Rough Sleeping: 'the canary in the coalmine' of failing housing policy

Report

June 2017

Launch HOUSING

IT'S TIME TO END HOMELESSNESS

launchhousing.org.au

Launch Housing

Launch Housing was established in July 2015 following a merger between Hanover Welfare Services and HomeGround Services. We have an unambiguous mission – to end homelessness in Melbourne and beyond.

Launch Housing is Melbourne's largest independent provider of homelessness services, delivering programs and support across 14 Melbourne sites. This includes crisis accommodation; transitional housing; support for people experiencing homelessness; Education First Youth Foyers; and HomeGround Real Estate, one of the first not-for-project real estate agencies in Australia.

You can find more information about Launch Housing by visiting www.launchhousing.org.au.

Acknowledgment

Many thanks to Lakni Algama, Deb Batterham, Deb Keys, Sian Mulgrew, Joshua Comyn, and Miranda Tooth for assistance with the intensive work involved in completing client summaries

This report was prepared by Violet Kolar, Launch Housing.

Acronyms

ABS	Australian Bureau of Statistics
AOD	Alcohol and Other Drugs
RSI	Rough Sleepers Initiative
MS2H	Melbourne Street to Home
SHS	Specialist Homelessness Services

Contents

Executive Summary

Key Findings

Client profile

- The characteristics of the 59 sampled clients show that they are a highly disadvantaged and marginalised group. Mainly men on their own and in the middle age range (26 to 45 years), they had low levels of education and limited employment histories. They were either on the Disability Support Pension (49%) or on the NewStart Allowance (46%), and nearly one-in-four (24%) were Indigenous;
- Some had family contact but nearly half (47%) were estranged;
- They had experienced long periods of homelessness, particularly sleeping rough, and had a history of incarceration and being in state care.

Complexity of need

- Tri-morbidity was pervasive, with the majority experiencing significant mental health difficulties (consistent with childhood trauma) and substance abuse problems as well as serious physical health problems;
- Cognitive impairment, as a result of head trauma and brain injuries, was common and impacted on day-to-day functioning and memory – many will need ongoing long-term support even when they are housed;
- Homelessness is a traumatic experiences and many of these needs were exacerbated as a result of sleeping rough;
- This means that for many, some of the physical and mental health issues could have been avoided, or perhaps minimised, if people had been able to obtain and sustain appropriate and affordable housing sooner;
- The significant multiple health issues that many people were facing, some as a result of rough sleeping, will require them to be in stable housing with ongoing health supports/services to ensure their survival;
- Without access to stable housing, extensive service and support efforts were undermined.

Structural issues – housing and income

- Very few people obtained or could be offered much beyond temporary accommodation;
- Cycling through short-term crisis or transitional accommodation is not an appropriate intervention for people who are rough sleepers, especially if they are long-term – the evidence shows that stability is crucial;
- The levels of income support trapped people in extreme poverty and ensured that they were excluded from the private rental market and had no option but to rely on public housing;
- Prevention is important. Many had received housing in the past – when it broke down, it was generally due to rent arrears, which highlights the critical role of prevention in terms of ensuring that people who face eviction due to rent arrears do not end up losing their home and becoming homeless.

Service system issues

- The intense efforts of initiatives like RSI are undermined by a service system response that struggles to meet increasing demand amidst a growing housing crisis;
- The housing crisis means that effective programs such as MS2H and supportive housing are seriously constrained in responding to rough sleeping; they are small programs unable to meet current levels of demand; as the evidence presented in this report showed, despite high levels of vulnerability, only one person was referred to MS2H and yet they were not able to access the program *immediately;*
- Evaluations of supportive housing such as Melbourne Street to Home (MS2H) have confirmed that this type of housing and support can improve outcomes for highly vulnerable rough sleepers;
- The service system is highly targeted to provide support to people enduring one of the most extreme forms of homelessness, rough sleeping. The irony, however, is that the system seems ill-equipped to deal with the complexities that clients present with (aggressive behaviour, significant levels of alcohol and drug use);
- The level of physical pain and psychological distress is astounding as is the level of brain injury, which affected day to day cognitive functioning; this impacted significantly on the ability of clients to deal with services, which was reflected in missed appointments with a range of services, as well as in the difficulty services had in contacting clients. Yet the service system applies a 'one size fits all' approach to expectation of client behaviour and capabilities – for example, that they can engage and attend appointments, be contactable, and can sort things out on their own. But they are not necessarily able to do so – the system seems to expect a certain level of functioning that for many has been beyond their capacity to fulfil, at least within the short-term and in the context of their harsh reality: thus not showing up for appointments is interpreted as lack of engagement, or not being interested, rather than the client's circumstances being overwhelming and, most likely, overshadowing the appointment they should have attended;
- Service rules and eligibility: There was a common theme of using up funding for emergency accommodation or HEF and therefore being ineligible for further support (usually for up to six months to one year) without a longer-term, or even medium-term, housing outcome;
- Engaging clients with highly complex needs – the window of opportunity to engage with clients is small, fragile and vanished quickly; it highlights the importance of an immediate response and the need for streamlined referrals into AOD services and mental health services – perhaps with priority service agreements like that used previously in the Homeless and Drug Dependency Trial.

Implications

Structural issues

- The success or otherwise of RSI and any broader response will be dependent upon the availability of permanent, affordable and supportive housing;
- Levels of income support are inadequate and exclude vulnerable people from accessing housing – with so many on NewStart Allowance, supporting clients to access private rental must be considered as a long-term undertaking that becomes possible only when independent financial circumstances have improved;
- Prevention of housing loss due to rent arrears is critically important.

System issues

- Longer term housing options need to be available so that people don't cycle through two week stays in hotels, crisis accommodation and the street over extended periods of time.
- Staff need caseloads that enable them to actively seek out clients and take them to appointments and advocate for them through service systems;
- There needs to be an emphasis on health and wellbeing, with particular regard to:
    - The extent of brain injury (due to assault or substance abuse) and the impact on cognitive functioning, making it extremely difficult for clients with a range of complex needs to engage with services;
    - Expectations around compliance and punitive responses (barring and eviction) if these are not met; and
    - The importance of a psychologically-informed response as a mechanism to deal with high levels of distress among clients with tri-morbidity;
- The acute and complex nature of client ill-health has implications for how services interact with this highly complex group. It underscores the importance of a specialised and tailored approach that is informed by a psychological and physiological model of care for as long as it is needed by the client, and not dictated by compliance and punishment;
- Support needs to be longer term and incorporate a recovery model of care;
- The use of HEF needs to be re-defined, focusing particularly on how it impacts on housing outcomes; 'complex care packages' with flexible funding offer a potential way forward, providing individuals with a two year period of assistance to access support and housing;
- Use the 'ALERT' tab in the client management system to ensure that clients are flagged as sleeping rough so they are not 'lost' as they are moved through the service system - in order to respond in a timely and appropriate way, with priority access to AOD and mental health services;
- An 'ALERT' is also needed to highlight housing applications made; while information recording in the client management system is extensive, the possibility of critical information being lost is high; the recording of applications for housing, or if offers of housing come through, tend to get buried in the detail recorded.

Research and evaluation

- Longitudinal monitoring and research of housing and non-housing outcomes;
- Monitoring of health and wellbeing.

1. Introduction

The City of Melbourne 2016 StreetCount documented 247 people sleeping rough in and around Melbourne's Central Business District (CBD). This is a 74% increase since the 2014 StreetCount. This shocking figure made its dramatic presence felt in the sheer numbers of people destitute in the CBD. Such confronting scenes are a potent indicator of just how acute the housing crisis[1] is as well as the demand for immediate and significant government action.

As a response, in January this year, the State Government[2] announced its emergency package to address rough sleeping. With new funding of close to $10 million, the package includes the provision of immediate housing for 40 vulnerable people sleeping rough, along with support to sustain their housing. Also included is case management and targeted support for up to two years. Furthermore, an inquiry was announced that will inform the development of a long-term strategy to tackle the issue of rough sleeping.

Rough Sleepers Initiative

The Rough Sleepers Initiative (RSI) provides a dedicated response to the growing crisis of people destitute on the streets of Melbourne. The RSI works at the most extreme end of the homelessness spectrum, providing support to some of the most vulnerable, traumatised and distressed people. However, it is a small program working at the front end of a much bigger system; for many vulnerable clients, it is not capable of being a beginning-to-end response.

RSI aims to connect with rough sleepers in order to provide interim housing assistance, including referrals to crisis accommodation, as well as assistance to access long-term permanent housing and a range of medical, financial and other supports. It uses a tool referred to as the Vulnerability Index to identify and prioritise vulnerable rough sleepers based on health conditions affected by homelessness; these are people most likely to die within five years if they continue to sleep rough[3]. In these instances, people are referred to the Melbourne Street to Home Program (MS2H), which provides permanent housing coordinated with support and health services.

The findings presented in this report have been informed by the analysis of administrative data specifically related to Launch Housing's Rough Sleeper Initiative. The RSI provided the initial point of reference to explore in detail the circumstances of highly vulnerable people who were sleeping rough. Thus, the report is not intended as a review or evaluation of RSI. Rather, it provides a detailed picture of the struggle and devastation of people's lives, and the chaos and trauma of sleeping rough. As such, it highlights the importance of urgent action that targets problematic structural and systemic issues.

[1] In both metropolitan Melbourne and regional Victoria, the proportion of affordable rental properties are the lowest since 2000: http://www.dhs.vic.gov.au/__data/assets/pdf_file/0008/988676/Rental-Report-March-quarter-2017.pdf

[2] See: www.martinfoley.com.au/giving-rough-sleepers-path-towards-home/

[3] Rough Sleepers Initiative, Practice Manual, 2015

2. Homelessness

The Australian Bureau of Statistics (ABS) defines a person as homeless if they do not have suitable accommodation options and their current living arrangement:

- is in a dwelling that is inadequate, or
- has no tenure, or if their initial tenure is short and not extendable, or
- does not allow them to have control of, and access to space for social relations[4].

