What makes a difference?
Building a foundation for nationally consistent outcome measures

Australian Housing and Urban Research Institute

HomeGround Services
Hanover Welfare Services
Melbourne Citymission

National Homelessness Research Agenda 2009–2013

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EXECUTIVE SUMMARY

This project sought a solid, credible basis for measuring the effectiveness of homelessness services. It assumed that an effective service creates successful results for people experiencing homelessness, results which make a difference. To identify which results, which ‘client outcomes,’ make a difference, the project used the international research evidence base and input from experienced practitioners and policymakers.

From this evidence, the project built a model of the steps needed to achieve results. The model, a ‘client outcomes model’, and the research synthesis that underlies it, provide a comprehensive guide to effective practice and a rigorous basis for nationally-consistent client outcome measures.

The research draws on three strands of evidence: research findings about homeless populations and service delivery, theoretical frameworks for outcome measurement, and findings from homelessness sector outcome initiatives.

The project identified convincing reasons for establishing nationally-consistent client outcome measures, as well as significant challenges. Benefits include providing direction, focus and driving innovation. Challenges include capturing the complexity and diversity of service delivery practice, and the fact that inappropriate outcome measures can lead to ‘fudging’ results or poor morale.

The project found that an evidence-based ‘outcomes model’ could provide a way to manage the challenges, while delivering the benefits of nationally-consistent outcome measures. An outcomes model establishes a transparent and refinable logic to link interventions and outcome measures. It provides a conceptual framework to identify indicators and measures based on what is needed and what works.

The project built an outcomes model by reviewing the homelessness research evidence and gaining reiterated input from experienced homelessness practitioners, policy and research staff. It delivers a comprehensive synthesis of national and international research, including findings from 125 empirical research publications.

What the project found were two simple but profound conclusions that guided development of the client outcomes model:

➔ A shift in focus from getting housing to sustaining housing will deliver better outcomes.
➔ Achieving outcomes for people experiencing homelessness takes shared accountability between mainstream and specialist services.

The client outcomes model broadly describes the practice interventions and sequencing which lead to successful outcomes, based on a synthesis of the evidence and practice understandings. This report provides significant details about all the studies used to develop the model.

Rather than focus on how clients should change, the outcomes model specifies what the service system should deliver, to give individuals and families the best chance at getting and keeping housing.

The model shows how families or individuals need to be engaged in housing focused support and then identifies two phases in achieving outcomes for people experiencing or at risk of homelessness: getting housing and keeping housing. Perhaps most significantly, the outcomes model recommends a significant shift of focus toward the keeping housing phase of delivering and monitoring the outcome of housing sustained.

Figure 1 below depicts the client outcomes model.
Figure 1: Client outcomes model

Getting housing and keeping housing
Mainstream and homelessness specialist services working together
SHARED ACCOUNTABILITY
The Getting Housing phase involves engaging a person or family in housing-focused support, securing suitable housing in a timely manner and assessing the need for specialist health supports while providing comprehensive, practical case-management. This phase needs to be completed quickly, as established by the Housing First evidence base, and it crucially relies on the availability of suitable housing options. Key characteristics of suitable housing include: affordable, timely availability and suitable in location and amenity.

The Keeping Housing phase is even more critical than the Getting Housing phase and is an area currently under-emphasised in the Australian service-system. It involves assisting a person or family to sustain their housing whether they have recently secured housing after homelessness, or are currently at risk of losing their home.

It is not clear from the existing evidence how long the Keeping housing phase of work is needed to achieve sustained housing for any given household, however longitudinal studies suggest that two to three years will be a minimum benchmark for most people with complex health needs (Johnson et al. 2008; Karabanow 2008; Northwest Institute for Children and Families 2008; Kolar 2004; Busch-Geertsema 2002).

It is clear that more research and evaluation is needed to better understand this critical phase of achieving housing sustained outcomes. Nonetheless existing research indicates that sustained housing outcomes requires at least effective case-management, specialist health supports where needed, homelessness prevention strategies and interventions to increase economic and social participation.

Homelessness prevention strategies include active and passive tenancy management strategies including systematic arrears monitoring. They also include elements like a flexible program design to allow for gradual adjustment to housed living and contingency planning for behavioural health relapses. Effective homelessness prevention relies on strong coordination between tenancy and health management supports.

Economic and social participation interventions for people experiencing homelessness are not common as yet, and there is little evaluative evidence on successful programs. However it is consistently clear that sustaining housing critically depends on increasing economic capabilities and resources as well as increasing social connectedness. The research documents the value of specialist education, training and employment programs—both one-to-one vocational support and tailored employment opportunities. Other effective programs include social re-integration initiatives, recreation and community engagement and connection to mainstream education.

Complex health management involves specialist support and treatment for problematic drug and alcohol use, mental health issues including trauma recovery, and ongoing disability support if required. The research provides consistent evidence for the need for an increased supply of specialist support, in particular drug and alcohol treatment and mental health specialists.

The evidence indicates that both phases of the outcomes model require partnership and coordination between specialist and mainstream services. And, accordingly, the client outcomes model strongly recommends shared accountability for the long-term outcomes of sustained housing. This report recommends that accountability for housing sustained client outcomes could provide a key strategy to drive effective homelessness prevention interventions from both housing and mainstream support providers.
Further development of the results of this research would test outcome measures based on the model, constructed from existing data collection tools.

<table>
<thead>
<tr>
<th>Outcomes achieved to date</th>
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<tbody>
<tr>
<td>1. Development of a new approach to nationally-consistent outcome measures using an evidence-based client outcomes model, built on findings from existing outcome measurement approaches.</td>
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<tr>
<td>2. Development of an evidence-based, practice-relevant client outcomes model that:</td>
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<tr>
<td>→ Provides a credible foundation for building national, cross-sector engagement in client outcome measurement.</td>
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<tr>
<td>→ Documents evidence-based good practice steps needed to make a difference for people experiencing homelessness.</td>
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<tr>
<td>→ Recommends indicators that can be used to track outcome progress.</td>
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<tr>
<td>→ Enables agencies to identify how their individual practice fits into the larger picture and contributes to long-term outcomes.</td>
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<tr>
<td>→ Clarifies cross-sector roles and responsibilities.</td>
</tr>
<tr>
<td>→ Identifies the need for a significant shift in homelessness assistance policy toward accountability for sustaining housing over time.</td>
</tr>
<tr>
<td>3. Creation of a comprehensive evidence resource for practice development in homelessness services, integrating 125 empirical research sources from national and international studies.</td>
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ACKNOWLEDGEMENTS

This project is supported by the Australian Government through the National Homelessness Research Agenda of the Department of Families, Housing, Community Services and Indigenous Affairs.

The research was conducted as a partnership between HomeGround Services, the Australian Housing and Urban Research Institute, Hanover Welfare Services and Melbourne Citymission.

HomeGround provided project management and a Steering Committee was formed by the project partners and invited participants. Each of the Steering Committee members made critical contributions to the research, and the partner agencies provided valuable, in kind support for the project.

The research was led by Hellene Gronda, Director of the AHURI Research Synthesis Service.

The Steering Committee included:
- George Hatvani, HomeGround (project manager)
- Heather Holst, HomeGround
- Shelley Mallett, Hanover
- Deb Batterham, Hanover
- Deb Keys, Melbourne Citymission
- Quynh-Tram Trinh, Victorian Government, Department of Human Services
- And representatives from the Australian Government, Department of Families, Housing, Community Services and Indigenous Affairs.

This research was also significantly improved by the input of the peer reviewers and their anonymous contribution is gratefully acknowledged.

The project partners thank and acknowledge the practitioners who generously gave their time to provide input into the development of the framework:
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- Lisa Tout, Bethany Community Support
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- Rosa Ryan Roberts, Hanover Welfare Services
- Kaylene Rowe, Hanover Welfare Services
- Robyn Bixby, HomeGround Services
BACKGROUND, PURPOSE AND OBJECTIVES

Background
The performance of homelessness services in Australia has to date been typically assessed by funders on the basis of throughput and output measures. While it is clearly important to document the numbers and types of clients who are serviced, this form of data collection provides no measures of program outcomes, particularly the outcomes obtained by and for clients. Without these measures it is difficult to assess the success of homelessness services or determine how they might improve the effectiveness and scope of their service delivery.

The importance of outcome measures is widely recognised throughout the sector and in the national White Paper on Homelessness (FAHCSIA 2008). Previous research in Australia has tested a variety of approaches and tools for collecting outcomes data within SAAP agencies (Baulderstone & Talbot 2004). However, while some individual agencies have continued to measure client outcomes, across the sector no clear rationale about what should be measured and no consistency in implementation or approach has emerged. This is not surprising given the conceptual complexity involved in understanding the range of relevant client outcomes across varied service types, and the time and resources required to engage with the research literature as well as collect and analyse data.

The National Homelessness Research Agenda has prioritised the development of short- and long-term client outcome measures for people experiencing homelessness. Development of these measures will enable all stakeholders to assess the effectiveness of both old and new service interventions and establish evidence-based programs and practices. A coherent conceptual framework is critical to this work. This project is a crucial first step in this process.

Purpose
The purpose of this project is to build on recent Australian and international research, policy and practice literature, to establish a conceptual framework for a nationally-consistent, practice-relevant set of client outcome measures for people experiencing homelessness. While primarily relevant to specialist homelessness services (SAAP and non-SAAP), this framework, and the identified measures, will also be of broader relevance to other agencies and sectors working with people experiencing homelessness. This conceptual framework is intended to provide a foundation for the development and implementation of client outcome measures at community, program and individual levels.

Objectives
The objective of this project is to address the following research questions:

1. What is credibly known about interventions that make a difference to people experiencing or at risk of homelessness?
2. Which client outcomes reliably indicate the effective performance of homelessness assistance?
3. How can the evidence most effectively contribute to a national foundation for client outcome measures?

The research project was framed by the following objectives, priorities and research questions from the National Homelessness Research Agenda 2009–13.
Objectives:
→ Inform and improve the service system and practice including evaluation.

Research priorities:
→ Measuring short- and long-term outcomes for homeless people.
→ Assessing the effectiveness of interventions, including mainstream services.
→ Studies to improve service practice.

Priority Research Questions:
→ What are the short- and long-term outcomes from interventions including health, housing, employment and education?
→ What combinations of support services are effective in preventing homelessness?
1 INTRODUCTION AND RATIONALE

‘… what we measure shapes what we collectively strive to pursue.’


‘What gets measured, gets done …’

A Toolkit on Performance Measurement for Ending Homelessness (Spellman & Abbenante 2008)

This project is motivated by the idea that national client outcomes data has the potential to make a difference for people experiencing homelessness.

The agency partners for this project, Hanover Welfare Services, HomeGround and Melbourne Citymission, all demonstrate a strong commitment to an outcomes focus for benefits to clients and the service system. All three partner agencies have a commitment to coordinating their efforts and avoiding duplication of work, as well as working to ensure comparability of outcome data across the sector. This commitment is reflected in seeking a nationally-consistent client outcome system, and the partnership demonstrated in this project.

A national framework for outcomes measurement is aligned with national and international understandings that goal-orientation can provide a powerful motivation for human achievement. This theory has underpinned widespread interest in outcome-oriented performance management in public governance generally over the last decade, as demonstrated in the Stiglitz, Sen and Fitoussi (2009) report cited above.

In homelessness particularly, the persuasive logic described in What gets measured, gets done (Spellman & Abbenante 2008) is palpably demonstrated in the reductions in street homelessness achieved in both the UK and the United States through active accountability to street counts and clear, public targets (Department for Communities and Local Government 2008) (Common Ground 2010) (National Alliance to End Homelessness 2007).

More broadly, the Australian Research Alliance for Children and Youth hosted a Roundtable \(^1\) in 2010 on ‘Measuring the outcomes of community organisations.’ (Australian Research Alliance for Children and Youth & KPMG 2010). The roundtable communiqué noted that the ‘time is right for a strong push toward better measurement of the impact and outcomes of community organisation’ but also cautioned about the complexity of the task (Australian Research Alliance for Children and Youth 2010).

This project sets out to contribute a conceptual foundation for meaningful homelessness client outcomes measurement using a synthesis of evidence from homelessness program evaluations and research. The research found that an evidence-based client outcomes model could provide the most coherent and robust foundation.

The project identified an opportunity and a gap in the homelessness client outcomes debate in Australia. Analysis of the research, policy and practice literature found that what was missing was not a set of client outcome data elements, but clarity about purpose and the steps required to achieve these goals.

Accordingly, the output of this project is a strategic framework for nationally-consistent outcome measures built on an ‘outcomes model’ that establishes a credible link.

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\(^1\) See http://www.aracy.org.au/index.cfm?pageName=measuring_outcomes_community_org
between what agencies are doing on the ground and what the community expects will be achieved for people experiencing homelessness.

As a cross-sector outcomes model it allows services to identify where their own specific local practice and services fit into the overall picture, thus supporting collaboration, joint working, and shared accountability for outcomes.

The client outcomes model is built on a comprehensive synthesis of national and international research sources, including 125 empirical research publications. The research synthesis found that the core goal and purpose of providing homelessness services is to not just to help people get housing but most importantly to keep housing. Accordingly, the model is strategically oriented toward two very simple but significant client outcomes: housing secured and housing sustained. Simplicity supports the project’s intention to develop nationally-consistent outcome measures across the range of specialist homelessness and mainstream human service agencies known to provide services to people experiencing homelessness.

This project’s contribution to the development of national outcome measures provides guidance about effective outcome indicators but it does not provide detailed specification of outcome domains and particular indicators down to an agency level. Instead, the approach empowers individual agencies to use their own data collection systems, while linking this data to a coherent outcomes model that demonstrates the significance of work being done on the ground. For example, indicators and measures for steps in the outcomes model can be constructed from data items in the Australian Institute for Health and Welfare’s new national, client-focused homelessness data collection, leveraging this significant investment.

This report describes the evidence for and the elements of effective practice in each step of the outcomes model. As with all outcomes models, it should be subject to regular review and refinement in order to incorporate emerging research and practice innovation about what makes a difference.

1.1 Structure of the report

Chapter 1 introduces the report and the rationale for the project.

Chapter 2 presents the research synthesis methodology and describes the scope and quality of the research evidence-base.

Chapter 3 Practice and theory of outcome measurement describes relevant conclusions from the literature on outcome measurement and program logic, including the benefits and challenges of an outcomes focus, and provides an overview of Paul Duignan’s ‘outcomes theory’ used to develop the outcomes model.

Chapter 4 Understanding homelessness identifies key implications for a national outcomes framework from an overall understanding of the homelessness research evidence-base.

Part 1 Getting housing presents the research synthesis for the first half of the outcomes model. Chapters 5–8 present the evidence supporting the steps in Part 1 of the outcomes model and Chapter 9 provides a table of relevant outcome indicators. Each chapter concludes with an in-brief summary of key findings.

Part 2 Keeping housing presents the research synthesis for the second half of the outcomes model. Chapters 10–12 present the evidence supporting the steps in Part 2 of the outcomes model and Chapter 13 provides a table of relevant outcome indicators. Each chapter concludes with an In brief summary of key findings.
Chapter 14 describes the full client outcomes model built from the research synthesis in Chapters 4–12. It includes a table of recommended indicators for each step in the model.

Chapters 15–16 discuss the policy and program implications and suggest further development of the research findings.

Chapter 17 provides a conclusion to the report.
METHODS

The following two chapters present the methods used in this research project.

*Chapter 2* presents the research synthesis methodology and describes the scope and quality of the research evidence-base.

*Chapter 3 Practice and theory of outcome measurement* describes relevant conclusions from the literature on outcome measurement and program logic, including the benefits and challenges of an outcomes focus, and provides an overview of Paul Duignan’s ‘outcomes theory’ used to develop the outcomes model.
2 RESEARCH SYNTHESIS METHODOLOGY

This project uses research synthesis, a proven methodology for cost-effective and timely use of existing research findings to facilitate evidence-informed policy and practice development.

In brief, research synthesis involves the identification of relevant studies that are then appraised in detail and assessed for quality, research rigour and relevance to the objective of understanding the research questions. Data is extracted to construct a synthesis of the evidence, including detailed findings and overall conclusions. More detail on the research synthesis methodology is provided below.

This research synthesis project has particularly drawn on the analytical approach called ‘realist synthesis’ which is an evaluation methodology developed by Ray Pawson and others associated with the UK Centre for Evidence-Based Policy and Practice (Pawson 2002a, 2002b, 2006; Pawson & Tilley 2001).

Realist synthesis is a theory-driven method of systematic review and is able to integrate both quantitative and qualitative evidence to create new understandings about why a given social policy intervention works, when and how. This method generates conceptual principles that can then be applied to a local context.

For this project, reiterated engagement with expert stakeholders, including steering group members and practitioners was used to guide, refine and test the research synthesis.

2.1 Project outline

The research design used the international research evidence-base to build a credible, independent foundation for outcome measures, guided by engagement with expert homelessness practitioners to ensure practice-relevance.

The first stage of the project included scoping the parameters of the investigation. This stage involved two practitioner focus groups to aid in defining the scope of the research synthesis. The focus groups were designed to identify practitioner theories and understandings about what makes a difference to people experiencing homelessness. The findings from the focus group were prioritised with the Steering Group to provide a framework for guiding the synthesis. This framework is provided for reference in Appendix B.

The second stage involved iterated engagement with the Steering Group on the three strands of the evidence (homelessness evaluations and research; outcomes theory and practice; homelessness outcomes work). This process was used to identify what we could understand from the evidence, including what was absent, and to shape a conceptual foundation for nationally-consistent outcome measures.

The final stage included two workshops with practitioners to test and refine the emerging findings and the outcomes model. Both processes were part of the project’s emphasis on practitioner engagement to ensure the practice relevance of the synthesis.

2.2 Search and selection of research sources

The focus of the research synthesis was outcome-focused program evaluations, international research evidence and credible commissioned evaluations. Where there were gaps in the evaluation literature, evidence was sought from the broader homelessness research literature.
The first stage of search and selection used search terms based on the research questions, and key academic research databases. The second and ongoing iterative search process included following up references from the identified studies, systematically searching major government and advocacy body websites for research and evaluations, as well as purposive searching on areas of weakness identified in the first phase of searching.

The search was guided by a framework of four client outcome areas prioritised from the practitioner focus groups in the first stage of the project (see Appendix B):

1. Improved ability to care of self, others and reach own goals.
2. Improved health and wellbeing.
3. Improved living situation – a home.
4. Improved capabilities.

The research synthesis focused primarily on peer-reviewed academic publications. The following academic databases were accessed during the search phase:

- EBSCO host
- Informit Plus
- ProQuest Social Science journals
- Informaworld
- Wiley
- CSA Illumina
- Google Scholar
- SAGE
- Cochrane and Campbell Collaborations Libraries

In addition, key advocacy and government websites from Australia, Europe and North America were also searched for credible outcome evaluations, particularly where there were gaps in the academic literature.

Database searching was initially conducted using combinations of the following terms:

- Homelessness
- Outcomes
- Measures
- Interventions
- Service delivery
- Evaluation
- Housing
- Mental health
- Case work

These search terms were used as a starting point; the bibliographies of each credible and relevant research publication were then assessed for further information sources (‘snowballing’). This is a powerful non-systematic research technique because it captures conceptual rather than terminological knowledge linkages.

### 2.3 Exclusion and inclusion criteria

There is an extensive body of homelessness research literature and to make the synthesis project feasible, a range of criteria were used to limit the scope. The research synthesis methodology uses criteria of relevance and rigour to select studies for inclusion.

Firstly, relevance to the synthesis project was determined using the theoretical framework developed in the first phase of the research (see Appendix B). Studies were selected if they provided empirical evidence of client outcomes relevant to the four outcome areas identified in the first phase of the project.

Secondly, a hierarchy of evidence was used to prioritise the selection of studies within these thematic areas of concern. Studies were selected for analysis using the following hierarchy of research designs (if the first methodological category did not yield an adequate depth of evidence, then studies were sought in the subsequent category):

- Outcome evaluations with strong methodological design including randomised controlled experiments, longitudinal designs, large cross-sectional studies or strong, in-depth qualitative analysis.
- Outcome evaluations including cross-site comparisons and analytic case studies.
Program description and analysis; descriptive case studies, particularly with comparative analysis.

