

THE WINSTON CHURCHILL MEMORIAL TRUST OF AUSTRALIA

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2007 Churchill Fellow

**TO EXAMINE PROGRAMS THAT ASSIST VULNERABLE AND
COMPLEX CHRONICALLY HOMELESS PEOPLE**

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Signed: *Felicity Reynolds*

Dated: 31 January 2008

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APPENDIX 2

WEBSITE ADDRESSES FOR FURTHER INFORMATION ABOUT SOME PROJECTS AND INITIATIVES AND ORGANISATIONS VISITED DURING THE FELLOWSHIP.

Picture 1: A patchwork quilt made by some of the women who use the Adelaide Resource Centre for Women in Toronto, Canada.



1. INTRODUCTION

1.1 BACKGROUND

Although chronic homelessness represents a small share of the overall homeless population, chronically homeless people use up more than 50 percent of the services (for single homeless adults). The most successful model for housing people who experience chronic homelessness is permanent supportive housing using a Housing First approach.¹

'Chronic homelessness', not 'homelessness'

This is a report about chronic homelessness. This is not a report about homelessness. The difference is significant and important to clarify. Homelessness can happen to any one of us. Many people will experience an episode of homelessness in their lifetimes. It may be caused by a house fire, natural disaster, moving interstate, family breakdown, sudden unemployment or illness or other unexpected crisis. The vast majority of people who experience homelessness will only have a brief episode and it will occur only once. Some may remain so well connected to family and community that they may not even think of their experience as 'homelessness'. Chronic homelessness is different.

Definition of chronic homelessness

Chronic homelessness is defined as an episode of homelessness lasting 6 months or longer or multiple episodes of homelessness over a 12 month period or more. People who experience chronic homelessness are likely to have 'complex needs', which usually means that they have more than one of the following conditions:

- Developmental disability
- Traumatic brain injury
- Serious physical health problems
- History of abuse and/or trauma
- Mental illness
- Mental disorder
- Psychiatric disability
- Addictions (to alcohol and/or drugs)
- Literacy problems

Incidence of chronic homelessness: 15-25% of homeless population

People who experience chronic homelessness and who have complex needs are, thankfully, a small proportion of any homeless population. They are a small group, but a troubled and troubling group. Although some countries (eg. USA) may have a total population of homeless people that is significantly higher than some other countries (eg. Australia), many developed countries have a vulnerable and complex group of chronically homeless people that make up

¹ National Alliance to End Homelessness, Washington DC.

approximately 15 – 25% of the total homeless population in the country. Most recent statistics for the USA estimate the percentage of chronically homeless people in their total homeless population at 23%².

It is important to note that although absolute numbers of a total homeless population in any one developed country may vary, the percentage of that population who experience chronic homelessness appears to remain constant. 15 -25% of all people experiencing homelessness will be chronically homeless. This statistical fact provides a good clue to what is going on. Our service systems have been *consistently failing* to meet the needs of 15 – 25% of people who experience homelessness.

Overseas responses to chronic homelessness are relevant to Australia

This also gives a good clue to how we might fix the problem. Programs, successfully implemented elsewhere, to address chronic homelessness are wholly applicable to Australia. Although the numbers of homeless people differ across developed countries and the social security, housing, community and health systems may be quite different, we all have approximately the same percentage of chronically homeless people who have not been helped by those mainstream systems. Their (other countries) answers to chronic homelessness can also be our answers to chronic homelessness! There is little need for us, in Australia, to re-invent too many new wheels. In fact, some of the strategies and programs now in place in other parts of the world are frightening in their simplicity.

Many pathways into chronic homelessness, just the one pathway out

There are often many generalisations made about people who experience homelessness, especially those who are chronically homeless. All people have their own experiences and complexities, there is no one route into chronic homelessness. There is, however, only one route out: Housing. That housing needs to be accessible and affordable and will also need, in most instances, to be provided in conjunction with ongoing (and sometimes, significant) support services. Housing, by itself, is not often the single answer to chronic homelessness. None-the-less, the answers to chronic homelessness need not be complex.

Report and Recommendations on Fellowship Program

There are a number of national and local strategies and programs being implemented in a number of countries to improve responses to people who experience chronic homelessness. During October and November 2007, I visited a number of organisations in the USA, Canada and the UK who are involved in these initiatives. This is a report on my observations, which includes recommendations for further action in Australia.

² NAEH; Homelessness Counts, January 2007.

1.2 ACKNOWLEDGEMENTS

Thank you to the Winston Churchill Memorial Trust

I am most grateful to the Winston Churchill Memorial Trust for enabling me to investigate this topic and a range of service and strategic responses for chronically homeless people in the USA, Canada and the UK in 2007. Thank you to all the staff in the Trust office who were so helpful throughout. Thank you also to those NSW Committee members who gave freely of their time, advice and experience.

Thankyou to the City of Sydney

I would also like to thank the City of Sydney for allowing me the time and opportunity to undertake the Fellowship. Special thanks to the Council's CEO, Monica Barone, who has personally supported and encouraged me in my work and in pursuit of this Fellowship. Thanks also to Ann Hoban for her ongoing and generous support for my work.

Liz Giles, my homelessness colleague at the City of Sydney, knows that I continue to hold her in awe and value her advice, insights and ongoing support.

Thankyou to people in the USA, Canada and the UK

I would also like to convey my very special thanks to the following people and organisations who planned and co-ordinated my itinerary of visits and meetings in all the cities I visited:

Rosanne Haggerty – Common Ground, New York, USA
 Kat Johnson – Common Ground, New York, USA
 David Gardner Zega – City of Philadelphia, USA
 Michele Mangan – City of Philadelphia, USA
 Nan Roman – National Alliance to End Homelessness, Washington DC, USA
 Webb Lyons – National Alliance to End Homelessness, Washington DC, USA
 Andre Alves – City of Toronto, Canada
 Sonia Zyvatkauskas – City of Toronto, Canada
 Colin Robinson - London, UK

Minimising intrusion into people's personal lives

Throughout my travels I was very conscious that the majority of services I visited were the 'homes' (in some instances), 'shelters' (in other instances) or 'places of safety or connectedness' for a number of people. I tried at all times to keep my intrusion into these places and spaces as minimal as possible. I am conscious that well meant efforts to not disrupt or intrude don't always work and that a stranger wandering through someone's place of residence cannot, by definition, be totally disruption free. I'd like to thank all those people, in whose spaces I visited, for the opportunity to do so. I would also like to acknowledge and apologise if my tour of some facilities served to sometimes remind people of the limited control they had over their personal space and living environment.

No photographs of service users or personal spaces

During my visits I did not request to enter anyone's private room or living area. This did happen on occasions, but only with permission from the people who used that space and organised in advance by consultation. I was able to see some client rooms and units in some services, but this was done when those rooms were not being used and were temporarily vacant. I did not take photographs of service users or of private or personal spaces that were being used. With permission from service managers, I took some photographs of general areas, hallways, office spaces, group rooms and the exterior of buildings.

Thank you to all those who met with me (more than 80 people), who showed me around their services, described their policy and programs, answered my questions and gave me the very precious gift of their time, their expertise and their experience. A complete list of people with whom I met is contained in Appendix 1.

1.3 OUTLINE OF REPORT

This report is not written as a chronological description of my visits to homelessness policy makers and homelessness services. It is divided into eight key themes which all shed some light on the primary objectives of the study.

In this way, the report has lessons and recommendations for Australian policy makers at all levels of government, as well as for organisations who provide health, homelessness and other community services. It also has information and suggestions for those people who experience chronic homelessness as well as for those who may work directly with them.

Picture 2: A corridor at 'Ready, Willing and Able', Harlem, The Doe Fund, New York, USA.



2. EXECUTIVE SUMMARY

People who are chronically homeless usually have multiple disabilities

People who experience chronic homelessness commonly have multiple disabilities and a history of trauma. It is estimated that people who are chronically homeless may make up 15-25% of any homeless population in developed countries.

We can agree to end chronic homelessness

As a community, we can agree to put an end to chronic homelessness. It is unacceptable in a developed and wealthy nation such as Australia.

Chronic homelessness can be expensive – high cost of crisis services

Chronic homelessness is also economically irresponsible. It costs significant amounts to sustain someone in a state of chronic homelessness. Use of crisis services, emergency departments, acute hospital admissions, mental health assessments, detoxification centres as well as police responses, ambulances, court and prison costs all add to the total cost and tragedy of chronic homelessness.

More cost effective to provide affordable housing and ongoing support

Research has shown that it can cost the same amount or less to provide people with suitable housing and good support to sustain that housing as it does to provide crisis services (such as those noted above).

Homelessness is about social exclusion, not just housing

Chronic homelessness is not just about a lack of shelter or housing. It is about disconnectedness from others in the community and about social exclusion. These issues must be addressed in tandem with housing solutions.

Need a plan to end chronic homelessness

To end chronic homelessness there must be a plan to end chronic homelessness. There also needs to be national, state and local leadership and direction.

British government reduced chronic homelessness by two thirds

The British government implemented a plan to reduce street homelessness by two thirds in 1998. They achieved that goal by 2002.

USA has so far reduced chronic homelessness by 12%

The United States is currently encouraging cities and other local communities to develop 10 year plans to end homelessness. To date, chronic homelessness has been reduced by 12% across the nation.

Need to count chronically homeless population

If it is decided to try to end chronic homelessness then the extent of the homeless population in a community must be enumerated. This is so that any progress towards that goal can be measured.

Accurately counting people who are street homeless is difficult, but can be done

Counting unsheltered homeless people is difficult. All methodologies have been criticised. However, there is now sufficient experience and evidence to perform a fairly satisfactory minimum count of publicly homeless people in any local government area.

Homeless people want permanent housing

A 2006 survey from Toronto in Canada found that almost 90% of all street homeless people interviewed said what they wanted was 'permanent housing'.

Change and leadership is needed

Champions and change agents in addressing homelessness carry out and promote effective, evidence based actions. They are generally very good communicators and share their knowledge and experience with others. They create and promote new ways of working and develop new services. They fully understand the link between the lack of affordable, supportive housing and chronic homelessness.

Good evidence that housing with support works well for formerly chronically homeless people

'Housing First' works. People with complex needs, including substance abuse and mental illness can move straight from the streets into housing. Most will require good support services to sustain that housing. People do not have to be deemed 'housing ready'. Housing First should become the dominant model for assisting chronically homeless individuals.

Housing stability promotes better health as well as other outcomes

Many people who are housed through a Housing First program will be able to attain greater stability and be in a better position to better tackle other problems, such as mental illness once they are housed. Anecdotal reports from some service workers are that a few of the people who look 'vulnerable and complex' while homeless on the street, look a lot less vulnerable and complex once they have stable housing and support.

Need good supply of affordable housing

For Housing First to work properly in any community there must be a good supply of affordable housing options. All levels of Government need to ensure they have strategies in place to ensure the availability of affordable housing. Affordable housing strategies and supply also help to prevent homelessness.

Street outreach with purpose and real options

Good street outreach is carried out using evidence based principles and building on the success of work done by other outreach programs. Whilst outreach is about relationship building with homeless people, this must be done with purpose and the availability of real service or housing options for people.

Harm minimisation

There is a solid place in the service spectrum for some small congregate care models and harm minimisation services. 'Safe havens' are a good example of a long term housing option in a supervised environment that has flexibility and minimal rules for those people who may prefer that as a long term option.

Supervised drinking residential services work for chronically homeless street drinkers

Seaton House Annex in Toronto is an innovative and highly successful example of a harm minimisation residential model for chronically homeless street drinkers. As a managed and supervised residential drinking program it has been highly effective.

Really good staff are essential

The best services have the best workers. Staff matter. These services have a culture of respect and inclusion.

Consumer involvement and empowerment

Good services actively involve consumers in management and service direction.

Moving on to mainstream services

Once formerly chronically homeless people have been housed and supported and achieve stability they should be actively encouraged to use mainstream services and leave the 'homelessness services sector' behind.

High rates of brain injury in the chronically homeless population

New research and observations by homelessness workers is indicating that the incidence of traumatic brain injury (TBI) in the chronically homeless population may be extremely high. TBI (usually known as acquired brain injury in Australia) can effect an individual's executive functions, memory and impulse control. People who work with the chronically homeless should take account of this and work in ways that may help compensate for these deficits and behavioural difficulties.

