at night and not having to stand out in the street waiting for the food van. That was tough and when you get sick you have nowhere to go … Here I feel safe. I have a place where I can put things and they don't continually get stolen.

Many people talked about the importance of having a garden and the joy they got working in their garden. Others talked about the importance of having a home so they could have access to their kids. Brendan (adult pathway) said:

> I was under orders from the family court that I couldn't have my children around me until I got a roof over my head … It took a while. These things don't happen overnight … but it came to pass and it was such a good day! … Well now I get to see my kids.

Brendan was determined to hold on to his housing:

Having a house is the best thing that can happen because honestly out there you're a bit bound by the bloody law of the jungle. When you've got a house, mate, you can actually make choices again … I've got all the things that I need, all the things that are precious to me … you know like food and drink in the fridge. I can tell you, mate, there aren't many fridges out there in the park.

Others talked about how their self-respect had improved and what things they had done to improve the quality of their life. Wayne (youth pathway) said:

Well, I've got my self-respect back. I pay my own bills and I do my own shopping. On a Monday, I usually go to Aldi's and get everything I need. I make real coffee at home and I buy the food I want to eat. I don't drink anymore … My life has improved a hell of a lot. I'm enjoying life.

People were determined to maintain their housing and all reported that their lives had improved greatly.

4.5 Conclusion

This chapter began by examining the housing outcomes for Street to Home participants. After 24 months, 70 per cent of Street to Home clients were housed and 80 per cent of them had been housed for one year or longer. Amongst those who had entered the homeless population on an adult pathway, the success rate was 79 per cent. In contrast, the success rate was 62 per cent for those who had become homeless on a youth pathway. It is more difficult to support those who have become homeless as teenagers and have little or no experience living in stable households

The Chapter also described the challenges that chronic rough sleepers face once they are re-housed. Most participants did not have basic furniture or kitchen equipment and Street to Home provided essential material items needed to establish a household. The everyday skills to run a household – such as cooking, paying bills on time and cleaning - were a major challenge for most of the participants. Everyone in Street to Home found the transition to independent living difficult, but some made the transition to independent living more easily than others.

Everyone was determined to maintain their housing and most were effusive about what they had gained from it. People explained the importance of 'having a home' in different ways, but there were common themes in their narratives. They talked about feeling safe and secure, having access to their children, re-gaining their

self-respect, and being able to cook and to keep their belongings clean – things that most Australians take for granted. Perhaps the most important empirical finding is that many long-term rough sleepers can maintain their housing if they are given appropriate accommodation and the opportunity to re-engage with the services when problems emerge. According to Maurice:

> When I was living on the streets I thought it was going to be like that for the rest of my life … Luckily I came here and got the help that I needed … Thanks to them I'm still alive.

5 Physical and mental health

The Melbourne Street to Home program has an explicit focus on reducing the risk of premature death by assisting people to access appropriate health services and provide a stable environment where they can recover. Chapter 3 pointed out that 86 per cent of the people we interviewed reported a chronic physical health condition, and half (54 per cent) had three or more chronic health conditions.

Many people thought that their poor health was a consequence of sleeping rough. Ilona said, 'My health is shocking. I've got cancer and I've had pneumonia. I've had a lot of really bad health. If I wasn't on the streets, maybe it wouldn't have happened'. Others attributed their poor health to excessive drug and alcohol use while homeless. For example, Tom told us that:

> I've got HEP C from sharing needles …I've also got cirrhosis of the liver from hitting the grog really hard. In the last year, I've also broken my wrist and had my gall bladder taken out.

People will not make a full recovery from many of these chronic health conditions. Judgments about the effectiveness of Street to Home must take this into account. Nonetheless, research shows that that permanent housing and good quality support can facilitate better health management, as well as making day-to-day life more tolerable (Muir and Fisher 2007; McDermott, Bruce, Oprea, Fisher Muir 2011). This chapter examines whether Street to Home has facilitated improved health for the participants.

Another goal of the Melbourne Street to Home program is to reduce the use of hospital services, particularly emergency departments. The long-term homeless often have severe physical and mental health problems and use public hospitals intensively (Culhane, Metraux and Hadley 2002; Sadowski *et al.* 2009). If there is an improvement in the health of the Street to Home participants, then we would expect to see a decline in their use of hospitals and emergency departments.

The chapter begins by examining the participants' perception of their physical and mental health 12 and 24 months after joining Street to Home; then it examines their use of hospitals, emergency departments and community health services. There were not marked differences in the health of those on youth and adult pathways and the focus is on all participants in Street to Home.

5.1 Physical health and emotional well being

At each interview, participants were asked how their general heath compared with 12 months ago. At the 12 month interview, 61 per cent of the participants reported that their health was better compared with 38 per cent at the baseline interview (Table 5.1).

Table 5.1: General health compared to 12 months ago (%)

	Baseline (N=71)	12 months (N=67)	24 month (N=57)
Same	25	18	46
Better	38	61	33
Worse	37	21	21
	100	100	100

People attributed the improvement in their health to a range of factors. For some people it was tied directly to having a permanent place to stay. Being stably housed improved access to treatment but also provided a safe place to recover. Rick said:

> When you are doing it rough you don't really want to go to the doctors to find out there's something wrong with you. Now that I'm stable I've been going to the doctors and found out there are things wrong. It's a bit hard but it is good to know.

When people sleep rough it is difficult to maintain a treatment regime. Lamar said:

> I'm doing better. Like I'm sticking to my medication and stuff even though it's not agreeing with me at the moment. I've got somewhere to stay where I can keep my medicine without having to worry about it getting pinched.

Many of the participants pointed towards the salutary effects of housing, but the Street to Home program also has two registered nurses as part of its service delivery model. Having a health professional on hand can make a difference. Damien told us that:

> She's a registered nurse and she's really nice. It was great being able to call her up when I needed her. You can ring up and pretty much see her that day or the next day. It's just really helpful.

Similarly, Lance said: 'It's really great that they have a properly trained nurse who knows about mental health issues, that's been really handy'. Importantly, access to health professionals is on-going. Damien mentioned that 'even though we are housed, the nurse still helps out which is good'.

At the 24 month interview, 33 per cent reported their health was better, compared with 61 per cent at the 12 month interview (Table 5.1), but the number who said their health was the same increased from 18 per cent to 46 per cent. This means for about one-half of the participants, the most dramatic improvements in their health occurred in the first twelve months and, in the main, these improvements were maintained. For example, Damien commented: 'Physically, my health is about the same as 12 months ago'.

For about one-third of the participants, there was a steady improvement in their health between the 12 and 24 month interviews, and many of these were people who had chronic ill health. For example, Jess had a serious heart condition. At her final interview she said:

> I'm getting better physically. I'm more energetic … I go walking on the beach and I go jogging sometimes. I take my friend's dog for a walk. I have a heart problem and walking is good for your heart.

Tom had a number of serious illnesses including Hepatitis C and cirrhosis of the liver. Like Jess, he reported feeling a lot better at his final interview:

> My health is much better than it was two years ago. The nursing program is really good. They've looked after my health the whole time, making sure I get to hospital appointments and so on. I would not have got this far without them.

Ilona, who was 'in remission' from cancer, also reported feeling better:

> Yes, my health is much improved. It's much easier to look after yourself when you have your own place. Like if I'm sick I'll stay in bed all day. When I was on the streets I couldn't do that. When I feel really sick I can get the nurse to come to me. She'll bring my medication and help out.

Finally, for about one-fifth of the participants their health declined between the second and third interviews. Lamar 'loves his place' because it means he can have access to his two sons, but:

My health has just gone downhill, it's declined a lot … I can hardly walk up hills these days. I get bad chest pains and stuff. I used to go to the park with the boys and kick the footy and play cricket. But lately I haven't been able to do that much, I am just tired a lot of the time.

Maurice said: 'My health has been up and down. I had a kidney stone'.

Although most people were happy with their accommodation, some people reported that their health had got worse, about half reported that it remained the same, and about one-third reported that their health had improved. This underlines the point that there are multiple factors that affect whether people feel their health is improving or declining, and there is no simple causal relationship between re-housing people and improvements in physical health.