In addition, the synthesis focused on the most recent publications, with additional older studies included if necessary to supplement weaknesses.

Particularly difficult selection decisions related to research about the phenomenon of homelessness. While this body of research has relevant evidence, the sheer scope of that evidence-base prohibited its comprehensive assessment and inclusion in most cases.

Criteria for including homelessness phenomenon research were:

- Unique and rigorous pathways or sub-group analysis.
- Australian research that provides additional findings not replicated in the international evidence-base.

Once the framework was constructed and tested, studies which did not add significantly by either challenging, refining or supplementing the framework were excluded for reasons of scope and readability. Certain sub-specialties also had to be excluded for reasons of scope, for example, the evidence on parenting and children’s development.

### 2.4 Limitations of this research method

The research synthesis methodology is inherently limited by the constraints of the evidence available in existing research publications. In addition, this research synthesis was biased toward English-language publications and partly as a result, the evidence from Europe is largely from the UK.

A particular limitation of this study is that the breadth of the scope needed to articulate the foundations of nationally-consistent outcome measures has necessarily limited the depth of the synthesis in particular specialist areas. Consequently, the synthesis describes the broad elements of effective practice. However future research could explore each step in much more detail, to document the particular activities being delivered and the client outcomes being achieved by specific agencies working at different levels of the overall picture.

These constraints mean that steps in the outcome model are underpinned by demonstrating a reasonable link between the actions of the service system and the achieved result. Categorical causal certainty cannot be achieved or expected since this often eludes even very rigorously designed experimental research studies.

The conceptual purpose of this project and the broad scope limits its capacity to provide a tight, categorical definition as required for data collection or service delivery reporting. What the project does contribute is a broad definition based in the evidence about what makes a difference. This purposeful, evidence-based foundation can be used to drive an outcome-focused use of existing data elements and definitions.

### 2.5 Defining the ‘client’ of the client outcome model

The research synthesis broadly defines the ‘client’ of the client outcomes framework as an individual or a household in any of the following three categories:

1. Housed but at risk of a first experience of homelessness.
2. Currently experiencing homelessness.
3. Housed but at risk of further homelessness.
This continuum definition of the ‘client’ in the outcome framework reflects the evidence that making a difference to homelessness cannot be achieved purely through a focus on persons currently experiencing a housing crisis.

<table>
<thead>
<tr>
<th>Table 1: Defining the ‘client’</th>
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<tbody>
<tr>
<td><strong>Type of client</strong></td>
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<tr>
<td><strong>Type of intervention</strong></td>
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<tr>
<td><strong>Outcome</strong></td>
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</tbody>
</table>

As will be further discussed in the next chapter, an experience of ‘homelessness’ as defined by a service delivery agreement or for research purposes never occurs in isolation, but happens in the context of an individual’s life and their socio-economic circumstances. These contextual factors contribute to the risk of homelessness before a person’s first experience, and can continue to generate housing vulnerability even after a successful housing intervention.

### 2.5.1 Defining homelessness

There is a wide range of subjective and objective definitions of homelessness deployed in different research and policy contexts, particularly across national boundaries (Greenhalgh et al. 2004). For the purposes of this project, a narrow definition is not useful because it would unnecessarily exclude relevant evidence from research that utilised different terms.

Accordingly, in order to identify common principles from across the diversity of international policy and research contexts, the synthesis operationalises three umbrella terms: at risk of homelessness, homelessness and long-term or chronic homelessness.

#### 2.5.2 At risk of homelessness

This category is very difficult to define because it is a forward projection rather than an objective category. There is no way to be certain that a person ‘at risk’ of homelessness will subsequently experience homelessness.

In the absence of a clear definition, the research evidence identified in this synthesis highlights the following groups who are known to be at high risk of either a first experience of homelessness, or at risk of further experiences of homelessness even after securing housing:

- People who have experienced long-term or chronic homelessness.
- People with serious mental illness.
- People with significant problematic drug or alcohol dependency.
- People who are transitioning to independent living for the first time or after a period of dependency—for example young people leaving care to live independently for the first time, women who have left a violent partner, persons exiting from psychiatric or correctional institutions.
- Older people.
- Members of families with incidence of family violence, child abuse, parental drug or alcohol dependency or mental illness.
2.5.3 Homelessness

This umbrella term encompasses the foundational categories in the Australian context, described in the ‘cultural’ definition of homelessness (Chamberlain & MacKenzie 1992) and utilised in Australian Census Analytics program to estimate national homelessness rates (Chamberlain & MacKenzie 2008). It is worth noting that Australia and the UK employ a broad definition of homelessness relative to international conventions.

The ‘cultural definition’ assesses homelessness against a minimum ‘cultural’ housing standard defined as a small rental flat with private amenities and some security of tenure. Further, it categorises three sub-types of homelessness: primary, secondary and tertiary homelessness.

Primary homelessness includes what the public might conceive as ‘real homelessness’, meaning living without any form of conventional shelter: people living on the street, in improvised dwellings, sleeping in parks, squatting, sleeping in cars or railway carriages. In Australia and the UK, primary homelessness is described as ‘sleeping rough’. Other terms used internationally include unsheltered homelessness (United States), absolute homelessness, rooflessness and street/service homelessness (Canada).

The US policy discourse uses the term ‘sheltered’ and ‘unsheltered’ to describe the different sub-types of homelessness. ‘Sheltered’ homelessness describes people who are currently dwelling in an emergency shelter or transitional housing program (HUD 2010).

In Australia, under the cultural definition, ‘sheltered homelessness’ is described as secondary homelessness. Secondary homelessness includes people moving frequently from one form of temporary accommodation to another, including emergency housing, boarding houses or staying with family or friends (called ‘couch surfing’). ‘Doubling up’ and the ‘hidden homeless’ are other terms sometimes used to describe types of secondary homelessness in the international literature.

Finally, tertiary homelessness refers to people staying for longer than 13 weeks in the same rooming house.

2.5.4 Long-term or chronic homelessness

Within the literature there are a range of definitions that aim to give a qualitative understanding of the difference between long-term and short-term homelessness. For example, in her study on the experiences of mentally ill homeless people Robinson (2003) uses the term ‘iterative homelessness' to describe a ‘constant cycle of losing, searching and maintaining accommodation’ (Robinson 2003, p.3). She stresses that even while apparently stably housed, a person can be vulnerable to homelessness and therefore is essentially still ‘iteratively’ homeless (Robinson 2003).

More simply, Johnson et al. (2008) suggest that homelessness be divided into three timeframes: short-term (0–3 months), medium-term (4–11 months) and long-term (12 months and onwards).

Chronic homelessness is the predominant term used in the US context. This term is used in legislation to circumscribe eligibility for services for a subpopulation of homeless people who have disabling conditions, have been homeless for more than a year and have had at least four experiences of homelessness in the past three years (HUD 2010).

The research synthesis suggests that people experiencing long-term or chronic homelessness are:
More likely to have experienced primary homelessness.
Highly likely to have either mental health or substance use issues or both.
Can be both individuals and families.
Vulnerable to further homelessness even when housed.

A disadvantage of using umbrella terms is losing some of the definitional nuances in the literature. For example, it is worth noting the evidence that mainstream definitions are not entirely suitable for understanding the homelessness experiences of Indigenous Australians (Birdsall-Jones et al. 2010; Memmott et al. 2003). Memmott et al. identified three types of homelessness for Indigenous people: public place dwellers, at-risk-of-homelessness persons, and spiritually homeless persons (Memmott et al. 2003, p.15). Birdsall-Jones et al. (2010) find that high levels of Indigenous overcrowding in public housing can be understood as a part of homelessness.

2.6 Scope and quality of the research synthesis evidence-base

In total, this research synthesis cites 125 published sources of credible, empirical research evidence from Australia and international sources. A comprehensive range of quantitative and qualitative research designs in the evidence-base provide breadth and depth to the analysis and understandings that emerge from the synthesis.

The following table presents an overview of the number and types of research studies incorporated into the research synthesis, to give a broad picture of the depth of evidence across the outcomes model.2

Table 2: Number and type of studies for each step in the outcome model

<table>
<thead>
<tr>
<th>No. of studies</th>
<th>Research design</th>
<th>Geographic source</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Quantitative</td>
<td>Qualitative</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pathways into and out of homelessness</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td>Engagement in housing-focused support</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Housing work</td>
<td>24</td>
<td>18</td>
</tr>
<tr>
<td>Case management</td>
<td>6</td>
<td>4</td>
</tr>
<tr>
<td>Homelessness prevention</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Complex health management</td>
<td>18</td>
<td>9</td>
</tr>
<tr>
<td>Economic and social participation</td>
<td>21</td>
<td>12</td>
</tr>
</tbody>
</table>

2 Note that some studies provided evidence for more than one step in the outcomes model, and some studies generated more than one publication; accordingly the numbers in the table do not sum to the total.
An overall weakness to note is that the research sources from Europe are predominantly from the UK and those from North America are largely from the US. This partly reflects a research bias toward English-language publications, and partly the research investment capacity in both these advanced industrial economies.

2.6.1 Strengths

Methodological diversity

A range of methodologies were found, including case studies, experimental program evaluation including randomised controlled trials and pre-post comparisons; quantitative data capture and analysis; qualitative analysis (interviews, case studies, focus groups), small- and large-scale evaluations; action research; ethnography and participatory observation.

The diversity in methodologies is useful for building the most robust and rich understanding possible from our current evidence-base. Diverse methodologies allow triangulation of findings (Olsen 2004) which means that conclusions derived from different methods can be tested against each other and a more objective picture can emerge. A related advantage is that findings that have both quantitative and qualitative support are usually more credible, detailed and meaningful.

International research has depth and considerable breadth

The breadth and depth of the international research literature is significant. And while there remain many gaps, there is certainly a coherent evidence-base adequate to the task of generating a robust foundation for client outcome measures.

Topics include:
- Prevention of homelessness.
- Housing types—housing first, shelters, supported housing, transitional housing, permanent options.
- Types of therapy—narrative, filial.
- Goal-setting—assessment frameworks, needs assessment.
- The impact of homelessness—on wellbeing, counselling relationships, trauma and trauma recovery.
- Dignity.
- Social support—peer support, life skills, employment and education.
- Life-course impacts on homelessness—foster care and subsequent homelessness, child abuse and neglect.
- Ongoing support once in stable housing—transitional care, social support, financial support.
- Physical and mental health.
- Programs and services—types of services, language used, linkages between service providers, rural services and special needs of specific age groups.

The advantage of breadth and depth is the possibility of greater confidence where there is consistency of major findings across Europe, North America and Australia.

In the UK, Europe and Australia, literature focuses on homelessness broadly, while in the US, persons with severe mental illness have taken the bulk of the focus to date.
**Strong experimental evaluation designs from the US**

The research synthesis draws heavily on the US research literature because of the significant and internationally unparalleled investment in empirical, experimental outcome evaluations.

In particular, this includes the rigorous experimental validation of *Housing First* and assertive community case-management.

**Australian qualitative homelessness research**

Australian homelessness research strengths include in-depth qualitative research focused on understanding the phenomenon of homelessness, including pathways in and out.

Themes covered and some of the key studies include:

- **Pathways** (Johnson, Gronda & Coutts 2008); mental illness (Robinson 2003); young people (Mallett et al. 2010); young people leaving care (Johnson et al. 2010).
- Young people (Mallett et al. 2006; Mallett et al. 2003; Mallett et al. 2010; Mallett, Rosenthal & Myers 2001; Robinson 2002a, 2002b, 2005).
- **Experiences** (Robinson 2010) (Parsell 2009, 2010).
- **Single women** (Murray 2009; Sharam 2008).

Quantitative analysis:

- **Census** (Chamberlain & MacKenzie 2003, 2009).
- **Inner-city homelessness** (Chamberlain, Johnson & Theobold 2007; Johnson & Chamberlain 2008a, 2008b).
- **Intergenerational homelessness** (Flatau 2010).
- **Studies of program outcomes** (Grace, Batterham & Cornell 2008; Grace & Gill 2008).
- **Costs of homelessness** (Flatau et al. 2008).

Australian research also includes a robust evidence-base on housing affordability and supply which provides an important context for achieving client outcomes in homelessness.

### 2.6.2 Weaknesses

The following list of weaknesses describes significant gaps in the evidence identified in the course of building the foundations for nationally-consistent outcome measures. These areas of weakness do not represent all the research gaps on the topic of homelessness.

**Overall weaknesses in the evidence:**

- Very few high-quality Australian program outcome evaluations.
- Poor differentiation in Australian quantitative research (little evidence about prevalence, in particular around intensity of need: how many people are experiencing homelessness long-term or have complex needs?).
Very little evaluative evidence on homelessness prevention and economic and social participation interventions.

Gaps in particular topics:

- Working specifically with cognitive disabilities and personality disorders.
- Effective post-housing support for drug dependency and other kinds of addictions.
- Psychosocial interventions to promote changes in self-efficacy and behavioural issues.
- Evaluations of recreational programs.
- Evaluations of programs targeting the barriers to private rental housing.
3 PRACTICE AND THEORY OF OUTCOME MEASUREMENT

This project reviewed literature and recent practice on outcome measurement in homelessness and community services and found that an evidence-based outcomes model would provide the strongest foundation for nationally-consistent outcome measures.

In reviewing the field of outcome measurement in homelessness and community services, it was clear that a significant and extensive literature exists on the theory and practice of outcome measurement, including the use of outcome models or program logic (Baulderstone & Talbot 2004; Burns & Cupitt 2003; Butcher et al. 2006; Crook et al. 2005; Duignan 2009d; Flinders Institute of Public Policy and Management 1999; Friedman 2005; Karmel 2009; Planigale 2010; Sonpal-Valias 2009; Spellman & Abbenante 2008).

This chapter describes the conclusions and recommendations from this literature relevant to this project, including the benefits and challenges of an outcomes focus. It also introduces the methodology used to develop the client outcomes model, Paul Duignan's 'outcomes theory'.

3.1 Outcome measurement initiatives in homelessness services

An important context for this project is the service development and research already conducted by service delivery agencies. Many homelessness agencies, including two of our project partners, have undertaken important outcome definition projects, including significant practice-development processes or components. For example, some recent initiatives include:

- Melbourne Citymission engaged service delivery staff in a reflective process to clarify program aims, specify service activities and from there derive program-specific outcome measures. Melbourne Citymission’s outcomes development process, MORF, explicitly adopted and adapted the Friedman and DeLapp Results-Based Accountability3 approach.

- HomeGround Services conducted a thorough literature review on outcomes measurement systems and a discussion paper on case work domains that captured a comprehensive range of assistance domains and client change loci (Planigale 2010).

- Measuring the outcomes of community organisations by the Australian Research Alliance for Children and Youth and KPMG (Australian Research Alliance for Children and Youth & KPMG 2010).

This project was explicitly designed not to replicate work already conducted by the project partners including the literature review, Measurement of client outcomes in homelessness services (Planigale 2010). Planigale (2010) comprehensively reports on the context, system design and implementation issues of introducing and maintaining client outcome measurement systems. The literature review addressed questions including:

- What types of information can be produced by outcome measurement systems and what conclusions can this information support?

What specific measures and measurement tools may be of relevance to homelessness services?

What are the options for data collection processes (when should data be collected, from who, by who, and in what format)?

How can results be presented to be of maximum benefit to clients and the organisation?

In contrast, this project focused on using research synthesis to identify:

- Which outcomes really make a difference to people experiencing homelessness?
- What are the steps that lead to successful outcomes?

Then this synthesis was used to build an overall model of the effective practice steps that lead to positive client outcomes.

### 3.2 Benefits and challenges of nationally-consistent outcome measures

#### 3.2.1 Outcome measures provide direction and focus

The outcomes literature indicates that a set of nationally-consistent client outcome measures has the potential to provide direction and motivation and drive innovation in service delivery and program design. By establishing a set of clear evidence-based outcome indicators rather than specifying program inputs or processes, service delivery agencies and funding bodies are invited to monitor their delivery of outcomes and modify their practice to work toward achieving the targets. A well-designed outcome system can create transparency and client-focused accountability.

The developer of the ‘outcomes theory’ used in this project, Paul Duignan, comments on the difference between 'program-focused' measurement systems and 'outcomes-focused' systems, making it clear how an outcomes focus can and should drive innovation:

> The preferred 'outcomes thinking' approach leaves open the possibility that one can consider that there may be more than one way (program, or intervention) through which an outcome can be achieved (Duignan 2009a).

This approach is driven by the idea that an outcomes-orientation can motivate good results and drive innovation. For example, in their review of US efforts to end homelessness through service system change, Burt and Spellman comment:

> Many communities and providers note that having a process in place to measure their actions and results holds them more accountable, and therefore makes them work harder to be productive so they will be able to demonstrate results (Burt & Spellman 2007, pp.2–33).

Internationally, significant work on developing and using outcome measures in homelessness and community services has proven their effectiveness. For example, Burt and Spellman (2007) highlight the value of ambitious client outcome measures to provide accountability and drive innovation. They comment:

> Ambitious goals multiply the amount of work needed to create change, but they also expand the pool of willing funders, advocates and allies (Burt & Spellman 2007, pp.2–17).

The last two decades of policy innovation and research have generated a significant change in international best-practice in homelessness assistance which has driven for
example, the ambitious, outcome-focused *Ten-Year Plan to End Homelessness* movement in the US.

Of note, the UK’s focus on reducing rough sleeping over the last two decades showed the effectiveness of assertive approaches to reducing primary homelessness (Busch-Geertsema 2002). This success reportedly inspired Roseanne Haggerty who consequently developed CommonGround’s Street to Home model in New York City.5 Meanwhile around a decade ago, research conducted in New York City established the effectiveness and cost-effectiveness of permanent supportive housing and changed the way homelessness services for people with chronic homelessness are delivered (Culhane 2008). This research was critical in establishing that long-term client outcomes could be achieved and that homelessness could be *ended* and not just managed.

A first important finding was that the urban homeless shelter population was comprised of two distinct categories of clients. One category, the majority, typically stayed for short periods of time in shelters, while a minority—estimated to be 10 per cent of all shelter users—accounted for around 80 per cent of the services and resources provided (Culhane 2008). This evidence suggested that innovation in serving this minority could have a radical impact on the overall costs to the public. A second key finding was evidence that the costs of assisting the chronically homeless with supportive housing was either cheaper or equivalent to the costs of emergency shelters and other emergency services (Culhane 2008).6 The first of these studies, an influential and ground-breaking study using administrative data for large-scale cost analysis by Culhane, Metraux and Hadley (2002), sparked consequent ‘cost studies’ which have replicated these findings and been important advocacy tools in the movement to end homelessness through ‘Ten-Year Plans’ (Culhane 2008, pp.104–7).

Culhane et al. (2002) found a net cost to government of only US$995 per year to provide a supportive housing unit, due to savings in other services. This influential US study tracked around 4500 homeless people over four years, pre- and post-placement in a supportive housing program. Using administrative data from multiple agencies, they find a reduction of US$16 281 in the costs of shelter use, incarceration and hospitalisation for people with severe mental illness. This saving nearly covered the cost of providing the supportive housing, as indicated in the net cost cited above (Culhane, Metraux & Hadley 2002).7

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4 See [http://www.endhomelessness.org/section/solutions/ten_year_plan](http://www.endhomelessness.org/section/solutions/ten_year_plan)

5 See [http://www.commonground.org/?page_id=21](http://www.commonground.org/?page_id=21)


7 In Australia, research has found a potential cost offset for effective homelessness programs of more than double the cost of delivering the programs Flatau, P., K. Zaretzky, M. Brady, Y. Haigh, & R. Martin. (2008) *The cost-effectiveness of homelessness programs: a first assessment.* AhURI Final Report No.119. Melbourne: Australian Housing and Urban Research Institute, Western Australia Research Centre.
These innovations in practice and research have demonstrated the motivational power of outcome targets and established that there are effective interventions which can really make a difference to homelessness.