3. FELLOWSHIP PROGRAMⁱ

17 – 29 October, New York, USA

- Common Ground
 - The Prince George (Supported and Affordable Housing)
 - Street to Home Outreach (Street Outreach)
 - The Times Square (Supported and Affordable Housing)
 - Hospital to Home Program
 - Court to Home Program
 - Psychiatric Services
 - The Christopher (Supported and Affordable Housing)
 - Scattersite (Supported Housing)
- The Doe Fund
 - Harlem Center for Opportunity
 - Brooklyn Transitional Shelter
- New York City - Department of Homeless Services
- The Center for Urban Community Services
- Pathways to Housing
- Volunteers of America
 - Clarke Thomas Single Male Shelter
- The Children's Aid Society
 - Milbank Family Shelter

30 October – 3 November, Philadelphia, USA

- Project HOME
 - Policy and operations
 - Outreach co-ordination
 - St Columba 'Safe Haven' for men
 - Women of Change 'Safe Haven' for women
- City of Philadelphia
 - Office of Supportive Housing
 - Department of Behavioural Health
- University of Pennsylvania – Social Policy and Practice
- Horizon House

- Operations of Homelessness services
- SPOT outreach team

4 – 10 November, Washington DC, USA

- National Alliance to End Homelessness
- Office of Senator Jack Reed (Rhode Island) – Legal Counsel and Senior Policy Advisor
- United States Senate Committee on Banking, Housing and Urban Affairs – Senior Professional Staff Member
- District of Columbia Government
 - Office of the City Administrator
 - Department of Mental Health
- US Department of Housing and Urban Development - Press conference on the reduction of chronic homelessness in the USA
- National Alliance to End Homelessness – Press conference at the National Press Club on the high number of veterans in the homeless population
- Window of Opportunity – Preserving Affordable Rental Housing: MacArthur Foundation Policy Forum
- Corporation for Supportive Housing - Supportive Housing Leadership Forum
- United States Interagency Council on Homelessness

11 – 16 November, Toronto, Canada

- Toronto City Council - Shelter, Support and Housing Administration (SSHA)
 - Social Housing
 - Hostel Services
 - Housing and Homelessness Supports and Initiatives
- Fred Victor Centre
- Ecuhome – Supportive Housing
- LOFT – Supportive Housing
- Parkdale Activity Recreation Centre (PARC)
 - Programs overview
 - PARC Community Ambassador Project
- Streets to Homes – Outreach service

- Overview - Policy, operations and outcomes
- Transition to Work Pilot Project
- Data collection and management

- Toronto North Support Services – Mental Health and Street Outreach

- Furniture Bank

- John Howard Society

- Seaton House and Seaton House Annex

- Adelaide Resource Centre for Women

- Bellwoods House

17 – 22 November, London, UK

- The Passage

- Broadway Homeless Services

- Westminster City Council

4. REPORT

4.1 VISION: WE MUST PLAN TO END CHRONIC HOMELESSNESS

"If good intentions, well meaning programs, and humanitarian gestures could end homelessness, it would be history by now. Since they don't, it is time to do something different, something that solves the problem, not services the disgrace."³

Reactive response to chronic homelessness

In most developed countries, including Australia, homelessness service provision has grown in response to the problem and tended to address the immediate or crisis needs of people. There has been less strategic development of systems that have anticipated ending chronic homelessness. In fact, the very notion that we could achieve such a goal remains almost as crazy as the Prime Ministerial notion that *"By 1990, no child will be living in poverty"* (Bob Hawke, 1987).

Planning to end chronic homelessness

However, trying to end chronic homelessness is no longer a crazy notion in the USA or Canada. Over the past few years, numerous cities (more than 300) have developed action plans and services and made affordable housing available which aims to do precisely that. Those city leaders have made the decision that they need not tolerate any level of chronic homelessness within their communities. They have decided to stop *'servicing it and begin solving it'*⁴.

Those city leaders no longer want to see their fellow citizens fed in parks, much like sea gulls. They no longer want to provide long term housing in crisis shelters, they don't want to see chronic alcoholics freeze to death on their streets or find people with psychiatric disability sheltered in hospital emergency departments or prisons. They have agreed that they want to try to put an end to chronic homelessness.

Measurable reduction in chronic homelessness

And these action plans to end chronic homelessness are working! Cities, such as New York, Philadelphia, Denver and Seattle in the USA, Toronto in Canada and London in the UK are seeing the results of their work. Better still, formerly chronically homeless people are living in houses and apartments, many of them with the assistance of ongoing support services.

Previously chronically homeless people with multiple problems are now sustaining tenancies. Across the USA, chronic homelessness has been reduced by 12%, with this achievement clearly measured (see later in this section a description of count methodologies). During my week in Washington DC, the

³ Philip Mangano, Executive Director, United States Interagency Council on Homelessness. Statement made to the author in an interview on 9 November 2007.

⁴ Philip Mangano, Executive Director, United States Interagency Council on Homelessness. From a conversation with the author on 9 November 2007

Department of Housing and Urban Development (HUD) held a press conference, which I attended, highlighting this important achievement.

Britain, which has a longer history of trying to reduce chronic homelessness, reported a two thirds reduction in rough sleepers (street homeless) between 1998 and 2001. In 2007, the British government reports that the number of rough sleepers in England is now about 500 people, a 73% reduction from the baseline figure identified in 1998.

It is clear that much can be achieved, when the goal is identified and a strategy is put in place to do it!

Paradigm shift

A report prepared for the U.S. Department of Housing and Urban Development, titled '*Strategies for reducing chronic street homelessness*' refers to the 'paradigm shift' that is required by communities in improving responses to street homelessness: "*The essential recognition underlying the paradigm shifts we observed was that existing approaches and homeless assistance networks were not reducing or ending homelessness, particularly chronic or street homelessness.*"⁵ The report goes on to clarify: "*The old paradigm was that street homeless individuals should be cared for more by charitable, often religious, organizations rather than by mainstream public agencies. The old paradigm relied heavily on emergency shelters, transitional housing, and sobriety-based programs. The old paradigm did not plan, or expect, to end chronic street homelessness.*"⁶

This same report, which was a study of strategies adopted in a number of cities in the USA, concludes that there are 11 key elements to successfully reducing chronic homelessness. The first five of these (shaded area) are considered essential elements of success. These are:

- Paradigm shift
- Clear goal set
- Community wide approach
- Organisational structure and leadership specifically for reducing chronic street homelessness
- Mainstream agency involvement
- Trigger event
- Private sector involvement
- Local elected official commitment
- Progress tracking mechanism
- New approaches to services
- Strategy to combat NIMBY (Not in my back yard)

⁵ HUD, '*Strategies for reducing chronic street homelessness*', Final Report, January 2004, page xv

⁶ HUD, '*Strategies for reducing chronic street homelessness*', Final Report, January 2004, page xv

Key components of plans to end homelessness

I spent a lot of time in Washington DC speaking with the CEO and other staff of the National Alliance to End Homelessness (NAEH). That organisation has done much over recent years to research homelessness issues and inform policy and service organisations of the need to plan to end homelessness. The NAEH recommends that the following components be included in any strategy to address homelessness.

1. **Plan** (envision and plan to end chronic homelessness)
2. **Data** (measure outcomes; be accountable for your services and actions)
3. **Emergency prevention** (close the front door)
4. **Systems prevention** (close the front door)
5. **Outreach** (open the back door)
6. **Shorten homelessness** (open the back door)
7. **Rapid re-housing** (open the back door)
8. **Services** (sustain)
9. **Permanent housing** (sustain)
10. **Income** (sustain)

Philip Mangano, Executive Director of the United States Interagency Council on Homelessness, identifies 10 elements that make 10 year plans truly 'great'⁷:

Disciplined People

1. *Political/Community Will*
2. *Partnerships*
3. *Consumer-Centric Solutions*

Disciplined Thought

4. *Business Plan*
5. *Budget Implications*
6. *Prevention AND Intervention*
7. *Innovative Ideas*

Disciplined Action

8. *Implementation Team*
9. *Broad-Based Resources*
10. *Living Documents*

New York City – Uniting for Solutions Beyond Shelter

In 2004, the Mayor of NYC put in place a 5 year plan to end chronic homelessness. The plan itself deals with more than chronic street homelessness; it also addresses issues to do with long term shelter use and access to public benefits that are more uniquely American, rather than Australian, problems. None-the-less the plan is a comprehensive one and one of the primary reasons I visited NYC during my Fellowship.

⁷ Ideas from Jim Collins' book 'Good to Great'.

Nothing would concentrate your mind on the problem at hand more than the large digital numerical display I spotted in the New York City Homeless Commissioner's meeting room when I met with him on 19 October 2007. Every day the display went down by one. It was indicating the number of days remaining before the commitment that was made to reduce street homelessness by two thirds by 2009 would be up. As I write this report in January 2008, I'm guessing that the display today reads '339 days'.

They are certainly making progress in NYC. The Homeless Commissioner has put in place a range of new and re-designed initiatives. Some of these programs and models are discussed in more detail in later sections of this report (4.2, 4.3, 4.5, 4.6, and 4.7). The NYC plan is based on the following 9 objectives.

1. Overcome Street Homelessness

Challenge: While major progress has been made in reducing street homelessness in New York City, several thousand individuals remain on the streets and in other public spaces.

2. Prevent Homelessness

Challenge: Thousands of individuals and families enter shelter each year without receiving homeless prevention assistance that might have saved or stabilized existing housing.

3. Coordinate Discharge Planning

Challenge: Many people enter shelter immediately or shortly after leaving correctional facilities, hospitals, or other institutional settings. For many of these at-risk populations, stable housing is key to recovery and/or successful integration back into their communities.

4. Coordinate City Services and Benefits

Challenge: By the time many individuals and families reach out for shelter, they have had extensive histories with other social service agencies and providers. Often, these agencies and providers do not share information, and some people are unaware of their eligibility for benefits that could provide critical assistance.

5. Minimize Disruption to Homeless Families and Children

Challenge: Families currently apply for shelter at the Emergency Assistance Unit in the Bronx. Dramatic increases in the numbers of families served in the office, as well as band-aid style efforts to ensure a workable intake process, have created difficulties for families and staff alike. Staff's ability to effectively assess and address the needs of families in this environment is challenged.

6. Minimize Duration of Homelessness

Challenge: Too many individuals and families remain in shelter for extended periods of time. In fact, the average family today spends nearly a year in shelter. Sixteen percent of the single adult population uses 50% of all of the resources.

7. Shift Resources into Preferred Solutions

Challenge: Despite the fact that shelters do not solve homelessness, a tremendous amount of resources are devoted today to supporting an extensive shelter network. Opportunities to shift these resources to interventions that solve homelessness, such as prevention, supportive housing, and rental assistance programs, are not maximized.

8. Provide Resources for Vulnerable Populations to Access and Afford Housing

Challenge: The City of New York is experiencing a profound shortage of available affordable housing. The demand for supportive and service-enriched housing for chronically homeless individuals, as well as rental assistance for at-risk populations, exceeds supply.

9. Measure Progress, Evaluate Success, and Invest in Continuous Improvement

Challenge: The city's approach to helping homeless people has been well resourced, but has not always benefited from quality improvement efforts based on data and emerging research.

Other homelessness plans

Canada and England have also put in place initiatives to end or to reduce chronic homelessness. I witnessed this first hand when I visited Toronto and saw their excellent use of outreach services (see section 4.6) and of Housing First (4.5) and some very impressive harm minimisation programs (4.7).

England – Plan to reduce rough sleeping by two thirds

England is an interesting example because their strategy to address chronic homelessness has a longer history than those in Canada and the USA. In 1998 the Blair Government announced a new initiative '*Coming in from the cold: The Government's strategy on rough sleeping*'.

In the foreword to that document, the Prime Minister wrote: "*On the eve of the 21st century, it is a scandal that there are still people sleeping rough on our streets. This is not a situation that we can continue to tolerate in a modern and civilised society. That is why, in a report last year by the Social Exclusion Unit, I set the tough but achievable target of reducing rough sleeping in England by at least two thirds by 2002*"⁸.

England's plan – 6 key principles

Whilst the British plan was not quite as ambitious as the plans to 'end chronic homelessness' in some North American cities, it was certainly ambitious. To reduce 'rough sleeping' by two thirds within a few years was a major objective. That plan cited six key principles. These were:

1. Tackle the root causes of rough sleeping.

We need to understand what causes people to sleep rough, and prevent it from happening.

2. Pursue approaches which help people off the streets, and reject those which sustain a street lifestyle.

Our aim is to reduce the numbers of rough sleepers, and to do everything in our power to persuade people to come in for help.

3. Focus on those most in need.

We want this strategy to help those whom other initiatives have failed. There is not

⁸ Coming in from the Cold, UK – Foreword by the Prime Minister, Tony Blair.

a bottomless pool of resources, and it is crucial therefore that we target our help on those who are least able to help themselves.

4. Never give up on the most vulnerable.

It is inevitable that some rough sleepers, especially those who have been on the streets for many years, will have difficulty in coming back in. They will need specialist help and support if they are to succeed.

5. Help rough sleepers to become active members of the community.

We need innovative and pragmatic approaches which build self-esteem, bring on talents, and help individuals to become ready for work and occupation away from the streets.

6. Be realistic about what we can offer those who are capable of helping themselves.⁹

We should be using our resources to help the most vulnerable and not to provide a fast track into permanent housing for healthy and able individuals.

It is interesting that the objective of the plan was to reduce street homelessness by two thirds and not to end it completely. Perhaps both the New Yorkers and the British were trying to be more realistic about what can reasonably be achieved in a few years. I think they may be right about that. However, I am of the view that a better plan, for both ethical and strategic reasons, may be to draw a very clear line in the sand and publicly announce that chronic street homelessness is unacceptable and must end. It is not something that a developed and wealthy country needs to expect or accept.

What happened in England?

In a progress report published in 2000 on the Government plan, it was reported that the goal of reducing rough sleeping by one tenth had been met by December 1999¹⁰. By 2001 the goal of reducing it by two thirds had been met, a year ahead of schedule. Very well done to our English friends! But, how did they know? The next section (4.2) of this report looks the issue of counting people who are chronically homeless.

A brief summary of the Australian response to chronic homelessness

In order to better understand how the strategic and policy lessons from the northern hemisphere might be applied to the Australian situation it is important to have a better understanding of what has been going on in Australia for the past 30 years or so to address chronic homelessness.

The response to chronic homelessness in Australia has mostly been a compassionate and charitable one provided by non-government organisations to people in great need. These have been important contributions and have helped meet the needs of many people, but it is now very clear that this response, by itself, has not been able to end chronic homelessness. Australia wasn't alone; exactly the same responses were made in other developed countries.

⁹ Coming in from the Cold: The Government's strategy on rough sleeping, 1998 UK

¹⁰ Coming in from the cold: A progress report (Summer 2000), UK

It has been clear for quite some time that the Federal, State and Local programs and services in place to address homelessness have made little lasting impact on the 15-25% of the homeless population, with multiple problems and disability, who continue to experience or cycle in and out of chronic homelessness. It is important to remember, however, that they are usually effective for the majority (75-85%) of people who experience (non-chronic) homelessness.

Supported Accommodation Assistance Program

The Supported Accommodation Assistance Program (SAAP), the primary funding program (a joint Commonwealth/State program) for homelessness services in Australia was neither established for the purpose, nor provided with the capacity to end chronic homelessness. SAAP residential services generally have great difficulty assisting people with multiple problems such as behavioural disturbances, mental illness, brain damage and/or addiction problems. SAAP services are commonly provided as short term (or crisis) 'congregate' care services and this type of program model is not as well designed to meet the multi-dimensional or long term needs of people with multiple needs. More often than not, in Australia, chronically homeless people either end up cycling through SAAP services, boarding houses or living semi-permanently on the streets.