Table 5.2: Amount of bodily pain last 4 weeks (%)

	Baseline (N=69)		12 months (N=67)		24 months (N=57)	
None	30		48		40	
Slight	22		22		25	
Moderate	26		10		18	
Quite a bit	15	48%	12	30%	10	35%
Extreme	7		8		7	
	100		100		100	

There was a notable improvement in the participants' experience of pain. At the baseline interview, 48 per cent reported they experienced moderate to extreme bodily pain in the preceding four weeks (Table 5.2). This had declined to 30 per cent at the follow up interview, with half (48 per cent) reporting no bodily pain. These positive changes indicate that when people are provided with stable housing, it enables them to manage their chronic health conditions more effectively.

Table 5.2 also shows that the number of people reporting no bodily pain in the last four weeks declined from 48 per cent at the 12 month interview to 40 per cent at the 24 month interview. Conversely, the number of people reporting moderate to extreme bodily pain increased from 30 per cent to 35 per cent. This is a relatively small change but it corroborates the point that simply re-housing rough sleepers does not necessarily result in an improvement in their physical health. It may enable

people to feel more positive about their lives, or to manage physical health conditions more effectively, but it will not necessarily alleviate pain arising from ill health.

We used the Depression, Anxiety and Stress Scale (DASS) to assess the emotional and mental well-being of participants. The DASS is a standardised tool that measures levels of depression, anxiety and stress. Participants were read 21 statements such as 'I felt I wasn't worth much as a person' and 'I found it difficult to relax'. Respondents were then asked to indicate how well each statement applied to them in the preceding week by choosing a number between zero and three. A zero indicated that the statement did not apply to them, whereas a three indicated that it applied very much. The DASS scoring system is shown in Table 5.3. A high score indicates a more severe level of anxiety, stress or depression.

Table 5.3: DASS scoring system

	Stress	Depression	Anxiety
Normal	0-14	0-9	0-7
Mild	15-18	10-13	8-9
Moderate	19-25	14-20	10-14
Severe	26-33	21-27	15-19
Extremely severe	34+	28+	20+

Table 5.4: DASS mean scores

	Baseline (N=65)		12 months (N=62)	
Stress	17.3	**mild**	14.1	**normal**
Depression	15.5	**moderate**	10.0	**mild**
Anxiety	13.5	**moderate**	9.0	**mild**
Total	46.3		33.1	

Over the first 12 month period there was an improvement in all three dimensions measured by the DASS. The overall score for participants decreased from 46.3 at the first interview to 33.1 at the second (Table 5.4). According to Farrugia (2011), homeless people have low self-esteem which is a consequence of the 'symbolic burden of homelessness'. Having a home can make a significant

contribution to people's feeling of self-worth. Alex had experienced the moral judgements of others but now he was:

> … getting my self-respect back … people used to look down on me but now I've got my own home I'm starting to feel better.

Tom reported that:

> My self-esteem has gone way up … and my mental health is much better now because I'm not drinking anywhere near as much nor taking drugs. It's just my natural endorphins kicking in. Sometimes I think, 'Wow, what's going on!'

Ziggy's reflections capture the sentiments expressed by many participants:

> Emotionally I'm a lot better than what I was 12 months ago. I was very unstable … when I look back at where I've come from, I think there has been a big change.

The participants' mean score for stress declined from 17.3 (a moderate level) at the first interview to 14.1 (a normal level) at the second (Table 5.4). There was also an improvement in the level of depression experienced by participants – from a mean score of 15.5 (a moderate level) at the first interview, to a mean score of 10.0 (a mild level) at the second. Their level of anxiety also decreased – from a mean score of 13.5 (a moderate level) to a mean score of 9.0 (a mild level).

Table 5.5: DASS mean scores

	12 months (N=62)		24 months (N=57)	
Stress	14.1	**normal**	13.6	**normal**
Depression	10.00	**mild**	9.6	**normal**
Anxiety	9.0	**mild**	9.2	**mild**
Total	33.1		32.4	

Table 5.5 shows that there was little change in the scores between the second and third interviews. The overall score for participants decreased from 33.0 at the second interview to 32.4 at the third. The participants' mean score for stress declined slightly from 14.1 (a normal level) to 13.6 (a normal level). There was a small improvement in the level of depression experienced by participants - from 10.0 (a

mild level) to 9.6 (a normal level). There was little change in the participants' levels of anxiety – from 9.0 (a mild level) to 9.2 (a mild level).

Nonetheless, at the 12 month and 24 month interviews many people made comments indicating that their mental health had improved. For example, Penny said:

> I feel complete now that I've got a place … I know it's my home and it gives me stability and self-confidence.

According to Alex:

> I am getting my self-respect back … people used to look down on me but now I've got my own home I'm starting to feel better.

5.2 Hospital and emergency wards

In the preceding sections, we saw that the physical and mental health of the participants improved in the first 12 months, but after that the rate of improvement slowed. However, another goal of the Melbourne Street to Home program is to reduce the use of hospital services, particularly emergency departments. If there was an *overall* improvement in the health of the Street to Home participants, then we would expect to see a decline in their use of hospitals and emergency departments.

Table 5.6 shows that at the baseline interview, one-third (32 per cent) of the people had been admitted to hospital in the preceding three months, and at the 12 month interview there was no change (Table 5.8). However, at the final interview this figure had fallen to 11 per cent.

There was also a marked decrease in the number of people using hospital emergency departments. At the baseline interview, 42 per cent had been admitted to an emergency department in the preceding three months, as had 40 per cent at the 12 month interview. This had declined to 18 per cent at the final interview (Table 5.8). One goal of the Melbourne Street to Home program is to reduce the use of hospital services, particularly emergency departments, and this seems to have been achieved.

At the same time, there was a noticeable increase in the number of people using community health services. At the baseline interview, 37 per cent reported that they had used them in the preceding three months, but at the second interview this had increased to 57 per cent, and at the final interview it was 51 per cent.

Table 5.6: **Health services used, preceding three months**

	Baseline (N=71)	12 months (N=67)	24 months (N=57)
General hospital			
% admitted last 3 months	32	33	11
If admitted, average number of times	2.0	2.0	2.0
Emergency department			
% admitted last 3 months	42	40	18
If admitted, average number of times	2.8	1.5	3.1
Community health service			
% who have used last 3 months	37*	57	51
Mental health service			
% currently receiving treatment	42	51	53

* N=67

There was also an increase in the number of people receiving assistance with mental health problems and this should be seen as a positive development. At the first interview, 42 per cent were receiving some form of assistance, but at the second interview this had increased to 51 per cent, and at the final interview to 53 per cent (Table 5.6). A number of people reported that since being re-housed they had started to have treatment for their mental health issues. Jess said: 'Street to Home have helped with my mental health issues … now I am seeing a psychiatrist'.

5.3 Conclusion

This chapter set out to investigate whether there has been an improvement in the physical and mental health of the participants in Street to Home. However, we pointed out that judgments about the effectiveness of Street to Home must take into account that 86 per cent of the participants reported a chronic physical health condition and 75 per cent had been treated for a mental illness at some point during their lives. Bearing this in mind, the improvement in the participants' physical and mental health was really quite striking in the first 12 months. The inclusion of two community health nurses in the Street to Home team improved clients' access to

health professionals and reduced barriers between homeless services and health workers.

In the second 12 months the rate of improvement in the clients' physical and mental health slowed. About one-third reported improvements in their health; roughly half reported that their health had not changed; and one-fifth said that their health had got worse. There was also little change in the three dimensions of mental health – anxiety, depression and stress – measured by the DASS.

However, the evidence indicated that there was an overall improvement in the health of the Street to Home participants over the duration of the program. We found that the number of people admitted to hospital in the preceding three months declined from 32 per cent at the first interview to 11 per cent at the final interview. We also found that the number of people using an emergency department in the preceding three months fell from 42 per cent at the baseline interview to 18 per cent. Finally, there was an increase in the number of people receiving assistance with mental health problems. This should be seen as a positive development.