3.2.2 An outcomes model provides a transparent logic to justify outcome measures

The research for this project identified the need for a robust outcomes model and not simply another list of indicators. This need was highlighted, for example, by a US review of outcome measurement in homelessness services. Crook et al. (2005) identify a range of validated and informal outcome indicators (see Appendix A), however, they conclude that there is as yet no basis for choosing between these indicators. They arrive at a set of further research questions, including ‘What outcomes should be measured? And which should not?’, and ‘What types of outcomes are important to measure: short-term, intermediate and/or long-term?’ (Crook et al. 2005, p.388). This project begins to answer these questions by creating an outcomes model that provides an evidence-based conceptual foundation for outcome measures.

In the online resource *Outcome Measurement Resource Network*, Plantz, Greenway and Hendricks describe an outcomes model as a theory about ‘how the program brings about benefits for participants’ (Plantz, Greenway & Hendricks). This theory will always include an ‘if-then’ chain of events with embedded assumptions about causality and control: *If we provide emergency accommodation then the person will be in a better situation than sleeping rough. If we provide information about affordable housing options and access to a phone, then a person will be able to access suitable accommodation.*

Articulating the relationship between a program output, the immediate client outcome and the desired longer-term outcome is a critical part of a credible outcome measurement framework. Acknowledging the inescapable contention involved in defining outcome steps, Plantz, Greenway and Hendricks comment that:

> It must be reasonable to believe that the program can influence the longest-term outcome in a non-trivial way, even though it cannot control it (Plantz, Greenway & Hendricks, p.5).

Use of empirical evidence to build the outcomes model is a way to adjudicate within a complex field of conflicting theories and value judgments. Funding bodies, service-delivery agencies and clients will not always agree about what is the most important outcome, or what are the outcome steps. As Planigale comments:

> Stakeholder perspectives necessarily impact on decisions about what outcomes to measure, and about the interpretation of results. Whether a given outcome is positive or negative is a value judgment; the effects of programs may therefore be positive in the eyes of some actors and negative in the eyes of others (Planigale 2010, p.32).

Recognising the contention in outcome models, Plantz, Greenway and Hendricks also advocate the inclusion of research evidence to establish the links and outcome steps involved, noting that in ‘the ideal case, the outcomes, indicators, measurement approaches and other materials derive from experimental research linking an intervention to specific outcomes’ (Plantz, Greenway & Hendricks, p.6).

This project also included practitioner engagement at both the start and finish of building the outcomes model in recognition that the evidence-base can never include everything that is known about steps in the real world that contribute to outcomes.
3.2.3 Risks of a focus on outcome measurement

Many commentators on outcome measurement also acknowledge the potential dangers of a focus on client outcome measures (Baulderstone & Talbot 2004; Crook et al. 2005; Planigale 2010; Plantz, Greenway & Hendricks; Spellman & Abbenante 2008). At an agency level, there are risks that client outcome-based performance assessment could distort agency practice in a negative way. At a practice level, it is noted that high-level unrealistic outcome measures could alienate workers or fail to capture the complexity and value of what has to be done, the steps along the way to achieve the outcomes.

At the agency level, there are risks that funders will set outcomes that do not reflect what works in making a difference to people on the ground, or will make agencies accountable for outcomes that agencies can have no control over. There are also fears about the use of outcome measurement to unfairly assess the performance of services. In the Australian homelessness context, Baulderstone and Talbot’s report, Outcome Measurement in SAAP Funded Services, found that the most common concern was:

... the potential for use of outcome measurement by funders as a means of evaluating and comparing services without cognisance of service and structural features ... some participants expressed a lack of confidence that program administrators fully appreciated the impact of these issues upon their services (Baulderstone and Talbot 2004, p.41).

Furthermore, if outcome measures were used to competitively assess agency performance it would create a potential conflict of interest and the risk that agencies would selectively choose clients who were the most likely to succeed. Baulderstone and Talbot note the possibility that ‘results would be fudged to ensure the agency ‘looked good’, particularly if such comparisons were used to influence funding allocations’ (Baulderstone & Talbot 2004, p.46).

Similarly, from the US non-government sector more broadly, Plantz, Greenway, and Hendricks caution:

Done badly, linking outcomes to funding can shift resources from service delivery to measurement with no offsetting benefit to programs, penalise prevention and development programs and other with harder-to-measure outcomes, promote ‘creaming’ (selecting participants who are more likely to succeed), inhibit innovation, punish risk-taking and discourage interprogram cooperation (Plantz, Greenway & Hendricks, pp.10–1).

At a practice level, client outcome measurement has the potential to depress and demotivate both workers and clients because of the external constraints which can prevent the achievement of positive changes. Baulderstone and Talbot document sentiments of resistance to outcome measurement because, from a practitioner viewpoint, the measures do not capture the work or the small changes which are occurring for clients. They report that ‘SAAP services have indicated that many changes are achieved by clients but are not being identified or measured’ (Baulderstone and Talbot 2004, p.1).

These concerns are significant and need to be addressed through transparency and a strong partnership approach, as well as a commitment to ongoing dialogue about the outcome indicators and measures. This project recommends a robust outcomes model as the ideal mechanism for enabling the transparency and dialogue necessary for credible outcome measurement.
3.2.4 Practice-based outcome measures

Review of the literature and practice of outcome measures identified some significant reasons for adopting an outcome model approach. The literature documented a number of alternative approaches to outcome measurement and highlighted some of the disadvantages and barriers to successful implementation in a national outcome system. The project finds that practice-based outcome measurement systems certainly have benefits, but result in a level of detail which is unfeasible for a nationally-consistent system.

In Australia, Baulderstone and Talbot made a sustained effort to develop practice relevant, nationally-consistent outcome measures for homelessness services, and concluded that it was not feasible (Baulderstone & Talbot 2004). They concluded that the diversity of service delivery practice mitigates against a nationally aggregated set of outcome indicators. Baulderstone and Talbot found that while there was 'no fundamental barrier to outcome measurement implementation in most instances' they determined that it was not possible to have an 'over-arching data aggregation mechanism' because different SAAP services required different tools. This problem is only amplified in the context of nationally-consistent outcome measures potentially applicable across both homelessness specific and mainstream agencies since people experiencing homelessness are clients of all kinds of services.

Baulderstone and Talbot focused on practice-relevant outcome measurement tools because they reasoned this would lead to better data quality (Baulderstone and Talbot 2004, p.37). However after testing goal and outcome scaling tools, Baulderstone and Talbot found they were of limited value for the purpose of nationally-consistent client outcomes measurement in homelessness. Abstract goal-scaling tools did not provide information about the types of goals that were achieved, while other tools supported the individualised and subjective nature of case-management goal-setting and resulted in lack of uniformity. None of the tools tested could support aggregate comparison of outcomes across the service system (Baulderstone & Talbot 2004, p.19).

A high level of detail would be required to capture the micro-outcomes which make up critical steps in successful and effective support, and to do justice to the very significant and painstaking work required to secure access to housing and specialist support resources in a very constrained environment. However, as Baulderstone and Talbot also found, there are logistical and feasibility constraints which mitigate against national consistency using an in-depth level of outcome detail.

Yet collating and reporting data at a national level is important to compensate for the many individual and structural contingencies that influence outcomes in a particular place, at a particular time. By obtaining big-picture results we can average out contingencies and identify population trends—is the system overall working well? Does the system need tweaking or are particular areas underperforming or facing particular challenges?

Indeed, this project finds there are three broad reasons for not requiring an outcomes measurement system to comprehensively reflect service delivery practice:

- Avoid the prohibitive level of detail required to cover the diverse and rich range of possible service practice on the ground (for example, the ‘BT Generic Outcome’ tool includes 21 outcome areas (Baulderstone & Talbot 2004)). This leads to data collection tools that are unwieldy for everyday service delivery and also generates a level of outcome detail which is difficult to interpret.
Avoid amplifying existing multiple reporting burdens by adding another set of detailed definitions. Many community agencies provide a range of human services and will prefer an internally consistent data system that can capture and reflect the range of work they do.

Avoid potentially stifling practice innovation by over-specifying practice-level detail.

Synthesis of the outcome measurement literature also recommends against the use of clinically validated outcome measurement tools in a national outcome set. The research literature provides an extensive set of validated outcome measurement instruments, however, these tools are rarely appropriate for everyday administrative data collection in service delivery. Baulderstone and Talbot (2004) find that detailed clinical indicators, such as level of functioning, or psychiatric symptoms, require trained assessment skills which cannot be assumed across homelessness agencies and are inappropriate for a national set of outcome indicators. In general, clinically validated survey tools are inappropriate because they require additional training to administer them correctly; are typically intrusive and time-consuming; and because credible interpretation of the data requires a well-designed experiment.

3.2.5 Limitations of nationally-consistent client outcome measures

There are important limitations that can be acknowledged for a strategic framework approach to nationally-consistent client outcome measures. As discussed above, feasible nationally-consistent outcome measures will not be able to capture the diversity of service delivery practice. Outcome measures also cannot substitute for evaluation, service quality monitoring or research. In their review of outcome measurement in US homeless services Crook et al. acknowledge that outcome measures do not prove how or why an outcome was achieved (Crook et al. 2005, p.380).

While client outcome measures can provide a guide to whether services are operating effectively, they do not measure service quality and cannot substitute for either quality assurance procedures or client satisfaction monitoring. As Planigale comments in Measurement of Client Outcomes in Homelessness Services:

... outcomes are only part of a larger picture of an organisation’s performance, and ... attention to inputs and to process is equally important to ensuring that an organisation is ‘doing a good job’ by providing quality service (Planigale 2010, p.28).

Finally, there are many client outcomes that require sensitive research efforts to document in a rigorous way. There are outcomes that are specific to particular client groups, particular locations or specialist agencies. It is clear from the research that not all client outcomes can or should be monitored in an administrative data set, or in a nationally-consistent way. In light of these constraints, outcome measures are best considered as one part of a system of monitoring service effectiveness (Duignan 2009d).

3.3 Duignan’s ‘outcomes theory’

This project identified the outcomes theory developed by Duignan as a significant resource for building a foundation for national outcomes measures (Duignan 2009d). The project has used the outcomes theory to create a coherent conceptual basis for homelessness outcome measures. This section provides an overview of Duignan’s outcomes theory.

Duignan’s outcomes theory establishes three important points that guide this project:
An outcomes model describes the steps which lead to the result

An outcomes model is a model of the real steps that lead to a result. Steps in the outcomes model represent accepted causal links between an action and a result:

... an outcomes model should be structured in the best possible way to communicate the hypothesized pattern of causality between lower level steps and higher-level outcomes (Duignan 2008b).

Baulderstone and Talbot highlight the value of developing an outcomes model in their report on outcome measurement in homelessness services:

There is substantial potential benefit in attempting to detail procedure/process/outcome relationships. If nothing else, it helps to surface the assumptions of service providers and funders (Baulderstone & Talbot 2004, p.55).

They also note that at the time of their research ‘little [had] been done to address this important basis for program management and improvement’ (Baulderstone & Talbot 2004, p.55). This current project similarly identified the need for an overarching outcomes model and found it to be a strong mechanism for building a foundation for nationally-consistent outcome measures.

The outcomes model is built of steps that represent accepted causal links between an action and a result. Duignan identifies two ways that these causal links can be established:

1. Empirical evidence from previous research.

He furthermore highlights that the credibility of these links is dependent on the acceptance by the stakeholders, who establish and/or accept the criteria for validating the outcomes model:

Causal links within an outcomes hierarchy are established when they meet the criteria for establishing a causal link of a community of users of that outcomes hierarchy. (Duignan 2005–10)

Accordingly, to create credibility for a nationally-consistent outcomes model, this project has used research synthesis to determine and establish the evidence-based links, and then tested and refined the model using practitioner and other stakeholder engagement.

Using empirical evidence to build the outcomes model is a way to adjudicate within a complex field of conflicting theories and value judgments. Funding bodies, service-delivery agencies and clients will not always agree about the most important outcome, or how to achieve outcomes. As Planigale comments:

Stakeholder perspectives necessarily impact on decisions about what outcomes to measure, and about the interpretation of results. Whether a given outcome is positive or negative is a value judgment; the effects of programs...
may therefore be positive in the eyes of some actors and negative in the eyes of others (Rossi 1997, p.22). Even where there is agreement on valuation of outcomes, there may be differences in views of priority. (Planigale 2010, p.32)

However, because the research evidence-base does not cover everything that is known about steps in the real world that contribute to outcomes, the project also included reiterated practitioner engagement.

An important feature to support the credibility and acceptance of the outcome measures over time is the capacity for the outcome model and its indicators to be updated with new evidence as it emerges.

In the outcomes theory, Duignan establishes a generic element—’steps and outcomes’—for inclusion in an outcomes model. A step or an outcome must be relevant to the highest level outcome, and then can have one or more of the following five characteristics: relevant, influenceable, controllable, measurable, provable and accountable.

These characteristics can be used to formally define typical terms employed in outcome measurement. Accordingly, he formally defines the commonly used term ‘output’ as an outcome model step which is relevant, influenceable, controllable, measurable, provable and accountable. Similarly, what is often called an ‘intermediate outcome’ may then be defined in terms of these characteristics. Is it a step which is simply relevant and influenceable? Or is it also required to be measurable and provable?

Duignan defines the characteristics in more detail as follows:

**Relevant**—relevant to outcomes it is hoped will be influenced by a program or intervention. All steps in outcomes models should have this feature. It should be noted that it also includes steps which are not necessarily able to be influenced by a program or intervention themselves but which may influence the possibility of a program or intervention influencing a higher-level outcome (e.g. these are often referred to as risks or assumptions within some types of outcomes models).

**Influenceable**—able to be influenced by a program or intervention. This is a hypothetical claim that a higher-level step or outcome is able to be influenced by a particular program or intervention. It is not yet a claim that it will be able to be proved in a particular case that the program or intervention did actually influence the higher-level step or outcome (this stronger claim is referred to as being demonstrably attributable and is discussed below).

**Controllable**—only influenced by one particular program or intervention. This is a claim that in the normal course of events the only significant factor influencing a higher-level step or outcome is the program or intervention. As a consequence, if the higher-level step improves then it can be concluded that it was the program or intervention which caused it to improve.

**Measurable**—able to be measured. A separate issue in regard to steps or outcomes is whether or not they are able to be measured. Measurability is a function of the feasibility and affordability of measurement at any point in time.

**Demonstrably attributable (Provable)**—able to be demonstrated that changes in the step or outcome can be attributed to one particular program or intervention (i.e. proved that only one particular program or intervention changed it). This is the claim that it can be proved that a particular program or intervention changed a higher-level step or outcome in a particular instance.
This is a separate claim from the claim set out above that a higher-level step or outcome is *influenceable* by a program or intervention.

**Accountable (Rewardable or Punishable)**—something that a particular program or intervention will be rewarded or punished for. It should not always be assumed that just because a change in a high-level step or outcome is *demonstrably attributable* to a program or intervention that the program or intervention should necessarily be held *accountable* for it. In some cases there may be mitigating circumstances which mean that it is inappropriate to reward or punish a program or intervention for a change in a high-level step or outcome. (Duignan 2009c)

The outcomes model, built with evidence-informed causal links, and kept live through active refinement over time, establishes the credible logic that links outcome indicators to the work being done on the ground and the high-level outcomes which are ultimately sought.

### 3.3.2 The model defines the rationale for outcome indicators

In Duignan’s outcomes theory, the outcomes model provides the foundation for a coherent set of outcome measures. Indicators and their associated measures are mapped onto the outcomes model.

As indicated in Figure 2, outcome indicators can be divided into two building blocks of an outcomes system: not-necessarily demonstrable (attributable) indicators and demonstrable (attributable) indicators. Attributable indicators are critical for measuring performance, but they rarely provide an indication of higher-level outcome achievement. Not-necessarily demonstrable indicators are relevant to the outcome but cannot be categorically attributed to one party.

A very strong feature of Duignan’s outcomes theory is that it does not exclude outputs or activities or restrict the outcome model only to controllable, demonstrably attributable outcomes and their indicators. If it is restricted to those elements, an outcomes model cannot provide a realistic representation of what he calls the ‘cascading causes’ that contribute to results.

Duignan explains that the omission of non-controllable or non-measurable elements in the outcome model is a common problem in outcome systems (Duignan 2008a). Non-measurable elements are typically excluded from outcome models because they are, obviously, not measurable. However the serious consequence is that the outcome model will lack credibility since it will not incorporate the real-world elements that influence the outcome and may, in many cases, be decisive.

Some outcome systems encourage not only constraining outcome models to the measurable, but even further down to the attributable. Duignan defines this common error in building outcome systems as ‘The Error of Limiting Focus to Only the Attributable’. This error, he explains, leads to the following negative consequences (Duignan 2009b):

- There is no incentive for providers to focus effort on achieving high-level outcomes where these cannot be, as is often the case, attributed to the particular provider. It incentivizes providers to just focus on the demonstrably attributable which normally tend to be lower down an outcomes model.
- It discourages collaboration between providers because, by definition, collaborative action will be harder, if not impossible, to demonstrably attribute to a single provider.
If keeps the focus just on measurable indicators when innovation and hence strategic advantage is often to be achieved by exploring areas where it is more difficult to measure and attribute.

Similarly, outcome measures which are not defensibly associated with an outcomes model logic will typically lose credibility and fail to provide either motivation or performance accountability. Duignan notes a further consequence that if non-measurable steps are not included in an outcome model, then it is difficult to monitor the steps that are not being measured, and this introduces an uncertainty which compromises performance management.

This project adopted Duignan’s outcomes theory because it addresses some of the challenges identified in the review of homelessness outcome measurement work. In particular, Duignan’s ‘outcomes model’ approach provides a way to create a credible link between what agencies are doing on the ground and what the community expects will be achieved for people experiencing homelessness. This is important because:

➔ Practitioner credibility and acceptance is critical for the reliability and value of any administrative outcome data set.

➔ Funder and community credibility and acceptance is critical for strong, consistent resourcing of services which make a difference.

In their report *Outcome Measurement in SAAP Funded Services*, Baulderstone and Talbot identify a practitioner viewpoint that much of the (often difficult) work being done in support services does not lead to measurable changes. This is highlighted as an obstacle to outcome measurement in homelessness services (Baulderstone & Talbot 2004).

Baulderstone and Talbot noted a culture of resistance to high-level outcome measurement because, from a practitioner viewpoint, the measures do not capture the work or the changes that are actually occurring for clients. Baulderstone and Talbot report that ‘SAAP services have indicated that many changes are achieved by clients but are not being identified or measured’ in the high-level indicators included in the SAAP IV Accountability Framework8 (Baulderstone & Talbot 2004, p.1).

Duignan’s approach to the outcomes model can address concerns about the loss of detail or the exclusion of real factors that influence the result. Duignan explains how a real world, credible outcomes model can underlie clear and effective ‘outcomes-focused contracting’ using an approach that is ‘realistic about what can be measured, what is demonstrably attributable to providers, and clear about what providers are being held to account for’ (Duignan 2008a).

This report proposes that the outcomes model is a way to capture the real steps along the way, while also delivering the direction and motivation of high-level national outcomes reporting.

3.3.3 **An outcomes model is one part of an’ outcomes system’**

Duignan generically defines an ‘outcomes system’ as ‘any type of system for identifying, measuring, attributing and/or holding parties to account for outcomes of any type’ (Duignan 2009e).

Duignan’s outcomes theory identifies how the outcomes model is only one component of an outcomes system. Figure 2 represents the ‘five-building blocks’ of an outcomes

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8 For example, two high-level indicators were: proportion of clients returning to SAAP within six months; and proportion of clients who exit to independent accommodation.
system in outcomes theory, and positions the outcomes model within the outcomes system.

Figure 2: The five building-blocks of any outcomes system

In Duignan’s outcomes theory, the important issues of how and what to measure, and who should be accountable are not discarded, but they are subordinated to the creation of a robust and credible outcome model. Once the model is created, then indicators can be identified and an accurate assessment made of the feasibility of attribution and the robustness of the causal links.
In brief: practice and theory of outcome measurement

**Why use client outcome measures?**
Outcome measures are a powerful tool for focusing public attention on the goals that motivate our work.

Focusing on outcome targets rather than specifying processes or inputs can drive innovation and improved performance while supporting diversity in local practice.

**Challenges of outcome measurement**
The complexity of service delivery practice can make national consistency impossible or unfeasible.

Inappropriate outcome measures can lead to ‘fudging’ results or hopelessness.

**A strategic approach**
A strategic approach will monitor outcomes that matter and ensure accountability for what makes a difference.