An estimated 105,237 people were homeless in Australia on Census night 2011, with 22,789 (22%) homeless in Victoria. While only 21,258 (20%) were in a homelessness service on Census night[5], many more people present to specialist homelessness services and receive assistance across the year. In the 2015-16 financial year, nationally, 279,000 people received support from a homelessness service with many more being turned away. For the same period, in Victoria, specialist homelessness services assisted 105,287 people[6].

Homelessness tends to be largely invisible, with the majority of people ending up in short-term or emergency accommodation, or in crowded dwelling staying with relatives or friends. Only 6% of people who are homeless end up sleeping rough on the streets, in parks or improvised dwellings. They are, however, the most visible and, arguably, the most vulnerable group.

The issue of trauma has been linked to homelessness both as a cause and a consequence[7]; this is especially relevant for people sleeping rough. Sleeping rough is extremely difficult, both physically and mentally. Drug and alcohol problems persist as mental and physical health deteriorates[8]. Premature ageing and premature death are common. People sleeping rough are at high risk of being victims of crime, including violent assaults and being killed[9] [10] [11]. The findings presented in this report highlight the extent of serious mental and physical health problems, including the pervasiveness of brain injury among the sampled group.

---

[4] Australian Bureau of Statistics. (2011). *Census of Population and Housing: Estimating Homelessness*. Cat. No. 2049.0. Canberra. ABS

[5] Australian Bureau of Statistics. (2011). *Census of Population and Housing: Estimating Homelessness*. Cat. No. 2049.0. Canberra. ABS

[6] AIHW 2017. Specialist homelessness services 2015–16: Victoria fact sheet. Cat. no. HOU 286. Canberra: AIHW. http://www.aihw.gov.au/publication-detail/?id=60129558593.

[7] Robinson, C. (2014). Trauma: a cause and consequence of homelessness, in *Homelessness in Australia: An Introduction*, Edited by Chris Chamberlain, Guy Johnson and Catherine Robinson, NewSouth Publishing, Sydney.

[8] Sanders, B. and Albanese, F. (2016). *"It's no life at all": Rough sleepers' experiences of violence and abuse on the streets of England and Wales*, Crisis UK, London.

[9] Thomas, B. (2012). *Homelessness Kills: An analysis of the mortality of homeless people in early twenty-first century England, Summary*.

[10] Murray, S. (2011). Violence Against Homeless Women: Safety and Social Policy, *Australian Social Work*, 64:3, 346-360.

[11] Robinson, C. (2010). Rough Living: Surviving Violence and Homelessness, UTS Shopfront Monograph Series No. 6, UTS Press, NSW.

3. Method

In order to further inform the Victorian government and City of Melbourne's response to local rough sleeping, we undertook an analysis of a sample of rough sleepers who were supported through Launch Housing's Rough Sleepers Initiative (RSI). This involved examination of case files including case or progress notes made by workers, assessments and referrals as well as administrative data collected for funding purposes. While we focussed on the most recent period of rough sleeping, many clients had longer histories of homelessness which were also examined through case files.

To extract this information from the case files, a template was used which collected basic demographic information along with details about housing and homelessness histories, current experiences of rough sleeping, services and supports provided, and reasons or factors for their most recent period of homelessness. Template data was then entered into SurveyMonkey for easy analysis.

Because information was gleaned from case files, which is collected for the primary purpose of delivering a service, some information was occasionally missing, or was insufficiently detailed, such as educational attainment or employment experience. The amount of missing information is noted throughout.

Selecting the sample

Over the 2016 calendar year, a total of 235 people were identified as having had a support period with the RSI program, which provided the population base from which to select a sample. Nearly four-in-five (78%) RSI clients were men. As a result, a stratified random sampling approach was used to select a sample of 59 clients. This means that males and females were separated into two lists; within each list, clients were then randomly selected to reflect the gender distribution of the broader RSI group.

It should be noted that this stratified random sample of 59 clients does not necessarily represent the broader population of people sleeping rough. As with the broader group of people experiencing homelessness, those who sleep rough are a diverse group with varied needs.

4. Who was sleeping rough?

Table 1 summarises the characteristics for gender, age, country of birth and indigenous status for the sample of 59 clients and compares this to the total number of clients who had a support period with RSI in 2016.

Using gender as the key factor in the stratified random sampling technique ensured that the gender distribution for the sample reflected the gender breakdown of the broader RSI client group. Accordingly, 78% of the 59 clients sampled were men.

In terms of age, the sample was slightly older with an average age of 42 years (ranging from 19 to 65 years) than the total RSI group which had an average of 39 years (ranging from 16 to 78 years).

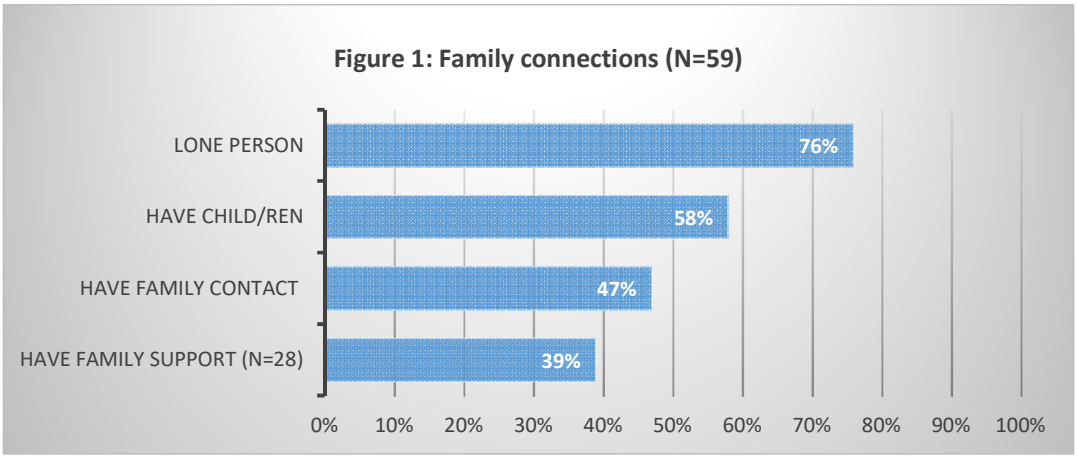
The majority (82%) of RSI clients were born in Australia and this was similarly reflected in the sample, although it was slightly more common at 88%. Indigenous people represented 11% of the RSI clients but were more than twice as likely to be in the sample group (24%)[12] .

Table 1: Selected characteristics	RSI total clients N=235	Sample N=59
Gender		
Men	182 (78%)	46 (78%)
Women	53 (22%)	13 (22%)
Age		
Average	39 years	42 years
Youngest	16	19
Oldest	78	65
Country of birth		
Australia	193 (82%)	52 (88%)
Other	42 (18%)	7 (12%)
Indigenous status		
Indigenous	27 (11%)	14 (24%)
Non-Indigenous	197 (84%)	45 (76%)
Unknown	11 (5%)	0

Family connections

- Three-quarters (76%) of the sample group were on their own (Figure 1). For the remaining 14 cases (24%), nearly all were part of a couple except for one person who was sleeping rough with his 15 year old son.
- Many had contact with family members. There was broader family contact (47%, n=28); and among this group (n=28), some type of family support was detailed in 39% (n=11) of the records.
- More than half 58% (n=34) also had children, although parental status was unknown in several cases (12%).
- The nature and extent of contact with children was not always clear; in some instances, children were living with their other parent or with grandparents, and in a handful of cases, DHHS involvement was recorded.

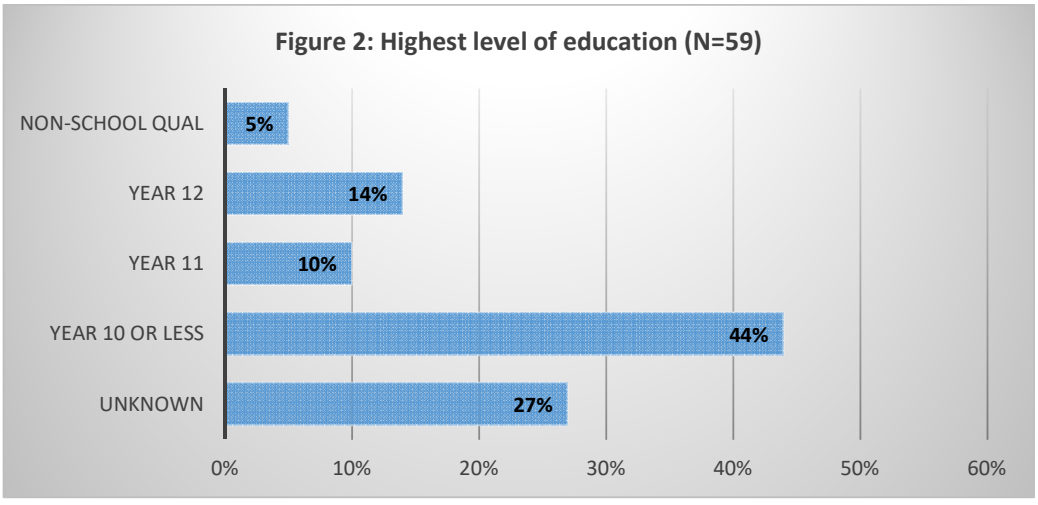
[12] This higher than the 18% Indigenous recorded in the AIHW profile of people sleeping rough – see http://www.aihw.gov.au/homelessness/shsc/profiles-of-homeless-clients/