People who are homeless want housing

As someone who works in the homelessness sector in Australia, one of the biggest myths I come across day after day is the very widely held belief that people who are chronically homeless want to be and to stay that way. This myth appears to be widely held by the general community and sometimes also by some people who work in the homelessness and community services sectors.

However, if you ask chronically homeless people what they want, invariably and more commonly than not, they will tell you they want a permanent place to live. In fact, the Toronto Streets to Homes team reported to me that in their street 'needs assessment', undertaken in conjunction with their street count, this was the most frequently stated need (by almost 90% of people).

Myths about chronically homeless people

I think the myth about chronically homeless people not wanting to leave the streets persists for a number of reasons. Pathways into longer term housing or other supported accommodation are often made via a crisis or transitional accommodation arrangement and some homeless people choose not to access crisis or transitional accommodation arrangements for a range of reasons (which might include; not wanting to separate from their pet or not wanting to live in a congregate care environment). Some homeless people may not be able to access crisis or transitional accommodation arrangements for a range of reasons (which might include; not meeting assessment criteria, behavioural problems or no vacancies).¹¹

¹¹ NDCA Needs Not Met SAAP Reports – 2000 - 2004

There are a few chronically homeless people who may genuinely prefer a transient street life or who have adapted, over time, to a life on the streets. There is certainly good evidence to suggest that the longer someone remains street homeless, the more entrenched they will become and the greater likelihood they will remain homeless. During my Fellowship program, I met a number of people who cited examples of this. Most outreach workers as well as supportive housing providers are familiar with people who have developed street skills and connections and find it difficult to leave a way of life to which they have adapted over many years.

Myths about homelessness and the closure of psychiatric institutions

The other commonly believed myth about chronically homeless people is that they are all mentally ill and are on the streets as a result of a 'misguided government policy that closed all the mental institutions in the 1970s and 1980s'.

The large mental institutions were not closed overnight and as the result of government edict (although it was governments who did ultimately close them). Psychiatric practice and treatment had already changed by the 70s and 80s. People were already being discharged from institutions or not being kept in hospitals for long periods. This was primarily the result of the development of effective medications for the treatment of psychotic and depressive illnesses (which occurred from the late 1950s). Even if the large institutions had kept their doors open, they would likely be almost empty today. A few people may still require longer term 24 hour care in hospitals (often because medications may not work for them), but not very many. The great majority of people with a mental illness are, with the right treatment and support, able to live in the community.

Whilst a high number of chronically homeless people may have a diagnosed mental illness (as well as other conditions) this does not mean that a large institution is the answer to their homelessness. Adequate housing and appropriate support is the answer.

Currently limited options for people who are chronically homeless

In Australia at present there are limited opportunities¹² for chronically street homeless people with multiple needs to move directly from the streets into a permanent, affordable and supported house or unit.

A plan for Australia to end chronic homelessness?

I believe that there is great scope within Australia to develop Federal, State and Local plans to end chronic homelessness. It may not even require any extra funding, but perhaps a re-configuration of funds that are currently available to provide support to people who are chronically homeless. It will, however, require much closer links with affordable and public housing. Along with good,

¹² There are a few notable projects. For example: Adelaide's development of a Common Ground model; City of Sydney and NSW Department of Community Services, Chronic and Complex Co-ordinated Needs Project.

direct support to people, the provision of adequate and affordable housing throughout the country will be crucial to trying to end chronic homelessness.

Such plans for Australia will also require a good understanding of what has and hasn't worked in other parts of the world. I don't believe that we need to re-invent any new wheels.

NEWS FLASH NEWS FLASH NEWS FLASH NEWS FLASH

As I write this report, the Australian Prime Minister has announced his intention for the government to tackle homelessness. The following is an excerpt from the Sydney Morning Herald on Monday 28 January 2008:

"KEVIN RUDD has declared a 10-year effort to tackle homelessness, warning that the problem is getting worse despite the nation's soaring wealth.

The Prime Minister said yesterday the Government's first white paper will be a policy document canvassing long-term options to reduce the growing number of homeless. About 100,000 people a night are homeless, including 10,000 children under age 12 who are forced to sleep outside or in crisis accommodation, boarding houses or with family and friends.

"We don't believe it is something which a country as wealthy as ours in the 21st century can just ignore," Mr Rudd said.

"It is dead wrong that ... on any given night some 14,000 people are sleeping rough. We should not be allowing this to happen."

Mr Rudd said Labor would fulfil its election pledge to spend \$150 million on new places in crisis shelters and will use the white paper to fund further policies aimed at prevention, such as tackling mental health and education problems. It will be overseen by one of the country's most experienced welfare advocates, Tony Nicholson, and is to be completed by August.

"I don't want to live in a country where we simply discard people," Mr Rudd said. "I don't want to live in a country where we accept people begging on the streets is somehow acceptable to the Australian way of life ... We are not like that." (SMH, 28/1/08)

4.2 COUNTING PEOPLE WHO ARE STREET HOMELESS: MEASURING THE SUCCESS OF PLANS AND PROGRAMS

Homelessness enumeration methodologies were never questioned when the numbers kept going up.¹³

A very important element of what has been happening in the United States, in Toronto and in England is the imperative to measure outcomes and progress towards the goal of ending or reducing street homelessness. You cannot state such an objective unless you are willing and able to measure it.

Difficulty counting people who are homeless

Most people who don't work in the sector or who know little about homelessness seem to think that counting homeless people is a simple matter. It is not. I have assumed that most people must think it a mere trifling; otherwise they wouldn't keep asking me "how many people are homeless?"

Invariably, this is the first question I am asked whenever I tell a new acquaintance that I work in the homelessness field. Sometimes I just feel like saying "too many". But usually I end up asking them a few questions, such as: Which ones? The people staying in homelessness hostels or the women's or the youth refuges? The people on the street? The people staying with friends? The people sleeping in cars? The people in squats? The people in temporary hotel accommodation?

Does it matter how many homeless people there are?

I have long been curious about this question, "How many people are homeless?" I'm sure that when people say they are a doctor or a nurse, the first question asked of them is not, "How many people are sick?" I'm sure Town Planners aren't asked, "How many people submit development applications?" So, why can people be obsessed with the number of homeless people? And why do so many people think it must be a fairly simple process to count them?

I'm guessing that the interest in the number of homeless people may be motivated by two factors. The first factor relates to a basic assumption behind the question. That is; that there is a 'permanent population' of homeless people. There isn't. As previously noted, for the majority of people it will be a very temporary experience. The second reason for people's interest, I think, is from a sense of care and compassion. That by understanding that there are a lot of homeless people is to also understand that we, as a community, are not doing enough to help very disadvantaged people. But, surely, any number of homeless people is a problem for us? Does it really matter how many there are?

It certainly does matter how many there are if we have a goal and a plan to reduce or end homelessness, because we won't know if our plans and programs

¹³ Philip Mangano, Executive Director, United States Interagency Council on Homelessness. From a conversation with the author on 9 November 2007

are successful if we don't have a baseline figure which is followed up with subsequent counts.

How many people are homeless in Australia?

The accepted estimated homeless figure for Australia hovers around the 100,000 mark at the moment. This statistic has been estimated based on the 2001 Australian census. It is also estimated that about 12% of the total homeless population (about 12,000 individuals) were experiencing 'primary' (or street) homelessness at the time of that census¹⁴. A new figure, based on the 2006 census, should be available soon.

Approximately 1 in 126 Australians received assistance from the Supported Accommodation Assistance Program in 2005-06¹⁵. It is important to note that by the very definition of 'street homeless' the group that I am referring to in this report may not have been included in that SAAP figure (although some may also have accessed SAAP services).

Examples of street count methodologies from three cities

Understanding how many street homeless (or rough sleeping) homeless individuals there are in any given area is difficult. However, Australia now has the benefit of the experience and methodologies used in a number of cities in the USA, Canada and the UK. The following are just three examples.

New York City – Homeless Outreach Population Estimate (HOPE)

NYC has been counting its 'unsheltered' homeless population (that includes streets, parks and the subway) since 2003. It also counts its 'sheltered' homeless population and a daily census of the homeless population in services in NYC is available on the NYC Homeless Department website.

There were some methodological changes to the count, as well as areas counted, between the 2003 and 2004 counts. In 2005, a final methodology seems to have been settled and it is the count from this year which is being taken as the baseline figure for the commitment to reduce it by two thirds by 2009.

All boroughs are included in the count. That is: Manhattan, Brooklyn, Staten Island, Bronx and Queens. They also do a 'subway' count of homeless people found throughout the NYC subway system.

Unsheltered adults in NYC since 2005

The following are the totals of 'unsheltered adults' on one night for each of the 3 years to date. The 2008 count is taking place on January 30, 2008.

- 2005 – 4,395 (Baseline)
- 2006 – 3,843
- 2007 – 3,755

¹⁴ AIHW, Australia's Welfare: Chapter 6 - The dynamics of homelessness, 2007, p.277 (from Chamberlain and MacKenzie: 'Counting the Homeless, 2003).

¹⁵ AIHW, Australia's Welfare: Chapter 6 - The dynamics of homelessness, 2007, p. 259

The methodology involves dividing NYC into small grids (which if you know NYC, you'll know this is very easy to do – it is just one big grid!). Thousands of volunteers are recruited to count homeless people within each sample area (they are seeking 2500 volunteers for the 2008 count). All areas in NYC that are likely to have homeless people are counted. However, only a sample of other areas, those areas that are less likely to have homeless people, are counted.

The NYC 'Shadow count'

The very neat statistical trick that they use to make the count quite robust is to also recruit a large number 'decoys' (200 for the 2008 count) for what they term the 'shadow count'. On the night of the count these 'decoys' place themselves in locations throughout NYC and are told to make themselves known to any 'counters' if they are approached. Depending on the percentage of 'decoys' that are found, an extrapolation of homeless people that may have been missed in the count can then be made.

Criticisms of NYC methodology

None-the-less, the NYC count, like most other street counts I've researched, has been criticised. Some critics argue that the statistical methods aren't right, some say the sampling of areas is wrong and some have said that the processes for carrying out the count are flawed. I think this helps to exemplify the very real problems associated with trying to understand the extent of street homelessness within any city.

Toronto – Street Needs Assessment

The City of Toronto has also had its share of detractors regarding its April 2006 'Street Needs Assessment'. However, I think the decision to attempt such a large needs assessment study, whilst doing a count of the homeless was a valid one. The results of their survey have helped to inform the community, not only about numbers but also about the identified needs of people who are homeless. They certainly helped end that myth that street homeless people 'want to be homeless', with the very clear result that almost 90% of all those surveyed stated that they wanted permanent housing!

On the one day, they surveyed people in shelters, on streets and parks and a sample in health or treatment facilities and correctional facilities. They used more than 1200 people (including over 700 volunteers). They also adopted the NYC 'decoy' system to assist with statistical extrapolation, given that not all areas of Toronto could be counted. A complete census, however, was done in the central area of the city. The survey and count was done between 8.30pm and midnight. Some areas were not completed until after 3am.

For street survey they divided Toronto into 422 'study areas' (areas of roughly equal size, no bigger than 2 kms). From these they chose 261 areas (62%) to survey. Homeless people who agreed to answer the survey were given \$5 vouchers for fast food restaurants.

The results were that 5052 homeless people were counted in Toronto, 818 on the street (or other public locations). More than 3000 people were using homeless shelters on the night of the count.

The City of Toronto acknowledges some of the limitations of its methodology. They confirm that the 'hidden homeless' will always be missed in any count and so the total figure can only ever be a minimum estimate.

Whilst it is very useful to have matched the count to a survey, I think one of the major problems with the methodology used in Toronto was the timing. 8.30pm – midnight (after midnight to finish some areas) would have significantly increased the chance of double counting and survey duplication.

None-the-less, the needs assessment has provided Toronto with an improved understanding of their homeless population and some great ideas for helping to reduce the incidence of homelessness. I believe that the following result from their report was well worth the effort in doing such a significant survey.

Table 1: Whether an Individual Wants Permanent Housing¹⁶

Location	Yes		No		Don't know		Question Response Rate (%)
	#	%	#	%	#	%	
Outdoor	235	85.8	27	9.9	12	4.4	95.1
Family Shelters	183	96.8	3	1.6	3	1.6	98.4
Youth Shelters	156	86.2	16	8.8	9	5.0	97.8
Mixed Adult Shelters	174	87.9	20	10.1	4	2.0	99.5
Men's Shelters	567	83.9	89	13.2	20	3.0	98.8
Women's Shelters	194	90.7	13	6.1	7	3.3	99.5
All Shelters	1274	86.4	141	9.6	43	2.9	98.8
Corrections	69	95.8	2	2.8	1	1.4	97.3
Health and Treatment	113	90.4	9	7.2	3	2.4	97.7
All Survey Respondents	1691	86.0	179	9.1	59	3.1	98.3

Counting rough sleepers in England

England probably has the one of the longest histories of counting people who are street homeless (termed 'rough sleepers') using a consistent methodology. From the late 1990s, every local authority has been obliged to count (or estimate) the number of rough sleepers within their council area on two nights of the year.

498 rough sleepers

This was initially done as a component of the national Government's commitment to reduce rough sleeping by two thirds by 2002. As previously

¹⁶ City of Toronto; Staff report: 2006 Street Needs Assessment: Results and Key Findings, June 2006. P.16

noted in this report, that goal was achieved. Counts and estimates continue to occur throughout England so that a total is available for the country. The most recent publicly available national estimate is 498 rough sleepers on any one night, throughout England¹⁷.