Getting housing and *keeping* housing is what makes a difference.

Homelessness is not a ‘one agency’ problem and to achieve outcomes we need an integrated response.

**A national framework for shared accountability**
This approach uses the *research evidence-base* and engagement with practitioners to build a practical and credible *outcomes model based on the work of Paul Duignan*.

An outcomes model:

Establishes a *transparent* and *refinable logic* to link interventions and outcome measures.

Provides a national framework for *shared accountability* for client outcomes.

Duignan’s outcomes theory establishes three important points that guide this project:

→ Outcome measures derived from a robust outcomes model provide the most credibility because they are transparently linked to the process that achieves change.

→ A robust outcomes model represents known and agreed real-world steps toward outcomes, including both measurable and non-measurable elements.

→ An outcomes model is only one building block of an outcomes system.
RESULTS AND DISCUSSION

The following chapters provide the results of the research synthesis and the discussion of the findings.

Chapter 4 Understanding homelessness identifies key implications for a national outcomes framework from an overall understanding of the homelessness research evidence-base.

Part 1 Getting housing presents the research synthesis for the first half of the outcomes model. Chapters 5–8 present the evidence supporting the steps in Part 1 of the outcomes model and Chapter 9 provides a table of relevant outcome indicators. Each chapter concludes with an in-brief summary of key findings.

Part 2 Keeping housing presents the research synthesis for the second half of the outcomes model. Chapters 10–12 present the evidence supporting the steps in Part 2 of the outcomes model and Chapter 13 provides a table of relevant outcome indicators. Each chapter concludes with an In brief summary of key findings.

Chapter 14 describes the full client outcomes model built from the research synthesis in Chapters 4–12. It includes a table of recommended indicators for each step in the model.

Chapters 15–16 discuss the policy and program implications and suggest further development of the research findings.
4 UNDERSTANDING HOMELESSNESS

This chapter identifies key implications for a client outcomes model from an overall understanding of the homelessness research evidence-base. It presents synthesis conclusions from findings included in the following chapters and it also presents six studies that investigate pathways into and out of homelessness, including four longitudinal research designs.

The chapter presents an overall understanding from the evidence-base that homelessness is a process that occurs within a social, economic and personal context and affects people over time. Indeed, the research shows that some challenges to getting and keeping housing can arise as a consequence of the experience of homelessness itself, highlighting the importance of timely and effective assistance.

The chapter then draws on the research to identify general principles of effective service delivery, to describe an overall ‘pathway out of homelessness’ and to show how service needs typically fall on two ends of a continuum of service intensity.

4.1 Understanding homelessness as a process within a social, economic and personal context

The research strongly and consistently represents an understanding of homelessness as a process. Homelessness, it seems, is best not understood as a state, an identity or category of person, but as an experience that reflects the relationship between a person and their housing situations over time.

For example, a recent in-depth qualitative study of 20 families in Melbourne found that ‘homelessness is not a single event but cumulative experiences, sometimes over quite a long period of time’ (Hulse & Kolar 2009, p.9). Similarly, the ‘cultural definition’ of homelessness described earlier reflects the understanding that the majority of people experiencing homelessness move between a range of marginal forms of housing over time.

The value of understanding homelessness as a process is that it enables the design of interventions which either arrest the process in a preventative way, or intervene within the process to avert further damage. For example, homelessness research identifies that particular ‘critical transitions’ are significant for reducing the harms related to homelessness. A particular and striking example is the transition from youth to long-term adult homelessness which entails a disproportionate risk of developing substance abuse issues. Australian research by Johnson and Chamberlain finds that first experiencing homelessness at 18 years old or younger made people four times more likely to develop problematic substance use while homeless, and was linked to long-term chronic homelessness for 85 per cent of this group (Johnson & Chamberlain 2008a; Johnson & Chamberlain 2008b).

Figure 3 below describes the situation of a person seeking assistance within a range of contextual factors identified in the research that can be both cause and consequence of homelessness. These factors function as barriers to getting out of homelessness, and are the challenges that homelessness assistance needs to address. To transition from the situation of homelessness to the situation of getting and keeping housing requires surmounting and transforming these challenges.
Figure 3: Understanding homelessness

The central circle of Figure 3 represents a moment in time when a person may seek assistance from homelessness or mainstream services, but it is important to note that this moment is both produced by and generates the challenges and barriers in the surrounding circle.

Developing a realistic outcomes model requires a frank recognition of these challenges and barriers which can inhibit the achievement of positive changes. These constraints are often formulated in two categories, though they are clearly inter-related factors:

- **Structural constraints**: housing and labour market conditions; income support levels; and intangible structures like discrimination based on mental illness or race.
- **Individual constraints**: a person’s own capacities and capabilities which may be long-term constraints such as challenging social behaviours due to acquired brain injury, or short-term such as a lack of skills and experience.

The synthesis identifies two key implications for client outcomes from an overall understanding of homelessness, as described in the above figure.

Firstly, the level of complexity of issues and barriers which a person must overcome in order to secure and sustain housing will necessarily be reflected in the duration over which client outcomes can be expected to be achieved.

Secondly, many of the challenges and barriers require specialist support and treatment. For example, studies consistently find that problematic drug or alcohol
dependency is correlated with unsuccessful outcomes in housing first or transitional housing programs.

**4.2 Principles of effective homelessness interventions**

The research synthesis demonstrates that while each individual will have their own path out of experiences of homelessness, there are some major stepping stones which are clearly identifiable from the existing evidence-base. These form the basis for the outcomes model. In addition, there are some common principles of effective homelessness interventions that emerge from the research synthesis:

- No single intervention will ensure that a homeless person successfully exits homelessness and reintegrates into the community.
- Services need to actively engage with people experiencing chronic or long-term homelessness (e.g. assertive outreach).
- A comprehensive housing first approach, which combines stable, decent accommodation with wrap-around social and health services appears to be the most successful approach to reducing homelessness across a range of demographic groups.

**Characteristics of successful approaches to sustaining housing:**

- Respect for the autonomy and personhood of people experiencing homelessness: research findings demonstrate that while assertive engagement strategies are critical, once people are housed they are more likely to remain housed if the housing and support program promotes their choices and self-determination—namely choice of location; accommodation without mandatory treatment requirements.
- A flexible model, which allows chronically homeless people to adjust gradually to stable housing, facilitates a sustainable pace of change.
- Recognition of the importance of individual change: research shows that internal cognitive events (such as an improved sense of self-worth) can be as powerful as satisfying immediate physical needs in turning around a person’s life. Similarly psycho-social therapies which allow the client to heal the impacts of negative life experiences can free them to create solutions in the present.

The research synthesis both confirmed and refined the understandings identified in the project’s first phase practitioner focus groups. Two strong messages from the practitioner focus groups were:

- Outcome priorities and steps were completely dependent on the individual and could not be generalised. What works for one person may not work for another and the key factor which makes a difference was that the worker provides an individualised service, matched to the client’s own goals and priorities.
- Different outcome areas have to be approached in a comprehensive and inter-connected way—there is no linear path out of homelessness, but often multiple outcomes need to be worked on simultaneously.

The research synthesis confirms practitioner theories that there is an extensive range of possible interventions and interim outcomes that may be appropriate and effective in working with an individual, and these must be selected in partnership with the client in order to demonstrate respect and mobilise the person’s own motivations, strengths and resources for change.

The synthesis also confirmed there is no single linear pathway to positive client outcomes, but refined this understanding by finding there are fundamental milestones.
which indicate that assistance is on track, and critical elements that are required for successful outcomes. The outcomes model defines these key milestones and the important elements which together generate the best possible chance of making a difference to homelessness.

4.2.1 Common steps in the pathway out of homelessness

Figure 4 represents a generalised pathway out of homelessness identified from a synthesis of the research literature. It includes the major common steps toward getting out of homelessness. This progression is not necessarily strictly linear, nor applicable to every individual, but it represents a rough order through which an individual may leap ahead, circle back and ultimately make progress towards stable housing and social reintegration.

Figure 4: Common steps in the pathway out of homelessness

- Stable, long-term or permanent supported accommodation
  → Gradual building of trust to allow clients to engage in services and service providers to assess needs
  → Engagement in specialist support services as required
  ↓
- Re-discovery of personal worth and self-efficacy
  → Improvements in mental and physical health
  → Permission and provision for setbacks along the path to recovery
  ↓
- Building of life and employment skills
  → Recovery of sense of purpose and goals
  → Social re-integration
  ↓
- Increased community participation including employment if possible
  → Gradual progression to stable inter-dependent living and sustained housing

Naturally, not everyone takes each of these steps, and there are indications that individuals and families on the lower end of the support needs continuum may move straight from securing stable housing to social re-integration.

The most fundamental and foundational outcome is stable supported accommodation with either no time limit or long timeframes. Where homelessness has been chronic or long-term, the gradual building of trust between clients and service providers is critical to allow people to reveal their needs and engage in services at their own pace.
Improvements in mental and physical health are typically supported by access to stable housing and engagement in specialist services including medical care, addiction treatment and therapeutic interventions, addressing underlying trauma and abuse where required.

The research consistently shows that discovery of personal worth and self-efficacy can be promoted through respectful practice that promotes client choices. It is also a critical outcome of increased economic and social participation. The development of life and employment skills including education/training milestones is strongly linked to the growth of self-esteem and also functions to develop social engagement, building or rebuilding supportive relationships and networks which are critical to sustaining housing.

Permission and provision for setbacks along the path to recovery is a realistic consequence of the complexity of challenges and barriers faced by anyone who is threatened with or experiencing homelessness.

Finally, it is important to recognise that not everyone will transition to completely independent living, so the term ‘inter-dependent’ is used. For some people, for example with severe degradation of intellectual or physical capacity due to substance abuse, or severe mental or physical illness, inter-dependent living may entail stability in permanently supported housing.

4.2.2 Service needs are clustered at two ends of a continuum

The research consistently identifies two broad sub-groups, requiring different service responses that cut across conventional demographic target group categories. The corresponding service responses can be best thought of along a continuum, however, it is consistent in the evidence that the responses are clustered, not spread evenly along the continuum, and this has significant resource implications.

This can be seen in the following two studies which demonstrate different typologies and clearly describe patterns in the level of support needs. While none of these groups imply a fixed or final identity for any individual, the robust analysis provides evidence of the need for differentiated programs and practice.

The first study focused on children affected by homelessness and identified two groups which clearly show the two ends of the continuum. The US research examined data from the Worcester Family Research Project and determined that the sample of homeless children (53 preschoolers and 69 school-age children) could be classified into two sub-groups based on measures of behaviour problems, adaptive functioning, and achievement (Huntington, Buckner & Bassuk 2008).

The analysis revealed two clusters: higher functioning children (doing well across all three domains, n=57) and lower functioning children (doing poorly across all three domains, n=65) (Huntington, Buckner & Bassuk 2008, pp.746–7). They found a similar two-cluster structure in both preschool and school-age children, and the pattern became more distinct in the higher age group, suggesting that this pattern will also persist as the children get older (Huntington, Buckner & Bassuk 2008, pp.746–7).

Huntington et al. find that higher functioning children do well despite the stresses they face during homelessness while ‘lower functioning’ children experience significant challenges in behavioural problems, adaptive functioning and achievement. They

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found that children in the lower functioning group had higher rates of physical and sexual abuse (Huntington, Buckner & Bassuk 2008, p.748).

A very different type of sub-group study used quantitative analysis of survey data from Project i, an internationally comparative longitudinal study of over 1200 homeless young people in Melbourne and Los Angeles10 (Mallett et al. 2004).

The analysis identified four distinct sub-groups of young people by analysing their daily routines and social connections (Mallett et al. 2004). In this study it is less clear, that the groups align into two clusters, but there is clearly one sub-group with high, complex needs while the largest group falls to the lower end of the continuum.

The largest group, comprising 45 per cent of the sample, were described as ‘service connected—harm avoidant homeless’. This group had the youngest members, with the shortest time since first leaving home. The majority were female. They generally spent their time connected to services, including school, rather than with friends or on the street, and were less likely to be engaged in illegal activities (Mallett et al. 2004, p.344).

In Australia, other young people were more likely to be part of two smaller groups: the ‘partnered homeless’ (16%) and the ‘socially engaged’ homeless (21%). The first group were more likely to be young women who had first left home a long time ago, while the second were typically young men who had left home a medium time ago and spent most time in recreational social activities (Mallett et al. 2004, pp.343–4).

A final sub-group was more common in the US than in Australia; it typically comprised young men with the longest duration of homelessness. This sub-group was just under 19 per cent of the sample and members spent most of their time in transient street locations. This group had the highest level of illegal activities and were only moderately connected to services (Mallett et al. 2004, p.344).

4.2.3 Pathways into and out of homelessness

At the level of individual assessment, qualitative research into pathways also provides evidence of the factors which lead to a person’s needs at different ends of the continuum. Three longitudinal studies, two from Australia and the other from Germany, provide qualitative evidence about the way a person’s life path and external circumstances can lead into and out of homelessness, and how this information can be used to better structure and target appropriate service responses.

One Australian study provides detailed, qualitative and longitudinal analysis of young people’s pathways into and through homelessness (Mallett et al. 2010). Mallet et al. (2010) report on a component of the Project i study discussed above. The qualitative, longitudinal component focused on 40 newly homeless young people in Melbourne and included a sample of young people selected to be broadly representative of the larger Project i sample in age, gender and service use. This group of newly homeless young people were followed up for an in-depth interview 18 months after recruitment to Project i, in addition to the five waves of survey data collection in the bigger project (Mallett et al. 2010, pp.36–7).

From this data, Mallet et al. (2010) identified four distinct homelessness ‘pathways,’ based on accommodation type and stability at the time of the in-depth interview. The research further explored the causes, challenges and resources associated with the different pathways.

The pathways are briefly described below (Mallett et al. 2010):

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10 For more information, see http://www.projecti.org.au/
‘On the streets’. This was the smallest and most vulnerable group, comprising five young people who were sleeping rough in squats or other transitory accommodation. They typically had experienced serious adverse family situations including abuse and violence, and had ongoing mental health and substance use issues of their own (pp.39–40). Despite their very significant challenges, all five shared an optimistic view of the future and maintained conventional aspirations for employment, long-term relationships, children and stable accommodation (p.92).

‘Using the system’. This group of seven young people had been living in some kind of assisted housing (transitional or supervised) for at least six months. They considered themselves homeless. This group were unlikely to have experienced abusive backgrounds (only two of the seven); and typically left home later than the ‘on the streets’ group. More than half of this group were from culturally and linguistically diverse backgrounds. This group were accessing services they needed to be able to continue their studies and maintain part-time employment (pp.40–1).

‘In and out of home’. The experience of this group of six young people was characterised by fluidity in moving between their family home and other forms of accommodation, and they did not identify themselves as homeless. They were, however, nearly all dealing with serious unresolved mental health and or substance use issues. (pp.41–2)

‘Going home.’ This group was the largest and included just over half of the sample (n=22). Their experience involved a comparatively brief11 period of homelessness followed by stable housing, either by returning home or by accessing some form of private or public housing of their own. This entire group had been housed for at least six months prior to the interview. They reported comparatively low levels of parental drug use or mental health issues, and in all cases their journey out of homelessness was facilitated by supportive relationships either with family, a support worker, or a partner (Mallett et al. 2010, pp.43–4).

Reflecting on these categories, the researchers highlighted the importance of sustained housing as a key indicator:

In our analysis of young people’s homelessness and their vulnerability to homelessness, the length of time that someone is securely housed is a key indicator of stability (Mallett et al. 2010, p.43).

Broadly speaking, the pathways can be clustered into high(er) needs—‘on the streets’ and ‘in and out of home’—and low(er) needs—‘using the system’ and ‘going home’. Of interest in this study is that the high(er) needs and the low(er) needs clusters do not coincide with accommodation status, indicating the importance of the outcome steps toward sustaining housing, once it is secured. While the ‘in and out of home’ group did not consider themselves homeless, the research found their vulnerability was closer to the ‘on the streets’ group; conversely, the ‘using the system’ group did consider themselves homeless, but had established the economic and social participation links which made them much more likely to be able to sustain housing stability over time.

These pathway groups, and the stories of the young people that make up the research, provide a nuanced evidence-base and supports the importance of individualised approach to achieving outcomes.

11 Ninety per cent of this group were homeless for less than a year ( n=7 for less than three months; n=7 for less than six months; n=6 for less than a year and the remaining 2 for less than 14 months) (Mallet et al. 2010, p.43).

One cluster can typically include people who first become homeless due to mental illness or substance abuse, and young people who leave home to escape violence and abuse, or are taken from home by the care and protection system. This cluster has typically the longest duration of homelessness and require significant, persistent supports and secure housing, to overcome multiple difficulties (Johnson, Gronda & Coutts 2008, pp.182–8).

The other cluster typically includes women and families who become homeless through domestic violence or financial disadvantage and young people who left home due to conflict with family rules. This group tend to have a shorter duration of homelessness, and the critical factor for ending their homelessness is affordable, well located housing. Keeping this group out of the ‘homelessness service system’ is vital for preventing further harms such as the development of mental illness or substance use issues (Johnson, Gronda & Coutts 2008, pp.174–182).

Table 3 below demonstrates the differences which define the two clusters.

**Table 3: Experience by pathway cluster**

<table>
<thead>
<tr>
<th>Experience by pathway ‘cluster’</th>
<th>Substance use, mental illness and youth</th>
<th>Housing crisis and domestic violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean months homeless</td>
<td>48</td>
<td>8</td>
</tr>
<tr>
<td>Mean number of times in transitional accommodation</td>
<td>5</td>
<td>1.8</td>
</tr>
<tr>
<td>Previously housed in transitional accommodation (%)</td>
<td>95</td>
<td>39</td>
</tr>
<tr>
<td>Experience of episodic homelessness (%)</td>
<td>78</td>
<td>48</td>
</tr>
<tr>
<td>Reports of being ‘barred’ from homeless services (%)</td>
<td>66</td>
<td>26</td>
</tr>
<tr>
<td>Reports of ‘sleeping rough’ (%)</td>
<td>77</td>
<td>18</td>
</tr>
<tr>
<td>Housed at the second interview (%)</td>
<td>52</td>
<td>83</td>
</tr>
</tbody>
</table>

Source: Johnson, Gronda & Coutts 2008

The study found that housing affordability was a key factor for all groups in getting out of homelessness, but it was not the only one. The quality of the housing and its social accessibility contribute to people staying out of homelessness. The findings also suggest that reintegration into mainstream society was as important as providing a physical dwelling. For people in ‘cluster one’, provision of long-term, individually tailored support was critical.

Table 4 shows how the strategies and challenges to getting and keeping housing differ across the different pathways:
Table 4: Strategies and challenges by pathway

<table>
<thead>
<tr>
<th>Reason for FIRST becoming homeless</th>
<th>Getting out and staying out – strategies and challenges</th>
</tr>
</thead>
</table>
| Problematic substance use, youth escapers | Becoming tired of the scene; critical triggers (death of a friend, children, life stage)  
Associational distancing—putting it all behind you  
Isolation and boredom  
Unrealistic expectations about ‘normal life’  
Shame about history of homelessness  
Barriers to housing and labour markets  
Overcoming traumatic history and addictions |
| Mental illness | Ongoing, episodic experiences of mental illness crisis  
Stigma and social isolation  
Long-term support with a housing focus to prevent future homelessness while unwell |
| Financial difficulties—housing crisis, domestic violence, youth dissenters | Passing as normal, resisting homeless identity and rejecting other homeless people  
Permanent housing is a critical source of self-esteem and the basis for recreating everyday life routines and connections  
Housing’s social accessibility (location, transport, amenities, neighbourhood) is a significant success factor  
Singles at highest risk of entrenchment in homelessness |

Source: Johnson et al. 2008, Chapter 6

A similar kind of study from Europe found slightly different sub-groups, but confirmed the general understanding that assessing people’s pathways into and through homelessness can aid in more effective targeting of interventions.

This 12-month longitudinal study with 28 homeless people in Berlin identified five distinct ‘life course types’ which impacted on people’s experience of homelessness and the interventions likely to be successful (von Mahs 2006). These five groups, while distinct from each other, similarly fall into two clusters. One cluster included two sub-groups that had led relatively stable lives prior to becoming homeless while the other cluster of three sub-groups had more irregular, unsettled life courses, and less social and economic integration.