Education, Employment, Income

Education

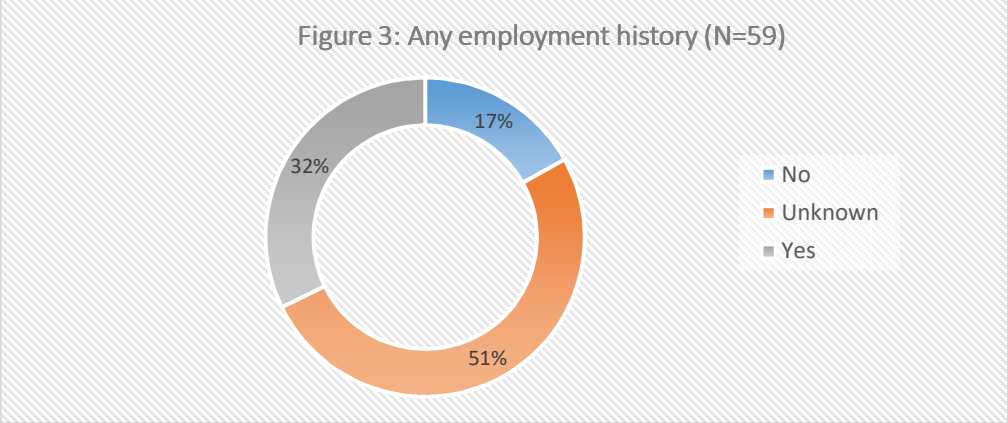
- This sample was much more disadvantaged educationally than the broader Australian population. More than twice as many people in the sample had attained Year 11 or below (54%) compared to the broader Australian population (25%); indeed, nearly half (44%) the sample had only very limited education (Year 10 or less).
- 14% of the client sample had recorded Year 12 as the highest level of education (Figure 2); nationally, the figure was 18%[13].
- Among the three clients who had a non-school qualification (5%), one person had a Masters in Accounting, another had Certificates I, II and III in Administration, while a third had only Year 9 but had a Certificate I in Construction.
- In more than a quarter of the sample cases (27%), the level of education was difficult to ascertain.



[13] ABS, Cat No. 6227.0 - Education and Work, Australia, May 2016 http://www.abs.gov.au/ausstats/abs@.nsf/mf/6227.0

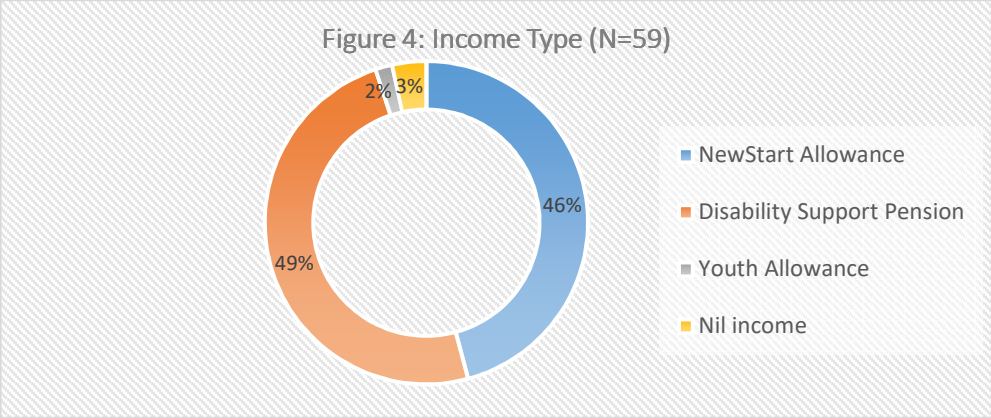
Employment

- Figure 3 shows that in a third of cases (32%), some information about a client's employment was referenced. For the majority, however, it was either unknown (51%), or there was no history (17%).
- Among the 19 clients who had an employment history, some limited information regarding the nature of work was available. In a couple of cases, clients were currently working, although this tended to be casual. In other cases, clients had been in full-time employment; one client had worked for 11 years doing maintenance and repair work in a family-run business. One person had worked as a personal carer and had also done volunteer work.
- Some had a history of manual work which had taken its toll on them physically. In a couple of cases, clients had suffered physical injury that meant *'severe restrictions on their mobility and pain'*.



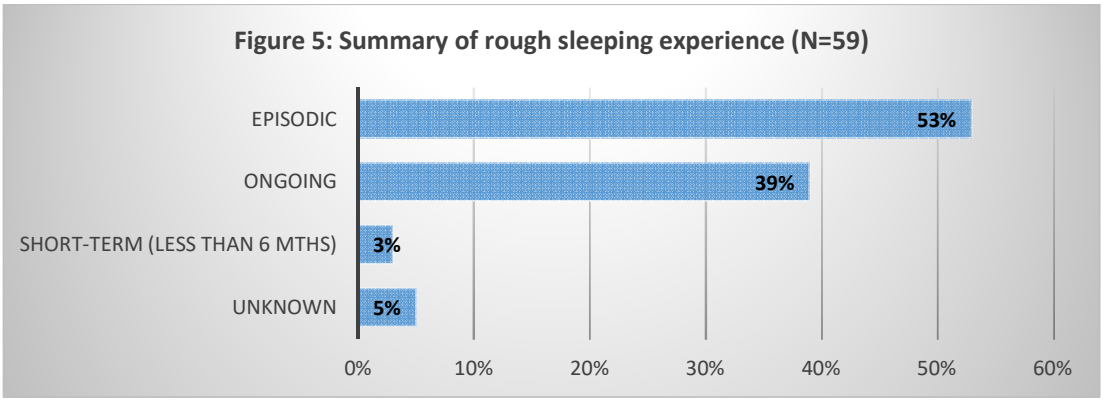
Income

- As shown in Figure 4, the most common sources of income were the Disability Support Pension (49%) and the NewStart Allowance (46%);
- One person (2%) was on Youth Allowance; and
- Two people (3%) had no income; in one case, it was related to the person being on a temporary visa which excluded them from many supports and government benefits. In the second case, the young person, in their mid-twenties, was yet to have income support reinstated following their exit from prison.



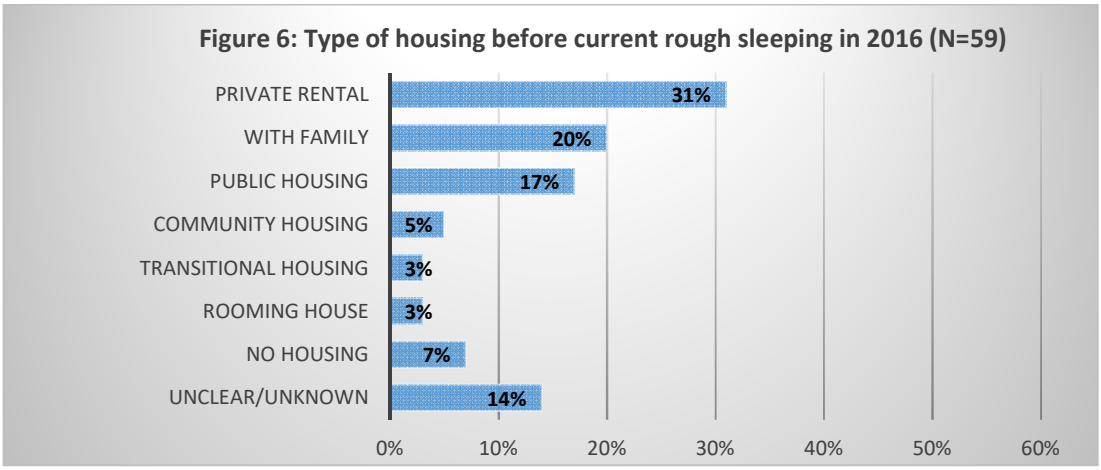
5. Rough sleeping experience

- For just over half of the sample group (53%), rough sleeping was episodic and interspersed with bursts of temporary stays in crisis accommodation and/or short-term emergency accommodation, such as hotels, motels or rooming houses (Figure 5);
- In contrast, two-in-five people (39%) had no respite from rough sleeping, experiencing it as an ongoing ordeal; and
- Only two people (3%) in the sample group had a one-off and short-term experience of sleeping rough:
    - One person, a woman in her 60s, moved back to a regional town in Victoria, although the nature of her accommodation there was unclear, and
    - The second person, a man in his 40s, was offered public housing.



Housing experience

- As shown in Figure 6 below, a third of clients had lived in private rental (31%) prior to sleeping rough;
- One-in-five lived with their family (20%);
- Around one-in-four lived in public housing (17%) or community housing (5%);
- Two people (3%) had lived in rooming houses, though it is unclear whether these were privately or state run.
- Four people (7%) had no housing prior to sleeping rough in 2016.