Description and limitations of the methodology

Like street counts everywhere, there has been some ongoing criticism of the count methodology by charity groups and other organisations in the UK. They believe the official number may be an under-estimate of the figures because in order to be counted, people must be 'bedded down' on streets or in parks and counters are advised not to enter car parks or other similar types of structures. It is also not possible to count the other hidden homeless. For example, those people who may shelter on late night buses. However, the government and the local authorities responsible for counting rough sleepers do agree that the counts are a minimum figure and acknowledge the 'snapshot' nature of the methodology.

Some commentators¹⁸ on the count suggest that the 498 snapshot figure is likely to equate to an annual figure of people who live on and off the streets of about 7000 people throughout the country, with about 3000 in London.

Participating in the Westminster count, November 2007

I can verify the methodology of the count. Thanks to the Westminster City Council Rough Sleepers Unit Manager and staff I was invited to participate in the Westminster count on 20 November 2007. Myself and another counter were given a small area of Westminster (a number of streets and lanes surrounding Victoria Railway Station) to patrol and count rough sleepers. We did this between 11pm – 2am. Other teams of two people were sent out to other areas within Westminster. The night began with a short briefing by the co-ordinator on processes for the count.

In the days prior to the count, I was advised that homelessness services workers had been observing local areas in order to understand where homeless people would likely be bedded down during the night of the count. Organisers informed me that this pre-count intelligence was a key component of what they did and helped to ensure they went to areas that were most likely to have homeless people on the night of the count.

The Westminster count is done in close liaison with local police and counters are required to note down the names of all rough sleepers. If the rough sleepers refuse to supply their name, a call must be made to the police who will then visit the location and request the person's name. I confess to having felt uncomfortable about this process and it is not an aspect of a count that I would choose to replicate, but I also understand the desire by the British authorities to ensure against double counting.

Police involvement in a street count is a hotly contested topic elsewhere in the world. HUD, in its guide to counting unsheltered homeless people¹⁹ note that:

¹⁷ Communities and Local Government: Homelessness Statistics September 2007 and Rough Sleeping – 10 Years on from the Target Policy Briefing 20

¹⁸ Charities, such as Crisis and Thames Reach.

“...the use of police officers must be considered very carefully. Because homeless individuals may have criminal records, be engaged in illegal activities, or have had negative experiences with the police, they may be less forthcoming with information or avoid being counted if they know that police are involved in the count. The participation of police officers could be particularly detrimental for data collection on homeless youth”.

Independent scrutiny

The Westminster count organisers used an independent scrutineer from a homelessness policy organisation to oversight the count processes. I can also verify this. The count was done with professionalism and rigour.

I have not been informed of the final and total figure for that most recent Westminster count, however the previous count identified 98 people. Westminster also reports that they see approximately 1800 rough sleepers each year at their Building Based Services.²⁰

An alternate count

A Charity in England (The Simon Community) has regularly disputed the official rough sleeper counts in London and conducts its own. They have reported that they found 301 people sleeping in 8 inner London boroughs in April 2007. I have not been able to sight their methodology.

Why weren't count methodologies criticised when the homeless population was growing?

I don't believe that there is likely to ever be a methodology that will please everyone. All cities have had their count methodologies debated and disputed. Interestingly, Philip Mangano also had something to say on this matter when I met with him in DC. He made the observation that no one criticised the count methodologies during the many years from the 1970s to the late 1990s when the homeless numbers kept growing year after year. It seems that a rough estimate made from the window of a journalist's office was once proof enough of the high numbers of homeless people.

Counts appear to have only been criticised since action has been taken to reduce the numbers of homeless people. It is almost like some people (media and advocates alike) don't really think it is possible to assist some people and to reduce homelessness. They seem to think the counts must be wrong.

¹⁹ HUD, Office of Community Planning and Development; A Guide to Counting Unsheltered Homeless People, October 2004.

²⁰ City of Westminster; Westminster City Council Rough Sleeping Strategy 2007-2010

Summary and key elements of counts

It is clear that accurately counting people who are homeless will always have its difficulties. Some of the key elements to a robust count appear to be:

- Use as many well briefed volunteers as possible, to ensure the count can be done across an entire area within 2 – 3 hours. This will minimise double counting.
- Seek advice from statistics experts on suitable sampling methods, if an entire count of a city is not feasible. Consider a methodology (such as the NYC 'Shadow count') to help extrapolate findings if a count doesn't or can't capture all areas.
- Do the count late at night/early morning to ensure that you are counting people who sleep on the streets and not people who may be housed but who socialise or drink on the streets.
- Use any advance intelligence you can gather about potential homeless hotspots. It can also be useful, if people are willing, to do the count in close liaison with people who are homeless or who have been homeless. Their co-operation is needed and they can provide expert advice on where homeless people might be found.
- Although a needs assessment of all identified homeless people is very useful, it may be necessary to separate it from an official count. The best counts are likely to be done midnight – 3am and this is not a good time to conduct a survey of people.
- Once areas where homeless people congregate are identified during a count, an interview or needs assessment process can be undertaken during daylight hours on a later occasion.
- Once a methodology for a local count has been agreed, it must remain the same for future counts. Consistent methodology is the key to understanding changes, increases or reductions in populations of people who are street homeless. If it is an annual count, it should also occur at the same time of year every year.
- If a total population of homeless people in a local area is required (eg. people who may be residing in homelessness services as well as street homeless people) then both counts need to occur on the same night. There will be a real risk of double-counting some people if this isn't done.
- Be prepared to provide direct assistance on the night, in case some homeless people ask for help.

Waking people in the middle of the night

I believe that a count should not involve waking up a suspected homeless person. It is not the purpose of a count to make people sleeping in public places feel more vulnerable or disrespected. Doing so has the potential to disturb good relations between services, volunteers and people who are homeless. Therefore 'counters' will need to make a judgement about whether they believe a person on the street is homeless or not.

4.3 CHAMPIONS: POLITICAL WILL AND LEADERSHIP

"You bastard, why did you let me stay out there so long?"²¹

Change requires champions

Effective policy and services never just appear magically. Good homelessness policy, strategy and effective service provision always has a high level driver (or drivers). A person (or people) with access to financial and other resources, who is in a position to actively influence strategy and the type of services being delivered to people experiencing chronic homelessness. Throughout my Fellowship travels, nothing was quite as clear as this lesson.

Courage and new approaches

Implementing new strategies, changed service structures, new program models and directing the re-allocation of scarce resources in order to effectively address chronic homelessness requires well informed, well placed and, often, courageous people. Sometimes this person is a politician; sometimes he or she is a political appointment or a high level bureaucrat. Sometimes this person just does it, they aren't appointed and no one asked them to do it. In this final example, I'm thinking of Rosanne Haggerty who founded 'Common Ground' in New York and who has developed a results driven response to chronic homelessness simply because she had enough practical insight and energy to do so. Another good example from the same city is Sam Tsemberis at 'Pathways to Housing' who has been pioneering the 'Housing First' model for over a decade.

In places where programs and policies are getting practical results for chronically homeless people with multiple problems, the political will, direction and drive was provided by someone (or an agency) well positioned to challenge and to change existing policies, services and programs. This person (or agency) was also challenging common thinking that chronic homelessness was an insoluble problem for some; that a few people will always be chronically homeless and the best we can manage, as a community, is to keep people warm and fed.

Articulate advocates

Nan Roman at the National Alliance to End Homelessness and Philip Mangano from the United States Interagency Council on Homelessness, are articulate advocates for planning to end homelessness in local communities. Both are based in Washington DC and have done much over the past few years to envision and inform cities across the USA that they can and should implement 10 year plans to end homelessness.

²¹ Reportedly the response of a formerly street homeless woman to a service manager, who had remarked how well she looked, compared to the times he knew her when she was on the street. This anecdote was relayed to me by the senior manager of a local government housing and homelessness department.

Homeless 'Czar'

So, even though it may appear to the casual observer to be the case, the 10 year plans to end homelessness, now implemented in many cities in the United States, did not just appear out of nowhere. Philip Mangano (who was appointed by the US President), and who is often referred to as the 'homeless czar' has been spreading the word about ending homelessness for some years. My meeting with him was nothing short of electrifying. I left his office wanting to race back to Australia and try and end homelessness immediately. The man has a special gift for communication and a long background in homelessness services and policy.

That is not to say that people like Mr Mangano don't have their detractors. Some critics of his suggest that the 10 year plans and the 'Housing First' model is punitive and is causing displacement of people and services that assist homeless people²². The fact that he was appointed by a conservative President is also enough for many people (including myself) to question his motives and methods. At the moment, though, the results appear to be speaking for themselves. Throughout the USA and Canada, formerly homeless people are housed and are sustaining that housing. There has been a reduction in chronic homelessness.

Highlighting new research and best practice

Nan Roman, President and CEO of the National Alliance to End Homelessness is an impressive and highly knowledgeable researcher, policy driver and advocate. She has done much to ensure that there is an informed debate in the USA and a base of evidence upon which services and local communities can act to address homelessness. During the week I was in Washington DC I had the great fortune to discuss homelessness with Nan and to see her speak at several events.

A key event for NAEH during that week, and one at which Nan spoke, was the launch of their research into the incidence of homelessness in the veteran population in the United States. Military veterans make up a disproportionate number of people in the total homeless population (26% of homeless population, compared to 11% of total US population). Although this research is of less relevance to the homeless situation in Australia, it is important to note that some of the reasons for the high number remain the same the world over: post-traumatic stress, substance abuse, health problems, disability and mental illness.

Just do it!

Rosanne Haggerty, Founder and President of Common Ground is already fairly well known in Australia. She has been here on a number of occasions and was the South Australian 'Thinker in Residence' during 2005/06. Again, she is a compelling thinker and speaker. Importantly she is a very practical woman!

She has developed Common Ground, in New York City from an interesting idea in 1990 into a significant affordable housing provider, street outreach and

²² An example is Cathy Crowe's Blog, Michaelann Land, June 22, 2007.

support organisation for people who are chronically homeless and formerly homeless. Common Ground has developed more than 2000 new affordable and transitional housing units and intend to develop more. Rosanne took some old, run-down, unwanted buildings and turned them into affordable housing in the middle of Manhattan.

Picture 3 shows one of the Common Ground affordable and supportive housing in NYC.

The three Common Ground buildings I visited during my stay in NYC did not look out of place in the streetscape. In fact they looked quite attractive. What was different about them was the fact that each of them housed formerly homeless people as well as others in low wage jobs who need affordable housing.



Rosanne began developing this because she saw the connection between a lack of affordable and supportive housing and chronic homelessness and she did something about it. Then she told people about it and has continued to help people do similar things around the world since then. She is a tireless worker and advocate and represents the very essence of a homelessness champion.

The authority to make major changes

Rob Hess, the current Commissioner for Homelessness in New York City (NYC), after reviewing the work of the street outreach services being funded by NYC, had the courage and the delegation (with support from the NYC Mayor) to cease all outreach service contracts and to re-write and re-tender these services to provide, what he believes, are more effective and results oriented services. There is more detail about the changed outreach approach in NYC in section 4.6 of this report.

I can't think of an official in Australia who would have sufficient delegated authority to make such a decision. There are government directors who may have the authority to discontinue funding to services if they fail to meet required standards or if they act outside their service agreement. However, I am not aware of anyone who has the delegated authority to re-configure an entire funding program and re-tender it to ensure that changed policy and service requirements are implemented (literally, 'on the street') as rapidly as possible.

Wide community agreement and written commitment

In places where chronic homelessness was being actively and positively addressed, there was a clear (usually written) understanding that a civil community need not accept a permanent population of significantly disabled and homeless people. This was usually written into 10 year plans to end homelessness and articulated by the Mayor or similar authority in the vision statement about the plan. An example, from the Washington DC 10 year plan is below.

"It is my pleasure to present Homeless No More, a plan to end homelessness in Washington, D.C. by the year 2014. At the top of this plan is a clear vision of what we intend to do: "To improve the quality of life for all residents of the District of Columbia by preventing and ending homelessness within ten years."

That vision means all of us have a stake in making this plan succeed. Ending the social and economic scourge of homelessness - rather than just continuing to manage it will benefit not only those who suffer the problem personally, but will also improve the quality of our neighbourhoods and the experience of all residents and visitors.

A city that acts to make room inside for its most vulnerable citizens fits squarely within our Comprehensive Plan and its vision for "growing an inclusive city." The 6,000 units of affordable housing called for in Homeless No More will be an important part of creating new, inclusive communities that meet both the material and social needs of our residents. Responsive mainstream city services wrapped around the new affordable housing will help people get housed, stay housed and thrive".²³

Great research and using evidence based interventions

Improved service responses and the development of evidence based actions usually rest on top of really good research. The importance of good research into homelessness, its causes, prevention and eradication cannot be underestimated. In the next section (4.3) I refer to the costs research by Denis Culhane, which appears to have inspired much more work in this field and may ultimately, have convinced many governments to try to end chronic homelessness.

The best services that I visited clearly based their work on good evidence and research. Service managers could cite references about why and how they worked in particular ways. In NYC, the street to home outreach team was basing their actions on clear methodologies (see section 4.6) that were getting sustainable results. Observations made by Common Ground staff about the high incidence of traumatic brain injury in the chronically homeless population (see section 4.8) were being tested. The 'Housing First' and assertive community treatment model used by Pathways to Housing was subjected to robust analysis and a four year follow-up and was recently the subject of a scholarly paper in the Journal of Primary Prevention²⁴.

²³ Homeless no more: A strategy for ending homelessness in Washington DC by 2014, Mayor Anthony A Williams, December 2004.

²⁴ Stefancic, A; Tsemberis, S; Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: Four-Year Study of Housing Access and Retention, Journal of Primary Prevention, Springer, 2007.

Changes being made to how homelessness is being addressed are not being made on a whim. There is a growing body of research and evidence that these new plans, programs, service models and interventions work.

So, what makes a champion?

Champions are practical people, great communicators, they keep up with the research and implement informed and evidence based interventions. They generously share their work and their knowledge. Importantly, they understand that not only *should* chronic homelessness be ended, they believe it *can* be ended.