In the more stable cluster, one group, consisting of eight older homeless people (aged 35 or more years) had led ‘inconspicuous lives’ (i.e. regular schooling, employment, social relationships, etc.) until a ‘culmination of negative events … caused a gradual descent into homelessness’ (p.4). Living in shelters dealt a major blow to the self-esteem of this group and they experienced fears about their increasing age and their ability to reintegrate into ‘normal’ lives (p.7). They frequently resorted to alcohol as a means to ‘cope with the pain and anxiety’ of their condition (p.7). They experienced fear, shame and defeatism in shelters, ‘which reinforced alcohol problems’ (p.8).

As a result, members of this group had developed distrust and ambivalence towards welfare services which impeded their successful return to ‘normal’ lives (p.8). Yet ‘immediate, continuous financial support’ and diligent, proactive services provided by social workers assisted five of this group into stable housing and employment (p.9). The author recommends helping this group find employment and deal with substance abuse issues in order to re-establish stable housing.
A smaller group of four younger homeless people had a normal upbringing and schooling until conflict with parents resulted in homelessness. Their lack of job qualifications acted as a barrier to economic self-sufficiency. Members of this group tended to rely on self-initiative and exited from homelessness the fastest (p.6). Interventions had a stabilising effect in their lives, and they tended to view shelters opportunistically until they could exit this form of housing. However, they required ongoing welfare support to maintain stable housing (p.7). The author recommends job training as the most needed intervention to assist these people out of homelessness (p.5).

Of the less stable cluster, one sub-group of eight people had experienced what the research called ‘transient life courses.’ This group may have started with regular lives, but lacked social networks due to factors such as ‘unemployment, residential instability, and frequent moves’ (p.5). They often became homeless when they moved to Berlin.

Von Mahs found this group the most unsuccessful in finding stable housing and employment (p.11). The longer they spent in shelters, the more distrustful they became, which inhibited the ability of social workers to engage them. Some even became suspicious that they had been abandoned or intentionally harassed by welfare workers (p.12). The key outcome objective recommended for this group was therefore ‘integration into the city’ and securing stable employment (p.5).

A second sub-group in the unstable cluster included four people with disabilities, which may have been either lifelong or induced by an accident. Severe mental or physical disabilities meant they were unable to work. Welfare intervention was crucial in assisting two of these people into stable, supportive housing (p.10). Their most urgent need for intervention is health services and permanent, supported housing (p.5).

The final sub-group were four younger homeless individuals with ‘deviant’ life courses. They had troubled lives, typically including abuse during childhood, foster care, substance abuse, repeated episodes of homelessness and periods of incarceration. The author suggests they are the most challenging group to successfully house, as they needed a broad range of services, yet were distrustful towards the welfare system due to past negative experiences (p.5). The author found that these people could only be engaged in services if ‘assistance is applied in flexible and creative ways’ (p.10).

Von Mahs found that across all the sub-groups, individualised assistance, stable income support and housing subsidies were common success factors for generating long-term housing stability (p.14). The research also found that welfare provision itself could both facilitate or hinder exit from homelessness (p.13). In particular, positive outcomes were reduced where case workers did not give clients sufficient ‘time and opportunity to state their needs’ (von Mahs p.14).

4.3 Service responses are needed at two ends of a continuum

The research and program evaluation evidence suggests that service needs exist on two ends of a continuum—cutting across conventional ‘target groups’—with very different resourcing implications.

- High needs—affordable housing; intensive specialist case management for mental health and addiction issues, including trauma recovery and cognitive disability; significant physical health support; social integration.
Low(er) needs—affordable housing, comprehensive, practical case-management, employment and social integration.

Two points are important to make about this continuum:

1. Everybody benefits from affordable housing and assistance to access housing.
2. Most people and families at the 'low(er)' end benefit from significant post-housing support focused on social reintegration and building employment capabilities.

**Figure 5: Service response continuum**

<table>
<thead>
<tr>
<th>Low(er) needs</th>
<th>High(er) needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>affordable, suitable housing</td>
<td>affordable, suitable housing</td>
</tr>
<tr>
<td>comprehensive, practical relationship-based case-management</td>
<td>intensive specialist case-management (e.g. for mental health and addiction issues, including trauma recovery or cognitive disability; significant physical health support)</td>
</tr>
<tr>
<td>post-housing community participation interventions</td>
<td>post-housing community participation interventions</td>
</tr>
</tbody>
</table>

It is likely that people fall into either of the two ends rather than being spread evenly across the continuum because the addition of multiple challenges and issues is not strictly linear. Common experience indicates that while one significant problem may be a challenge, once you face two or more challenges, there is a further level of complexity because the problems themselves interact in potentially damaging ways.

4.3.1 Predicting the need for complex service responses

In Australia we do not currently have robust quantitative data on the prevalence of people experiencing homelessness across these two ends of the continuum, unlike the US research on shelter-users described earlier (Culhane 2008).

However an indication that many people using homelessness services are toward the higher end of the continuum is emerging from a current AHURI research project examining intergenerational homelessness and the use of specialist homelessness service. The research, investigating the incidence of intergenerational homelessness, has conducted a survey with a total of 650 respondents from a random sampling of homelessness agencies across Australia (Flatau 2010).

The study has found that nearly 75 per cent (of a sample of 358 with relevant data) first experienced homelessness under the age of 18, and for 44 per cent it was under the age of 12. Around half of all these adult respondents reported that one or more of their parents had also experienced homelessness. This rate was higher for...

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Indigenous respondents (69%) compared to non-Indigenous (45%). Indigenous respondents were more likely to have experienced homelessness as children or teenagers. The rate of experiencing homelessness under the age of 12 was 63 per cent compared to 37 per cent for non-indigenous respondents; and the rate for those under the age of 18 was 90 per cent compared to 68 per cent for non-Indigenous respondents.

The survey found that this representative sample of people using homelessness services had high rates of parental problematic drug use. Of all respondents aged 18 or over, 24 per cent reported problematic alcohol use and 12 per cent reported problematic drug use by their mothers. Problematic alcohol use by fathers was reported by 45 per cent and problematic drug use by 19 per cent of these respondents.

The survey asked people about the level of violence in the family home when they were growing up. Nearly a quarter of all adult respondents reported that either ‘quite a lot’ or ‘all the time’ they witnessed their parents or carers physically hurt or fight with each other. Around 40 per cent reported the police coming to their childhood home (13.2% more than 10 times) while close to 50 per cent reported that they had to leave the home due to violence in the home (15.3% more than 10 times).

The Intergenerational Homelessness Survey also investigated the kinds of problems respondents had experienced over their lifetime, and documents a range of issues interfering with mental and social wellbeing. Close to 40 per cent of respondents reported they had a serious problem with feeling depressed, anxious or stressed at some point in their life. High rates of significant problems (>20%) were also reported with respect to ‘being lonely’, ‘being bored’, ‘drinking too much’, ‘taking drugs’, ‘repeating the same mistakes’, ‘doing things on the spur of the moment’, ‘losing your temper’ and maintaining relationships with family.
4.4 In brief: Understanding homelessness

An overall understanding of homelessness from the research literature highlights the following key implications for a national client outcomes framework:

- Adequate time is required to achieve client outcomes that really make a difference. Durations of two to three years are a realistic threshold for sustained positive change in cases of people experiencing chronic or long-term homelessness.

- Significant specialist support is needed for many people, particularly for drug and alcohol issues, trauma recovery and other mental health issues, and support for cognitive disabilities.

- Barriers and challenges include socio-economic disadvantage, social stigma and discrimination. Accordingly, economic and social participation interventions (including vocational support and social integration) are critical for sustained recovery from homelessness.

- The challenges and barriers to getting and sustaining housing typically worsen or become more complex, the longer someone experiences homelessness.

- The resource requirements to achieve successful client outcomes are expected to differ because service responses are needed at two ends of a continuum of service intensity: high and low(er). Research and monitoring is needed to identify the quantitative prevalence of needs across this continuum in order to allocate resources efficiently.

- People experiencing homelessness require access to affordable, suitable housing AND individualised assistance to ensure they can sustain it.
PART 1: GETTING HOUSING

Part 1 of the synthesis report focuses on the evidence underpinning the steps that lead to getting housing. The research evidence consistently demonstrates that housing-focused support and access to affordable housing dramatically improves the housing outcomes for people experiencing homelessness.

As shown in the following figure, the synthesis found four inter-linked elements that contribute to the outcome of housing secured.

Engagement in housing-focused support is the critical first step in getting housing, but in order to achieve the outcome, this element needs to be supported by simultaneous service-system level interventions to increase the supply of available, affordable housing options and increase accessibility to specialist support services including mental health, trauma recovery and drug dependency. The core finding from the rigorous Housing First evidence base is the necessity and effectiveness of timely access to housing, provided in a way that maximises client choice and delivered along with effective support.

Figure 6: Getting housing outcomes model

Mainstream and homelessness specialist services working together
SHARED ACCOUNTABILITY
In brief, the research synthesis identified four critical elements for achieving the outcome of *housing secured*:

1. Engagement in housing-focused support.
2. Housing-focused support, which includes:
   - housing work
   - effective case-management.
3. Available specialist health support.
4. Available, affordable housing options.

The following chapters present the research findings identifying the significance of each element for sustaining housing and the evidence-based strategies that contribute to outcomes in these areas.

These steps together, suggests the evidence, provide the best chance of achieving *housing secured*. In addition, to maximise the likelihood of achieving the second key outcome, *housing sustained*, the synthesis finds that continuity of case management and (where required) specialist health supports are provided along with housing.
The synthesis finds that *housing-focused support*, support that combines housing work and effective case-management, has demonstrated ability to achieve the outcomes of getting and keeping housing. This chapter presents evidence about effective engagement, while the following two chapters present the evidence about housing work and effective case-management.

The research synthesis identifies *engagement* in housing-focused support as a unique and distinct step in the outcomes model based on the strong evidence that assertive engagement strategies significantly improve outcomes for the ‘hardest to reach’ including people sleeping rough and/or with complex health problems. The research
findings indicate that service accessibility cannot be taken for granted and that effective services actively pursue engagement with clients.

This chapter presents findings from four quantitative studies, three from the US and one large-scale evaluation from the UK.

The research shows that effective engagement strategies occur at two levels:

- Individual relationship level.
- Systemic/service level.

5.1 Effective engagement

Engagement is a commonly used but poorly defined term in homelessness service delivery, research and practice literature. The research synthesis suggests there are two, inter-related, important aspects of engagement:

- Individual relationship-level engagement—facilitated by persistence and continuity; a ‘whatever it takes’ attitude; relationship qualities of trustworthiness and respect; and strengths-focused practice to inspire self-esteem, motivation and hope.

- Systemic/service level engagement—facilitated by a service system model that enables reaching out and staying engaged with a person or family from initial contact through to getting housing and doing what it takes to ensure that housing is sustained.

The evidence in this chapter demonstrates how systemic-level strategies, in other words the right service model, supports individual-level engagement and consequently delivers successful improvements for people experiencing homelessness.

5.2 Individual relationship-level engagement

The qualities and practices which support individual relationship-level engagement are described in the next chapter on effective case-management, as this intervention has produced a significant body of evidence. However, it is worth noting here some particular evidence about the effectiveness of ‘peer’ involvement for engagement outcomes (i.e. the involvement of people who have themselves experienced homelessness or mental illness).

5.2.1 A promising direction: ‘peer’ involvement in service delivery

There is evidence that initial engagement in services can be improved with peer involvement in case management. In this context the term ‘peer’ is used to mean people who have recovered from a mental illness. While the following study was not conducted with an exclusively homeless target group, it demonstrates the positive impact of peer-involvement in service engagement with a vulnerable group. In the context of homelessness, this and other studies (e.g. Barrow et al. 2007) suggest that greater involvement of the formerly homeless in service design and delivery is a promising direction.

Sells et al. (2006) report on a randomised controlled study that compared peer-based and regular case-management with a sample of 137 participants selected for severe mental illness (psychotic disorder and/or major mood disorder) and treatment disengagement. It compared the quality of treatment relationships and engagement in peer-based and regular case-management (Sells et al. 2006). It finds that early in treatment, peer providers seem to be more effective at communicating positive regard, understanding, and acceptance to clients, particularly those most disengaged, and this leads to better treatment retention and reported motivation levels.
For a sub-sample rated by providers as the least engaged at the beginning of the study, the peer provider group showed improved engagement results. Contact rate with the peer case managers increased over the first six months while decreasing for the regular case-management condition (Sells et al. 2006, pp.1181–2). There were no between-group differences at 12 months, suggesting that regular case-management relationships can ‘catch up’ over 12 months (Sells et al. 2006, p.1182).

5.3 Systemic/service level engagement

There is consistent evidence about the effectiveness of assertive service delivery strategies to engage with people experiencing homelessness. These engagement strategies can be implemented in both outreach\(^\text{13}\) and drop-in service models.

A recent doctoral study from the US shows the continued need for service reform to ensure that homelessness services are delivered through active engagement approaches. While Collins’ (2010) focus is on health services rather than housing-focused support, the study demonstrates the importance of ongoing effort to engage people in the services they need.

Collins’ study of 379 client case records from a drop-in centre in suburban New York demonstrated that flexible and long-term, incremental engagement strategies were key to connecting those most in need to the services they required (Collins 2010). Collins finds that ‘the data contradicts the generally held belief that chronically homeless people are unwilling to seek treatment’ (p.98) and recommends agencies actively modify their practices in order to increase the accessibility of services for the long-term and/or chronically homeless.

The author uses retrospective client data collected over 24 months to assess differences in the rates of referral, engagement in or denial of services to the adult individuals accessing this centre (p.53). She finds that while this group of homeless people sought medical, psychiatric, housing and other services, they faced increased rates of service denial (p.102) and struggled to integrate into existing treatment systems.

Collins suggests the barrier to receiving service is that many homeless adults present with multiple issues, such as mental illness and substance abuse, and do not fit neatly into categorical service eligibility criteria (pp.1–2). Therefore, they are easier to turn away from increasingly under-resourced service providers (p.5). She recommends development of a coordinated and flexible system of services to assist the chronically homeless (p.29) including active development of ‘mechanisms by which to effectively engage homeless people in human service systems’ (p.115).

While there are many studies which demonstrate the value of individual level engagement, two large-scale outcome evaluations from the US and the UK broadly and robustly establish the evidence-base for also employing systematic efforts for actively engaging an individual or a family in housing-focused support.

5.3.1 Evidence from the United States ACCESS evaluation

An important source of evidence about engagement in support services for people experiencing homelessness with severe mental illness is the U.S. national evaluation of the Access to Community Care and Effective Services and Supports (ACCESS) program (1994–98). This large-scale evaluation demonstrated the effectiveness of direct, outreach-service delivery to people living on the streets.

\(^\text{13}\) A current AHURI project is focused on assertive outreach for addressing primary homelessness. See, http://www.ahuri.edu.au/publications/p20607/.
The ACCESS program provided outreach and intensive case-management at 18 sites in an initiative to enhance service use and quality of life for homeless people with serious mental illnesses. Between 1994 and 1998, the program was implemented in nine States, covering the major geographical areas of the US, and providing services to 100 homeless people at each site each year, in four annual cohorts. For the evaluation, baseline data was obtained from 7055 clients and 6385 (90.5%) completed at least one follow-up survey; 5800 (82.2%) completed the three-month interview and 5471 (77.5%) completed the 12-month interview.

Primarily designed to test the impact of service system integration, it was a rigorous, large-scale evaluation that also tested new ways of reaching a group experiencing chronic homelessness: assertive outreach case-management. Evaluation of the ACCESS program demonstrated the effectiveness of direct service delivery, outreaching to people living on the streets with severe mental illness:

> These individualised services improve both the physical health and the mental health of these people and can help in moving them into independent housing (Goldman et al. 2002, p.969).

The study found evidence of overall greater access to services over the 12 months and significant improvement in all the client outcome domains (Rosenheck et al. 2002, pp.963–4), however, there was no relationship found between clinical outcomes and service system integration. The research found that the implementation of outreach and assertive community treatment was a significant element in the observed outcomes.

The evaluation unexpectedly found that the explicit service integration initiatives did not produce better social and clinical client outcomes than what was achieved by effective clinical services, for example assertive community treatment. Significantly better housing outcomes were achieved in more integrated systems, however this was independent of the ACCESS initiatives. The evaluation found that systems integration was significantly related to overall levels of community capital and additionally, that better housing affordability predicted better housing outcomes (Rosenheck et al. 2002, p.958, p.965). The authors note: ‘Some communities are just better integrated for a variety of reasons’ (Goldman et al. 2002, p.968).

The study used two primary outcome measures: mental health symptoms and independent housing.14 In addition, there were five secondary outcome measures and three service-use measures:

- Secondary measures included alcohol abuse, drug abuse, employment, social support (people who could help out with a loan or transport in a crisis) and subjective quality of life.
- Service-use measures included receipt of public support payments, range of services received and having a primary case manager.

### 5.3.2 Lessons from the UK’s 1998 Rough Sleeper Initiative

The UK’s 1998 Rough Sleepers Initiative provides solid evidence for establishing the outcome step of Engagement in housing focused support based on the successful use of assertive outreach.

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14 Independent, stable housing was defined as living in your own apartment, room or house, either alone or with someone else for 30 consecutive days.
Randall and Brown evaluated the UK’s 1998 *Rough Sleepers Initiative* and found it achieved its target of reducing the number of people identified in rough sleeping counts by two-thirds (Randall & Brown 2002).

The study identifies the assertive outreach of Contact and Assessment Teams (CATs) as one of the major successes of *Coming in from the cold*. In London 2000/01 CATs contacted 3031 people living on the streets. Of this number, 1679 people were assisted into accommodation by CATs.

Some of the key strategies that assisted CATs in their aims to get people off the streets were:

- A focus on intensive street work, with up to three-quarters of staff time spent on the streets, compared with less than a third in some areas previously.
- Persistence by outreach staff, with contact attempted every day with individual rough sleepers in their ‘patch’.
- Abandoning the policy of leaving people alone who were not initially willing to engage with staff and instead contacting them as often as possible.
- A switch from what might be characterised as a ‘social work’ approach, which sought to meet a wide range of needs on the street, to a more interventionist stance aimed at a very specific and limited goal of moving the client into accommodation, from where more detailed assessment could be made and support put in place.
- Detailed action plans for individual clients, particularly longer-term, entrenched rough sleepers.

Other effective system level strategies included strong, target-oriented management of teams and team, rather than personal, caseloads. This enabled more intensive and continuous support than possible with a single worker. Another important element of success was close and coordinated work with other agencies including the police, day centres, medical services, hostels and any other services in regular touch with rough sleepers. Finally, the evaluation of *Coming in from the cold* also emphasises the importance of adequate affordable housing options.
5.4 In brief: Engaged with housing focused support

Research shows that service accessibility cannot be taken for granted and that effective homelessness assistance actively engages clients in the services they need.

US and UK experience, documented in four quantitative studies, has shown that assertive outreach case-management combined with housing resources, has demonstrated capacity to deliver outcomes that make a difference for people experiencing long-term homelessness.

The research synthesis suggests there are two important aspects of effective engagement:

- Individual relationship-based engagement—facilitated by persistence and continuity; a ‘whatever it takes’ attitude; relationship qualities of trustworthiness and respect; and strengths-focused practice to inspire self-esteem, motivation and hope.

- Systemic and service model engagement—facilitated by a service system model that enables reaching out and staying engaged with a person or family from initial contact through to getting housing and doing what it takes to ensure that housing is sustained.

The research demonstrates that engaging a person in persistent and practical housing-focused support is a critical first step in securing and sustaining housing.

Housing-focused support combines housing work and effective case-management and has demonstrated potential to achieve the outcomes of getting and keeping housing.
6 EFFECTIVE HOUSING WORK

Figure 8: Outcomes model: effective housing work

Housing work is the intervention required to assist someone experiencing or at risk of homelessness to access suitable housing. The research synthesis finds that effective housing work provides timely access to appropriate housing options. The research demonstrates a range of possible models for appropriate housing for people who have experienced homelessness, however four key characteristics are consistently linked to good client outcomes:

- Timely access.
- Suitable housing (minimum standards, location, access to relevant amenity).
- Affordability.
- Supportive housing, maximising client choice.