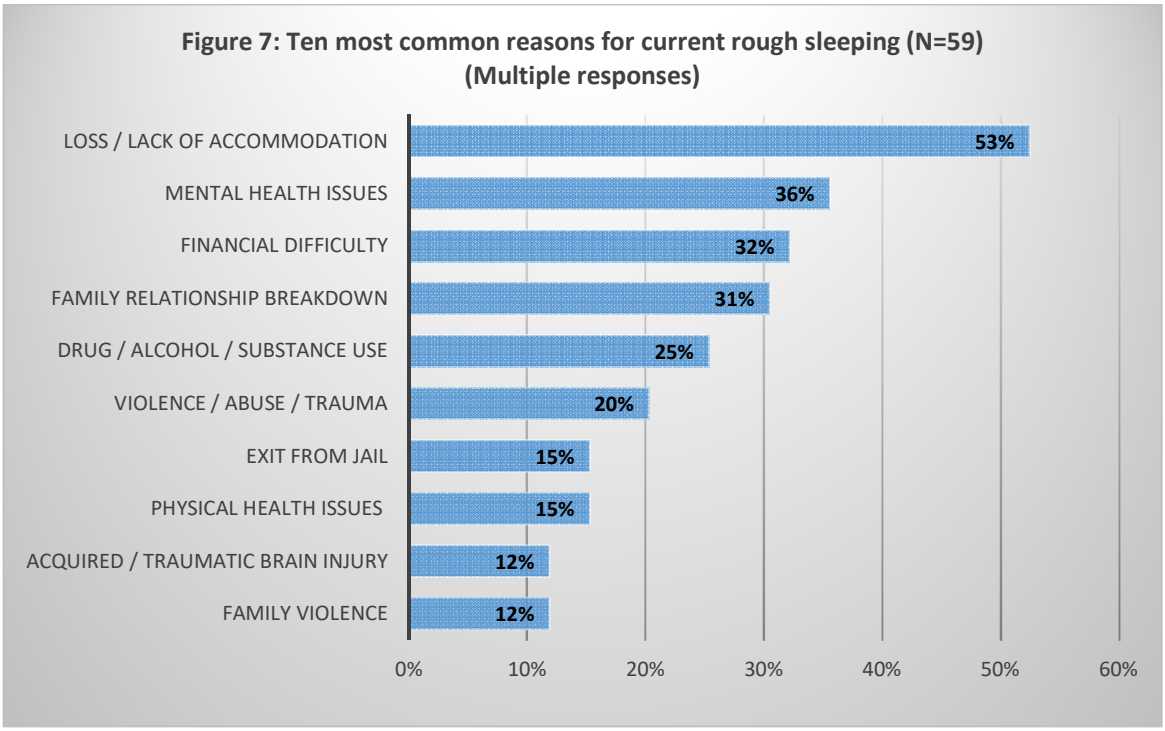
Reasons for rough sleeping in 2016

There were a range of reasons why people were sleeping rough during 2016. And usually there were multiple reasons reported for each person. The ten most common reasons why people were sleeping rough are illustrated in Figure 7, which shows:

- The most common reason was related to housing (53%), either the loss of housing or the lack of it;
- Mental health issues were identified in 36% of the sample cases;
- Financial difficulty impacted a third of cases (32%);
- Family relationship breakdown similarly affected a third of cases (31%) and included the breakdown of intimate partner relationships;
- Drug/alcohol/substance use was a reason in 25% of cases, and violence/abuse/trauma in 20%; and
- Other reasons included exit from prison (15%), physical health issues (15%), acquired /traumatic brain injury (12%), or family violence (12%).

Unsurprisingly, loss or lack of housing and financial difficulty tended to be connected. It was generally the case that people lost their housing because of evictions following rent arrears. In one case, a person was evicted from Elizabeth Street Common Ground after just 12 months due to rent arrears.

- Importantly, a change in income support status, experienced by a number of people, meant that they could no longer afford their current accommodation, for example:
    - One person could no longer afford to live in a rooming house when they were changed from a Disability Support Pension to the NewStart Allowance;
    - A couple, who lost the Family Tax Benefit after their children were taken into care, fell into rent arrears and were evicted from their public housing; and
    - Another person lost his Disability Support Pension when he went to jail and, as a result, accommodation was lost because rent could not be maintained.



The following excerpts from case files highlight the difficulty clients experienced in relation to accessing and sustaining housing given extreme financial hardship caused by inadequate levels of income support, exacerbated in the context of Melbourne's housing crisis.

This also means that any service or support response is significantly curtailed. When agencies provide financial support for rent arrears or assist with the first week's rent, they do an assessment of a client's income to check the accommodation will be affordable and sustainable. This is done to ensure that the client does not end up in a situation which will likely break down and perpetuate their homelessness.

While this tends to work in most case, as indicated in the following:

> *Financial difficulty is directly related to client's housing instability, alternating between rough sleeping and emergency accommodation. It was identified that his weekly DSP is not enough to cover two weeks RIA (rent in advance) plus living expenses. [Crisis accommodation] option was encouraged to client, although the uncertainty of his impending court hearing meant he was not interested in going down that option as yet (Case note 6).*

In some cases, it fails. As shown in the following example, private rental was secured despite an agency assessment indicating that it was unaffordable and therefore, could not be sustained by the client. Without ongoing financial assistance, the client unfortunately lost their housing:

> *Low income has been a barrier to securing private rental. Unpaid rent led to eviction from rooming house where [client] resided for 7 months. Income assessment in mid-2015 deemed rooming houses in $220 per week range were 'unsustainable on NewStart Allowance'. Despite this assessment, [agency] secured [the client]… private rental ($200 per week) in February 2016 in which*

[the agency] covered the first week's rent. Client sought additional financial assistance for rent from [agency] in April, [but client] was no longer eligible for HEF (Housing Establishment Fund). Sometime in July, [client] was evicted from the property when a warrant was executed in relation to outstanding rental areas, after which [client] began sleeping rough (Case note 5).

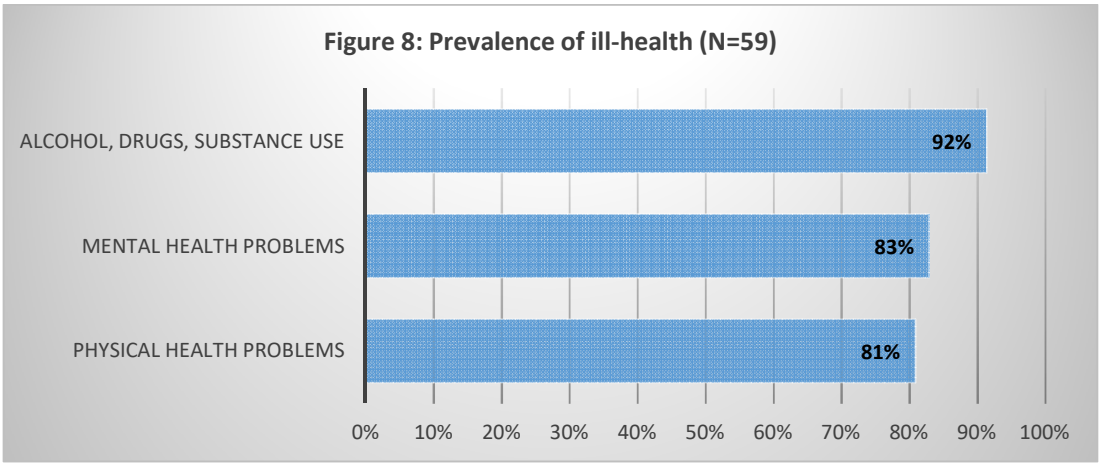
6. Acute and overlapping complex needs

The prevalence and overlap of complex health difficulties among the client group was significant. Most had recorded difficult alcohol, drugs and substance use, and serious physical and mental health problems (Figure 8).

- Nearly all clients (92%) in the sample had recorded history of use of alcohol, drugs or other substances; only 4 people had no recorded history and for one person, this was unknown;
- A high proportion (83%) had serious mental health issues that included schizophrenia, bi-polar disorder, borderline personality disorder, depression and anxiety, and post-traumatic stress disorders (PTSD); and
- A similarly high proportion (81%) had substantial physical health problems, with Hepatitis C, dental problems, asthma, skin diseases, diabetes, and head injuries commonly recorded in case files; intellectual disabilities and traumatic brain injuries were also common.

Experiencing any one of these issues can cause hardship and difficulty for the client and present enormous challenges for agencies and the provision of services and support. A combination of all three of these issues, referred to as tri-morbidity, makes things that much more difficult, interacting and causing further distress and suffering in the lives of clients.

Tri-morbidity was especially prevalent among the sample group. For example, in the 92% of cases with recorded substance use, many also had mental health problems (80%) as well as physical health problems (83%). To illustrate the range of experiences of these issues and the extent of their impact on clients' lives, several excerpts are detailed below.



Alcohol, drugs and substance problems

Most substance use involved the use of multiple substances (poly-drug use) in a somewhat opportunistic way:

> *Has history of AOD (alcohol and other drug use) where he had substance abuse issues associated with amphetamines (ice, cocaine, and speed). Overdosed 15 years ago however self-identified as currently using recreationally and only 'when [he] can get a hold of some'. (Case note 12)*
>
> *Self-identified as consuming alcohol every day for past month. First used at age 18. Heroin: self-disclosed as having an addiction, with daily intravenous use. First used at age 16. Has been known to become physically violent while using with an incident where he attacked his father. Has disclosed that his addiction lead to a 9 year prison sentence although did not wish to disclose the charges that led to this period of incarceration. Ice: uses regularly. Is heavy smoker…Treatment: received treatment for AOD 10 years ago (Case note 27).*

This pattern of substance use is consistent with other groups who experience long term homelessness and have alcohol and drug issues[14].

Alcohol and other drugs were used to self-medicate:

> *Alcohol: History of alcohol dependency and addiction, generally drank more 'when feeling sad'. Client demonstrated that he had an awareness of his own triggers and changes in emotional states. He had previously completed a detox program through [agency] although had aspirations to do a longer term detox …Client expressed a desire to enter longer term rehab for his alcohol dependency...Drugs: Was admitted to hospital psych ward 15 years ago for drug induced psychosis. There were three further episodes of drug induced psychosis where he had to be re-admitted [to hospital]. Has recovered from speed addiction whilst in psych ward (Case note 26).*
>
> *Issues with alcoholism from age 13 right through until early 40s; some AA & counselling support in the past; smoked cannabis also during that time. Began taking ICE approx. three years ago as a coping mechanism to deal with past trauma & unmanaged mental health issues; client wants to re-engage with AOD counselling, wants to stop substance use (Case note 39).*

Mental health problems

People struggled with a range of mental health problems, as highlighted in the following:

> *PTSD, Adjustment Disorder, history of psychosis, delusions (thought extraction), self-harming behaviour. Suicidality due to lack of support he has had to address the diagnosed illnesses he suffers with (Case note 22).*

[14] Rayner, K., Batterham, D. and Wiltshire, R. (2005), *Rebuilding Lives: Final year findings on the Homeless and Drug Dependency Trial's Continuous Primary Case Management and Pathways Response* (Part B), Report 9, Hanover Welfare Services, Melbourne.