6 Drugs and alcohol

At the first interview, all participants were asked whether they had *ever* received treatment for a drug or alcohol problem. Table 6.1 shows that: 62 per cent of Street to Home participants had been treated for a drug problem; 56 per cent had been treated for an alcohol problem; and 80 per cent had been treated for one or both of these problems at *some point in their lives*. However, there were some differences by pathway. Two-thirds (67 per cent) on a youth pathway had received treatment for a drug problem compared with 57 per cent on an adult pathway. In contrast, 61 per cent on an adult pathway had been treated for an alcohol problem compared with 50 per cent on a youth pathway.

Table 6.1: Ever treated for an alcohol or drug problem, baseline data (%)

	Youth pathway (N=32)	Adult pathway (N=31)	Total (N=63)
Treated for alcohol problem	50	61	56
Treated for drug problem	67	57	62
Overall	(N=33)	(N=33)	(N=66)
Treated for alcohol, drugs or both	85	76	80
Neither problem	15	24	20
	100	100	100

It has been estimated that the misuse of alcohol and other drugs accounts for about one-third of all homeless deaths (Thomas 2012). This chapter investigates whether there were changes in the participants' drug and alcohol use during their involvement with Street to Home.

6.1 Drug use

Snow and Anderson (1993) have pointed out that people who are chronically homeless can disengage from the homeless sub-culture. They refer to this process as 'associational distancing'. One form of associational distancing occurs when homeless people start to think of themselves as different from other homeless people and attempt to reduce contact with them. Another form of associational

distancing occurs when people disengage from recreational practices common in the homeless sub-culture, such as excessive alcohol and drug use.

Table 6.2 shows that 72 per cent of Street to Home clients' had been IV drug users at some point during their lives and this rises to 91 per cent amongst those on a youth pathway. However, at the baseline interview, only 28 per cent had used IV drugs in the last four week. The proportion on the youth pathway that had injected drugs in the preceding four weeks was nearly double that of the adult pathway (37 per cent vs 19 per cent), in total 20 people.

Table 6.2: Frequency of IV drug use at baseline interview, by pathway (%)

	Youth pathway (N=35)	Adult pathway (N=36)	Total (N=71)
Have injected drugs during lifetime	91	53	72
Past 4 weeks			
Have injected drugs frequently (every day or 2nd day)	9 ⎤	6 ⎤	7 ⎤
	⎥ 37%	⎥ 19%	⎥ 28%
Have injected drugs occasionally in past 4 weeks	28 ⎦	13 ⎦	21 ⎦
Have not injected drugs	63	81	72
	100	100	100

The difference between the lifetime and baseline rates likely reflects two interlinked factors. First, as already explained drug and alcohol use often declines when homeless people attempt to disengage from the homeless sub-culture. Second, the existing research indicates that after the age of 40 there is a considerable decline in narcotic drug use (Snow 1973; Levy, Levy and Meyer 2011). Most Street to Home clients were in their 40s and 50s and they could no longer physically or emotionally sustain IV drug dependency. Many people reported that they were 'worn out'. For those who had long-term substance abuse issues, heroin in particular had lost its allure. Many people had seen friends die from overdoses and this had a deep symbolic impact on them. Nick (youth pathway) said:

> There were 10 of us who were all friends on the streets, but now there's only me and one other bloke left. The others have all died, mainly form overdoses.

According to Helen (youth pathway):

I had lots of friends on the streets when I was younger but … most of them have passed away now.

Similarly, Dino (youth pathway) said:

I have friends who have died … I've watched people die around me … I know I could be a statistic.

In order to give up or reduce IV drug use many people made a conscious decision to disengage from the homeless subculture. For example, Mandy (youth pathway) ceased contact with her drug using friends. When asked why she avoided her old friends she said:

To stop people influencing me. It's too easy to buckle and start using again. When you tell people you're not using, they just offer you gear. It's crazy. Even friends that I thought wouldn't do it … They try to give me drugs and shit like that … It's crazy.

Some people stopped using boarding houses as a distancing strategy to avoid encountering drugs. After Ziggy (youth pathway) gave up drugs and alcohol he preferred to sleep rough:

I can't handle living in boarding houses … It was OK when I had the drink and drug problem, I could live with the same people as myself. That was OK for many years … Now things have changed and I just can't handle that environment any longer.

Sandra (youth pathway) was staying in an emergency hostel for homeless people. However, she tried to distance herself from other residents:

Of course, I've used heroin and all that, but I've lost everything through drugs, so I am not going back there. I've got no interest sitting with someone with a bottle of port. I'd rather just be with my partner and my son.

Street to Home's strategy towards problematic substance use is to focus on harm minimisation. The aim of a harm minimisation approach is to assist people to manage their substance use in a way that reduces physical and emotional harm, the risk of premature death, and the risk of losing their housing. The role of services is not to stop people using IV drugs, although services will always support people who want to abstain from drug and alcohol use completely. Services can also play a crucial role in supporting people to maintain their sobriety, or providing counselling when someone has relapsed.

Table 6.3: Frequency of IV drug use in past four weeks (%)

	Baseline (N=71)	12 months (N=67)	24 months (N=57)
Have NOT injected drugs in the past 4 weeks	72	70	77
Injected drugs frequently (every day or 2nd day) in the past 4 weeks	7	8	5
Injected drugs occasionally in the past 4 weeks	21	22	18
	100	100	100

Bracketed totals: Baseline 28%, 12 months 30%, 24 months 33%

Table 6.3 shows that the proportion of people using IV drugs only changed marginally over the 24 months. At the baseline interview, 28 per cent had injected drugs in the past four weeks. This subsequently increased to 30 per cent at the 12 month interview and then declined to 23 per cent after 24 months. The proportion of Street to Home clients reported injecting drugs every day or every second day ('frequent users') remained relatively constant.

A closer examination of the data revealed some of the people who were not using at their baseline interview had used in the four weeks prior to either their second or third interview. Conversely, some people who were using at either their first or second interview had not used in the four weeks prior to their final interview. This pattern is not surprising and is consistent with a harm minimisation approach. Proponents of harm minimisation recognise that addressing long term drug dependency is a complex process and that individuals manage this in different ways and at their own pace.

At the baseline interview, 21 per cent reported that they had used IV drugs 'occasionally' in the preceding four weeks (defined as less frequently than every day or second day). At the 12 months interviews, the number of occasional users increased to 22 per cents and at the final interviews it decreased to 18 per cent. Some people had an occasional 'treat', such as when they were paid. Others had an occasional 'lapse'. For example Helen (youth pathway) said:

Well sometimes when I've saved a bit of money I'll go and have a hit … Then (later) I'll look at myself and think, 'Why did you do that?' … but I don't beat myself up about it.

At the baseline interview 72 per cent reported that they had not injected IV drugs in the preceding four weeks (Table 6.3). This decreased to 70 per cent at the 12 month interviews and increased to 77 per cent at the 24 month interviews. Some people appeared to have made a 'clean break', whereas others had cut down gradually, and some had 'stopped' and 'started' a number of times. Once again, there was variation in the different clients' accounts of how they abstained from IV drug use, but most said that having stable housing was extremely important.

The fact that the majority of people who previously had problems with IV drug use had not relapsed is a particularly promising sign. It indicates that through the provision of housing and ongoing support, Street to Home has done much to mitigate feelings of hopelessness and worthlessness that can make drug use attractive. Lamar (youth pathway) said: 'Twelve months ago I didn't care if I lived or died … now I have something to look forward to'. Damien (family breakdown pathway) reported that when he was on the streets he was spending $1500 to $2000 per week on heroin. At his final interview he said:

> I've broken my heroin addiction since I got accommodation. If I was on the streets I'd still have the habit. There's no doubt about that.

6.2 Alcohol use

For most rough sleepers, heavy drinking is an everyday occurrence. For example, Josh told us he would 'drink from morning until night' when he was on the streets while Eddie (housing crisis pathway) said he consumed 'up to two bottles of port a day, or a cask of wine, or a litre of metho'. Colin told us he drank 'four to five litres of port everyday'.