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- Affordability.
- Supportive housing, maximising client choice.
Reflecting the interconnection of housing and other supports, the evidence in these evaluations of housing programs also points to the significance of outcomes in the areas of improved health, improved economic resources, and increased mainstream social connectedness. It also indicates the reality of long time-frames, at least two–three years, for achieving improvements in mental health symptoms and substance use rates, economic resources and social connectedness.

The evidence in this chapter is strong and consistent, including a body of well-designed experimental research supporting the Housing First model of permanent supportive housing. The quality, breadth and depth of the evidence credibly establishes that securing and sustaining housing are critical and fundamental outcomes in the process of ending homelessness for an individual or a family.

The chapter presents evidence from 24 studies, including 18 quantitative and six qualitative research designs. The research was drawn from North America (11 US and three Canadian studies), Europe (two UK and one pan-Europe) and Australia (seven studies).

6.1 Timely access

Housing work is fundamentally about making housing accessible. A person seeking housing assistance has been unable to access appropriate housing with their own resources. As well as affordability and shortage of supply, barriers can include discrimination in the private housing market (Short et al. 2008) or simply logistical constraints like lack of access to transport needed to find private housing.

The synthesis finds that effective housing work has three core components:

→ Overcoming barriers to housing access.
→ Timeliness—the most effective models use a ‘Housing First’ approach.
→ Ensuring that housing options are appropriate.

A strong source of quantitative evidence for the overall finding of the need for housing work is provided by a meta-analysis of 16 evaluations of housing and support interventions for people experiencing homelessness and a severe mental illness, including 10 controlled studies. Nelson et al. (2007) find that combined housing and support is significantly more effective than support alone. The effect size for combined interventions was 0.67 compared to 0.47 and 0.28 for support alone, measured for two different case-management models respectively (Nelson, Aubry & Lafrance 2007).

In the UK, over the decade 1990–99, London’s Rough Sleepers Initiative (RSI) demonstrated successful rehousing of people sleeping rough. Busch-Geertsema reports that the RSI provided 3500 specially funded permanent housing association homes in London and housed 5500 people in RSI tenancies. Centrally organised rehousing procedures and data-collection allowed monitoring of long-term outcomes, and by September 1997, of the 4900 tenancies registered, 62 per cent had been sustained, 13 per cent had ended with a positive outcome (transfer or move to better quality, non RSI housing) and 16 per cent had ended in abandonment or eviction (Randall/Brown 1999, p.14; Dane 1998, p.6—cited by Busch-Geertsema 2002, pp.5–6).

The importance of housing work is confirmed qualitatively by a Canadian study using the perspective of people who have experienced homelessness. The study surveyed 58 currently homeless and 80 formerly homeless people in Vancouver to find out about the factors perceived as facilitating their transition from homelessness. It found
that housing was consistently rated by both homeless and formerly homeless as the most important factor in ending homelessness (Patterson & Tweed 2009).\footnote{Those who had exited homelessness successfully also highlighted the significance of less tangible outcomes including gaining a sense of self-worth, recognising the disadvantages of living on the street and establishing social supports (Patterson & Tweed 2009, p.855). These factors are discussed further in Chapter 12, Community participation.}

The research literature on effective housing work underlines that timeliness is critical for housing interventions. In fact, the critical point to draw from the Housing First and Street to Home research may be the importance of timely provision of permanent housing options.

The effectiveness of Housing work relies on the complementary outcome step of increased supply of affordable housing. As discussed in Chapter 8, Australia has a shortage of available affordable housing options, and this was reflected in the way practitioners consulted for this project described extensive, time-consuming and often frustrating housing work which often failed to lead to a housing secured outcome. For example, the extensive work required to secure a priority housing application and sense of achievement for the worker was contrasted with the complete lack of housing outcome from the client’s perspective. When priority housing applications receive a waiting time of years, there can be little sense of accomplishment.

This may explain why the evaluation of the Victorian Homelessness and Drug Dependency Trial reported a very low proportion of housing goals set. Staff feedback suggested that the very significant constraints on housing availability was a reason for lack of explicit goal-setting in this area:

... setting additional housing goals focused on long-term housing is limited by the small range of housing options available to participants. Because of these limitations and difficulties, some primary case managers appear to not be as active in this area of work (Rayner, Batterham & Wiltshire 2005 p.150).

No strong recent evidence was found evaluating housing work which seeks to overcome the barriers people and families face when trying to access private rental housing, although many Housing First programs use private market housing which is head-leased by the housing provider. An Australian study of private rental support programs found that financial assistance to pay tenancy start-up costs was effective for low-income households, but that there were ongoing issues including affordability, lack of living skills and rental black-listing which were not addressed in the existing programs (Jacobs et al. 2005). Further evaluation of programs that tackle the barriers to private rental access for people experiencing or at risk of homelessness would be a valuable addition to the evidence-base.

6.2 Suitable housing

As well as conventional minimum standards, there are also suitability considerations that are specific to recovery from homelessness and its associated challenges, particularly, for example, substance use (e.g. proximity to substance using networks) or socio-economic disadvantage (e.g. access to transport), children’s development (e.g. maintaining continuity of schooling).

Evidence of the need for a minimum standard of suitable housing based on a cultural definition as proposed by Chamberlain and MacKenzie (Chamberlain & MacKenzie 1992) is provided by Canadian data on mortality rates for people living in ‘secondary or tertiary homelessness’. A longitudinal study of 15 100 Canadians living in shelters, rooming houses or hotels found they had a dramatically lower life expectancy (e.g. for men it was 10 years less than the population average, and six years less than those in
the lowest income group). The study found significantly higher mortality from preventable conditions, in particular those associated with substance use, mental disorders and violence (Hwang et al. 2009).

Qualitative data from the evaluation of London’s Rough Sleepers Initiative describes a picture of conditions in rooming houses that echo findings from Australia research on the topic.

As discussed above, the UK’s Coming in from the Cold 1998 Rough Sleepers Initiative was successful at reducing the number of people sleeping rough by two-thirds over four years. However, despite the effectiveness of the outreach approach for assisting people into accommodation, 41 per cent of this group returned to the street eventually.

The evaluation reveals evidence of the importance of securing suitable housing in order to really make a difference. Access to beds in hostels featured heavily in this initiative. In London in 2000/01, 78 per cent of accommodation outcomes were hostels and only 6 per cent of clients went from the street to permanent housing.

Participants were asked why they left the hostel accommodation and returned to the streets:

→ ‘Full of people with needles—waking up in the middle of the night and nearly stepping on a dirty needle—it makes me angry. You can’t find a hostel without drugs’ (Randall & Brown 2002, p.23).

→ ‘Sometimes—it’s safer [on the streets]. In most shelters you get aggravation and you can’t escape from it. In the open you can see the aggravation coming and you can hide where no-one can see you’ (Randall & Brown 2002, p.23).

→ ‘Yes—all my friends were on the streets. We could drink and take drugs together. It felt more secure there—it’s hard to explain, we were all together’ (Randall & Brown 2002, p.23).

While hostels provide a short-term way to get people off the street, lack of suitability, particularly concerns about drug use and violence, resulted in people returning to homelessness.

While the Canadian study design cannot prove that rooming houses and shelters cause higher mortality rates, it is a striking population representative correlation. Combined with the strong and consistent qualitative data about damaging conditions in rooming houses, it presents a clear recommendation that these forms of accommodation cannot be considered a housing outcome.

Another Canadian study, an evaluation of the Toronto Street to Home program describes the process of delivering timely access to housing, as well as the outcome constraints created by lack of suitable housing options (Falvo 2010). It also highlights in particular the negative impact that shared housing arrangements can have on client outcomes. The Toronto Street to Home program reports good results for clients, but affordability and limited housing options pose some constraints and challenges.

The Toronto Street to Home program commenced in 2005 and has housed around 600 people who were living on the streets each year since February 2005. It is reported that 87 per cent of the tenants it has housed remain housed (Falvo 2010, p.20).

16 While Coming in from the Cold focused on making hostel beds available, the initiative also provided 787 permanent homes for former rough sleepers and included significant pre-tenancy and post-housing support programs (Tenancy Sustainment Teams).
Falvo reports that it takes an average of 16 days from the third contact with a client sleeping rough until they are provided with keys to a permanent housing unit (Falvo 2010, p.14). The Street to Home program staff accompany the client to see housing units, and once an appropriate housing unit is found that the client likes, the lease is signed. Once housing is secured, support for the client is transferred from the outreach worker to a ‘follow-up support worker’ in a joint meeting with the client and both workers (Falvo 2010, p.14).

A post-occupancy study conducted by the City of Toronto found that 62 per cent of program participants were housed in some kind of privately owned housing, 20 per cent in social housing and 18 per cent in purposive supportive housing (Falvo 2010, p.17). However Falvo reports that the program is delivering a high proportion of shared housing arrangements (39%) because of inadequate housing resources.

Falvo reports that positive client outcomes are lower in shared arrangements. People are less likely to feel secure, less likely to have had nutritional improvements, are more likely to move and less likely to have reduced emergency service use or reduced substance use (Falvo 2010, p.27).

Falvo suggests that a second and related challenge to sustaining housing is housing affordability. Unlike the New York Housing First models which limit rent to 30 per cent of income, Toronto’s Street to Home participants were paying an average of 41 per cent of income on rent (Falvo 2010, p.27).

### 6.3 Affordable housing

Housing affordability can be delivered through demand-side housing subsidies either provided to the individual (e.g. Commonwealth Rental Assistance in Australia, Housing Benefit in the UK or Section 8 Housing Vouchers in the US) or provided to a supportive housing agency to subsidise rent paid in the private market. Supply-side subsidies like funding for public or other forms of social housing can also be used to deliver affordable housing.

The homelessness research literature consistently reports the importance of securing affordable housing for sustaining housing for people who have experienced homelessness. The evidence is coherent and robust from the findings across countries and target groups. And it is logically clear that the affordability of housing is a fundamental baseline characteristic of housing that can be sustained over the long term. A number of studies are presented here to represent the consistency of these findings.

A US five-year longitudinal study followed up 244 families at least three years after their first shelter experience in New York City and found that 80 per cent of families who received housing subsidies were stable at follow-up, compared to only 18 per cent of families who did not (Shinn et al. 1998, p.1654). The study clearly found that the positive impact of subsidised housing far outweighed the impact of demographic variables or individual risk factors, such as behavioural disorders or disrupted social ties.

An independent evaluation of Scotland’s Rough Sleeping Initiative (1999–2003) found that while the initiative was significantly effective, housing affordability was a barrier to success in some areas, notably Edinburgh and rural areas, due to supply shortages in a pressured housing market (Fitzpatrick, Pleace & Bevan 2005).

A more recent US study of family homelessness re-confirmed the significance of housing subsidies. The role of affordability was confirmed in an outcome evaluation for 942 families who had exited the Sound Families transitional housing program (Northwest Institute for Children and Families 2008), further discussed in Chapter 7.
Effective case-management. The evaluation found that two-thirds (68%) of all exiting families moved into permanent housing, after an average of 12.3 months in transitional housing. Permanent housing exits were facilitated by Section 8 housing vouchers that subsidise private rental and reduce rents to 30 per cent of family income, public housing or other affordable or fair market housing rentals.

Housing subsidies were critical for assisting a family to secure permanent housing: only 12 per cent did so without assistance (14). Nearly half of families secured permanent housing using a Section 8 voucher; another 6 per cent obtained public housing; and 9 per cent did so with another type of housing subsidy. Despite successfully completing the transitional program, 11 per cent of families were unable to secure permanent housing and this was due to affordable housing shortages or lack of subsidy availability (Northwest Institute for Children and Families 2008, p.14).

A similar correlation was found in a comparative review of outcomes from three follow-up studies of European housing programs intended to house and reintegrate people who have experienced homelessness (Busch-Geertsema 2002). The review compared outcomes for 36 people from housing programs in Germany, Ireland and Milan. While the sample size was small, the review provides a rare, international comparison of outcomes.

All three studies found that self-contained, independent housing (‘normal’ housing) was an essential basis for re-integration. Participants reported that self-contained, individual housing gave them a sense of autonomy, security, privacy and normality. And each of the three programs emphasised the importance of municipal accommodation, contractual agreements and the promotion of similar ventures in the voluntary sector in order to secure affordable permanent housing.

Housing affordability and also the administration arrangements clearly impacted on the risk of tenancy failures. While the majority of participants (n=29; 80%), successfully sustained their housing, in Germany four participants left or were evicted. In Dublin, three participants were unable to obtain long-term housing despite extensive preparation, due to the lack of supply.

In Germany, with relatively higher rents and additional charges, tenants experienced problems with maintaining regular rent payments and keeping up with extra charges. These problems were not as prevalent in Milan due to low rent, or in Dublin due to direct debit rent payments (Busch-Geertsema 2002).

Similarly, in Australia, the evaluation of a long-term intensive case-management program for people with drug dependencies experiencing homelessness concluded that:

Access to supportive and low-cost housing, however, is essential to achieving long term outcomes (Rayner 2006, p.40).

Two Australian longitudinal studies provide relevant evidence of the correlation between housing affordability and success at sustaining housing. One study followed up 79 households 9 to 12 months after transitional housing and found 90 per cent of those in public housing still housed compared to 67 per cent of those in private rental (Johnson et al. 2008, p.172).

The second study provides evidence that existing housing subsidies for private market housing are not currently adequate to secure affordable housing for a proportion of families (Kolar 2004). The study followed 30 families exiting from crisis support services in Melbourne over a two-year period. It found that a significant proportion of families in private rental (45%) were continuing to experience housing stress, despite receiving Commonwealth Rent Assistance (Kolar 2004, p.86). While families in private
rental had higher incomes and more income growth compared to public housing tenants, even these families were still receiving very low incomes, with a median below the recognised poverty line (pp.50–1).

Housing affordability and housing stress (indicated by rent as a proportion of income) for families in the private rental market showed variability over the course of two years, while it remained steady for public housing tenants (p.46). Changes in household income affect levels of housing stress, but it is likely that rental increases contributed to a destabilising volatility in housing costs as a proportion of income.

The Kolar finding is confirmed by the recent comprehensive review of Australia’s tax system, *Australia’s Future Tax System* (2010) which concludes:

… the current maximum levels of assistance for private tenants are too low, cutting out below a level that would ensure access to an adequate standard of housing. Indexation of assistance to the Consumer Price Index means that assistance is not well-targeted over time, exposing recipients to the risk of rent fluctuations (Part 2, Chapter F5 Henry Tax Review 2010).

### 6.4 Supportive housing, maximising client choice

Supportive housing, provided in ways that maximise people’s choices (i.e. permanent not transitional), with involvement in selecting the location and housing type, has proven ability to deliver high levels of housing sustained outcomes, measured over up to four years.

This and the following section presents findings from the strong, largely US evidence-base that establishes the value and effectiveness of permanent supportive housing for people who have experienced long-term or chronic homelessness (Substance Abuse and Mental Health Services Administration 2010).

It is worth noting that the US Report to Congress on Homelessness explicitly links a reduction in rough sleeping rates to the intensive investment in permanent supportive housing over the last decade. The annual Department of Housing and Urban Development’s (HUD) 2009 *Homeless Assessment Report* notes a decrease of 1.7 per cent of unsheltered homelessness over the period 2007–09, despite a growth in the overall numbers of people experiencing homelessness (HUD 2010). The HUD’s national estimations of the number of people experiencing ‘unsheltered’ homelessness are based on yearly point-in-time counts (PIT) and *Homeless Management Information Systems* (HMIS) data reported by Continuums of Care (CoC) (HUD 2010).

From the US, the model known as *Housing First* has developed a robust body of research evidence for its effectiveness, and gained widespread support in Europe and Australia. Detailed outcomes evidence is presented in Section 6.5.2 *Housing First outcomes* below.

*Housing First* has demonstrated impressive client outcomes including housing stability, reducing hospital and emergency service use and reduced harm from drug and alcohol use. It has also demonstrated a basis for increased economic and social participation. The outcomes of *Housing First* programs demonstrate the overall validity of the elements presented in this chapter, as they have been achieved with a very

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17 Homeless Management Information System (HMIS) is the electronic administrative databases that are designed to record and store client-level information on the characteristics and service needs of homeless persons accessing services. It provides a count of the ‘sheltered homeless.’ (HUD 2010, p.ii).

18 HUD requires that annual homelessness funding applications (Continuum of Care) provide one-night, Point-in-Time (PIT) counts in January of both sheltered and unsheltered homeless populations.
complex client group including people experiencing long-term chronic homelessness and serious mental illness.

The evidence suggests that the same elements with less intense support will generate positive outcomes for other groups experiencing homelessness.

The critical mechanisms of Housing First are:

➔ Secure permanent housing as quickly as possible.
➔ Ensure that client choice is maximised both by involving the person in the choice of housing option and in not requiring abstinence or other treatment compliance for housing access (Greenwood et al. 2005).
➔ Provide very active, assertive support and tenancy management (including for example, income management to guarantee rental payments particularly where active substance abuse is an issue) (Tsemberis & Asmussen 1999).
➔ Post-housing support should encompass social re-integration interventions including targeting education, employment and social connectedness (Yanos, Felton & Tsemberis 2007; Yanos, Barrow & Tsemberis 2004).

The Housing First approach was pioneered by Pathways to Housing Inc., founded in 1992 and led by Sam Tsemberis.19 The approach is firmly grounded in consumer preferences (Tsemberis & Asmussen 1999) (Barrow et al. 2007) and has been repeatedly proven effective at meeting the needs of people experiencing homelessness and severe mental illness.

The Housing First model as originally devised by Pathways to Housing offers immediate access to independent housing without mandatory psychiatric treatment or sobriety. Tenants are provided with intensive support services from interdisciplinary Assertive Community Treatment teams. The team can typically include social workers, psychiatrists, vocational trainers, substance abuse counsellors, and had added a nurse practitioner and a housing specialist.

Housing and support are closely linked but distinct. Two additional conditions are strongly encouraged—participation in a money management program including payment of 30 per cent of income in rent, and meeting with a Pathways staff member at least twice a month.

Researchers have also begun investigating community re-integration outcomes and found that further interventions are needed for a significant proportion of people (Yanos, Felton & Tsemberis 2007; Yanos, Barrow & Tsemberis 2004). Longitudinal outcome studies, as presented below, have consistently shown that neither severe mental illness nor substance use precludes formerly homeless people from maintaining housing.

However it is important to note some caution from a recent critical review of the Housing First literature (Kertesz et al. 2009). Kertesz et al. argue that Housing First studies have not categorically demonstrated the model's effectiveness for people with severe substance use issues. They identify the need for further research and practice innovation on effective models for people with active substance use problems.

From an Australian perspective, the evaluation of a NSW initiative to provide integrated housing and support to people with severe mental illness confirms the evidence in support of permanent supportive housing. The Housing and Accommodation Support Initiative (HASI) demonstrated the cost-effectiveness of

19 See http://www.pathwaystohousing.org/
combined housing and support programs for homeless adults with mental illness (Muir et al. 2007).

The HASI program provided combined housing and mental health support to 100 adults from marginal housing situations. Participants were predominantly Australian born men under 35 years of age (Muir et al. 2007, p.38). For an average recurrent cost of $57 530 per person per year, (not including the initial capital and set-up costs) the program achieved significant improvements across all the measured outcome domains.

- More than two-thirds of participants retained their tenancy in the same home (70%) for 12 months or more, and almost all participants remained with the same housing provider (85%) (Muir et al. 2007, p.34).
- Time spent in hospital in psychiatric units and emergency departments decreased by 81 per cent for 84 per cent of participants, an average of 70 days per person per year. (Muir et al. 2007, p.vii).

Other measured outcomes included improved health and social networks, a 77 per cent decrease in imprisonment, a tenfold increase in education and training participation, and a threefold increase in paid or voluntary work (Muir et al. 2007, p.34).

6.5 Evidence-based housing models

6.5.1 Evaluation of the ‘Collaborative Initiative to Help End Chronic Homelessness’

Positive client outcomes for permanent supportive housing are emerging from a large-scale longitudinal evaluation in the US (n=734) (Mares & Rosenheck 2007; Rickards et al. 2010). The 12-month findings indicate that permanent supported housing combined with primary healthcare, mental health services and social services has demonstrated effectiveness in reducing homelessness and improving the life situation for people experiencing chronic homelessness (Mares & Rosenheck 2007).