Diagnosis of: bi-polar disorder, depression, significant substance use (heroin, alcohol, cannabis) which impacts on mental health (Case note 10).

Anti-social disorder diagnosis, which results in verbal abuse and aggressive physical behaviour at times; client was banned from McDonalds due to assaulting a worker. Client has identified that going for a walk can help calm him down. Depression, anxiety and panic attacks, non-medicated but managed through his GP…anger management issues stemming from insomnia. Client has presented as agitated, rude and verbally abusive towards staff; his behaviour has been directly linked to his mental health illness (Case note 21).

For some, these mental health problems were the result of, or connected to, childhood trauma:

Client advised that since childhood he has issues with memory loss. Diagnosed with schizophrenia in 2012, result of undealt childhood trauma; has depression from early childhood, prescribed medication, was seeing psychologist regularly in the past – wants to re-engage with psychologist (Case note 35).

Diagnosed with depression, anxiety, borderline personality disorder & PTSD 2015 – Actively using heroin for past 6 months, 'in order to cope with living on the streets'; has experienced childhood trauma (Case note 36).

Physical health problems

The following case note excerpts show the extent of physical health problems and indicate that many people sleeping rough are likely to be in constant pain:

Bowel Cancer: Was diagnosed with having bowel cancer and was to have invasive surgery within 12 months of diagnosis. Kidney Stones & Damage: Had 4 surgeries done to his kidneys within previous 14 months which he stated was for kidney stones. Was on the waiting list for this surgery. Kidney damaged due to alcohol abuse. Hernia: Had a hernia problem which required surgery. Back Ache: Had a very sore back. The knowledge of requiring invasive surgery for his kidney stones within 12 months of being diagnosed [with bowel cancer] influenced his decision to terminate his lease on his transitional housing (Case note 20).

2015 - Knee infection, slight limp, suffers from chronic headaches & stress. Wound on right shin, was assaulted with a stick, would & leg became infected; had to go to hospital. Has fallen over numerous times & sustained injuries due to intoxication, generally resulting in hospitalisation. 2016 - IAP Type 2 Diabetes, Cirrhosis of the liver, Cellulitis, left leg. Client had 16 admissions to ED since 11th of February 2016. He was several times at St. Vincent's & the Alfred. He discharged himself on most occasions against medical advice. Client has a severe laceration on his right thumb and a possible dislocation. Operation was done on February. No admissions to hospital since May 2016, Renal disease & Hep C (Case note 25).

Blood clotting disorder which has resulted in clot to the brain that affects his memory, DVTs(deep vein thrombosis) in legs, pulmonary embolisms (clots in lungs) Asthma Heart attack in 2015, Back problems, Vision problems, Epilepsy, Chromosomal disorder - can be at risk of learning or behavioural problems, Benign intracranial hypertension. (Case note 23)

Childhood trauma, suffered multiple assaults, hits to head, he is hearing impaired & needs a hearing aid; only 12% hearing in his left ear; hearing loss is the result of childhood neglect. Nerve damage left thigh from sleeping on concrete, Asthma – uses Ventolin, Liver disease/cirrhosis, History of frostbite, hypothermia, Dental problems, and Vision problems. (Case note 24)

As highlighted below, physical ill-health also included head trauma and brain injury, affecting day-to-day cognitive functioning and memory. This alone made it difficult for people to engage with mainstream services requiring them to read and understand written materials and keep track of appointments:

Diagnosed personality disorder in 1980s; acquired brain injury suffered during an assault whilst sleeping rough approx. 7-9 years ago; suffers black outs because of his ABI; poor memory (Case note 49).

*Schizophrenia. Multiple involuntary hospitalisations. Possible undiagnosed PTSD and post natal depression. Client reported being suicidal during support period. (*hospitalisation on numerous occasions for head injuries and alcohol consumption, she may have Acquired Brain Injury) (Case note 6).*

Diagnosis of schizophrenia, client has experienced auditory hallucinations in the past. Psychiatric medication prescribed although no compliance in 2015-16. Acquired brain injury with subsequent hospitalisation in 2011 following an attack (Case note 25).

Sleeping rough directly impacted and exacerbated the physical health difficulties that clients faced:

Has experienced sudden weight loss due to stress and rough sleeping. Has physical disability that limits mobility which resulted from multiple attacks on the streets. Has vision problems due to having surgery on his eye socket… (Case note 11)

Fatally High Blood Pressure: has high blood pressure which she struggles with due to living on the street. Her doctor previously advised her if her blood pressure does not come down, this may be fatal for her. (Case note 18)

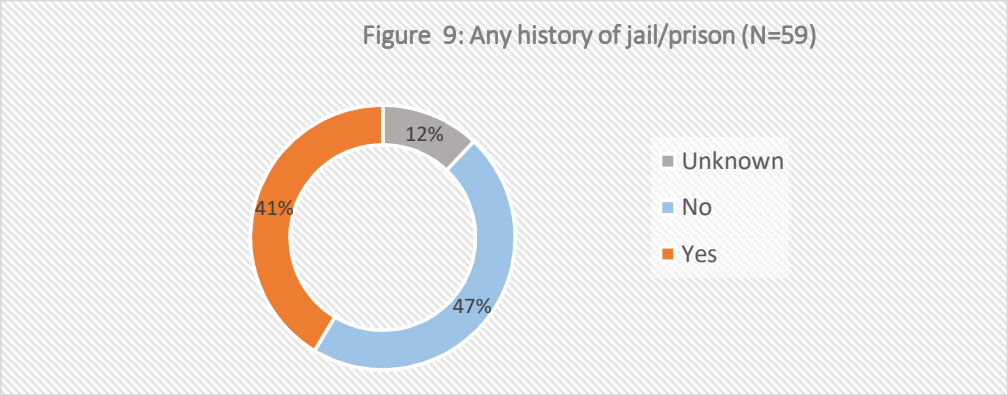
Cellulitis, Asthma, Hepatitis C, reports chronic health condition…, Epilepsy, reports brain injury, reports having suffered from an infection in his heart due to being run down from sleeping on the street. Reports having to leave accommodation due to physical health. (Case note 31)

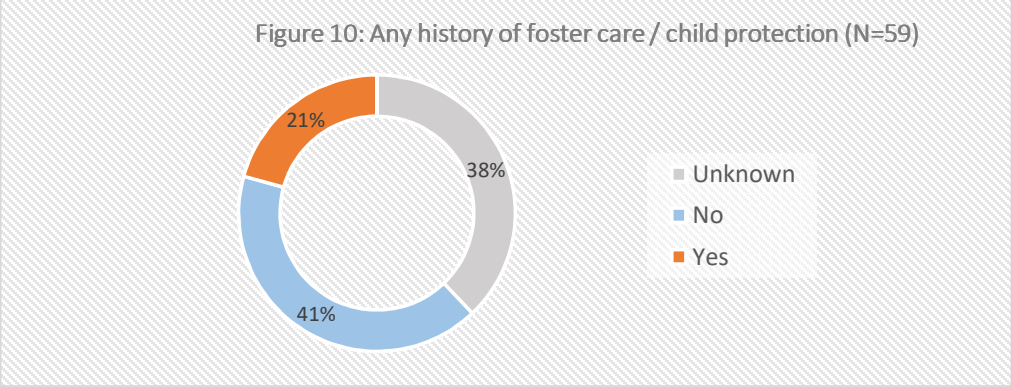
7. Institutional history

Among the sample of 59 cases files, 41% had some history of incarcerated (Figure 9) and 21% had a history of out-of-home care (Figure 10).

Among the 41% (24 clients) where some history of incarceration was recorded, further analysis showed that several clients were Indigenous (29%), a number had also experienced out of home care (33%), and a similar number (38%) ended up sleeping rough following their exit from jail. In several cases:

- Incarceration was the result of relatively minor offences, for example, shop-lifting, theft, possession, or for unpaid fines (this was roughly 29% of those with a history of incarceration). In one case, a client had been arrested 57 times in 2014 for drunk and disorderly behaviour, and then in 2015, he spent one month in prison for accrued fines. These types of minor offences are associated with the destitution of homelessness and, along with street based sex work and drug use, are sometimes referred to as crimes of survival[15] or crimes of desperation[16].





[15] Boyer, B. (2010). *Foster care, homelessness, crimes of survival, and independent living programs: some recommendations,* Project submitted in partial fulfilment of the requirements for the degree of Master of Arts, School of Criminology, Southern Oregon University.

[16] United Way of Calgary and Area, (2008). *Crimes of desperation: the truth about poverty-related crime, Full Report*. United Way of Calgary and Area, Calgary.

Among the group of 24 clients with a history of incarceration, there were also several cases (29%) that involved serious crime such as domestic/family violence, assaults, or criminal damage. In one case, a client spent 10 years in prison for offences including assaulting a police officer and criminal damage. Another client spent three months in jail for breaching an Intervention Order.