Picture 4: Rosanne Haggerty (CEO) and Hilary Morgan (Director of Street Outreach) from Common Ground, NYC.



4.4 THE COST OF NOT ENDING CHRONIC HOMELESSNESS: COST/BENEFIT STUDIES

"Existing research into the quantitative costs of homelessness and the benefits of reducing its incidence generally identified significant cost savings (especially to government) and net gains to the homeless arising from appropriate public policies." (Berry, 2003)

Costs research and Professor Denis Culhane

One of the main reasons I went to Philadelphia during my Fellowship program was to meet Professor Denis Culhane who is based at the University of Pennsylvania. For some years I have been very interested in his work. He was one of the first researchers that I am aware of to look at the cost of crisis services for people who are chronically homeless and the potential savings that might be made by ensuring people have affordable housing and ongoing support. His study in New York, *'Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing'* (2002)²⁵ looked at the costs of shelter use, hospital presentations and interactions with corrective services by chronically homeless people in New York. He and his co-authors then estimated that the annual costs of all this service use was about \$US 41,000. They then went onto compare the annual costs of formerly homeless people placed in supportive housing. This annual cost was just an additional \$US995 per year. It made a most compelling argument.

So, exactly how much does it cost to remain homeless?

Other researchers have since gone on to do similar investigations. In fact, I presented a paper at the 2006 National Homelessness Conference titled: *So, exactly how much does it cost to remain homeless?*²⁶ This received a lot of interest at the time because, I think, the argument must have appeared counter-intuitive. Superficially it must look to most people that those who are chronically homeless don't cost us very much, they keep to themselves, sleep on the streets and receive free food from charity run food vans. However, we estimated that it could cost as much as \$34,000 a year for some people to remain chronically homeless in Sydney.

The paper I presented and similar studies that have also been done in a number of cities in the USA have attempted to add up the types of costs that chronically homeless people, with multiple health and other needs might require in any given year. These will usually include:

- Hospital emergency department visits
- Ambulance transport
- Medical/surgical hospital admissions

²⁵ Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, *Housing Policy Debate* · Volume 13, Issue 1, 2002

²⁶ Reynolds, F; Giles, E; Manion J: *So, exactly how much does it cost to remain homeless?* Paper presented at National Homelessness Conference, Sydney, 2006.

- Admissions to mental health units
- Interactions with the criminal justice system, such as police, courts and prison
- Admissions to detoxification units
- Stays at homelessness hostels
- Stays at intoxicated persons units

HASI in NSW

In fact, the Housing and Support Initiative (HASI) in NSW has shown similar results. This is a joint program by the NSW Health Department and Housing NSW which provides housing and support package funding to non government organisations for people with a diagnosed mental illness. Calculations from many HASI providers are showing that people in HASI are requiring far fewer acute hospital admissions after they are in HASI than in the years preceding their involvement in the program. This has clear cost savings for the public acute care mental health system.

The Million Dollar Man

Since some of the original costing studies and thanks to the New Yorker magazine most people have now heard of *Million Dollar Murray*²⁷. This article describes a simple costing of hospital and other service use by one chronically homeless man and shows how it easily added up to over a million dollars. And, without having actually solved the fellow's homeless problem!

An economic and a moral argument

There is now some interesting evidence from a range of places (including other Australian studies²⁸) that it may be significantly more cost effective to provide people with appropriate supportive housing rather than continue, year after year, to watch people remain homeless and try to have their needs met via crisis services, hospitals and the police. The argument is not just a moral one, but an economic one.

It is now clear that some of the work being done in cities in the USA to try to end homelessness is based on local cost/benefit studies that show that it is likely to be costing more to manage the problem rather than to solve it. Perhaps it is disappointing to think that governments may only have sprung into action since better understanding the economic cost of chronic homeless, but at least they have sprung into action.

Back to Professor Culhane

It was great to have the opportunity to talk directly with Professor Culhane about his research. He reported to me that there have been at least 60 new homelessness cost/benefit studies in the USA in the past few years, usually done in conjunction with local 10 year plans to end homelessness.

²⁷ Million-Dollar Murray, February 13, 2006, The New Yorker.

²⁸ Berry, M; Chamberlain, C; Dalton, T; Horn, M & Berman, G: Counting the cost of homelessness: A systematic review of cost effectiveness and cost benefit studies of homelessness, AHURI, 2003

A key point that Professor Culhane wanted to make clear is that we must develop ways to ensure that people who leave chronic homelessness and go into affordable and supportive housing services are, over time, able to make it back to utilising mainstream services.

Encouraging people to stay within a 'homelessness or housing sector' service for long periods is not helpful to them or to the sector. It is everyone's right to use mainstream health, mental health, other community services and work opportunities and people must be encouraged to do this, once they are stable and able to do so. This not only assists an individual's ongoing recovery but it also serves to ensure that the (always limited) affordable and supportive housing options can continue to be used by people who might otherwise become or stay chronically homeless.

A media report from Seattle, USA

"More proof that compassion isn't just good for the soul, but also good for one's pocketbook: Seattle and King County's housing projects targeting the chronically homeless work, and they save us \$3.2 million each year. The Housing First projects are fiscally prudent, and, indeed, the very thing that made them controversial also makes them effective by seriously lowering the number of homeless patients needing emergency medical care.

Critics blasted one project's approach -- the 1811 Eastlake building -- to dealing with homeless alcoholics. The housing project, which attracted national attention for allowing its residents to drink, was seen by some as a waste of public money and as subsidizing alcoholics. But the investment -- providing inexpensive housing with on-site care -- is paying off. A preliminary study shows that over a year, days residents spent in jail are down nearly 30 percent, while visits to Harborview Medical Center have dropped a third. And at Plymouth on Stewart, the number of short-term days required for medical care went from 1,107 to zero in one year, while Harborview visits dropped 75 percent. The success of Plymouth on Stewart can be attributed largely to its location (in the old St. Regis Hotel downtown, which some felt ought to be a prime spot for developers and high-rollers), which is close to vital services, such as medical clinics, mental health programs and food banks.

Sure, the St. Regis would have made a pretty condo building, but helping the needy seems like a better use of space to us".²⁹

²⁹ From an article titled: Homelessness: Good for the soul, *Seattle Post-Intelligencer Editorial Board* January 9, 2008

4.5 WHAT WORKS: HOUSING FIRST AND SUPPORT

"When we conducted the first Street Needs Assessment in April 2006, homeless people told us overwhelmingly they wanted permanent housing and the help to make this happen".³⁰

'Housing First' as a model for assisting chronically homeless people is a relatively simple concept. It requires a suitable and affordable house or unit and, for most formerly homeless people, the provision of ongoing support to help ensure they sustain their tenancy. This is not a difficult service model to grasp.

Numerous examples of Housing First

During my Fellowship travels I visited a number of organisations that were delivering examples of the 'Housing First' model. These included Common Ground in New York, through its 'Streets to Home' Program; Pathways to Housing, also in New York; the Streets to Homes program being implemented by Toronto City Council in Canada and Ecuhome, a service also based in Toronto, Canada.

Key components of 'Housing First'

'Housing First' is based on a number of elements. These include:

People do not have to be assessed as 'housing ready'. This is a criterion that is regularly used in other service models and requires homeless people to first transition through a support service or transitional housing option and/or to undertake independent living skills training and assessment. The key reason being that people not be 'set-up' to fail in their tenancies. Whilst this is a valuable objective (it is essential that we not set people up to fail), it may not be substantiated by evidence.

Housing is provided as quickly as possible. Offers of housing to move from chronic homelessness on the street are provided as soon as possible after someone agrees that they want to move into housing.

People are provided with adequate and appropriate support services in their home. Whatever level of ongoing support needed, is provided. In the model used by Pathways to Housing in NYC, this is termed assertive community treatment.

People with alcohol or other drug addictions can access housing. Many other program models that may require a transitional period in a congregate care environment may also require a period (or longer) of abstinence from alcohol and/or other drugs. Most Housing First models do not require this and people will be able to access housing regardless of their substance use issues. However, this does not mean that their substance use will be ignored over the longer term. In the first instance there will be support to try to manage it

³⁰ Toronto City Council, S2H Brochure, May 2007.

better and over the longer term, support to understand it, reduce or even to cease it. There is some evidence accumulating that once people are in a stable housing situation they are in a better position to try and tackle their addictions.

People do not need to be 'compliant' with mental health treatment. Most other programs will usually require people with a diagnosed mental illness to be compliant with a prescribed treatment regime (usually medications). Again, the Housing First model does not insist on this. Compliance with medication will generally be encouraged as part of the ongoing support provided.

"Housing First is an effective intervention that ends and prevents homelessness for individuals with severe mental illness and co-occurring addictions. By providing permanent, independent housing without prerequisites for sobriety and treatment, and by offering support services through consumer-driven Assertive Community Treatment teams, Housing First removes some of the major obstacles to obtaining and maintaining housing for consumers who are chronically homeless".³¹

Separate the behaviour from the diagnoses. Common Ground as an example of a service that provides Housing First makes it clear that they do not ask anything more of their lease holder tenants than any other landlord asks. No other private landlord would feel they could ask if someone is drinking in their apartment or not taking their prescribed medication. However, as Rosanne Haggerty states, "*But we're very strict about behaviour. If someone behaves badly we get on it very quickly, figuring out what needs to be changed. We have few rules but we enforce them vigorously.*"³²

Separate the management of the housing from the support. Most organisations who provide Housing First try to make a separation between the management of the tenancy and the support of the client. Common Ground does this, using a different agency (CUCS) to provide support to people in Common Ground buildings.

Streets to homes

The Toronto Streets to Homes (S2H) programs is getting people straight from chronic homelessness into housing. Their 'Housing First' program has just 3 key requirements for people who want to access the program. These are:

1. Must agree to pay direct to the landlord
2. Must agree to have follow-up supports
3. Must agree to complete an application to be on the centralized waiting list for subsidized housing

That is all that is required. Toronto's program is sometimes able to get people off the street and into their own place within a week or two. It can take longer and sometimes people may choose to stay on the street or live at a shelter for a few weeks. The S2H team have priority access to a few shelter beds for this purpose.

³¹ Stefancic, Tsemberis et al.

³² Vitullo-Martin, J; Homeless in America, The Wall Street Journal, January 18 2007. Quote cited in article by Rosanne Haggerty, Common Ground President.

'Housing First' requires adequate supply of affordable housing options

The most important element in implementing a Housing First program is the adequate supply of affordable housing options. Housing First cannot work in an environment that does not have this supply. This makes the implementation of affordable housing strategies in cities that want to implement 'Housing First' absolutely obligatory.

Only being able to offer people a limited range of housing options will not make for a successful 'Housing First' program. Homelessness, which so often is linked to disconnectedness and poor health cannot be solved by inviting someone to go and live in a studio apartment in the outer suburbs, away from social and other support networks. A range of adequate, safe and affordable housing models are needed.

Whilst I was in the USA and Canada, I noticed that there was a lot of debate about the notion of people 'living independently', usually alone. Whilst I understand the importance of people having the choice to live with other people or not, I think it can be a choice that could be offered.

'Interdependence' rather than 'independence'

Social exclusion and disconnectedness can lay at the core of chronic homelessness and by encouraging people to live alone, their only contact with paid service providers, this hardly engenders connections. Nor should people need to live in large boarding houses or other large congregate care institutions, but Australia should give further thought to the single occupancy model that dominates affordable housing options. There is some middle ground between 'large boarding house' and 'studio apartment'. A small house, with 4 – 6 people has the potential to become a small interdependent (rather than independent) community.

Housing voucher schemes

One of the key ways by which many of the Housing First programs in the USA are being implemented is through the use of 'housing voucher' schemes. This means that people assessed as in need of subsidised housing can access housing on the private market but have some (or all, in some instances) rent paid by the Federal Government (Section 8 vouchers) or a local authority. This is clearly an excellent way to use the private sector to provide affordable housing. NYC has a scheme that encourages savings by people on housing subsidies. At the end of the subsidy period, people will have their savings matched.

Subsidised housing in NSW

We have a similar arrangement in NSW (which is not titled a voucher scheme). People assessed as eligible for public housing can access private housing and only pay 30% of their income in rent (NSW Housing pays the remainder). However, this type of program could be made more widely available, with currently homeless people fast tracked into such housing. Support services, however, will need to be available.

4.6 STREET TO HOME: STREET OUTREACH WITH PURPOSE AND METHOD

Shift the paradigm from "Can I help you?" to "Can I help you get housing?"³³

New York City

I mentioned earlier in this report that the NYC Homeless Commissioner, Rob Hess, took the decision in 2007 to re-design how street outreach was being performed in NYC. He has since re-contracted services so that they are all expected to co-ordinate with each other and collect the same kind of data. There is also now a much higher expectation of housing outcomes.

NYC – re-designing outreach and expecting results

Most street outreach services have long focussed on 'relationship building' with homeless people. I have always believed in this approach. However, both I and the Commissioner agreed that good relationships between homeless people and outreach workers mean very little if it results in nothing other than 'good relationships'. With an informed approach to working in homelessness hotspots, a focus on 'housing first' and providing significant ongoing support to people once they are housed, NYC is doing much to address their chronically homeless population. In fact, Common Ground, who are one of the street outreach providers have recently reported that they have reduced chronic homelessness in Times Square by 87%.

Whilst I was in NYC I went out with the street outreach team at 5am. Just across the road from a seriously swanky hotel was a building that has about 30 men sleeping on its steps every night.

Picture 5: Times Square, NYC – late afternoon – October 2007.



³³ Toronto S2H presentation to the author in November 2007.

The outreach team was focussing on this homelessness hotspot in recent weeks and were actively engaging people and developing relationships. They had already been able to offer some immediate assistance and some housing options to a few of the men. I am not going to go into further detail of my involvement at this location because the people who may be continuing to use that space have every right to their continued anonymity. It is enough to say that I was impressed with the outreach workers and grateful to a couple of the homeless guys, who so generously shared their stories with a stranger from Australia.