Many talked about the adverse consequences of excessive drinking, both for their health and their relationships. Brendan (adult pathway) said he 'loved drinking' but 'it was one of my biggest downfalls because it led to alcohol-fuelled violence'. Tom said: 'In the mornings I'd get up, but I'd be very sick, my hands would start trembling, I'd have diarrhoea and I'd have terrible flatulence'. Ben (substance abuse pathway) said, 'Drinking destroyed all my friendships … I've only got one sister left but she doesn't want to see me'.

Table 6.4: Frequency of alcohol use over past four weeks (%)

	Baseline (N=70)	12 months (N=67)	24 months (N=57)
Daily use	21	13	10
Every 2 to 6 days	10	8	18
Once or twice every 1 to 2 weeks	13 32%	16 36%	14 44%
About once a month	9	12	12
Have not consumed alcohol	47	51	46
Total	100	100	100

It has been pointed out that alcohol use often declines when people attempt to disengage from the homeless sub-culture. Table 6.4 shows that only 21 per cent of respondents reported drinking alcohol on a daily basis at the first interview, and this had declined to 13 per cent at the second interview, and to 10 per cent at the final interview. Unfortunately, there was no information on the quantity consumed by these daily drinkers, and this is needed to assess the significance of their consumption.

Another one-third of the sample (32 per cent) reported that they drank alcohol occasionally at the baseline interview, ranging from a few times a week to about once a month (Table 6.4). At the 12 month interview, then number who drank occasionally increased to 36 per cent, and at the final interview it increased to 44 per cent. Again there was no information on the quantity consumed and it is possible that some people were 'binge' drinking, but the qualitative data indicates that many were moderate drinkers. For example, Mitchell (substance abuse pathway) said:

> When you are squatting you tend to drink a lot more to numb yourself from the reality of it all. Now that I have my own place … I don't drink so much. I am much more comfortable with myself.

Cookie (family breakdown pathway) reported that he had periods of heavy drinking, particularly when he had been sleeping rough with a 'heap of other blokes' along the Brisbane River:

> I've been through periods when I've drunk a lot, but after a couple of weeks you think, 'Hang on, I couldn't o this forever'. That's the way I am. As I said I like a drink now and again. But I

don't have to have it … Of course, I've known blokes who are like that. But, I couldn't be like that. I've never been like that.

Anthony (family breakdown pathway) was another who reported that he had been able to reduce his drinking:

> When I was on the streets, I was very depressed the whole time and I just wanted to forget about the world and wipe myself out. But that's all changed now I've got my own place … I still drink … but I don't drink that much now.

At the first interview, 47 per cent of the sample had not consumed alcohol in the preceding month. This had increased to 51 per cent at the second interview, declining to 46 per cent at the final interview. Roughly half of the Street to Home Participants were non-drinkers and many of these reported that they had made a conscious decision to abstain from alcohol altogether. For example, Josh said:

> I used to drink from morning til night when I was on the streets … I had nothing else to do … I don't need to drink now (sober 6 weeks).

According to Brendan (adult pathway):

> I have been doing counselling about my alcohol use. There's been temptation but I haven't had a drink for 8 months.

Craig said: 'I stopped drinking about 20 months ago. I guess you'd say I'm a retired alcoholic'.

6.3 Conclusion

This chapter has presented a number of important empirical findings. First, many Street to Home participants have had a problem with drugs or alcohol at some point in their lives, but their drug and alcohol issues were no longer so pronounced. The proportion who injected drugs regularly did not change over the 24 months (7 per cent to 5 per cent), nor did the proportion that used them occasionally (18 per cent to 21 per cent).

With respect to alcohol use, there was a decline in the proportion drinking daily (21 per cent to 10 per cent), an increase in the number drinking occasionally (32 per cent to 44 per cent), and no meaningful change in the number who abstained from alcohol use (46 per cent).

The aim of a harm minimisation approach is to assist people to manage their drug and alcohol use in a way that reduces the risk of physical and emotional harm. Services can also support people who want to abstain from drug and alcohol use and the importance of this support should not be under-estimated. A number of participants reported that they had learnt 'not to beat myself up' when they had 'lapsed', and this support is often vital. The provision of housing and ongoing support has helped to defuse those feelings of hopelessness that make excessive use of drugs and alcohol attractive.

7 Service usage

This chapter investigates whether the participants' use of homelessness services had changed. Our methodology relied on self-reported behaviour, so we were conscious that some participants might have difficulty recalling what services they had used in the preceding 12 months. Instead, people were asked about their use of homelessness services in the preceding six months, making it easier for them to answer.

Many of the long-term homeless are known to cycle in and out of crisis and transitional accommodation (Culhane and Kuhn 1998; FaHCSIA 2008). At the first interview, 59 per cent of respondents reported that they had used homelessness services in the previous six months (Table 7.1). After 12 months, the proportion using homelessness services had declined to 12 per cent and after 24 months it had decreased to 7 per cent. There was also a sharp drop in the average number of times that people had used services. At the baseline interview, people had used homeless services on average 9.9 times. This declined to 2.8 times at the 12 month interviews, and increased slightly to 3.5 times at the final interview.

The overall reduction in the proportion using homelessness services was substantial. Breaking the cycle of repeat service use has the potential to free up scarce resources in the specialist homeless service system. Of course, the aggregate impact of Street to Home on a system that provides assistance to thousands of people each year is likely to be marginal, but this does provide some indication of the potential benefits that may accrue from a scaled up approach to tackling long-term homelessness.

Table 7.1: Service use, last six months

	Baseline (N=69)	12 months (N=67)	24 months (N=57)
Use of homeless services			
% who have used	59	10	7
If used, average number of times	9.9	2.8	3.5
Use of meals programs			
% who have used	80	55	56
If used, average number of times	132.8	109.3	139.7

Chronically homeless people rarely have access to adequate cooking facilities and they are heavy users of meals programs. At the first interview, 80 per cent of the sample had used a meals program in the previous six months and they had used them, on average, 132.9 times (Table 7.1). At the final interview, 56 per cent had used meals programs and they continued to use them intensively, on average 139.7 times.

There are a number of reasons why fewer people used meals programs. For some having a house meant they could now cook their own meals and they could do this when they wanted to. Rick told us that he was:

> … eating better…you don't have to wait until certain hours …and to cook your own food is good. It just a good feeling! … It was my missus's birthday on Wednesday and I made the cake.

Other people stopped using meals programs because they recognised that the places where meals were available were also places that exposed them to drugs and other 'risky' business. Jane stopped using meals programs to avoid the 'temptation of drugs and alcohol'. Jane's decision was part of a deliberate strategy to cease having contact with her formerly homeless friends.

Nonetheless, about half of the participants still used meals programs and for many of these people meals programs provide a space where they could interact with other people. This is one way people try to counter the effects of loneliness and boredom which formerly homeless people often experience when they first become housed (Padgett 2007; Johnson, Parkinson, Tseng and Kuehnle 2011).

Mithran told us that one of the reasons why he'd been going to a meals program was to counteract his sense of isolation:

> I wouldn't see people for weeks except going to the chemist a couple of times a week. So now I don't keep as much food in the house because that forces me to go to use the drop in centre, so I get some social contact.

At his second interview, Mitchell had been re-housed for six months but he told us that loneliness was still a problem:

> I've been used to squatting with other mates and I've been in crisis accommodation where there are a lot of other people around … so, yeah I do get lonely at times.

54

Dusan has not made new friends since being re-housed and he wanted to keep contact with former acquaintances:

> Well I don't work so I have to find things to do with my time. So I usually attend the drop in centre in the morning and then I go to Sacred Heart Mission for lunch. I usually play billiards or snooker or pool at the drop-in centre. I like to catch up with people I know and have a chat.

This chapter has shown that the overall reduction in the use of homeless services was substantial, with only seven per cent of people having used them in the six months prior to their final interview. However, about half continued to use meals programs and drop-in centres. Many people reported that they appreciated a cooked meal in the middle of the day and others mentioned that this was where they met and socialised with other people.

8 Social networks

The social adaptation thesis contends that when people become homeless they start to develop friendships with other homeless people who provide them with a sense of 'belonging' that is often missing in their lives (Sosin, Piliavan and Westerfelt 1990; Pears and Noller 1995; Wasson and Hill 1998; May 2000; Auerswald and Eyre 2002; Van Doorn 2005). For those who become long-term homeless, these social networks take on added significance because they lose contact with their friends and relatives in the housed population. The social adaptation thesis argues that the long-term homeless gradually come to accept homelessness as a 'way of life' and there is little that can be done to assist them.