In a number of instances, a client's tri-morbidity had been compounded by childhood trauma, time spent in out-of-home care *and* time spent incarcerated, along with periods of homelessness:

> *Client has a history of child sexual abuse. He suffers from mental illness and cognitive impairment (has suffered head injury). He has a long history of heroin addiction and has spent time in prison for a number of offenses (burglary, theft and driving related matters). His initial experience of rough sleeping in 2016 was as a result of leaving jail. Besides this he has spent a lot of time in crisis accommodation. Client's accommodation in 2016 consisted of a mixture of jail, rough sleeping, short term accommodation in hotels/motels, and crisis accommodation (Case note 45).*
>
> *Client has a long history of homelessness starting when he went into care as a child aged 13 due to his 'destructive behaviour'. His life has been interspersed with numerous stays in hospital, a six month stint in prison for possession, episodes of rough sleeping and couch surfing. Physical and mental health are key issues for client. He has a life threatening illness which results in frequent hospital admittances. He was in and out of hospital throughout the most recent support period, mainly for blood clots, and an overdose of painkillers. Client stopped preventative medication because he couldn't afford the treatment. He also reported intravenous ice and heroin use...Client has poor memory and often rapid changes of mind. His intellectual ability is below his age, which can lead to poor decision making which works against stabilising his life (Case note 33).*
>
> *Client left home aged 11 and ended up sleeping on the streets following issues at home. At age 13 he was picked up by protective services and moved between various foster carers as a Ward of the State. As an adult, client has spent time between prison and temporary accommodation, sleeping in squats, sleeping rough, couch surfing, staying in rooming houses, hotels and motels – he has never had stable accommodation. Client's most recent release from prison saw him exit with nowhere to go due to a referral not being made…Client has multiple physical health issues, including Epilepsy, Hepatitis C and Cellulitis. Client suffers from PTSD, anxiety and depression (Case note 41).*

8. Service use

The findings presented here relate to length of support, and the type of support provided to the sample group of clients. It also relates to the accommodation provided as well as difficulties with access.

Length of support

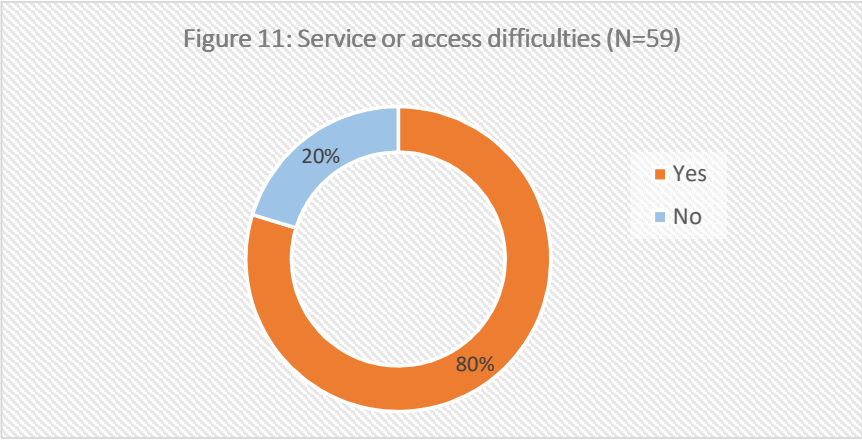
- For the current period of sleeping rough, clients had received an average of seven months of support.
- Some had been supported for only a few days while 51% had been supported for up to six months;
- In a high proportion of cases (39%), support had extended beyond six months, and in one instance, this was as long as four years.

Type of support

- Type of support offered to people sleeping rough included food vouchers, blankets or sleeping bags, mobile phones and financial support via brokerage funds;
- In a number of cases (10%), clients had no identification (ID), so assistance was provided to obtain new ID, which was especially important given that ID is required for public housing applications and income support payments;
- Referrals were made to a range of services including: RDNS, hospitals, general medical services, specialist mental health services, alcohol and drug services, legal and financial services, migrant and refugee services, and Centrelink.

Service or access difficulties

Service or access difficulties were recorded for 80% of cases (Figure 11). Difficulties were related to contacting or locating clients, the nature and complexity of their needs which manifested in difficult and challenging behaviour, and eligibility restrictions for assistance.



<u>Unable to contact/locate</u>

Difficulty contacting or locating clients, particularly to follow-up on support or accommodation needs, was a key complication in at least 41% of cases. To overcome this obstacle, the RSI would give clients mobile phones, but even this did not guarantee that clients were contactable. The problem with mobile phones seemed to be that once they were flat they were not recharged. This proved problematic because clients actually missed out on offers of temporary accommodation or permanent housing:

> *[Client] had public housing offer in July 2016 but worker had not been able to contact client since March 2016 and his phone was no longer operational, so he was removed from the list (Case note 42).*

The additional difficulty in recharging a mobile phone while rough sleeping was likely to be exacerbated for people with chaotic substance use or mild to moderate cognitive impairment.

Level of complexity

A second complication, detailed in 31% of cases, related to clients' level of complexity (level of drug and alcohol use, serious mental health issues, aggression/violence), which impacted on access to services:

> *Client blacklisted from rooming houses…did not maintain mobile phone's battery and was difficult to reach; needs outside service capabilities – his referral to [crisis service] was unsuccessful due to his needs being "too high" (Case note 18).*

Eligibility restrictions

There were also cases where service rules, eligibility criteria, or lack of engagement made access difficult, for example:

> *Lots of difficulty for client in accessing services she needs, despite being fairly proactive and having high vulnerability score…referral made to [program] which provides support for comorbid substance use and mental health issues, specifically for those with diagnosis of Borderline Personality Disorder – even though client eligible for program, was not accepted because housing unstable (Case note 39).*

> *Active drug use and mental health problems meant client and partner were very chaotic while staying in [crisis accommodation] so very little engagement…records show that client was victim of violent attack around December 2015…client needs to get on Pharmacotherapy program before [being accepted into rehabilitation] – eligibility for this program: needs to be mentally stable and needs to be in stable housing…record showing that client advised that since they were not compliant/engaged with detox, they were not yet committed to going to rehabilitation; as a result, client got angry and didn't want to discuss any further…file was closed (Case note 41).*

In some cases, clients were ineligible for services, such as emergency accommodation, because funding limits were exceeded. This usually resulted in clients being excluded from support for between six months to a year, as highlighted in the following excerpts:

Client repeatedly use up available funding so could not be re-assisted for a period of time, despite a lack of resolution to their lack of housing (Case note 3).

Client could not be assisted with HEF (Housing Establishment Fund) for six months because had received HEF for two weeks emergency accommodation (Case note 7).

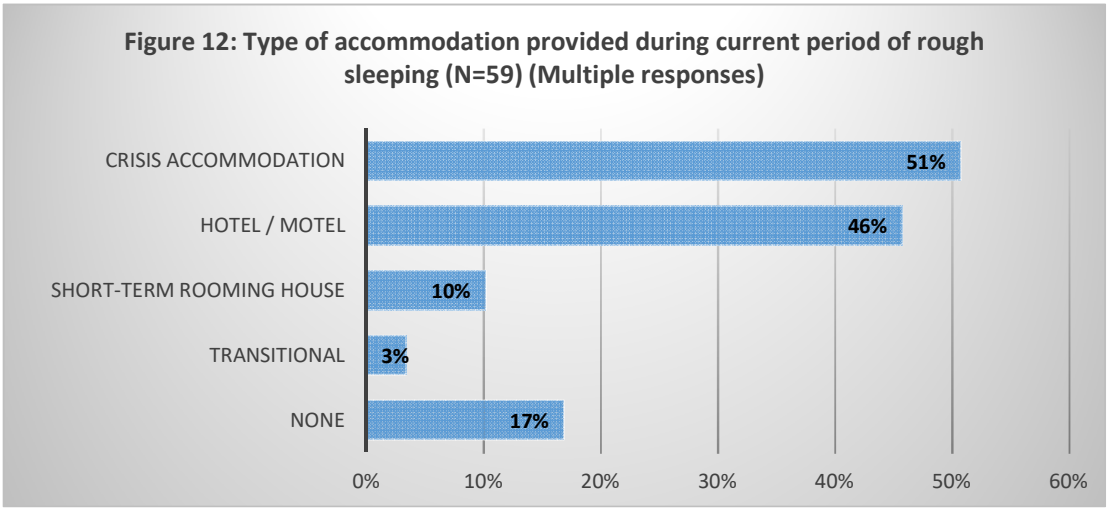
Client sleeping rough in CBD but told that he needs to get assistance from [agency located in outer eastern suburb 61 kms from CBD] for emergency accommodation because he was already assisted with emergency accommodation last week (Case note 31).

Accommodation difficulties

In general, the number of people seeking support is so high that specialist homelessness services are struggling to keep up with demand. In 2015-16, an average of 100 people were unable to be assisted each day in Victoria[17]. The lack of vacancies for crisis accommodation meant that once clients were engaged with RSI, they could not always be accommodated immediately. A common response was to place clients on a waitlist or priority waitlist.

- During the current period of sleeping rough, the majority of people (83%) were provided with accommodation. However, as shown in Figure 12, it was mostly short-term accommodation in crisis services (51%) or in hotel/motels (46%), or in rooming houses;
- In a lot of instances, it was a combination of one or more of these types of accommodation; thus people would cycle in and out of various temporary facilities;
- In 17% of instances, no accommodation was secured, not even temporary.