Streets to Homes (S2H), Toronto, Canada

The City of Toronto has developed a plan and a raft of new initiatives (named 'Streets to Homes') that are aiming to end chronic homelessness in the city. As part of these initiatives was the implementation of a S2H outreach team in 2005.

S2H outreach state: *We are committed to ending homelessness for people living outside. Streets to Homes provides leadership, focused initiatives, innovation and system coordination to help people find and keep housing.*³⁴

The S2H program has a steering committee which is made up of 30 community and health agencies as well as other City Council Divisions. This committee provides advice to the General Manager, of Shelter, Support and Housing Administration at Toronto Council, which directly provides the S2H service. This performs a guidance role on key projects (such as the Street Needs Assessment) keeps workers linked in with other key services and housing programs.

Like their counterparts in NYC, they are conducting street outreach in an informed and evidence based way. They focus on hotspots and encampments and even though Toronto has a by-law prohibiting encampments, this isn't often used. S2H reported to me that almost 80% of encampments are resolved and people assisted without the need for involvement by enforcement services.

The Toronto S2H outreach team has found it most effective to change their opening line of engagement with homeless people from, 'How can I help you?' to, 'How can I help you access housing?' They have reported an increase in people being interested in talking with them. It also gives the engagement process more purpose. That is not to say that all that homeless people will need is housing. That isn't true. Many people will also need help from mental health and/or drug and alcohol services, but it takes the emphasis from a personal/private problem to acknowledging the most obvious and apparent problem (lack of housing).

To ensure that people housed through S2H have adequate support to sustain tenancies, 13 different agencies are currently providing follow-up support to housed clients.

In a recent follow-up survey of clients housed by S2H, the following responses were made:

³⁴ Toronto S2H presentation to the author in November 2007.

Are you happy with housing?

Very Happy **50%**
 Mostly Satisfied **37%**
 Somewhat Unsatisfied **8%**
 Very Unhappy **5%**

Has housing changed your life?

Improved a lot **61%**
 Somewhat improved **30%**
 Stayed the same **7%**
 Gotten worse **2%**

The same survey also found some interesting results regarding people's reported drug and/or alcohol use:

17% reported no drinking since being in housing.

Homeless 2+ years much more likely to report decrease in alcohol use (**59% vs. 27%**).

31% reported they had quit using drugs completely since being in housing.

Those homeless 2+ years most likely to report decrease in drug use (**78% vs. 62%**).

Another key result of this survey was the report of significantly reduced presentations to crisis and emergency services by housed, formerly homeless people. See below for the % reductions.

Reduced use of crisis and emergency services

Clinics	- 28%
ER	- 40%
Hospital	- 25%
911 (emergency call)	- 35%
Ambulance	- 38%
Fire	- 71%
Police detox ("Drunk Tank")	- 75%
Getting arrested	- 56%
Jail	- 68%
Court	- 58%
Probation	- 38%

By May 2007, Toronto City Council had reported that 87% of people assisted into Housing by the S2H team had sustained their tenancies.

"The City of Toronto's Streets to Homes program is one of the finalists for the 2007/08 World Habitat Awards, making it one of the world's finest examples of housing projects

that deliver practical and innovative ways to house people. Two winners will be chosen from the 12 finalists at the annual United Nations global celebration of World Habitat Day, October 6, 2008.

"Streets to Homes is helping us to end street homelessness," said Mayor David Miller. "It is making Toronto a more inclusive city, and the world is taking notice. This recognition is a tribute to both City staff and our community partners, who have worked together tirelessly and seamlessly to help some of our most vulnerable citizens."

Approved by City Council in February 2005, Streets to Homes has since helped more than 1,500 homeless people find housing directly from the streets, parks and ravines in the city. Almost 90 per cent remain housed. The program is operated by City staff in partnership with 25 community not-for-profit agencies that provide street outreach, housing support, and related services.

"Streets to Homes is the front line of our overall "housing first" approach,"
 "Homeless people tell us they want permanent homes, and we are focusing our limited resources across all services for homeless people on helping them to find and keep permanent housing. You have the best chance of dealing with your problems when you have the safety and dignity of a place to call home. Housing is the very best medicine."³⁵

Effective street outreach

Street outreach with people who are chronically homeless can be the subject of a very long book. It is art and it is science and there is much to know. This report cannot hope to encapsulate all that knowledge. Below are a few key observations about effective outreach services.

Well trained outreach workers – great staff do great stuff (anywhere!)

Targeting 'anchors' – this involves identifying the 'key' people in any street homeless group and working intensively with them to help them get a housing and support outcome. By doing this, sometimes other members of the group may be encouraged and form a firmer belief that it is possible to leave the streets and get permanent housing.

Use Housing First – about 90% of chronically homeless people want permanent housing. Give it to them!

Tackle hotspots – focus on areas and work intensively with people before moving onto other areas. It helps people understand you are serious about assisting them. You must prioritise, unfortunately you cannot help everyone all at the same time.

Co-ordinate actions – work with other street and local services and ensure you don't work at odds with each other.

Make sure there is good data collection and counts – so you know if things are working (or not!).

³⁵ Media announcement January 9 2008, Toronto City Council's website: www.toronto.ca

Be aware that some disconnected people can make valuable and deep human connections with other people on the street. Don't suggest options that may remove people from these important connections. Think of a way to keep the networks and the support and provide the housing options (maybe some people might like to live together).

Westminster, UK – moving away from the streets and into buildings

Most parts of the UK with a rough sleeper population have a long history of providing street outreach services. Westminster City has, over the past few years, decided to do something a bit different. They have adopted a 'Building Based Services' model. They have a strong 're-connections' strategy which involves getting people to return to their last settled address. One of the reasons cited for introducing BBS was to remove the 'perverse incentive' for people to 'sleep rough' to access services.

There have been some concerns by advocates that this form of service delivery could miss the very vulnerable rough sleepers with mental health and other problems. Westminster City confirms that it takes actions to ensure they are able to continue to engage with this group.

Below is a description of the BBS model.

"Building Based Services Model:

In July 2005 Westminster adopted its current Building Based Services (BBS) model for rough sleeper services. The intention was to provide services for rough sleepers exclusively within buildings such as their three day centres, so that the full range of Westminster's services were then available to clients. Rapid and needs led assessment and support planning is carried out within the BBS.

Whilst the focus is on provision of services from these buildings, there is still an element of street work to undertake verification, tackle hot spots and work with the small number of vulnerable, entrenched people unwilling to come into day centres. By creating dedicated, quiet time indoors, more of this group have been encouraged to go into day centres and the BBS are steadily achieving positive outcomes within this group. Refocusing resources from the streets to the BBS means that rough sleepers are now aware that a street lifestyle is more difficult to sustain, and that the services they require are to be accessed through BBS and will not be provided on the streets – except to the most vulnerable clients.

Reconnections:

An important strand of the move to BBS has been a commitment to reconnection of rough sleepers whose last settled address is not Westminster. A 10 bed Reconnections Unit pilot was established in a hostel to provide short term accommodation for people needing help to link into services and support in their home area. Local and national reconnections protocols have also been drawn up to ensure there is a consistent policy across local authorities.

Police Enforcement:

Westminster is able to call upon the services of a dedicated police team to assist in managing its rough sleeping and street population. The team has been very successful in assisting to disperse large groups of rough sleepers, either directing them to BBS or just ensuring that large groups do not form.

Impact of Reforms on Street Counts:

All of the measures above have had a significant positive impact on the numbers seen on recent street counts. At the latest count in March 2007, numbers had fallen to 112 – Westminster's lowest ever official count".³⁶

³⁶ Communities and Local Government: Homelessness Statistics September 2007 and Rough Sleeping – 10 Years on from the Target– Policy Briefing 20. P.15

4.7 HEAPS MORE STUFF THAT WORKS: OTHER USEFUL PROGRAMS AND ELEMENTS THAT MAKE SERVICES SUCCESSFUL

The reason we try to attract the very best staff, highly qualified and well regarded is that we are dealing with the most traumatised and vulnerable people in our society. They need the very best.³⁷

Harm minimisation services

Although there are a number of harm minimisation programs across the world (including some great examples in Australia) it looked to me like the Canadians in Toronto had a very special gift for harm minimisation innovation and service delivery, especially with the chronically homeless population.

The 'Housing First' model, which has already been described in this report, can be considered a harm minimisation model as it doesn't require abstinence or treatment to access housing (just the willingness to accept support services).

Safe Havens

These type of homeless shelters have been developed in a number of cities (including NYC, Philadelphia and Toronto). I visited two good examples in Philadelphia. They are 'low demand permanent environments for the very hard to reach chronically homeless'. Usually the clients also have significant mental health problems. They have minimal rules and require very little of people (in fact payment is often optional). They do provide a long term sheltered option for those who find it suits their lifestyle. There are reports that some people may use this kind of accommodation for a period, become stable and decide to move onto something else. Other people may choose to stay long term.

The Housing and Urban Development Department (HUD) in the USA have described the model and developed a guide for those that want to establish Safe Havens.

In from the Cold - Safe Havens for Homeless People

(<http://www.hud.gov/offices/cpd/homeless/library/havens/>) is worth having a look at if you are interested in this model.

Fred Victor Centre, Toronto, Canada

The Fred Victor Centre in Toronto is a housing program (in one apartment building) in which people can stay long term. It has minimal rules and people can do any number of things in their rooms, except have guests. I found it an interesting service, more like the safe haven model, and probably suitable for people with ongoing multiple problems who prefer 24 hour supervision but minimal intrusion into their lives.

³⁷ Paraphrased from a discussion with Suzanne Wagner and Linda Shimer of CUCS, NYC.

Seaton House Annex, Toronto, Canada

This may be one of the most controversial harm minimisation models I visited; highly controversial, but also highly successful.

Supervised free alcohol at Seaton House Annex

Seaton House Annex runs a managed residential drinking program for 120 formerly chronically unsheltered men. The service purchases and provides the alcohol (wine) and it is given to the men on an hourly basis. Each man may have a maximum of 10 drinks each day. Some men may be only allowed fewer drinks if they have health problems and it has been advised they have less than 10. If a program participant goes elsewhere and drinks they are refused further alcohol that day.

Stability through harm minimisation

These men are now securely sheltered, warm and able to continue to drink every day. Although the amounts may seem excessive, they are far less excessive than the drinking they had probably been doing on the streets. These men are no longer freezing to death after passing out and they are no longer causing a nuisance by being publicly intoxicated. It is an impressive and replicable program.

I have previously been critical of the concept of 'wet centres' as a way of assisting chronic street drinkers. I always had a problem with the idea of what people would do after the wet centre closed for the day. The bad behaviour that they were supposed to fix would simply occur outside after closing time.

I believe that the residential component, along with the managed and supervised drinking, is the key to a great program for minimising harm to this very vulnerable population of long term street drinkers. The Manager of the program also reported that some men, over time, have reached a level of stability and decided to move on and do something else with their days instead of drinking.

Programs based on 12 step models

Whilst there is a solid place for harm minimisation models with this population, I believe there is also a place for abstinence based 12 step programs. Most people who are unfamiliar with 12 step programs see them as some kind of secret religious sect. They are not. There are many myths about 12 steps fellowships, mainly because there is no effort by these programs to proselytise about the effectiveness of the model. They are a self help model with no paid staff and so few ways in which to invite academic review or criticism.

12 step models can help people in a number of ways. At their most basic, they can simply give people (especially excluded people) a social support network and connections with other people who are trying to do the same things (stop drinking or drugging and get on with their lives). At a more sophisticated level they can provide advice from others who have experienced the same thing on ways by which they stopped drinking or drugging. At an even more important level, the story telling that goes on can help some people make better sense of

their lives and experiences and relieve them of much self blame and self loathing. Continued self esteem problems make it difficult for many chronically homeless people to make positive decisions about their lives.

Ready, Willing and Able is a service I visited in NYC which is based on a 12 step model. It is briefly described in section 4.9 of this report.

Consumer led programs and services

There are few specific programs for chronically homeless individuals which actively involve consumers in service provision and management. This may be partly because of the significant level of disability that is often experienced by this group. However, there are many services that actively recruit formerly homeless people to positions in outreach and housing services. This should be actively encouraged, with people adequately trained and resourced to exemplify the very real opportunities there are to leave the streets.

A very good example of consumer empowerment and involvement is the PARC and Ambassador program at the Parkdale Activity and Recreation Centre in Toronto, Canada. This is briefly described in section 4.9 of this report.

'Court to Home' – nothing quite like this anywhere else!

Common Ground, which has already led the way in a number of program areas, implemented in October 2007 a new program, 'Court to Home'. The premise is relatively simple.

Unfortunately, many chronically homeless people find themselves regularly in court on petty matters (fare evasion, shoplifting, begging etc). The judge may have a range of options which include fines, prison time or community service. None of which may be very useful or effective.

Common Ground's C2H program identifies any chronically homeless people that may be facing court on any one day and then makes recommendations to the judge regarding possible sentencing. If the judge so decides, people can be 'sentenced' to 2 days or 5 days working with Common Ground staff to complete a housing application and work to access housing. Housing applications in NYC can be quite complex and require multiple health and other assessments. The sentence can involve completion of HRA2010e Housing Application, a psychosocial assessment, psychiatric evaluation, sign-up for Public Assistance and a TB test.

Severe weather alerts – a northern hemisphere thing

In most places I visited in North America, they had a mechanism for preventing deaths in the street homeless population during severe weather. In some places this involves opening up church or municipal halls and inviting all homeless people to come in and stay and be warm. In other places and where some people may refuse to leave the streets during very cold weather there is a procedure (similar to a mental health 'schedule') by which people can be forced to leave the streets and go to a shelter.