The first evaluation report (Johnson and Chamberlain 2012) argued that this overstates the extent to which rough sleepers develop a sense of solidarity with one another. Moreover, Snow and Anderson (1993) have pointed out that chronically homeless people can disengage from the homeless sub-culture and they refer to this as 'associational distancing'. Earlier it was pointed out that one form of associational distancing occurs when homeless people start to think of themselves as different from other homeless people. Another form of associational distancing occurs when people disengage from recreational practices common in the homeless sub-culture, such as excessive alcohol and drug use.

Many of the participants in Street to Home had started to distance themselves from their homeless peers prior to engaging with S2H and this process continued. After years of hustling and scamming to get by, Josh did not trust other homeless people:

> I no longer trust (them) … You know they're all out for themselves … You send them down the street to get you a packet of smokes and they'll run off with your money and your smokes.

Sergei said:

> You've got to be very wary with (homeless) people. You have to try to pick the right ones. There's a lot of people out there that will take advantage of you.

Ted told us he was sick of people taking advantage of him:

> Yeah, I reckon I could have had some reasonable friendships, but most of the people that I've thought were friends were users … People take advantage of you if they can.

This chapter examines what happened to the participants' social networks after joining Street to Home. It focuses on their friendships, their relationships with their family, and their sense of acceptance by the wider community. Understanding social networks is important for addressing the broader goal of reducing social exclusion.

8.1 New friends?

When homeless people are first re-housed, they sometimes feel isolated because they lack a network of friends and acquaintances in their new community. Table 8.1 shows that at the first interview about two in every five (38 per cent) reported that they did not have friends that they talked to every week.

Table 8.1: People who have friends they talk to every week (%)

	Baseline N=64)	12 months (N=63)	24 months (N=56)
Talk to friends every week	62	81	79
Do not talk to friends every week	38	19	21
	100	100	100

At the final interview, about one in five (21 per cent) of the Street to Home clients remained acutely isolated. Some people told us that they did not know how to make friends. Damien said, 'I haven't had friends for over 10 years, so I don't know how to deal with that'.

Others said that they did not want to have friends. Cookie had been itinerant for more than 15 years, travelling around Australia, doing casual work and often sleeping rough. When he was asked about his friendships, he said: 'I don't really have any friends'.

> Interviewer: Did you have any friends when you were sleeping rough?
> Cookie: No, I had acquaintances. I'd say hello to them but that was all.
> Interviewer: What about in your new place? What are your neighbours like? How are you fitting in?
> Cookie: I don't try to fit in. I say 'hello' to them, but that's all. I don't want to get involved with them … They don't talk about the stuff that I like to talk about.
> Interviewer: You said earlier that you don't have any friends?

Cookie: No, I don't.

Interviewer: What about if you met someone who had similar interests to you. Do you think
                you could develop a friendship?

Cookie: I've never met anybody yet.

There were a minority of people were 'loners' in the homeless sub-culture and they appeared to remain isolated when they were re-housed.

However, at the 12 month interview 81 per cent of the participants said they had friends they talked to every week (Table 8.1), and the proportion has remained constant since then. People negotiated friendships in different ways, but four broad strategies were employed. We refer to these strategies as 'rebuilding', 'disengagement', 'partial disengagement' and 'acquiring new friends'

The first strategy involved 'rebuilding' old friendships. Adrian had lost contact with many of his friends when he was homeless because he felt 'ashamed', but now he was catching up with them again. Brendan had also been reconnecting with old friends who he had lost contact with. This strategy was often used in conjunction with other strategies

The second strategy was 'disengagement'. This strategy was widely used and involved severing ties with friends and acquaintances on the streets. Rick and Jane had been re-housed and were determined to keep away from 'the temptation and drugs and alcohol'. Consequently, they cut their ties with people on the streets. Rick said:

I had hundreds of acquaintances when I was sleeping rough but I have lost contact with all of them. I chose this to do this. This is Jane and my chance of getting our lives back together.

When asked about homeless people, Adrian said:

No I avoid them like the plague … There's nothing there for me now … You can't be friends with drug addicts. That's not logical.

The third strategy – partial disengagement – involved maintaining limited contact with former friends and acquaintances on the streets. For example, Brendan said that he continues to have contact with some of his homeless friends who have also been re-housed:

They've all got houses now … These guys were 'streeties' and now they've got rooves over their heads … They haven't got much in their houses, but they are just so happy.

Jacques also made a distinction between those who were still on the streets and friends who were in a similar position to himself:

> I no longer have contact with those on drugs … you know, pot, smack, speed, whatever … Some of my new friends are in the same boat that I'm in. They're also trying to re-build their lives.

When Tom was asked about his friends on the streets, he said:

> I still see about a quarter of them, but that is only because they've moved on. They've got housing too … and that's why they're doing OK.

Many of the people who used meals services employed a partial disengagement strategy.

The final strategy was 'acquiring new friends'. Some people were doing this fairly tentatively, but many people had started to acquire new friends in their local neighbourhood. For example, Ilona said, 'There's about four neighbours that I talk to nearly every day … I've made some really good friends since I've been here'.

Irrespective of whether people were maintaining friendships with formerly homeless people, making new friends or rebuilding old friendships, a key theme in most narratives was that they wanted friends who were a positive force in their lives. Rick described his new friends as follows:

> They are more positive … you know, not drinkers and not drug users … more working people … people that go out and earn money. It just feels better to know that you've got stable friends as well as feeling stable yourself.

Many participants had started to develop new social networks and these were an important source of support. Strong social networks can help people maintain their housing and can provide them with other opportunities to re-engage with the broader community.

8.2 Rebuilding family

Half (49 per cent) of the Street to Home participants first became homeless when they were 18 or younger. As we saw in Chapter 3, their family relationships were often characterised by traumatic experiences such as abuse or neglect. For others, problems with their families emerged later in life. It is not surprising that some people had no desire to re-engage with their family. Doug had a family but he did not:

… know if they are alive or dead. And I don't care anymore. They don't care about me.

Ziggy had never had a strong relationship with his family:

It's been over five years since I've had any contact with any family members … there's been too much water under the bridge. There was just nothing there as a child and there still isn't much there.

Table 8.2: Family acceptance (%)

	Baseline (N=62)	12 months (N=61)	24 months (N=40)
Feel accepted by their family	50	51	68
Do not feel accepted by their family	50	49	32
	100	100	100

Table 8.2 shows that at the first interview only 50 per cent felt accepted by their family and this did not change in the first 12 months. It subsequently increased to 68 per cent at the third interview, as some people had started to re-build family relationships. In most cases, people specified particular family members with whom their relationships had improved. For example, Tran said:

I'm closer to my sister now and it is good because I see my nieces and nephews, and they acknowledge me as Uncle Tran which is a good feeling.

According to Eddie:

In the last 12 months I've been working on rebuilding the relationship with mum. I spent the long weekend at her place and that was all good and positive.

Maurice noted that:

My relationship with my children has improved, but not with my sister and brother.

Ilona said:

When I was on the streets my family wouldn't talk to me … but now that's getting better.

For some people rebuilding a relationship with their children was the catalyst for change. Lamar was elated that he could now look forward to seeing his children:

'I've worked so hard to get this place and the boys love it'. Others were determined to maintain their housing because they wanted to see their children. Brendan said:

> Being homeless has done a lot of damage. I've always had my children around me. To suddenly have them ordered from you makes you angry … My Street to Home worker attended the court hearing with me and all the previous orders were dismissed … My parental role has been restored. My son is at my house now.

Table 8.3: Agree/strongly agree with various propositions (%)

	Baseline	12 months	24 months
I have people I can confide in	56[a]	67[a]	86[b]
There is someone who can always cheer me up when I'm down	53[c]	60[a]	79[b]
When I need someone to help me out, I can usually find someone	67[d]	70[d]	86[b]

Valid N sizes: a=63; b=56; c=62; d=64

We asked various questions to investigate how much support people received from family and friends. Table 8.3 shows that at the first interview 56 per cent said they had someone they could confide in, but this had increased to 86 per cent at the final interview. They were also more likely to have someone who could cheer them up when they felt down, up from 53 per cent at the first interview to 79 per cent at the third interview. The number of people who said they could find someone to help them out if they needed assistance had increased from 67 per cent to 86 per cent. Overall, the participants' social networks had improved significantly after 24 months.