Figure 12: Type of accommodation provided during current period of rough sleeping (N=59) (Multiple responses)

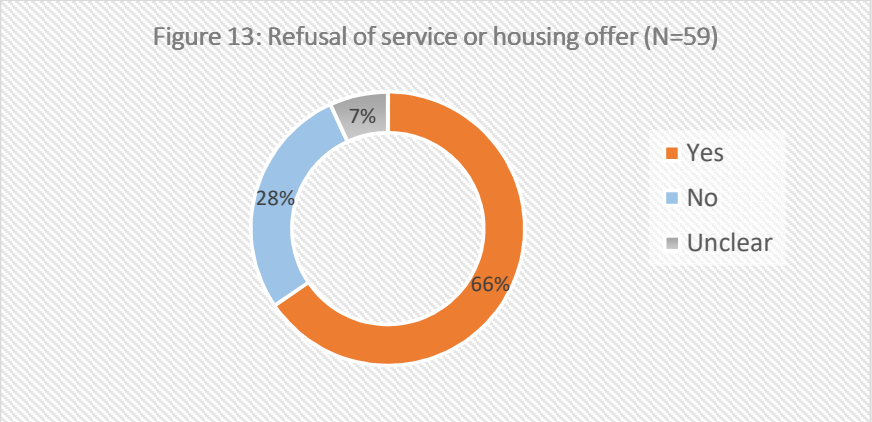


Refusal of service or housing offer

It was common to find examples where a service, especially a housing offer, had been refused by a client sleeping rough (Figure 13). Among this group of 38 clients (66%), many had an ongoing history of homelessness (63%), and had experienced ongoing rough

[17] AIHW 2016. www.aihw.gov.au/homelessness/specialist-homelessness-services-2015-16/

sleeping (37%). As noted earlier, accommodation options offered to clients were limited and tended to be temporary (45% had spent time in crisis accommodation) or short-term (42% had been in a hotel/motel or rooming house).



Where this type of accommodation was declined, it generally had to do with client concerns about personal safety, and/or drug use, as highlighted in the following:

> *Did not want crisis accommodation or hotel/motel due to fears for safety and not wanting to be around people who are substance affected (Case note 23).*
>
> *Client has had negative experiences with a couple of rooming houses so was not interested in them. Due to lack of vacancies, client had been provided with multiple night's emergency accommodation as respite. Financial difficulty also meant he could not afford two weeks RIA (rent in advance) plus living expenses on his DSP. It is evident that this has been a contributing factor to him disengaging with services repeatedly from May to December. Client presented as agitated and stated he was 'extremely tired and sick of sleeping rough'. [Client] cannot read or write & requires assistance completing forms. Client struggles to disclose this to certain people. This may be a barrier to him engaging well with services. [Client] has impending court appearance for Feb 2017 (following release from Prison in April 2016) has created a sense of uncertainty for Client in that he has had to decline any IAP assessments for [crisis accommodation];…this has resulted in numerous stays at [motel] (Case note 6.)*
>
> *The temptation to drink in certain types of accommodation meant [client] declined both rooming house and motel vacancies...reporting that he needed to avoid these types of accommodation to avoid a relapse in his substance use. When offered a one night stay at [a hotel/motel], [client] declined…[stating] that if he was given a hotel room, he would 'get bored and drink to excess' (Case note 17).*
>
> *No refusal as such, [client] has simply identified that he is not particularly interested in rooming house accommodation or crisis accommodation…has had bad experiences in rooming houses and crisis accommodation, with*

people using drugs and alcohol…[Client's] hearing impairment is a major reason why he is reluctant to accept crisis accommodation options as he needs to take out his hearing aid at night, which makes him feel very vulnerable…(Case note 19).

Clients were also reluctant to stay in shared accommodation due to their own mental health issues:

[Client] states he does not manage well in shared environments because of his mental health issues: schizophrenia, depression and claustrophobia; states that although he is taking his medication he does not respond well to others 'setting their own rules' (Case note 25).

[Client] clarified that she needs to live on her own, not in shared accommodation, due to her mental illness; she stated that she would like to live in supported accommodation so she can receive support for her mental illness (Case note 27).

And in another case:

[Client] is reluctant to access mental health services while in crisis accommodation, would prefer to concentrate on securing some form of stable accommodation first and then access mental health services that are close to that accommodation (Case note 29).

In the following example, a client turned down offers of accommodation and financial support, but eventually agreed to do an application for public housing:

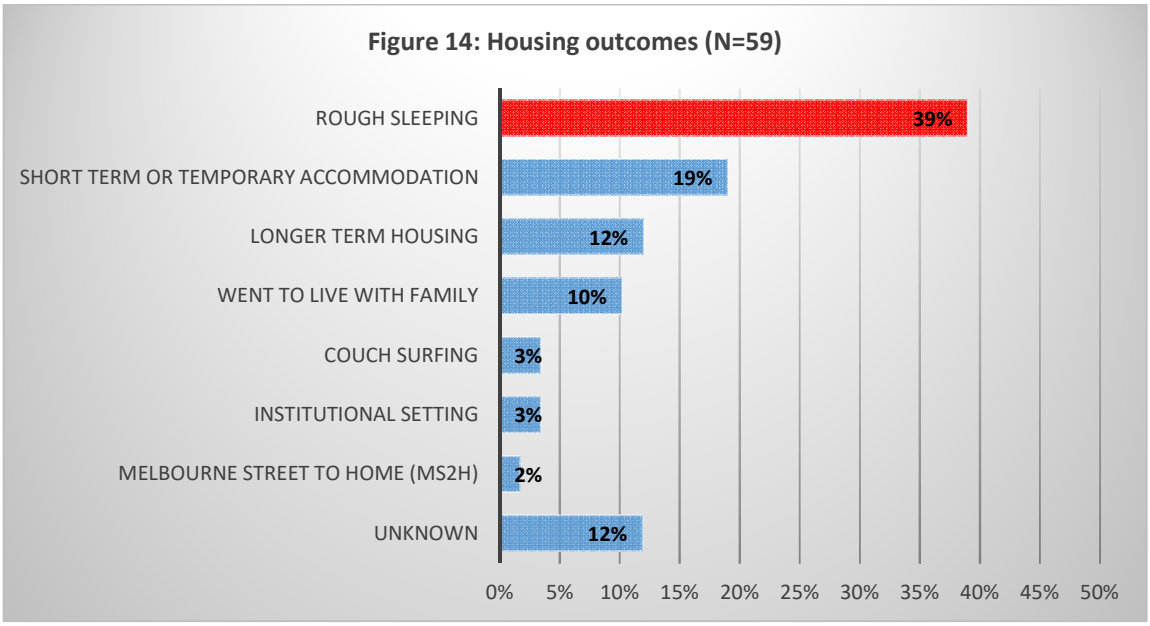
Discussed with [client] about a couples referral to crisis accommodation, however [client] reiterated that he does not want to consider this option, only private rental, as he does not want to 'get comfortable' somewhere that isn't permanent. [Client] stated that he has been looking for private rental…[Client] was advised of the assistance available (rent-in-advance, bond loan etc.)...[Client] declined financial assistance for rent-in-advance…[Partner] not keen but [client] agreed to do application for priority public housing (to be able to get access to son) (Case note 20).

9. Housing outcomes

In the main, after an average seven months of support, housing outcomes for the 59 people who slept rough in 2016 were poor (Figure 14), at the end of 2016:

- Almost two-in-five (39% or n=23) clients remained sleeping rough;
- A further one-in-four (22% or n=13) had only short-term or temporary accommodation (crisis accommodation 10%; hotel/motel 2%, rooming house 5%, transitional 2%) or couch surfing (3%);
- Six clients (10%) went to live with family; and
- In two cases, clients went into an institutional setting (one was admitted to hospital, another was incarcerated); but

- Only seven clients (12%) got into longer term housing such as public or community housing (10%) or private rental (2%); and
- For the whole 12 month period of 2016, only one person (2%) got into 'Melbourne Street to Home'; however, further analysis indicated that this outcome referred to a successful referral to the program in November 2016 with supported accommodation due to begin in 2017. In other words, despite the referral, the client was unable to be accommodated immediately.



Non-housing outcomes

As detailed earlier, the service access difficulties experienced by this client group, especially in terms of their health and wellbeing, meant that housing outcomes were severely constrained. This was, to a large extent, connected to the lack of stable and safe housing. Indeed, the lack of housing undermined attempts by services to support and refer clients to a range of mental health and drug and alcohol services.

The following excerpt underscores the significance of stable housing, especially in addressing serious physical and health issues:

> *Client had stable housing in his THM from 2014 to early 2016, during which time his mental health was stable. By April 2016, a combination of concurrent events prompted client to terminate his lease, including: relationship pressures, physical health – he needed surgery within 12 months of being diagnosed with kidney stones and bowel cancer; he had a significant amount of debt owing due to rental arrears on the property; he had drug and alcohol issues and wanted to enter longer term alcohol detox. When the client left his transitional property he stayed with his girlfriend for around 1.5 months; when the relationship broke down, he ended up sleeping rough sleeping. Client faced a great deal of pressure to then regain housing due to mental and physical health issues - his surgery could not be scheduled without him being in housing. All this pressure and stress*

affected his mental health, which had deteriorated as a result of homelessness (Case note 31).

In another case involving a young woman whose housing outcome was negative, a range of services were involved, and yet little was achieved to support her significant physical and mental health needs:

Client has been diagnosed with HIV and Hepatitis C but is not receiving treatment. Has experienced childhood trauma and was in foster care until the age of 19. Is re-traumatised through triggers in her current environment. Scored high on vulnerability index (has complex mental health issues, depression, and borderline personality disorder). Daily drug use to cope with life on the streets and to self-medicate for physical pain (back problems, dental needs). Client's general health has deteriorated over this time, despite numerous appointments made with GP and Royal Women's Hospital. Ongoing periods of periods sleeping rough and couch surfing, she has been in and out of hospital and has history of self-harm and suicidal ideation; but in 2015, the CAT team assessment put this as low risk. She has family support but difficult relationships due to mental health and drug use. Lots of services involved: mental health sector, alcohol and drug services, and legal – attempts to coordinate this support but integration difficult, particularly given different service rules and expectations. Numerous attempts by services to contact client have failed despite client being given a mobile. Many appointments missed, with a range of services (Case note 44).

Aspirations

Housing, health and family

Despite their complex and multiple hardships, this group of clients had hopes for the future. This is consistent with other studies that show that people experiencing homelessness have aspirations similar to all of us particularly in terms of accommodation[18].