Commenced in 2004, the Collaborative Initiative to Help End Chronic Homelessness was a coordinated effort by three US Federal Departments\(^\text{20}\) and the US Interagency Council on Homelessness to house and provide comprehensive supportive services to individuals with serious psychiatric, substance use, health, and related disabilities who were experiencing long-term chronic homelessness.\(^\text{21}\) Eleven communities received either three- or five-year grants to implement the initiative.

On average, clients in the program had been homeless an average of eight years in their lifetimes; 72 per cent had substance abuse problems; 76 per cent had mental health problems, and 66 per cent reported medical problems. For the program evaluation, data was obtained at quarterly assessments from 734 (59%) of 1242 clients enrolled in the program. After 12 months, the following findings were significant:

- The average number of days housed in the previous 90 days increased from 18 at baseline, to 68 at the three–month follow-up, and rose steadily thereafter to 83 at the 12–month follow-up. This was substantially better than the observed change among comparison group subjects, from 17 at baseline to 50 days at 12 months.

\(^\text{20}\) US Departments of Health and Human Services, Housing and Urban Development, and Veterans Affairs.

\(^\text{21}\) A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for one year or more or has had at least four episodes of homelessness in the past three years.
Mean monthly public assistance income increased 50 per cent over 12 months, from $316 at baseline to $478. A 25 per cent increase was observed for comparison group subjects.

Significant improvements of modest magnitude were also observed in overall quality of life, mental health functioning, and reduced psychological distress.

Alcohol and drug problems remained largely unchanged over time.

Total quarterly health costs declined by 50 per cent, from $6832 at baseline to $3376 at 12 months.

The comparison group was identified from clients of five sites, and although this was not randomised assignment, statistical controls were used to make the outcome comparisons more robust.

6.5.2 Housing First outcomes

Outcome evidence from the following five key Housing First longitudinal outcome studies is included in the synthesis:

A four-year randomised controlled experiment evaluating the outcomes of Housing First, known as the New York Housing Study and conducted over eight sites. The study recruited 225 individuals randomly assigned to either Housing First (n=99) or a treatment-contingent program (n=126; intentionally over-sampled) (Padgett, Gulcur & Tsemberis 2006).

An 18-month randomised controlled study of 407 homeless people with chronic physical ill-health in Chicago. Participants were randomly assigned to Housing First with post-discharge case-management (n=201) and the control group (n=206) received the usual care (Sadowski et al. 2009).

A 12-month study of homeless individuals with severe alcoholism in Seattle. Participants were selected from a rank-ordered list of highest total costs for alcohol related services. Ninety-five people received a Housing First response (53 immediately housed, and 14 housed after three months). Costs and outcomes were compared to a small control group and to previous year data for the participants (Larimer et al. 2009).

A 12-month comparison of housing stability outcomes in three different Housing First programs (New York, Seattle & San Diego) with a sample of 80 chronically homeless people with mental illness (Pearson, Montgomery & Locke 2009).

A four-year study of housing stability in New York County with a sample of 260 participants (two Housing First programs (total n=209) and a control group (n=51)) (Stefancic & Tsemberis 2007).

Housing stability

The New York Housing Study was the first randomised experiment evaluating the outcomes of Housing First. The study began in 1996 and was part of a federally funded national demonstration project over eight sites.

At 24 months there was a clear finding that the Housing First group reduced their homelessness significantly faster. They spent less time homeless and more time stably housed than the control group at each of the time points. Additionally, after two years, 80 per cent of the original participants were still housed (Tsemberis, Gulcur & Nakae 2004). After four years, Housing First achieved a housing retention rate of 87%

Hypertension, diabetes, renal failure, cirrhosis or congestive heart failure.
per cent, with the four-year findings extending and confirming the 24-month results (Padgett, Gulcur & Tsemberis 2006, pp.79–80).

Compared to the control group, the Housing First participants had significantly higher housing stability rates: in the previous six months, Housing First clients were stably housed 75 per cent of the time compared to 50 per cent of the treatment-first clients (Padgett, Gulcur & Tsemberis 2006).

A later, separate study compared outcomes for randomly selected shelter users who were placed in one of two Housing First programs or a control group (Stefancic & Tsemberis 2007). The sample included participants assigned to Housing First delivered by Pathways to Housing (n=105) or by a consortium of local agencies (n=104) and a control group of 51 participants.

- The control group was offered the county’s usual services including shelter-based programs. This study evaluated the housing retention rate and psychiatric status for all groups at 20 months and evaluated housing retention for the Housing First groups at four years.

After 20 months, Pathways to Housing had successfully housed 57 people (62 housed and five people discharged). The consortium had housed 46 people (52 housed and six people discharged). In contrast, 12 control group members were in supportive housing, seven were in emergency housing or shelters, three entered into various institutions, four left the country and only one client was living independently. The remaining 21 participants had left the shelter system, leaving no information of their whereabouts. During the 20-month period, members of the control group cycled in and out of the system, returning to the shelter an average of 3.6 times.

The study found that after two years in Housing First programs, 84 per cent of all Housing First participants remained housed. Specifically, 88.5 per cent of all Pathways to housing participants were housed as were 79 per cent of all Consortium Local Agency participants.

At four years, 68 per cent of all Housing First participants remained housed. Specifically, 78.3 per cent of all Pathways to Housing participants were housed compared to 57 per cent of consortium participants. This differential result indicates that experience in implementing the Housing First model may be a factor in successful tenancy retention.

The cost assessment findings indicated that the two Housing First programs cost $55.92 per diem or $20 410 per client per year, whereas shelter reimbursement rates cost $66.49–$119.26 per diem or between $24 269–$43 530 per client per year.

Similarly, another study compared the performance of different Housing First programs for a total sample of 80 chronically homeless people: Pathways to Housing in New York (n=26), and two other programs comparable in size and operating experience in DESC, Seattle, Washington (n=25) and REACH, San Diego, California (n=29) (Pearson, Montgomery & Locke 2009).

The key finding of the study was that 84 per cent of participants across the three programs were still housed 12 months into the program. The 16 per cent that did not remain housed either left the program or passed away during the follow-up. Four people died, two needed more intensive care, two were incarcerated, two lost their housing due to assaulting other residents and three participants left to return to a ‘wanderer’ lifestyle.
Although differences between housing retention rates were not statistically significant, 92 per cent of Pathways to Housing participants remained housed at 12 months, while 80 per cent of both DESC and REACH participants also sustained their housing.

A difference between the three programs emerged from the data on ‘housing problems’. The research defined ‘housing problems’ as failure to upkeep the apartment, failure to upkeep personal hygiene, flooding, hoarding, excessive noise or behavioural problems (hallucinations). Pathways to Housing participants reported less than one housing problem during their participation in the study, while REACH participants reported 4.2 problems on average and DESC participants reported 3.2 problems on average.

A predictor of housing breakdown was duration of nights spent in other living environments. The study found that participants who stayed in their tenancy for 12 months spent an average of 29.8 nights in other living environments (psychiatric hospitals or short stays on the street), compared to an average of 60.8 nights for participants who had left their programs by 12 months.

Reducing emergency service use

Sadowski et al.’s (2009) study tracked 407 homeless people with chronic physical ill-health over 18 months in Chicago. Two hundred and one participants were randomly assigned to a Housing First program which placed them into permanent housing after short stays in respite care and provided post-discharge case-management during their tenancies, while 206 received usual care.

The study found that:

- **Housing First** participants showed a 29 per cent reduction in hospital days and 24 per cent reduction in emergency department visits (Sadowski et al. 2009).
- Prior to being placed in a **Housing First** program, participants had high levels of hospitalisation, after participating in the study 27 per cent of housed participants had no hospitalisations or emergency department visits (Sadowski et al. 2009).
- The researchers comment that ‘for every 100 homeless adults (similar to those included in our study) offered the intervention, the expected benefits over the next year would be 49 fewer hospitalisations, 270 fewer hospital days, and 116 fewer emergency department visits’ (Sadowski et al. 2009).

Greenwood et al. (2005) analysed psychological outcomes in the New York Housing Study and found evidence that a person’s subjective experience of perceived choice was a factor in the severity of their psychiatric symptoms. The **Housing First** group consistently perceived their level of choice to be higher than those in the control group (Greenwood et al. 2005, p.234).

Treatment-first approaches which require treatment compliance or abstinence to secure or maintain independent housing are contrasted and challenged by the consumer-led movement toward **Housing First**. In the **Housing First** model, respect is built into the program with a basic philosophy about housing readiness that assumes ‘if individuals with psychiatric symptoms can survive on the streets then they can manage their own apartments’ (Tsemberis, Gulcur & Nakae 2004, p.652).

Managing drug and alcohol use

The New York Housing Study found that **Housing First** client drug and alcohol outcomes were comparable to the treatment-first outcomes, despite less service use and no abstinence requirement.

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23 Hypertension, diabetes, renal failure, cirrhosis or congestive heart failure.
After two years, the groups did not differ significantly in substance use or psychiatric symptoms. The control group reported significantly higher use of substance abuse treatment services, increasing over time, while the Housing First group reported a decrease in service use (Tsemberis, Gulcur & Nakae 2004). The findings at four years extend and confirm the findings from 24 months (Padgett, Gulcur & Tsemberis 2006, pp.79–80). No significant differences were found between the groups in either alcohol or other drug use, though there appeared to be a small trend for Housing First participants to use less alcohol.

Larimer et al.’s (2009) study of Housing First programs for chronically homeless people who had recorded the highest alcohol related emergency service usage in Seattle demonstrated both cost-savings and alcohol use reductions. Ninety-five individuals received a Housing First response and were tracked over 12 months. The study found:

- Alcohol use was reduced after participants were housed. The average number of drinks reduced from 15.7 per day before being housed to 14.0 per day, six months after housing, and 10.6 per day at twelve months.
- Cost reduction was significantly related to the length of time housed, and service costs decreased as time housed increased (Larimer et al. 2009).
- Prior to the Housing First placement, participants accrued on average $4066 per month per individual for their use of emergency services. Once housed service use costs fell to $1492 after six months, and $958 after twelve months of housing.
- Overall, housed participants accrued 53 per cent less costs than their control counterparts six months after this study commenced, which was the equivalent of $3569 less in costs per person each month.

As noted above, critical evaluation of the Housing First evidence-base suggests that its effectiveness for people with severe drug and alcohol use has not been convincingly demonstrated. Kertesz et al. (2009) do acknowledge the Larimer et al. study as one of the only Housing First studies which housed participants with significant drug or alcohol use.

It is critical to underline that the research evidence consistently finds a proportion of people for whom housing sustained and other outcomes are not achieved. There is also a clear pattern in the findings which links problematic drug and alcohol use to continued homelessness, indicating the need for further innovation in program design and research in this area.

**Economic and social participation**

Additional analysis of participants in the Housing First New York study provides some indications that housing is a critical first step toward social re-integration, but it is not adequate on its own to secure economic and social participation for many people with complex health needs.

One study examined quantitative and qualitative dimensions of the transition to housing including the reaction to being housed, impact on sense of safety and the sense of ‘fitting in’ to the community. The sample comprised 80 individuals who had been housed for at least six months prior to data collection (Yanos, Barrow & Tsemberis 2004). The study sought to examine the social and psychological dimensions of integration, reflected in the extent to which someone feels they participate in and belong to the community (Yanos, Barrow & Tsemberis 2004, p.138).

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24 Participants were drawn from a list of individuals who had incurred the highest total costs in 2004 for use of alcohol related hospital emergency services, the sobering center, and King County jail.
The sample comprised 80 individuals who had been housed for at least six months. It included all 34 eligible individuals from the control group and a randomly selected group of 46 from the Housing First group\(^{25}\). The sample was predominantly male (75\%) and included a little over one-third Anglo American and one-third African American participants (Yanos, Barrow & Tsemberis 2004, p.137). Seventy per cent were living in independent apartments and 26 per cent were living in some kind of supervised housing.

The study found that the majority of participants had a positive reaction to being housed and reported psychological benefits and feelings of greater social inclusion. For example, participants commented (Yanos, Barrow & Tsemberis 2004, pp.140–1):

I have some dignity. I feel like a real part of society again.

I could see myself getting back to normal, back to society, to living. I see a future living independently.

Biggest difference: keys to my own place. Not being chased around like cattle all day.

I felt like I was not a homeless animal any more.

... when I live on the street, I don’t care about myself. Now having an apartment, I care about myself. I take showers, I dress, and care how I look ...

I watch the news to see what’s going on.

Indeed the findings indicated that for many people, ‘becoming housed facilitated a feeling of being ‘normal’ or part of the mainstream human experience’ (Yanos, Barrow & Tsemberis 2004, p.139).

Privacy and a sense of security were very important to many study participants. For example, being able to ‘put my pocketbook and food down without worrying that it will be stolen’ and no longer sleeping ‘with one eye open’ was a positive and valued change (Yanos, Barrow & Tsemberis 2004, p.142).

While the majority of participants reported positive experiences of being housed, a significant minority experienced challenges to adjusting to housing and to community integration. Adjustment challenges included coping with loneliness and managing the tasks of independent living (Yanos, Barrow & Tsemberis 2004, p.146). Persons discharged from institutional settings were particularly likely to experience these difficulties; this group were also likely to feel unsafe without the security presence in hospitals and shelters. Conversely, participants housed in staffed settings were more likely to report challenges due to inflexible rules and lack of privacy (Yanos, Barrow & Tsemberis 2004, p.147). Over a third of participants reported some difficulties ‘fitting in’ to their community. The qualitative data indicated this was partly a consequence of the interaction of the individual with the cultural and socio-economic make-up of the community, including the level of tolerance for difference (Yanos, Barrow & Tsemberis 2004, p.147).

A second study investigated the relationship between housing type and community integration outcomes for people with serious mental illness after being stably housed for at least one year (Yanos, Felton & Tsemberis 2007).

The study could not reach significant conclusions about the effect of housing type but it does identify the importance of post-housing interventions to develop a person’s connections to the neighbourhood or employment. It also establishes that community

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\(^{25}\) Nearly twice as many Housing First individuals were housed at 12 months (80 versus 41) so the sub-sample was purposively constructed to include as many control group participants as possible.
integration for a significant sub-group of people recovering from mental illness and homelessness will require more intensive and long-term efforts to achieve outcomes.

The second study used a sample of 44 persons, 27 of whom were housed in independent apartments and 17 in congregate settings. Yanos et al. found that people whose focus of ‘meaningful activity’ was their building, neighbourhood or job had a stronger sense of community and ‘fitting in’ than those focused on their apartment or room, and more than those who had no locus of meaningful activity (Yanos et al. 2007, p.715).

Of particular note, the researchers found they were unable to identify any ‘locus of meaningful activity’ for nearly 40 per cent of participants. The study was unable to categorise a significant proportion of participants (38.6%) who reported no meaningful activity. This finding while partly reflecting a limitation of the survey tool, also indicates a real and important phenomenon:

   ... many of the respondents in this group did seem to live lives without an involving pursuit or set of meaningful social connections: in this category, respondents said, ‘I lay in my bed and look at the walls. I am broke and all tapped out,’ or ‘I want to get out ... But I don’t have the energy. I am on too many medications.’ (Yanos et al. 2007, p.712)

The study identifies that ‘locus of meaningful activity’ is a significant variable for assessing economic and social participation outcomes, and a potentially useful dimension for program design.

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26 The study created a purposive sub-sample from individuals who had completed the 36-month follow-up interviews and had been stably housed for at least one year. In order to compare congregate care and independent apartments, the study purposively attempted to recruit all individuals in congregate living and only recruit a similar sized group from apartments. However the small sample size and the time elapsed since the random allocation of people to Housing First and control groups compromises the validity of the housing type comparison findings.
6.6 In brief: effective housing work

There are robust and coherent findings across the evidence-base that effective housing work secures housing options that are:

⇒ **Timely.** The research literature on effective housing work underlines that speed is critical for housing interventions. In fact, the critical point to draw from the Housing First and Street to Home research is the importance of timely provision of permanent housing options.

⇒ **Affordable.** The research consistently reports the importance of securing affordable housing for sustaining housing for people who have experienced homelessness. The evidence is coherent and robust from findings across countries and target groups.

⇒ **Suitable.** As well as conventional minimum standards, there are also suitability considerations that are specific to recovery from homelessness and its associated challenges, particularly, for example, substance use (e.g. proximity to substance using networks) or socio-economic disadvantage (e.g. access to transport), children’s development (e.g. maintaining continuity of schooling).

⇒ **Supportive housing, offered in a way that maximises a person’s choices.** For example, permanent rather than transitional housing and maximised client involvement in location and housing type. Client involvement allows people to select the most suitable housing with the best chance of meeting their location and social amenity needs.
Effective Case-management

The research synthesis identifies effective case-management as a critical step in both getting housing and keeping housing. Effective case-management is a critical part of housing-focused support:

Case management is an often used and often poorly defined term. Drawing on a recent synthesis of the evidence on case management that works for people, this report defines case management as a relationship-based, practical and assertive model of one-to-one support (Gronda 2009). Continuity, persistence and follow-through are critical elements in the achievement of outcomes that make a difference, and these elements characterise successful steps in the outcomes model, both for getting housing and for keeping housing.
The research on case-management outcomes highlights the importance of continuity in relationship-based, practical support. The evidence suggests that for some people with higher needs, ongoing case-management could be the key strategy in homelessness prevention as well as coordinating social inclusion and complex health management.

Delivery of effective case-management is a critical part of the housing-focused support outcome step because of the evidence that stronger and persisting relationships with a case manager are associated with better housing outcomes, and also with less tangible social and personal outcomes like self-esteem and goal-motivation. These less tangible social and personal outcomes are also strongly linked in the research to economic and social participation outcomes, and are discussed further in Chapter 12.

This step in the outcomes model is also supported by evidence from Housing First evaluations. As explained further in the next chapter, Housing First explicitly relies on a proven intensive approach to case management, Assertive Community Treatment.

Important characteristics of effective case-management support which emerge from the research are:

- Minimum thresholds of duration and intensity to develop a case-management relationship. Effective case-management relies on and builds a trusting relationship which research shows can take six months to develop. Some client outcomes can only be expected over two–three years.

- The objective and the responsibility to ‘stay the course’ and provide continuity from engagement to housing sustained. Successful transfers of case-management responsibility take skill, patience and care.

The studies in this chapter demonstrate that case-management has been evaluated and found effective across a range of different groups who experience homelessness. The chapter presents evidence from six studies, with the research designs including four quantitative, one qualitative and a research synthesis that incorporated evidence from a further 53 empirical sources.

### 7.1 Persistent, reliable, comprehensive and practical support

An Australian synthesis of fifty-three credible sources of international empirical evidence finds that effective case-management for people experiencing homelessness relies on a relationship, with the characteristics of persistence, reliability, intimacy and respect, in order to deliver comprehensive, practical support (Gronda 2009).

Gronda (2009) describes a model for understanding effective case-management for people experiencing homelessness in the following figure, and description below.
Case management provides comprehensive, practical support and results in an increase in a person’s self-care capacity.

The mechanism is a relationship with these essential characteristics:

- Persistence and reliability
- Intimacy and respect.

The mechanism operates within the contexts of the capacity and design of the service system, and staffing issues. Each context has two significant enabling factors, and these form the basis for the policy, program and practice implications:

- **Service system design and capacity**
  - timely access to appropriate resources, including housing, and specialist supports
  - determination of support duration and intensity on an individual basis

- **Staffing issues**
  - high-level assessment, relationship and communication skills
  - adequate staff supervision, training, and recognition. (Gronda 2009, pp.30–1)

Gronda (2009) finds that effective case-management is a time- and resource-intensive intervention that can nonetheless prove to be cost-effective because it increases a person’s self-care capacity and consequently reduces other service system expenditure. To be effective, the case-management relationship relies on highly skilled staff and access to resources, particularly housing and specialist supports (for example, expertise in psychiatric and substance use issues).

The research synthesised for this report confirms this model and shows that continuity of case management allows trust to build naturally over time and can be a critical step in engaging a person in specialist health supports. For example, two longitudinal studies with families have found that it can take a number of months of stable housing before underlying support needs can be identified (Kolar 2004; Northwest Institute for Children and Families 2008).