8.3 Accepted by society?

David Farrugia (2011) argues that popular typifications portray homeless people as 'dirty, obscene, irresponsible, dangerous or passive, and are morally and ontologically inferior' (Farrugia 2011, p.73). He argues that homeless people have a low sense of self-worth and feel ashamed of their situation because they have to carry the 'symbolic burden of homelessness'. Our findings indicate the situation is more complex than Farrugia recognises and some people feel more stigmatised than others.

Table 8.4: Accepted by society (%)

	Baseline	12 months	24 months
Feel accepted by society	61[a]	67[b]	70[c]
What I do is valued by others	62[d]	90[f]	91[e]
Playing a useful part in society	49[d]	70[d]	78[e]

Valid N sizes: a=56; b=51; c=50; d=63; e-55; f=59

At the first interview participants were asked whether they felt accepted by society and 61 per cent said they did. At the final interview, this had increased to 70 per cent (Table 8.4). Respondents were also asked whether they felt what they did was valued by others. At the baseline interview, 62 per cent said 'yes', but after 24 months this had increased by to 91 per cent. Finally, clients were asked whether they thought they were playing a useful part in society. At the first interview, 49 per cent said 'yes' and this increased to 78 per cent.

Many people commented that they 'part of the community' now they had been re-housed. For example, Brendan said: 'Yeah, I did feel stigmatised when I was homeless. Now I wholly feel like I'm part of the community again'. Maurice said: 'Having a roof over your head makes a big difference. I feel more settled, more connected with the community and everything'. According to Mithran:

> It's a marked change from a year ago … Like I'm going out and doing things with the kids … I'm getting a sense of community back.

When Sergei was asked whether he felt more accepted by society his sense of self-worth was obvious:

> I mean people look at me and they say: 'Well, he's doing really well that Sergei, doing really well. Doing a good job and he's been housed for nearly 12 months'.

The process of overcoming 'stigma' and low self-esteem is often lengthy, but having a home and reliable social networks can make a difference. Many participants were more confident about themselves and their place in the world.

8.4 Conclusion

This chapter set out to examine what happened to people's social networks after joining Street to Home. We found that most people re-assessed their relationship with

other homeless people once they were re-housed, but they did this in different ways. We referred to these strategies as rebuilding, disengagement, partial disengagement and acquiring new friends. Many who were re-housed employed a disengagement strategy, effectively severing all ties with homeless friends. Others employed a partial disengagement strategy, maintaining limited contact with people they had known on the streets.

Half (49 per cent) of the Street to Home participants first became homeless when they were 18 or younger and some of them had no desire to re-engage with their family of origin. At the final interview, two-thirds (68 per cent) of all participants were re-building relationships with their family and this was a positive experience for most people.

Finally, we asked three questions to investigate whether people felt accepted by society. The number who gave positive replies to these questions increased from between 50 and 60 per cent at the first interview, to between 70 and 90 per cent at the final interview (Table 8.4). Many people did not feel accepted by society at the baseline interview, but their level of self-confidence was appreciably higher at the final interview. The provision of housing and support had improved their sense of self-worth.

9 What have we learnt and where to next?

This report set out to investigate how Street to Home clients were travelling 24 months after joining the program. Chapter 3 showed that all of the clients were chronic rough sleepers, and most of them were in poor health when they started with Street to Home. The second evaluation report found that Street to Home had maintained its focus on chronically homeless people in the second intake (Johnson and Chamberlain 2013).

However, Chapter 3 included an important new finding. Half (49 per cent) of the participants had their first experience of homelessness when they were 18 or younger and, on average, it was 29 years since they had first become homeless. These participants were on a 'youth pathway' and their average age was 13.1 years when they first became homeless.

In contrast, 51 per cent of the participants were on an 'adult pathway' and their average age was 34.8 years when they first lost their accommodation. On average it was now 13.9 years since those on an adult pathway had first became homeless, compared with 29.1 years for those on a youth pathway. Those on an adult pathway were more likely to have had periods of stability in their early adult years, including employment, stable housing and, in some cases, marriage and children. They were also less likely to have had traumatic childhood experiences. Thus it was often easier to help them.

Chapter 4 showed that after 24 months, 70 per cent of the participants' were housed and 80 per cent of them had been housed for one year or longer. Amongst those who had entered the homeless population on an adult pathway, the success rate was 79 per cent. In contrast, the success rate was 62 per cent for those who had become homeless on a youth pathway. Overall, there was a marked improvement in the participants' housing circumstances but it was more difficult to help those clients who first became homeless as teenagers

Chapter 5 showed that there was a significant improvement in the participants' physical and mental health in the first 12 months. However, in the second 12 months the rate of improvement slowed: about half reported that their health had not changed; about one-third thought that it had improved; and one-fifth said that it had got worse. However, the number admitted to hospital in the preceding three months

declined from 32 per cent at the first interview to 11 per cent at the final interview; and the number of people using an emergency department in the preceding three months fell from 42 per cent at the first interview to 18 per cent at the final interview. The inclusion of two community health nurses in the Street to Home team improved clients' access to health professionals and reduced barriers between homeless services and health workers. This is an important achievement.

Street to Home employs a harm minimisation approach is to assist people to manage their drug and alcohol use safely. We found no change in the overall patterns of IV drug use over the two years, but we did observe some changes in alcohol use – fewer people were drinking on a daily basis. The provision of housing and ongoing support has helped defuse those feelings of desolation and hopelessness that make excessive drug and alcohol use attractive.

The report has also shown a significant reduction in the participants' use of homeless services. At the baseline interview, 59 per cent of clients had used them in the preceding six months, but this had dropped to seven per cent at the final interview. However, about half (56 per cent) continued to use meals programs and drop-in centres. Many people appreciated a cooked meal in the middle of the day and met acquaintances at these services.

Chapter 8 showed that many clients had begun to improve their relationships with family and friends. These relationships are an important source of support if they get into difficulties in the future, and they also connect them to the wider community. We found that most people re-assessed their relationship with other homeless people once they were re-housed, but they did this in different ways. Many severed their ties with former friends and we referred to this strategy as 'disengagement'. Others maintained limited contact with former friends and we referred to this as 'partial disengagement'. About two-thirds were rebuilding their relationship with their family and this was an important goal for many people. Overall, the participants' social networks had improved significantly.

9.1 Understanding what works

The central premise of the Housing First approach is that it is more effective to begin by providing the long-term homeless with permanent housing and then work with them to address other issues in their lives. However, at the baseline interviews only

one-quarter (23 per cent) of the participants were housed and, on average, it took nine months to re-house people. In practice, most clients did not receive 'housing first'.

The alternative strategy employed by Street to Home was to build relationships with clients, so they did not become dispirited during their long wait for housing. It was often necessary to help people secure temporary accommodation so that they were not 'on the streets'. This can be the 'first step' towards building a relationship with them. Another common strategy was to assist clients with issues that could be resolved more quickly, such as access to dental services, medical appointments and legal assistance. Many clients need help to resolve a range of medical conditions and this sort of help was always much appreciated. As we saw earlier, there was a significant improvement in the participants' physical and mental health.

At the same time as caseworkers start building relationships with their clients, they must also identify the longer-term strategies that will be employed to help their client find housing. This involves consulting each client to ascertain his or her needs, explaining the tasks that need to be undertaken to secure various accommodation options, and involving the clients in the application process. Clients need to be regularly updated on the progress of their applications, so they feel that a positive outcome is possible in the future. A report by the Australian Housing and Urban Research Institute (AHURI) found that the most effective approaches to case management are those where there is a strong relationship between the caseworker and the client, typically characterised by mutual respect and understanding (Gronda 2009).