Not surprisingly, housing was first and foremost (88%). Terms such as stable housing, long-term housing, public housing, and private rental were common as was reference to having one's own space. Many also wanted to address their health issues, including alcohol and drug use, or had expressed a desire to reconnect with children or other family as illustrated in the following:

To work on her mental health and to engage with [agency]; hopes to see her sons as they provide good motivation for her to engage with AOD supports and to try to stay sober. Client wants to be referred for AOD counselling and hopes to limit her alcohol consumption and continue her medication. Client wants to join a sewing group for her recreation; to get an operation to fix her sore knee; to engage with court supports and the Court Integrated Services Program (CISP) to be able to stay out of prison,

[18] Hanover Welfare Services (2008), *Hanover 2008 Annual Client Survey*, Hanover Welfare Services, Melbourne.

given her impending court hearing. Client wants to take out an Intervention Order against her partner. To have an MRI completed as she suspects she may have a brain injury as a result of previous physical assaults which may have affected her memory (Case note 26).

In some cases, notes also recorded client goals in relation to work or study:

Client goals are to obtain permanent or stable housing and to give back to the community by engaging with work that would be of service; he hoped to work with youth at risk of incarceration where he would be able to act in a mentoring capacity (Case note 15).

In another case, several goals were recorded:

Get off heroin. Get mentally stable. Get health routine. Get out of abnormal way of living, pay bills, rent and support self. Go to gym. Get tertiary education set up. Massage course and factory work…Client expressed desire to be linked with appropriate services to assist her in overcoming her housing barriers and recently has been proactive in finding a psychiatrist and engaging in other supports (Case note 40).

Delayed housing and support, and lost opportunities

The analysis showed that even when clients got housing, it was not necessarily possible to move in immediately. Instead, people were on waiting lists for housing as well as for other supports such as rehabilitation and mental health programs:

Client was hopeful that the process of accessing housing through the Council of [name] would be finalized within the new year as he had a positive meeting with their staff and successful property inspection in mid-December [2016]. Note recorded in April 2017 indicates client was still waiting for stable housing (Case note 28).

Client said that she has reached a stage in life where she would like to settle down and find her way yet requires stable and affordable accommodation to do this. Client receives DSP and has advised that she has struggled financially in the past when attempting to maintain private/shared accommodation; she would benefit from supported accommodation… With her relationship ending and the prolonged instability of her life, IAP form shows that client was at a turning point in her life and wanted to 'settle down and find her way'. But she was unable to be located during outreach and her file was eventually closed (Case note 46).

Where once clients may have been positive and hopeful, their experiences of the service system eventually left them despairing and weary:

There was a pattern of client presenting to [agency] when he was motivated to make change and then, due to there being no options on the day, he was unable to be assisted. When something came up later, client

was not contactable or had become despondent and declined the offer (Case note 1).

Segment 1 for Office of Housing done. Both RSI (Rough Sleeper Initiative) and MS2H (Melbourne Street to Home program) at capacity. Client would like to secure accommodation where he has his own space; he has shared with others in the past and his experiences have been bad. Client states that he is currently quite depressed and feels that housing will never eventuate for him. Client stated that he feels isolated due to his poor hearing. Suicide risk assessment completed: no plan or intent, only ideation (Case note 30).

Client was temporarily housed in [crisis accommodation]; may get longer-term housing with [agency], but client has said he has no motivation and feels 'like shit' most of the time (Cast note 31).

Client was evicted due to being in rental arrears; it is evident that clients housing needs are financially unsustainable and this is compounded by his ongoing financial difficulties which push him to rough sleeping, particularly when he was no longer eligible for Housing Establishment Fund. On top of this, client does not identify as having any family or friends, reporting that he has been alone for many years. Earlier in 2016, client expressed an interest in engaging with medication for his mental health. However, by the end of September, client had become somewhat resigned about his mental health prospects. When he was offered to reconnect with mental health support, he stated that it would be 'no use' (Case note 20).

10. Summary of key findings

Client profile

- The characteristics of the 59 sampled clients show that they are a highly disadvantaged and marginalised group. Mainly men on their own and in the middle age range (26 to 45 years), they had low levels of education and limited employment histories. They were either on the Disability Support Pension (46%) or on the NewStart Allowance, and nearly one-in-four (24%) were Indigenous;
- Some had family contact but nearly half (47%) were estranged;
- They had experienced long periods of homelessness, particularly sleeping rough, and had a history of incarceration and being in state care.

Complexity of need

- Tri-morbidity was pervasive, with the majority experiencing significant mental health difficulties (consistent with childhood trauma) and substance abuse problems as well as serious physical health problems;
- Cognitive impairment, as a result of head trauma and brain injuries, was common and impacted on day-to-day functioning and memory – many will need ongoing long-term support even when they are housed;

- Homelessness is a traumatic experiences and many of these needs were exacerbated as a result of sleeping rough;
- This means that for many, some of the physical and mental health issues could have been avoided, or perhaps minimised, if people had been able to obtain and sustain appropriate and affordable housing sooner;
- The significant multiple health issues that many people were facing, some as a result of rough sleeping, will require them to be in stable housing with ongoing health supports/services to ensure their survival;
- Without access to stable housing, extensive service and support efforts were undermined.

Structural issues – housing and income

- Very few people obtained or could be offered much beyond temporary accommodation;
- Cycling through short-term crisis or transitional accommodation is not an appropriate intervention for people who are rough sleepers, especially if they are long-term – the evidence shows that stability is crucial;
- The levels of income support trapped people in extreme poverty and ensured that they were excluded from the private rental market and had no option but to rely on public housing;
- Prevention is important. Many had received housing in the past – when it broke down, it was generally due to rent arrears, which highlights the critical role of prevention in terms of ensuring that people who face eviction due to rent arrears do not end up losing their home and becoming homeless.

Service system issues

- The intense efforts of initiatives like RSI are undermined by a service system response that struggles to meet increasing demand amidst a growing housing crisis;
- The housing crisis means that effective programs such as MS2H and supportive housing are seriously constrained in responding to rough sleeping; they are small programs unable to meet current levels of demand; as the evidence presented in this report showed, despite high levels of vulnerability, only one person was referred to MS2H and yet they were not able to access the program *immediately;*
- Evaluations of supportive housing such as Melbourne Street to Home (MS2H) have confirmed that this type of housing and support can improve outcomes for highly vulnerable rough sleepers;
- The service system is highly targeted to provide support to people enduring one of the most extreme forms of homelessness, rough sleeping. The irony, however, is that the system seems ill-equipped to deal with the complexities that clients present with (aggressive behaviour, significant levels of alcohol and drug use);
- The level of physical pain and psychological distress is astounding as is the level of brain injury, which affected day to day cognitive functioning; this impacted significantly on the ability of clients to deal with services, which was reflected in missed appointments with a range of services, as well as in the difficulty services had in contacting clients. Yet the service system applies a 'one size fits all' approach to expectation of client behaviour and capabilities – for example, that they can engage and attend appointments, be contactable, and can sort things out on their own. But they are not necessarily able to do so – the system seems to expect a certain level of functioning that for many has been beyond their capacity to fulfil, at least within the short-term and in the context of their harsh reality: thus not showing up for appointments is interpreted as lack of engagement, or not being interested, rather than the client's circumstances being overwhelming and, most likely, overshadowing the appointment they should have attended;
- Service rules and eligibility: There was a common theme of using up funding for emergency accommodation or HEF and therefore being ineligible for further support (usually for up to six months to one year) without a longer-term, or even medium-term, housing outcome;
- Engaging clients with highly complex needs – the window of opportunity to engage with clients is small, fragile and vanished quickly; it highlights the importance of an immediate response and the need for streamlined referrals into AOD services and mental health services – perhaps with priority service agreements like that used previously in the Homeless and Drug Dependency Trial.

Implications

Structural issues

- The success or otherwise of RSI and any broader response will be dependent upon the availability of permanent, affordable and supportive housing;
- Levels of income support are inadequate and exclude vulnerable people from accessing housing – with so many on NewStart Allowance, supporting clients to access private rental must be considered as a long-term undertaking that becomes possible only when independent financial circumstances have improved;
- Prevention of housing loss due to rent arrears is critically important.

System issues

- Longer term housing options need to be available so that people don't cycle through two week stays in hotels, crisis accommodation and the street over extended periods of time.
- Staff need caseloads that enable them to actively seek out clients and take them to appointments and advocate for them through service systems;
- There needs to be an emphasis on health and wellbeing, with particular regard to:
    - The extent of brain injury (due to assault or substance abuse) and the impact on cognitive functioning, making it extremely difficult for clients with a range of complex needs to engage with services;
    - Expectations around compliance and punitive responses (barring and eviction) if these are not met; and
    - The importance of a psychologically-informed response as a mechanism to deal with high levels of distress among clients with tri-morbidity;
- The acute and complex nature of client ill-health has implications for how services interact with this highly complex group. It underscores the importance of a specialised and tailored approach that is informed by a psychological and physiological model of care for as long as it is needed by the client, and not dictated by compliance and punishment;
- Support needs to be longer term and incorporate a recovery model of care;
- The use of HEF needs to be re-defined, focusing particularly on how it impacts on housing outcomes; 'complex care packages' with flexible funding offer a potential way forward, providing individuals with a two year period of assistance to access support and housing;
- Use the 'ALERT' tab in the client management system to ensure that clients are flagged as sleeping rough so they are not 'lost' as they are moved through the service system - in order to respond in a timely and appropriate way, with priority access to AOD and mental health services;
- An 'ALERT' is also needed to highlight housing applications made; while information recording in the client management system is extensive, the possibility of critical information being lost is high; the recording of applications for housing, or if offers of housing come through, tend to get buried in the detail recorded.

Research and evaluation

- Longitudinal monitoring and research of housing and non-housing outcomes;
- Monitoring of health and wellbeing.