Factors in successful programs

Great services have:

- Effective, well trained and thoughtful staff (just like good 'champions' in regard to new strategies, see section 4.3)
- Value and promote co-ordination and collaboration with other local services.
- Involve and empower consumers.
- Aim to minimise the length of stay anyone needs to live in a large congregate care environment.
- Staff who follow through on any promises made to clients. They also have a respectful service culture (see section 4.9).
- New ideas and they test them. They stop doing ineffective things and they continue to do effective things.
- Believe that no one needs to stay chronically homeless.

4.8 A TROUBLING OBSERVATION: TRAUMATIC BRAIN INJURY

"Severe or repeated TBI can cause cognitive impairment, attention deficits, disinhibition, impulsivity, emotional lability"³⁸

High incidence of history of trauma and abuse in chronically homeless population

I had known for a long time that the majority of people who experienced chronic homelessness in Australia commonly have multiple disabilities, which include mental illness, addiction, intellectual disability, physical disability and chronic health problems. I also knew that a number of this group also have behavioural problems, such as poor impulse control, that often made it difficult for them to sustain staying in a homelessness hostel or in their own home. Australian studies have also shown that 90-100% of the chronically homeless have a history of trauma and abuse.

Use of test (RBANS) for TBI

Whilst I was in New York, talking with some professional staff of Common Ground, I heard about a very interesting observation regarding the chronically homeless population. They told me that they had been using a test (RBANS) to determine if their clients (with consent) may have a traumatic brain injury (TBI) and the resulting impairments in functioning. They have found very high rates amongst the chronically homeless and formerly chronically homeless.

Chronically homeless have increased chance of TBI

TBI is more commonly known as acquired brain injury (ABI) in Australia. However, I think I prefer the term TBI, as it more accurately describes the likely method by which the injury was 'acquired'. It speaks to the likelihood of a traumatic and, possibly violent, childhood, as well as the TBIs that can be acquired when you have to cope on the streets and live in unsafe places, the violent experiences of prisons and other institutions and, of course, the experiences of being regularly intoxicated and falling down a lot. These are all ways in which someone might do permanent damage to their brain.

Current research: TBI and homelessness

At present it seems to be a little understood phenomenon within the population of people who are chronically homeless. A Canadian doctor, Stephen Hwang has been doing some interesting research. Also, Jennifer Highley, the Director of Psychiatric Services for Common Ground, who I met with in New York, is also continuing to investigate the issue.

It appears that TBI may not only be a real danger for people who are homeless but also a precursor and risk factor for becoming chronically homeless. There is

³⁸ Hwang, S; Center for Homelessness Prevention Studies, Columbia University, Grand Rounds: Traumatic Brain Injury and Homelessness, October 18, 2007.

an urgent need to better understand the extent of this problem amongst chronically homeless people in Australia.

Understanding impact of TBI and working appropriately with people who may have it

As Hwang notes, “severe or repeated TBI can cause cognitive impairment, attention deficits, disinhibition, impulsivity, emotional lability”³⁹. Because the behaviour associated with TBI might appear to be personality disorders or just behavioural problems there may be a chance that some people are not being appropriately treated. Once service workers realise that people may not be turning up for appointments not because they are ‘treatment resistant’ or ‘non-compliant’ but because they have impaired memory and brain functioning, there may be alternative work practices that can be put in place. For example, workers might write a list for clients or they might go and get them and take them to appointments. They also may not get frustrated with the chaos of some people’s lives and form the belief that ‘they don’t want help’.

Results of recent study of 1200 homeless people in Toronto

Hwang and some colleagues have recently conducted a study of the prevalence of TBI in a large representative sample (1200) of homeless people in Toronto, Canada. He notes, that to date there have been no other studies of a similar nature, even though the incidence of TBI, anecdotally, appears high in the chronically homeless population. Although there were some methodological limitations of his study, the results were startling. See below for a summary of findings and recommendations for service providers.

Summary observations

Lifetime prevalence of TBI in a representative sample of homeless people is more than 5 times greater than in the U.S. general population

TBI prevalence among homeless people is within the range reported among prison inmates.

First TBI usually antedated first episode of homelessness

History of TBI strongly associated with wide array of adverse health outcomes.

Cognitive sequelae of TBI may increase the risk of subsequent mental health, alcohol, and drug problems.

However, pre-existing mental health, alcohol, and drug problems may increase the risk of experiencing TBI.

Implications for service providers

Clinicians should routinely screen homeless patients for history of TBI.

TBI should be considered a possible cause of neuro-psychological dysfunction and behavioral problems.

³⁹ Hwang, S; Center for Homelessness Prevention Studies, Columbia University, Grand Rounds: Traumatic Brain Injury and Homelessness, October 18, 2007.

Further efforts should be directed at the management of TBI-related problems such as impulsive behavior, and the treatment of co-occurring alcohol or substance abuse.

Persons with brain injuries may have attention deficits, making it difficult for them to focus on tasks and understand, remember, or respond to directions.

These individuals may need more time to follow instructions; slowness should not be misinterpreted as a lack of effort or cooperation.

TBI-related brain dysfunction can predispose to irritability or impulsivity that should be understood in the context of the person's previous injury.

Implications for housing programs

Provision of permanent supportive housing is essential to end homelessness among individuals with significant neuro-psychological impairments due to TBI.⁴⁰

⁴⁰ Hwang, S; Center for Homelessness Prevention Studies, Columbia University, Grand Rounds: Traumatic Brain Injury and Homelessness, October 18, 2007

4.9 SERVICE ESSENTIALS: RESPECT, DIGNITY AND INCLUSION

"We are often dealing with people who have a 'care' deficit"⁴¹

I visited numerous homelessness, health and community services in North America and London. I remain most grateful for the kindness and generosity of those service users, managers and staff of those many organisations who shared with me their time, their services, experience and insights. I know well, myself, that visitors to a workplace can take up precious time as well as leaving ourselves and our services open to critical analysis.

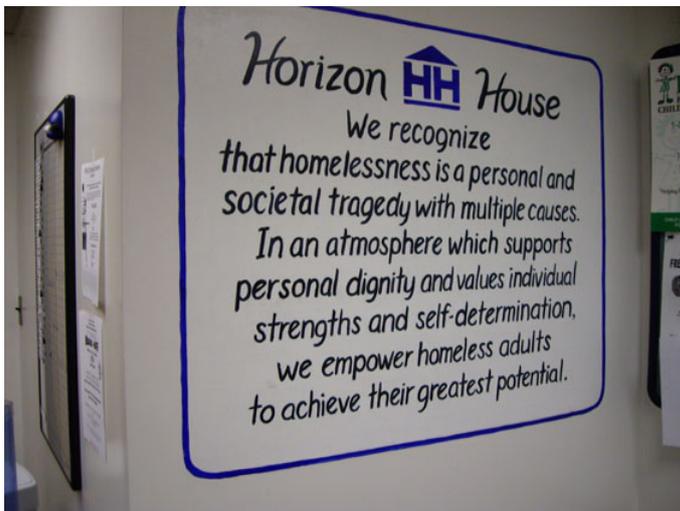
Observing organisational cultures

One of the most interesting aspects of visiting any organisation, apart from the obvious purpose of witnessing services in action, are the observations that can be made about the culture of that organisation. This is often very difficult to do accurately, when the service visit may only last only an hour or two. I don't purport to have fully understood the cultural nuances of any or all organisations I visited during my Fellowship travels.

However, there are observations that can be made as you watch managers, staff and service users interact amongst themselves in offices, corridors, kitchens or waiting areas. I know this is not a major insight, but it is clear that great services treat people well and with dignity. That includes staff, clients and visitors. A respect for others permeates their interactions. A great many services I visited also articulated this approach in writing.

A few examples

Many of the services I visited were great illustrations of this, so if they are not mentioned here it is not because they didn't have a respectful culture, it is because space in this report only permits me to provide a few examples.



Picture 6: Horizon House, Philadelphia, USA

⁴¹ Jennifer Highley, Director of Psychiatric Services, Common Ground

Ready, Willing and Able, New York, USA

The Doe Fund in New York is an interesting case in point. Respect for all is formally articulated throughout the 'Ready, Willing and Able' program. What is expected of service users is also expected of staff. This program uses an abstinence (from drugs and alcohol) based approach, and whilst random drug screens are conducted on clients, they are also conducted on staff. This program takes 'consistency' to a new level.

In fact, the Ready, Willing and Able (RWA) program is based on a philosophy that through paid work, improved living skills and sober living, men who have been chronically homeless, in and out of gaol and addicted to drugs will regain self respect, long term employment and independence. Whilst there are many harm minimisation models in the homelessness/housing sector (especially most examples of 'Housing First') there is also a valid place for abstinence based models. There are certainly many men who have passed through the RWA program who remain grateful for the opportunity to get their lives back together.

Respectful mental health evaluations of people who are homeless

Common Ground is an organisation that is many things; innovative; pro-active, effective and most definitely respectful. A great resource for people who work with homeless or formerly homeless people with a mental illness was provided to me by Jennifer Highley, an impressive and insightful woman who is the Director of Psychiatric Services for Common Ground. She has written '*A Guide to Psychiatric Evaluation of the Homeless*', September 2007.

Some of us may wonder why psychiatric evaluations of people who are homeless need be any different from any other psychiatric evaluation. Jennifer's guide makes this difference clear. She acknowledges the trauma and abuse which may have formed part of the homeless person's background and provides suggested questions that are respectful of a troubled past which has culminated in social exclusion and homelessness. The following are some selected extracts from the guide:

"If the patient seems wary or guarded, explore his resistance to the interview. Ask about past experiences being interviewed by psychiatry and make assurances that this experience will not be a repeat performance of the bad experiences he's had in the past. Assure the patient that he can tell you if they become uncomfortable at any time during the interview, and you will talk about something else". (p.2)

Begin all psychiatric evaluations with the family and social history. "Where are you from originally?" is the initial question. Since so many homeless persons have lived in a large number of family (and non-family) constellations, ask "Who raised you?" instead of assuming patients were raised by their parents. Often there is shame associated with being raised by people other than one's parents, so care must be taken to use non-judgmental language. (p.2)

In questioning patients about histories of abuse, it is essential to acknowledge your sorrow at any revelation of abuse, whether physical, emotional or sexual, by stating "I'm so sorry that happened to you", or a similar expression. Do not fail to acknowledge

the patient's pain. Don't make the mistake of not making eye contact and simply proceeding to the next question. (p.4)

The patient may reveal that he was diagnosed with schizophrenia in the past, when he told a doctor he felt like people were out to get him. You can let him know that it is hard for many clinicians to tell the difference between feeling scared, guarded and suspicious because you have a long history of being hurt by others, and the patient who comes to him feeling paranoid because he has schizophrenia. You can let him know that one is based in the reality of a history of abuse, and the other is based in delusion." (p.18)⁴²

Safe Haven for Men, Philadelphia, USA

I knew I was visiting a special service when, whilst I was being told about the program in the Director's office, a very loud commotion occurred just outside the office door. She didn't even stop talking with me. I later found out that this was caused by a resident who was quite upset about something. The response by the worker was calm and collected and he wasn't reminded of rules or told to leave or told to come back when he'd calmed down. The man was treated with respect and the reason he was upset was explored in greater detail, with a clear plan and resolution discussed. The level of care provided him as well as the lack of drama created throughout the small building was impressive. Everyone then just got on with their day.

At that service, like most other Safe Havens, they have just a few very key rules (no weapons, no drug taking on the premises etc) and the rest of the behaviour and problems that occur just get dealt with as they arise. This approach, with a very difficult population group, requires great staff and a respectful service environment.

Bellwoods House, Toronto, Canada

This is another impressive program. In a lovely old house in an inner city suburb of Toronto is a quietly successful program for women aged over 55 who have been chronically street homeless or who have spent many years in homelessness shelters.

Acknowledging that older women may have different needs and experiences to others in the homeless population, this program has a cosy home-like feel. The co-ordinator who showed me around was kind and thoughtful; the environment was welcoming and not at all institutional. It felt like home and it is for approximately 8 older women.

Unfortunately it remains a 'transitional' program and so the women are expected to move onto their own homes at some point. They do experience difficulty with this at times and I understand why. The interdependence and shared home with others is a fact of life for most of us. I think it can also help some people who have been disconnected and socially excluded feel more connected with others. I'm not entirely sure that a home or apartment of one's own is always the answer for everyone. Sometimes a 'home' (as opposed to a 'house') involves sharing your life with other people.

⁴² Highley, J: A Guide to Psychiatric Evaluation of the Homeless, September 2007 (pages 2, 4, 18)

It was also reported that many of the women who may have had histories of behavioural problems or mental illness tend to settle well into the home like environment. Sometimes the hustle and bustle and drama of the streets or a large shelter can exacerbate someone's problems.

PARC, Toronto, Canada

The Parkdale activity and recreation centre (PARC) in Toronto exemplifies consumer directed service provision. Consumers are closely involved in planning and managing many of the programs. My guide for the tour of the service was a formerly homeless man who is actively involved in the program. The focus at PARC is about facilitating community connectedness and a place to come where everyone is welcomed and can be part of the service. There is an emphasis on recovery and many of the people now involved have since moved off the streets and are sustaining housing.

PARC also provides an 'Ambassador' program which trains people who have experienced mental illness in public speaking and community development. They are then paid to attend public meetings or speak at events. This program has done much to break down barriers between people who are homeless or who have a mental illness and other members of the local community.

Picture 7: Streetscape in Westminster, London, which is home to The Passage Homeless Service.



5. CONCLUSION

"As soon as you put the money in a different place, the providers will go there." (Mangano, 2007).

Philip Mangano repeated the above axiom when I met with him. I can't help but agree. It is time that Australia solved its chronic homelessness problems by providing some incentive and a funded strategy to do so. If we keep putting our funding into crisis services we will continue to have people with crises, who need crisis services. It is much like a self fulfilling prophecy.

Maybe if we put our money into long term housing and support options we will see people who need long term housing and support. Again, much like a self fulfilling prophecy.