Table 9.1 shows that 79 per cent thought that caseworkers were 'available when you need them' and 80 per cent thought that caseworkers were 'courteous and respectful'. For example, Lamar said:

My worker was really good. She didn't treat me like a client … she treated me like a friend.

Sandra found that:

They really try to help … I can ring my caseworker at any time and if her voice mail comes on I guarantee that she'll ring me back … Lots of services say they'll get back to you and they never do.

Jess thought:

> They're very open and very honest. You can ring them at any time and talk to them if you
> need to.

Table 9.1: Percentage who agreed or strongly agreed with various
statements, final interview

	All (N=56)
Caseworkers are available when you need them	79
Caseworkers are courteous and respectful	80
Caseworkers help sort out problems	84

The acquisition of permanent housing was of great symbolic significance for clients and most people were excited when this milestone was achieved. As Maurice put it, 'Well, they got me a place. Then things really started looking up for me'. Nonetheless, most people had few material possessions and the next challenge for Street to Home was to equip people with the resources and the skills to maintain permanent accommodation.

As we saw earlier, the provision of practical support after people have been re-housed is central to the Street to Home approach. According to Doug:

> Well, they've helped me with how to manage my money, how to get on Centrepay, how to pay
> my bills, how to clean my house.

Alex was glowing in his praise:

> I got assistance with orthopaedics, shoes, housing, everything. They put me in this great
> place, helped me set it up. It's been awesome, absolutely unbelievable.

Wayne said he got support for both housing and health issues:

> They helped me out with my dental problems and they helped me to get my eyes fixed …
> They bought me fresh linen and a bed. They also got me a washing machine and a fridge …

Table 9.1 shows that 84 per cent agreed or strongly agreed that 'caseworkers sort out problems'.

People also commented that the caseworkers delivered on what they had promised. According to Anthony: 'They didn't just talk about things, they always

made sure they did them'. Wayne said: 'They do what they say they are going to do. They're interested in your whole situation, not just giving you a feed and a room for the night'. Others commented that their Street to Home worker had gone out of their way to help them. Lamar said: 'They went above and beyond really … She used to come and pick me up and take me to appointments and stuff like that. She was really good'.

In fact, there was a widespread sense that Street to Home is different from other services. As Tom put it:

> Some agencies won't go out of their way to help you. You know it's just a 9 to 5 job for them. It's not like that with S2H. Sometimes my worker has rung me at the weekend, just to check up that I'm OK.

According to Anthony:

> Most homeless services make you go round in circles all the time … you get shoved here, shoved there … they provide people with accommodation in motels but they can only afford to give you two or three nights and then after that you're back on the streets again.

Brendan emphasised the importance of long-term support:

> The long-term support is vital … It's been really important in my case … It was just what the doctor ordered … I've never seen this approach before and I've seen all kinds of stuff in the sector.

Many of the participants expressed confidence that they could maintain their housing once Street to Home support was withdrawn. For example, Tom said:

> Well, I'm a bit worried. But it's like anything else. In the end you've got to start copping all the responsibility yourself.

According to Rick:

> I'd hate to go back on the street after living in my own place for 12 months. It would be terrible.

These findings are positive, but it is important to recognise that some clients will need support in the future to maintain their housing. This is particularly the case for those who have serious mental health issues. We estimate that about one-third of the clients will need on-going support. In our view, Street to Home should be funded to undertake this task.

9.2 Moving forward

The ability to secure positive outcomes with the long-term homeless is closely tied to the resources available to a service and how these resources are used. The capacity to develop meaningful, trusting relationships is essential for effective case management and this is dependent on Street to Home workers having sufficient time to work with the participants. A clear strength of the model is the capacity of Street to Home to provide intensive support both before and after the participants have secured housing.

The integration of community health nurses is an important strength of the Street to Home approach. Not only does this provide rapid access to health assistance, but it has also broken down the barriers that commonly exist between health and specialist homelessness services. The findings confirm that the provision of health care does not resolve chronic medical conditions, but it does enable people to manage them more effectively.

A further strength of Street to Home is that it has a clear target group who the caseworkers are committed to working with. The second evaluation report found no evidence that the service has started to work with people whose circumstances are less challenging (Johnson and Chamberlain, 2013, Ch. 3). If anything, the evidence indicated that Street to Home now identifies its target group more effectively.

Nonetheless, the Street to Home program still faces some challenges and finding suitable housing for the clients is the most pressing problem. Housing options in the inner city are limited and the failure to integrate the provision of housing into the model is a major policy oversight. It is imperative that future policy discussions take into account the need for 'housing first' services to have access to good-quality housing. If this could be achieved, it would be a major step forward.

References

Auerswald, C. and S. Eyre (2002). 'Youth homelessness in San Francisco: a life cycle approach', in *Social Science and Medicine*. 54: 1497-1512.

Australian Government (2008). *The Road Home: A National Approach to Reducing Homelessness*, Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA), Canberra.

Australian Institute of Health and Welfare (2009). *Homeless people in SAAP: SAAP National Data Collection Annual Report 2007-2008 Australia*. Canberra, AIHW (cat no Hou 191).

Bourdieu, P. and J. Passeron (1973). 'Cultural reproduction and social reproduction' in R. K. Brown (ed.) *Knowledge, Education and Cultural Change*. London, Tavistock.

Buhrich, N., T. Hodder and M. Teesson (2000). 'Lifetime prevalence of trauma among homeless people in Sydney,' in *Australian and New Zealand Journal of Psychiatry* **34**(6): 963-966.

Busch-Geertsema, V., W. Edgar, E. O'Sullivan and N. Pleace (2010). *Homelessness and Homeless Policies in Europe: Lessons from Research*. European Consensus Conference on Homelessness, FEANTSA.

Button, E. and Baulderstone, J. (2013). *Thunder in the Soul: Experiences of Sleeping Rough and Service Interventions in Three Australian Locations*. Canberra: Department of Families, Housing, Community Services and Indigenous Affairs.

Calsyn, R. and G. Morse (1991). 'Predicting chronic homelessness,' in *Urban Affairs Quarterly* **27**(1): 155-164.

Casey, S. (2001). Snakes and ladders: Women's pathways into and out of homelessness. Competing Visions: Refereed Proceedings of The National Social Policy Conference, University of New South Wales.

Chamberlain, C. and G. Johnson (2013). 'Pathways into adult homelessness', in *Journal of Sociology*, 49(1), 60-77.

Cohen, C. and K. Thompson (1992). 'Homeless mentally ill or mentally ill homeless?', in *American Journal of Psychiatry*. 149(6): 816-82

Council of Australian Governments (2009). *National Partnership Agreement on Homelessness*. Canberra, Australian Government.

Culhane, D. and S. Hornburg, Eds. (1997). *Understanding Homelessness: New Policy and Research Perspectives*. Washington D.C, Fannie Mae Foundation.

Culhane, D. and R. Kuhn (1998). 'Patterns and determinants of public shelter utilization among homeless adults in New York City and Philadelphia', in *Journal of Policy Analysis and Management*. 17(1): 23-44.

Culhane, D., S. Metraux and T. Hadley (2002). 'The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections, and emergency shelter systems: The New York-New York Initiative', in *Housing Policy Debate*. 13(1): 107-163.

Culhane, D. and S. Metraux (2008). 'Rearranging the deck chairs or reallocating the lifeboats,' in *Journal of the American Planning Association* **74**(1): 111-121.

Dupuis, A. and D. Thorns (1998). 'Home, home ownership and the search for ontological security', in *The Sociological Review*. 46(1): 24-47.

Evans, T., K. Neale, J. Buultjens and T. Davies (2011). *Service integration in a regional homelessness service system* Canberra, Department of Families, Housing, Community Services and Indigenous Affairs.

FaHCSIA (2008). *The Road Home: A National approach to reducing homelessness.* Canberra, Department of Families, Housing, Community Services and Indigenous Affairs.

Farrugia, D. (2011). 'The symbolic burden of homelessness: Towards a theory of youth homelessness as embodied subjectivity', *Journal of Sociology*. 47(1): 71-87

Foster, G., H. Gronda, S. Mallet and R. Bentley (2011). *Precarious housing and health: research synthesis.* Australia, Australian Housing and Urban Research Institute, Hanover Welfare Services, University of Melbourne, University of Adelaide & Melbourne Citymission.

Gronda, H. (2009). *What makes case management work for people experiencing homelessness? Evidence for practice.* Melbourne, Australian Housing and Urban Research Institute

Gulcur, L., D. Stefanie, M. Shinn, S. Tsemberis and S. Fischer (2003). 'Housing, hospitalisation, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and Housing First programmes', in *Journal of Community and Applied Social Psychology*. 12(2): 171-186.

Hiscock, R., A. Kearns, S. Macintyre and A. Ellaway (2001). 'Ontological security and psycho-social benefits from the home: Evidence on issues of tenure', in *Housing, theory and society*. 18(1-2): 50-66.

HomeGround Services (2010). *Melbourne Street to Home Registry Week: Bulletin 1.* Retrieved 6 March 2013 from: http://www.homeground.org.au/assets/ms2hbulletin1.pdf

HomeGround Services (2011). *Melbourne Street to Home: Bulletin 2 Progress and Challenges.* Retrieved 6 March 2013 from: http://www.homeground.org.au/assets/ms2hbulletin2.pdf

Hopper, K. (2003). *Reckoning with Homelessness*. Ithica and London, Cornell University Press.

Johnson, G. and C. Chamberlain (2012). *Evaluation of the Melbourne Street to Home program: Baseline report.* Canberra, Department of Families, Housing, Community Services and Indigenous Affairs.

Johnson, G. and C. Chamberlain (2013). *Evaluation of the Melbourne Street to Home program: 12 month outcomes.* Canberra, Department of Families, Housing, Community Services and Indigenous Affairs.

Johnson, G., S. Parkinson and C. Parsell (2012). *Policy shift or program drift: Implementing Housing First in Australia*. Melbourne, Australian Institute of Housing and Urban Research.

Johnson, G., H. Gronda and S. Coutts (2008). *On the Outside: Pathways in and out of homelessness*. Melbourne, Australian Scholarly Press.

Johnson, G., S. Parkinson, Y. Tseng and D. Kuehnle (2011). *Long term homelessness: Understanding the Challenge*. Melbourne, Sacred Heart Mission

Johnson, G., D. Kuehnle, S. Parkinson and Y.-P. Tseng (2012). *Meeting the Challenge: Transitions out of long-term homelessness. A randomised controlled trial examining the 24 month costs, benefits and social outcomes from the Journey to Social Inclusion pilot program*. Melbourne, Sacred Heart Mission.

Kearns, A., R. Hiscock, A. Ellaway and S. Macintyre (2000). "Beyond four walls'. The psycho-social benefits of home: Evidence from west central Scotland', in *Housing Studies*. 15(3): 387-410.

Kermode, M., P. Miller, N. Crofts, B. Speed and J. Streeton (1998). 'Health indicators and risks among people experiencing homelessness in Melbourne, 1995-1996,' in *Australian and New Zealand Journal of Public Health* **22**: 464-470.

Levy, Y., D. Levy and J. Meyer (2011). 'Computational hypothesis for maturing out of addiction and mindfulness-based cognitive techniques', in *Biologically Inspired Cognitive Architectures*. doi:10.3233/978-1-60750-959-2-222.

Liebow, W. (1993). *Tell them who I am: The lives of homeless women*. New York, Penguin Books.

May, J. (2000). 'Housing Histories and Homeless Careers: A Biographical Approach', in *Housing Studies*. 15(4): 613-638.

McDermott, S., J. Bruce, I. Oprea, K. R. Fisher and K. Muir (2011). *Evaluation of the Mental Health, Housing and Accommodation Support Initiative (HASI) - Second Report*. Sydney, University of New South Wales, Social Policy and Research Centre

Mee, K. (2007). '"I ain't been to heaven yet? Living here, this is heaven to me": Public housing and the making of home in inner Newcastle', in *Housing, Theory and Society*. 24(3): 207-228.

Mission Australia (2012). *The Michael Project, 2007-2010: New perspectives and possibilities for homeless men*. Sydney, Mission Australia.

Muir, K. and K. Fisher (2007). 'Stable Housing: The foundation of improved mental health. Findings from the Housing and Accommodation Support Initiative (HASI)', in *New Paradigm/Parity*. September: 50-53

O'Connell, M., W. Kasprow and R. Rosenheck (2009). 'Direct placement versus multistage models of support housing in a population of veterans who are homeless', in *Psychological Services*. 6(3): 190-201.

Padgett, D. (2007). 'There's no place like (a) home: Ontological security among persons with a serious mental illness in the United States', in *Social Science and Medicine*. 64(9): 1925-1936.

Parsell, C., T. Tomaszewski and A. Jones (2013). An Evaluation of Brisbane Street to Home: Final Report. Canberra, Department for Families, Housing, Community Services and Indigenous Affairs

Pears, J. and P. Noller (1995). 'Youth homelessness: abuse, gender, and the process of adjustment to life on the streets', in *Australian Journal Of Social Issues.* 30(4): 405-424.

Pearson, C., A. Montgomery and G. Locke (2009). 'Housing stability among homeless individuals with serious mental illness participating in Housing First programs', in *Journal of Community Psychology.* 37(3): 404-417.

Rosenheck, R. (2010). 'Service models and mental heath problems: Cost-effectiveness and policy relevance', in. *How to House the Homeless.* I. Ellen and B. O'Flaherty (editor). New York, Russell Sage Foundation.

Sadowski, L., R. Kee, T. Vanderweele and D. Buchanan (2009). 'Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial', in *Journal of the American Medical Association.* 301(17): 1771-1778.

Snow, M. (1973). 'Maturing out of narcotic addiction in New York City', in *The International Journal of Addictions.* 8(6): 921-938.

Snow, D. and L. Anderson (1993). *Down on their luck: A study of street homeless people.* Berkeley, University of California Press

Sosin, M., I. Piliavan and H. Westerfelt (1990). 'Toward a longitudinal analysis of homelessness', in *Journal of Social Issues.* 46(4): 157-174.

Thomas, B. (2012). *Homelessness kills: An analysis of the mortality of homeless people in early twenty-first century England.* London, Crisis and the University of Sheffield.

Tsai, J., A. Mares and R. Rosenheck (2010). 'A multisite comparison of supported housing for chronically homeless adults: "Housing First" versus "Residential Treatment First"', in *Psychological Services.* 7(4): 219-232.

Toro, P., B. Owens, C. Bellavia, C. Daeschler, D. Wall, J. Passero and D. Thomas (1995). 'Distinguishing homelessness from poverty: a comparative study,' in *Journal of Consulting and Clinical Psychology* **63**(2): 280-289.

Tsemberis, S. (1999). 'From streets to homes: an innovative approach to supported housing for homeless adults with psychiatric disabilities', in *Journal of Community Psychology.* 27(2): 225-241.

Tsemberis, S. and R. Eisenberg (2000). 'Pathways to housing: supported housing for street-dwelling homeless individuals with psychiatric disabilities', in *Psychiatric Services.* 51(4):487-493.

Tsemberis, S. (2010). 'Housing First: Ending homelessness, promoting recovery and reducing cost', in. *How to house the homeless.* I. Ellen and B. O'Flaherty (editor). New York, Russell Sage Foundation.

Van Doorn, L. (2005). 'Phases in the development of homelessness - a basis for better targetted service interventions', in *Homeless in Europe.* Winter: 14-17.

Wasson, R. and P. Hill (1998). 'The process of becoming homeless: An investigation of female headed families living in poverty', in *Journal of Consumer Affairs*. 32(2): 320-342.

Winkleby, M., B. Rockhill, D. Jatulis and S. Fortmann (1992). 'The medical origins of homelessness,' in *American Journal of Public Health* **82**(10): 1394-1398.

Wood, G. and R. Ong (2009). *The dynamics of housing affordability: Movements in and out of housing affordability 2001–2006: Final Report no 133.* Melbourne, Australian Housing and Urban Research Institute.

Zugazaga, C. (2004). 'Stressful life event experiences of homeless adults: A comparison of single men, single women and women with children,' in *Journal of Community Psychology* **32**(6): 643-654.