There is good evidence to support the need for a complete range of programs for people who are chronically homeless, from crisis to long term options. There is also good evidence to support the notion that we can end or significantly reduce chronic homelessness, but we must make a plan to do so.

It won't just happen.

6. RECOMMENDATIONS

1. Australia needs a vision and plan to end chronic homelessness:
 - The Federal Government should develop a new National Homelessness Strategy, which has as its key aim, a plan to end chronic homelessness.
 - Any new National Homelessness Strategy must be closely linked or fully incorporate a National Affordable Housing Strategy.
 - Any new National Homelessness Strategy need to include actions that will prevent homelessness as well as address homelessness.
 - Any new National Homelessness Strategy should include incentives for State Government's to develop and implement homelessness and affordable housing strategies.
2. State Governments should develop new Homelessness Strategies, with the key aim to end chronic homelessness. They should also include affordable housing strategies as well as mechanisms for preventing homelessness.
 - State homelessness strategies should include incentives for city council's to develop and implement homelessness and affordable housing strategies.
3. Federal and state governments should review current programs and mechanisms which aim to address chronic homelessness and cease funding ineffective models.
4. 'Housing First', with appropriate levels of support for people who require that support, should be implemented as an evidence based effective model of long term assistance for chronically homeless people.
5. There is a need for research into the Australian prevalence of traumatic brain injury (TBI) in the chronically homeless population. As well as the likely need for improved education/training for working with people with TBI.

7. DISSEMINATION

PowerPoint presentation highlighting key observations

Before returning to Australia in late November 2007 I wrote a brief PowerPoint presentation which highlighted key findings and observations. I have already given this presentation to a range of workers and services. These include staff in my own Unit at the City of Sydney (which includes the Homeless Persons Information Centre, the state-wide telephone information and referral service for people who are homeless); staff from the NSW Department of Community services and the NSW Department of Housing.

I have also sent the PowerPoint slides to Homelessness NSW.ACT, the state peak for homelessness services. I am also presenting a summary presentation, focussing on homelessness service models, at the February 2008 meeting of the Inner Sydney Homelessness Action Committee. This committee is made up of NGO and government homelessness services representatives and is convened by the NSW Department of Housing.

I will continue to provide this summary PowerPoint presentation opportunistically throughout the year.

Conference presentations

I will be presenting a paper at the Inner City Mental Health Conference – The Ultimate Challenge in April 2008. My paper is based on the observations made during my Fellowship and is titled: International Initiatives for Homelessness. I will also be giving a presentation on my Fellowship findings at the NSW Salvation Army Homelessness Services Conference in March 2008.

I have submitted an abstract to the 5th National Homelessness Conference in May 2008. The proposed paper is based on a critique of the 10 year plans to end homelessness being implemented in the USA and observed during my Fellowship program.

Dissemination and distribution of this report

A copy of this report will be made to a number of people and organisations. These will include:

- The Lord Mayor of the City of Sydney
- Council to Homeless Persons
- Homelessness Australia
- Homelessness NSW.ACT
- Housing NSW
- NSW Department of Community Services
- Commonwealth Department of Families, Community Services and Indigenous Affairs
- Various NGOs and other community and health services

8. REFERENCES

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Coming in from the cold: A progress report (Summer 2000), UK

Communities and Local Government: Homelessness Statistics September 2007 and Rough Sleeping – 10 Years on from the Target, Policy Briefing 20

City of Toronto; Staff report: 2006 Street Needs Assessment: Results and Key Findings, June 2006

City of Toronto, S2H Brochure, May 2007

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Dennis P. Culhane, Stephen Metraux, and Trevor Hadley, Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing, Housing Policy Debate · Volume 13, Issue 1, 2002

Highley, J: A Guide to Psychiatric Evaluation of the Homeless, September 2007

Homelessness: Good for the soul, Seattle Post-Intelligencer Editorial Board
January 9, 2008

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Homeless no more: A strategy for ending homelessness in Washington DC by 2014

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Reynolds, Giles, Manion: So, exactly how much does it cost to remain homeless? Paper presented at National Homelessness Conference, Sydney, 2006.

Stefancic, A; Tsemberis, S; Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: Four-Year Study of Housing Access and Retention, Journal of Primary Prevention, Springer, 2007

Vitullo-Martin, J; Homeless in America, The Wall Street Journal, January 18 2007

For a complete listing of resources and documents collected during my Fellowship travels please contact me at the following email address:

felicityreynolds@iprimus.com.au

APPENDIX 1

List of people with whom I had meetings and/or service visits 17 October – 22 November 2007 Churchill Fellowship			
NAME	TITLE	ORGANISATION	DATE OF MEETING &/OR VISIT
NEW YORK, USA			
Rosanne Haggerty	President	Common Ground	17 & 29 October
Kat Johnson	Assistant to the President	Common Ground	17, 25 & 26 October
Kristin Barlup	Director, Street to Home	Common Ground	23 October
Hilary Morgan	Director, Outreach and Housing Placement	Common Ground	23 & 29 October
Jennifer Highley	Director, Psychiatric Services	Common Ground	26 October
Jennifer Hawkins	Director, New Initiatives	Common Ground	26 October
Becky Kanis	Director, Innovations	Common Ground	26 October
Heather	The Times Square, Tenant Services	Common Ground	23 October
Paul Gregory	Scattersite Clinical Director	Common Ground	26 October
George T McDonald	Founder and President	Ready, Willing and Able, The Doe Fund, Inc.	18 October
Nazerine Griffin	Program Director	Ready, Willing and Able, Harlem, The Doe Fund, Inc.	18 October
Bradley Solomon	Communications	Ready, Willing and Able, The Doe Fund, Inc.	18 October
Robert V Hess	Commissioner	New York City Department of Homeless Services	19 October
Lesley Peterson	Special Assistant, Commissioner's Office	New York City Department of Homeless Services	19 & 25 October
Maryanne Schretzman	Deputy Commissioner, Policy and Planning	New York City Department of Homeless Services	23 October
Suzanne Wagner	Director, CUCS Housing Resource Center	Center for Urban Community Services	22 October
Linda Shimer	Program Director	Center for Urban Community Services	22 October

Sam Tsemberis	Executive Director	Pathways to Housing	24 October
Marshall Flauntleroy	Manager	Clarke Thomas Single Male Shelter – Volunteers of America	25 October
Tracey Brown	Program Analyst	Milbank Family Shelter – Children’s Aid Society	25 October
Linda Penoyer	Program Administrator	Milbank Family Shelter – Children’s Aid Society	25 October
PHILADELPHIA, USA			
Leticia Egea-Hinton	Deputy Director	City of Philadelphia, Office of Supportive Housing	31 October and 1 November
Michele Mangan	Project Manager	City of Philadelphia, Office of Supportive Housing	1 November
Kali Karras	Asst. Managing Director	City of Philadelphia, Office of Supportive Housing	31 October
Roberta Cancellier	Deputy Director	City of Philadelphia, Office of Supportive Housing	31 October
Katrina Pratt	Director of Housing Assistance	City of Philadelphia, Office of Supportive Housing	31 October
Kevin Brezeale	Deputy Director	City of Philadelphia, Office of Supportive Housing	2 November
Marcella Maquire	Director, Homelessness Services	City of Philadelphia, Department of Behavioural Health	1 November
Laura Weinbaum	Director of Public Policy	Project HOME	30 October
Dwayne Wharton	Director of Residential and Homeless Programs	Project HOME	30 October
Sarah Erdo	Acting Manager Outreach Co-ordination	Project HOME	1 November
Karen Subach	Residential and Homeless Programs	Project HOME	30 October
Amanda David	Program Manager, St Columba	Project HOME	1 November
Emily Lattimore	Program Manager, Women of Change	Project HOME	1 November
David Dunbeck	Director of Homeless Services	Horizon House	2 November
Denis Culhane	Professor (& researcher on homelessness)	Social Policy and Practice, University of Pennsylvania	2 November
WASHINGTON DC, USA			
Nan Roman	President	National Alliance to End Homelessness	5,6,7 & 8 November
Webb Lyons	Assistant to the President	National Alliance to End Homelessness	6,8 & 9 November

Casey Rogers		The Hilton Foundation	5 November
Laura Green Zeilinger	Health and Human Services Special Assistant	Government of the District of Columbia – Office of the City Administrator	6 November
Stephen T Baron	Director	Government of the District of Columbia – Department of Mental Health	6 November
Barbara Bazron	Deputy Director Programs, Policy and Planning	Government of the District of Columbia – Department of Mental Health	6 November
Kara M Stein	Legal Counsel and Senior Policy Advisor	Senator Jack Reed, Rhode Island. US Senate	6 November
Mark A Calabria	Senior Professional Staff Member	United States Senate Committee on Banking, Housing and, Urban Affairs	6 November
Jenn Fogel-Bublick	Counsel	United States Senate Committee on Banking, Housing and, Urban Affairs	6 November
Press Conference on reduction in chronic homelessness	Representatives from HUD and a range of homelessness agencies	Housing and Urban Development (HUD)	7 November
Affordable Housing Forum	Representatives from Councils and a range of affordable housing agencies	MacArthur Foundation	7 & 8 November
Press Conference on veterans and homelessness	Representatives from NAEH and a range of homelessness agencies	National Alliance to End Homelessness/National Press Club	8 November
Supportive Housing Leadership Forum	Representatives from Councils and a range of support agencies	Corporation for Supportive Housing	9 November
Tina Orwall Shamseldin	Taking Healthcare Home Coordinator	Office of Housing, City of Seattle	9 November
Philip Mangano	Director	United States Interagency Council on Homelessness	9 November
TORONTO, CANADA			
Andre Alves	Special Projects Manager	Shelter, Support and Housing Administration (SSHA) – City of Toronto	12 & 13 November
Denise Bryan	Administrator	Fred Victor Centre	12 November
Sharlene Cobain	Agency Review Officer	Streets to Home, SSHA	12 November
Angie Hains	CEO	Ecuhome	12 November
Terry McCullum	CEO	LOFT	12 November

Phil Brown	General Manager	SSHA – City of Toronto	12 November
Sonia Zyvatkaukas	Public Education and Awareness	SSHA – City of Toronto	13 & 15 November
Terence Williams	Consumer/Survivor & Ambassador Project	Parkdale Activity Recreation Centre (PARC)	13 November
Glen Papin	Consumer/Survivor & Ambassador Project	Parkdale Activity Recreation Centre (PARC)	13 November
Jacques Tremblay	Ambassador Project	Parkdale Activity Recreation Centre (PARC)	13 November
Kathleen Blinkhorn	Director, Social Housing	SSHA – City of Toronto	13 November
Katherine Chislett	Director Housing and Homelessness Supports and Initiatives	SSHA – City of Toronto	13 November
Anne Longair	Director, Hostel Services	SSHA – City of Toronto	13 November
Iain De Jong	Manager, Streets to Home	SSHA – City of Toronto	14 November
Toby Druce	Agency Review Officer, Streets to Home	SSHA – City of Toronto	14 November
Joseph Stalteri	Agency Review Officer, Streets to Home	SSHA – City of Toronto	14 November
Sue	Agency Review Officer, Streets to Home	SSHA – City of Toronto	14 November
Gordon	Agency Review Officer, Streets to Home	SSHA – City of Toronto	14 November
Leonard Howe	Executive Director	Furniture Bank	14 November
Susan Meikle	Executive Director	Mental Health and Street Outreach, Toronto North Support Services	14 November
Donna Read	Housing Team Leader	John Howard Society of Toronto	14 November
Boris Rosolok	Manager	Seaton House and Seaton House Annex	15 November
Tracy Campbell	Program Supervisor	Adelaide Resource Centre for Women	15 November
Jermet Levene	Program Lead	Bellwoods House	15 November
LONDON, UK			
Colin Robinson	Researcher and consultant		20 November
Mike	Deputy CEO	The Passage	20 November
Dave Barratt	Residential Services Manager	The Passage	20 November

Beki Winter	A/Manager	Conninghams, Broadway	21 November
Janet Haddington	Manager, Rough Sleeping and Street Activity	Westminster City Council	21/22 November
Victoria Van der Knapp	Deputy Rough Sleeping Manager	Westminster City Council	21/22 November
Nick Ward	Deputy Rough Sleeping Manager - Outreach	Westminster City Council	21/22 November
Irmani Darlington		Homelessness Link	21/22 November

APPENDIX 2

Website addresses for further information about some projects and initiatives and organisations that I visited during the Fellowship.

Common Ground, NYC

<http://www.commonground.org/>

Center for Urban Community Studies, NYC

<http://www.cucs.org/>

Pathways to Housing, NYC

<http://www.pathwaystohousing.org/>

The Doe Fund, NYC

<http://www.doe.org/>

NYC Department of Homeless Services (DHS)

<http://www.nyc.gov/html/dhs/html/home/home.shtml>

NYC DHS - Uniting For Solutions Beyond Shelter: The Action Plan for New York City

<http://www.nyc.gov/html/endinghomelessness/html/home/home.shtml>

Project HOME, Philadelphia (include safe havens)

<http://www.projecthome.org/>

Horizon House, Philadelphia

<http://www.hhinc.org/Index.asp?ArticleID=276>

National Alliance to End Homelessness, Washington DC

<http://www.naeh.org/>

United States Interagency Council on Homelessness, Washington DC

<http://www.ich.gov/>

Toronto City Council – Shelter, Support and Housing Administration, Toronto, Canada

<http://www.toronto.ca/housing/index.htm>

Streets to Homes, Toronto, Canada

<http://www.toronto.ca/housing/pdf/s2h-brochure.pdf>

Seaton House Annex, Toronto, Canada

<http://www.toronto.ca/housing/about-story-annex.htm>

Furniture Bank, Toronto, Canada

<http://www.furniturebank.org/>

Westminster City Council, London, UK

<http://www.westminster.gov.uk/housing/housingoptions/hphoptions/>

The Passage, London, UK

<http://www.passage.org.uk/>