The qualities of persistence and a service model that allows continuity of service delivery are similarly identified in the definition of ‘assertive outreach’ models in homelessness services, claimed to be best-practice. For example, in their review of...
the research and practice literature on assertive outreach, Phillips et al. (2011) state that assertive outreach is distinguished as a service delivery model which is ‘persistent and aiming to work with people over the medium to long-term as a means to assist people to access housing and sustain their tenancies post-homelessness’ (p.2).

7.1.1 Serious mental illness

The ACCESS program evaluation discussed in Chapter 5 Person engaged with housing-focused support also established a robust link between better housing outcomes and a strong case-management relationship.

Chinman, Rosenheck and Lam analysed the data from the first two cohorts in the program (1994–95). At baseline, 3481 participants consented to participate, 2943 completed the three-month interview and 2798 (80.4%) completed the final interview, 18 months after commencement. They found that a stronger relationship at three months predicted better housing outcomes at 12 months; in addition, those who reported the strongest case-management relationship at three months experienced 50 per cent fewer days homeless at twelve months than those reporting no relationship (Chinman, Rosenheck & Lam 2000, p.1146).

A predictive correlation was found between presence and strength of the case-management relationship at three months, and days of homelessness at 12 months. A significant association was found between relationship strength, days of homelessness and general life satisfaction. At 12 months, those in the high alliance group experienced 50 per cent fewer days homeless than those with no relationship with their case manager. A similar but much weaker correlation was found between a high alliance and general life satisfaction (Chinman, Rosenheck & Lam 2000, p.1146).

7.1.2 Drug dependency

Australian evidence of the effectiveness of persistent, comprehensive relationship-based case-management for people with drug dependency experiencing homelessness was found in the evaluation of the Victorian Homeless and Drug Dependency Trial. The Trial demonstrated the value of the primary case-management relationship, based on an understanding of the person, and a commitment to staying with them, for assisting a person to get the help they need (Rayner, Batterham & Wiltshire 2005).

A significant component of the trial was the provision of ‘Continuous Primary Case Management.’ The program also included additional housing resources to create pathways out of crisis accommodation, a day recreation program and capacity-building among staff at the crisis accommodation services.

The Trial model of case management was explicitly ‘client-centred’ and ‘relationship-based’ with a comprehensive and practical focus acknowledging the interconnection of issues such as drug use, housing, health, family and unemployment (Rayner 2006).

Over three years (2001–04) 213 people entered the Trial, and 161 consented to be part of the evaluation. Participants in the trial were mostly young, disadvantaged men,

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27 A three-year trial funded by the Victorian Department of Human Services and operating across Melbourne’s three Crisis Supported Accommodation Services – Hanover Southbank, the Salvation Army’s Flagstaff and St Vincent de Paul Aged Care and Community Services Ozanam House. For more detail, see http://www.health.vic.gov.au/drugservices/pubs/hddt.htm
reporting high lifetime use of both licit and illicit substances\textsuperscript{28} high rates of mental illness\textsuperscript{29} and long-term experiences of homelessness.\textsuperscript{30}

The Trial was successful in engaging and retaining participants, and exceeded previously reported durations of drug treatment for homeless people (Rayner 2006). Median treatment duration by the end of the Trial’s third year was 13 months, compared to an earlier study which found that two-thirds of homeless clients stayed less than 35 days (Rayner, Batterham & Wiltshire 2005, p.16).

The majority of participants in the Trial achieved significant positive changes in key outcome areas including housing, substance use and health and social connectedness. However there was also a significant minority for whom conditions had not significantly improved across all of the outcome areas (see the Complex health management Chapter 11 for more detail).

The evaluation also conducted nine interviews with Trial participants, three months after they exited the program (Rayner, Batterham & Wiltshire 2005, pp.161–3). Four things stand out from these case studies:

1. The complexity of the life situation faced by people—extended homelessness, mental illness, experience of violence, troubled or absent relationships, social isolation, sexual abuse and trauma histories, low income, poor employment and education, legal, criminal and police involvement, anti-social behaviour, crime and illegal substance use.

2. The importance of housing.

3. The importance of managing on one’s own.

4. The importance of the case-management relationship.

The ‘importance of managing on one’s own’ is also highlighted in the report’s conclusion, noting that there were concerns prior to the Trial that long-term support would lead to dependency. In fact, clients were generally eager to disengage once their goals had been met, often in fact, before program goals such as abstinence or social integration were achieved (Rayner, Batterham & Wiltshire 2005, p.176).

The fourth point relates to the positive impact of a good relationship with the case manager, including the role of the case-management relationship in making effective referrals to other specialist supports. A number of case studies describe the difficulty of making a link that sticks. These qualitative findings indicate that it is not simply a lack of information about services that prevents the person getting what they need. Engagement with services may be an essential outcome area in its own right.

The evaluation concludes that effective practice involved: ‘pro-active engagement at the point where homeless drug users are in crisis’ followed by ‘continuity of care from that point onwards and ‘a relationship-based approach to case management’ with a ‘holistic’ approach to support. Timely access to specialist drug treatment, housing and social inclusion were also critical (Rayner, Batterham & Wiltshire 2005, p.19).

\textsuperscript{28} Alcohol was the most commonly used substance (94%, n=156), followed by cannabis (86%, n=156), heroin (76%, n=155), amphetamines (73%, n=155) and benzodiazepines (69%, n=156).

\textsuperscript{29} 72% (N=120) previously diagnosed with a mental illness; depression was the most common diagnosis, followed by anxiety disorder and psychosis. Forty per cent of participants (n=144) had previously attempted suicide, and 20% were experiencing suicidal ideation at the time of assessment (Rayner, Batterham & Wiltshire 2005, p.14).

\textsuperscript{30} Close to half of participants (49%) felt they had not had a home for longer than a year, while 23% of participants could not remember having a home or felt that they had never had a home.
7.1.3 Young people

The effectiveness of persistent case-management with young people experiencing homelessness was demonstrated in Australian research evaluating integrated service delivery for young people experiencing both homelessness and unemployment (a trial known as ‘YP4’). The research found that a minimum of 20 case-management contacts over about 12 months was linked to better housing, employment and education outcomes (Grace & Gill 2008).

The Victorian study included 414 participants aged 18 to 35 years from four different geographic areas of Victoria including inner, suburban and regional centres (Grace, Batterham & Cornell 2008, p.23). A randomly selected group of 224 participants were offered YP4’s intensive, continuous single point of contact case-management for up to 18 to 30 months, while the remaining group remained eligible for standard services.

A within-group analysis of those in the YP4 case-management group found improved housing, education and employment outcomes for participants who engaged with case management for 20 contacts or more (Grace & Gill 2008, p.10).

For both affordability and suitability of housing, the highest rate of good outcomes was achieved for clients receiving more than 20 support contacts. The proportion peaked at 21 to 40 contacts, and showed a small decline for those receiving 41 to 156 contacts (Grace & Gill 2008, pp13–14). The decline may imply a sub-group of clients facing extreme challenges.

Participants with more than 20 case manager contacts were significantly more likely to be in private rental accommodation, less likely to access no-rent accommodation (sleeping rough, staying with friends), and less likely to be reliant on financial assistance to maintain housing (Grace & Gill 2008, pp.15–7).

About a third of participants engaged in education or training, and Grace et al. found that participants with more than 20 case manager contacts were more likely to persist with their involvement (Grace & Gill 2008, p.18). The group with 21 to 40 support contacts reported nearly double the number of education or training days over the year (77 compared to 40) than the 1 to 5 contacts group (Grace & Gill 2008, p.19).

In contrast, and providing evidence for the importance of longer support durations through the negative case, a study of young people receiving short-term-services at a youth homeless shelter found that while the programs produced positive outcomes immediately post-discharge, the effects tended to attenuate over time. This research examined a range of client outcomes from 371 clients at 11 homeless/runaway youth shelters at six weeks, three months and six months post-discharge to assess their long-term effectiveness (Pollio et al. 2006). The findings suggest that crisis services provide immediate benefits but are not associated with long term outcomes (p.864). While the authors do advocate for the ongoing provision of short-term services, they also recommend ‘post-discharge coordination of care, particularly around substance use and family issues’ (p.865).

7.1.4 Families

Australian research on families recovering from an experience of homelessness indicates how persistence, continuity and individually tailored support are needed to match the real process of change and stabilisation. In addition, US research specifically demonstrates the value of practical, relationship-based case-management in a large-scale evaluation of transitional housing for families.

31 Outcome data was available for 196 participants from Centrelink administrative data, and from 24 months interviews with 157 participants.
An Australian longitudinal study of 30 families exiting from crisis support services in Melbourne over a two-year period robustly identifies some processes of change and indicates distinct trajectories and associated support needs, confirming findings throughout the evidence-base (Kolar 2004).

Kolar suggests that families experienced an initial ‘honeymoon’ period, with most families reporting between zero and two concerns at the six-month survey, contrasting sharply with results at 12 months, at which point a substantial proportion of many families reported three or more concerns.

Further analysis showed that from the 12 to 24 months there were three broad trajectories within the sample (Kolar 2004, pp.89–90):

- Families with few or no concerns remaining stable (n=17). Over half of those reporting few or no concerns maintained their housing and overall stability. Concerns for this group were financial and employment.
- Families with multiple problems that improved over time (n=16). Over half this group experienced positive changes in health, relationships and financial factors. Financial difficulty concerns remained.
- Families with multiple problems which did not improve. Health issues were the most common concern, but families also reported concerns with relationship/family issues, financial problems and employment difficulties.

Kolar also finds that parents’ emotional wellbeing had deteriorated in families with multiple problems that struggled over the two years, in contrast to overall improvements in parents wellbeing, and common high wellbeing scores for parents in the other two groups (p.94).

A key finding was that the majority of participants who remained in the study remained in stable housing over two years; in other words, more than two-thirds of the original sample were able to stabilise their housing following a significant housing crisis requiring formal homelessness assistance. Stable housing was associated with good outcomes for the children in the family. Health issues improved and school absenteeism declined to half the initial rate of days absent (Kolar 2004, pp.91–2).

A study in the US which evaluated a large-scale transitional housing program, described details about the role and impact of case management. The Sound Families Initiative combined housing with supportive services, in a transitional housing model for up to two years. Nearly two-thirds of families in the program (64%) had had a previous episode of homelessness, with some having four or more episodes (p.12).

A goal-oriented case-management approach was adopted at all sites and strongly linked to positive outcomes by the participants. Case management involved weekly in-home visits and additional phone contact, with a case load of 15 families.

The evaluation assessed quantitative outcome date for 942 families who had exited the program. It also conducted a longitudinal study with 203 families during the program and over three years following exit (though note the three-year follow-up group had dwindled to 27 families).

Families who successfully completed programs resided in their transitional housing units nearly four months longer (13.1 months), on average, than those who were evicted or asked to leave (9.6 months). Among families who successfully completed the transitional program, 89 per cent were able to secure permanent housing after exit

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32 Measured using The Self Esteem Inventory.
(2008, p.13). Many successful families continued to need housing subsidies and also intermittent support services after they left transitional housing (p.8).

The program had positive impact on income and employment. Forty-eight per cent of families increased their income between entry and exit and employment rates improved. Overall employment (including full and part time) among primary caregivers increased from 22 per cent at entry to 45 per cent at exit, and full-time employment tripled (p.15). Families repeatedly referenced the case management as a service from which they greatly benefited, and many identified case managers as the factor making ‘the most difference’ for them while in the programs (p.9).

The case management was goal-oriented and comprehensive, practical and relationship based. For example:

… eating with the family, praising children’s art projects, and listening to and understanding parents’ histories and traumatic experiences. … Many case managers were advocates for children at school, attended funerals and birthday celebrations, and were physical participants on moving days (p.9).

Case managers participated in family life and found themselves ‘acting as both a therapeutic agent and a participant in families’ daily lives’.
7.2 In brief: effective case-management

Effective case-management is one of the two critical components of housing-focused support:

Effective case-management + Housing work = Housing focused support

National and international research has robustly demonstrated the effectiveness of persistent, reliable, practical case-management support for people experiencing homelessness.

The evidence emphasises that persistence, continuity and intensity are critical effective elements: trusting relationships entail a minimum duration threshold to establish (e.g. up to six months with people experiencing complex health needs).

Case management has demonstrated results across a diverse range of target groups including people experiencing serious mental illness, drug dependency, young people and families.
8 INCREASED SUPPLY OF HOUSING AND SPECIALIST SUPPORT

The outcomes model describes how client outcomes in Specialist Homelessness Services depend on simultaneous outcome steps in mainstream services including Housing and Health.

The two steps described in this chapter are clearly not the purview of service delivery agencies assisting people experiencing homelessness. However, without including them as steps in the outcomes model, two of the most consistently identified essentials for achieving client outcomes would be missing and the model would lose its credibility.

8.1 Increased supply of affordable housing

Figure 11: Outcomes model: increased supply of affordable housing
The agencies and practitioners associated with this project provided consistent advice and anecdotal evidence that the lack of affordable housing options is a key barrier to achieving client outcomes which make a difference. The Australian housing research evidence-base has rigorously established there is a housing supply and affordability problem.33

Three key understandings from the Australian evidence-base indicate the need for an increased supply of affordable housing:

1. There is a long-term, structural housing affordability problem in Australia—requiring concerted, persistent, coordinated policy actions to create change (Yates & Gabriel 2006; Yates et al. 2007).

2. Housing affordability stress is particularly acute for low-income private renters, and this group is projected to grow (Yates et al. 2008; Yates et al. 2007, p.19).

3. There is a market failure in the supply of housing accessible to people on low incomes which requires innovation by government and the private sector (Milligan et al. 2009; Yates et al. 2007, p.46).

Factual dimensions of the housing affordability problem include:

- By 2008, the average earning household had less than half the required repayment capacity to purchase the median-priced home (National Housing Supply Council 2008, p.84).

- An existing absolute housing shortfall of 85 000 dwellings in 2008 is projected to grow by around 23 000 dwellings per annum over the next five years to reach 203 000 by 2013 (National Housing Supply Council 2008, p.73).

- Private rental dwellings are particularly in shortage with an estimated 26 000 dwellings required to return the private rental market to equilibrium (National Housing Supply Council 2008, pp.67–8).

- For low-income renters in particular, there was only one dwelling available for every five very low-income households, with an estimated 211 000 shortfall of available, affordable private rental dwellings in 2006 (Wulff et al. 2009, p.34).

- Private rental stock in the four lowest rent categories declined from 50 to 37 per cent between 2001 and 2006 (Wulff et al. 2009, p.1).

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33 The AHURI National Research Venture on Housing Affordability for Lower Income Australians makes a very significant contribution to the evidence-base. For more publications, see http://www.ahuri.edu.au/nrv/nrv3/
8.2 Increased supply and effectiveness of specialist support

The need for more specialist support was repeatedly raised by practitioners in describing their difficulties in obtaining access to specialist assistance for mental health and drug and alcohol treatment. Other issues raised included specialist help for children’s needs, for Indigenous Australians and also new arrivals or asylum seekers.

The evidence for this step in the outcomes model is by implication rather than direct findings. As described in Chapter 4, Understanding homelessness, the experience of homelessness is typically accompanied by a range of associated issues, which may be a cause or a consequence of homelessness, or may simply be an ongoing difficulty which a person has to manage.

There is evidence that adequate specialist support can aid in tenancy retention (i.e. supportive housing models) and that lack of adequate specialist supports can lead to tenancy failure (i.e. ‘low need’ targeted transitional housing). From the evidence
throughout homelessness research and housing program evaluations, the need for more effective drug and alcohol treatment is the strongest finding.

While these specialist support needs are not typically reported through Australia’s national homelessness statistics (AIHW 2010), it is unsurprising that people do not report the stigmatised needs associated with drug dependencies. Gambling is another addiction area which may impact on housing, but about which very little is known for similar reasons. As discussed elsewhere in this synthesis, longitudinal studies consistently report that underlying complex issues tend to be revealed only after a period of time in stable housing, and after the development of trust with support workers.

The mismatch between services and needs can be spatial as well as simply quantitative. This is shown for example by a study of Indigenous rough sleepers in Sydney which identified that the lack of Indigenous specific detoxification and rehabilitation services in the inner-city area where Indigenous people arrive from interstate and become connected to rough sleeping and housed communities was a significant barrier to effectively addressing the complex health issues of this group (Memmott & Chambers 2005).

A particular gap in the research evidence is about strategies to ensure effective referrals and linkages between specialist health and specialist homelessness services.
8.3 In brief: Increased supply of housing and specialist support

- Increased housing supply and increased specialist support are critical outcome steps for making a difference to homelessness.
- Australia has a significant housing supply and affordability problem, which is particularly acute in the low-income rental market. Consequently, people at risk of or experiencing homelessness confront intense competition for both social and private housing.
- The evidence for increased specialist support is presented throughout the synthesis. It includes the findings that intensive specialist support aids in long-term tenancy retention (Housing First studies) while lack of support, particularly for drug and alcohol issues is linked to tenancy breakdown.
9 GETTING HOUSING OUTCOME INDICATORS

The following table summarises outcome indicators from the research literature that can be used to monitor an agency’s contribution toward making a difference in this part of the outcomes model.

Table 5: Getting housing outcome indicators

<table>
<thead>
<tr>
<th>Outcome step</th>
<th>Outcome indicators</th>
</tr>
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<tbody>
<tr>
<td>Housing secured</td>
<td><strong>Individual level</strong>&lt;br&gt;Person or household secures permanent housing&lt;br&gt;OR&lt;br&gt;No set housing standard BUT linked to accountability for achieving sustained housing situation&lt;br&gt;Affordability—defined using an agreed convention, e.g. housing costs no more than 30 per cent of income.<strong>Population level</strong>&lt;br&gt;Housing availability measures:&lt;br&gt;→ Number of affordable and available rental properties&lt;br&gt;→ Private rental vacancy rates&lt;br&gt;→ Private rental median prices by area.</td>
</tr>
<tr>
<td>Engagement in housing-focused support</td>
<td>Rate of clients engaged to housing secured outcome.&lt;br&gt;Rate of persons exiting institutions with no fixed address engaged with housing-focused support PRIOR to exit&lt;br&gt;Rate of rough sleepers&lt;br&gt;Proportion of rough sleepers offered housing-focused support.</td>
</tr>
<tr>
<td>Housing work</td>
<td>Housing secured meeting minimum standards for:&lt;br&gt;→ Timely access&lt;br&gt;→ Suitable housing (dwelling quality standards, location, access to relevant amenity)&lt;br&gt;→ Affordability&lt;br&gt;→ Maximising client choice.&lt;br&gt;OR link to and monitor housing sustained outcome over time&lt;br&gt;Time elapsed between engagement and housing secured&lt;br&gt;Proportion of people seeking assistance who secure housing within three months.</td>
</tr>
<tr>
<td>Generalist case-management</td>
<td>Continuity of service delivery from engagement to housing secured.&lt;br&gt;Successful referrals to specialist support</td>
</tr>
<tr>
<td>Available, affordable housing options</td>
<td>Private rental vacancy rate&lt;br&gt;Rental affordability index, monitored by location and housing type&lt;br&gt;Social housing availability (public and community access times)&lt;br&gt;Low-income homeownership opportunities&lt;br&gt;Housing subsidy (e.g. CRA) availability &amp; affordability outcomes</td>
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PART 2: KEEPING HOUSING

The key finding of the synthesis overall is that the Keeping housing phase of client outcomes is absolutely critical to making a difference and that it needs more focus in policy, practice and research.

Part 2 of the synthesis report presents the available evidence on the steps involved in keeping housing, whether the person or family has been previously homeless or are at risk of losing their home for the first time. As shown in the following figure, once an individual or family has been engaged in housing focused support, there are three, inter-linked elements which contribute to the outcome of sustained housing.

The research evidence-base demonstrates that these steps are linked to successful outcomes. However there is less high-quality evidence available for the Keeping phase and the findings are broad and indicative.

Further research is particularly needed on engagement in housing focused support and homelessness prevention for people at risk of their first experience of homelessness. Accordingly this part of the report does not present any new evidence on Engagement in housing focused support, and the reader is referred to the findings presented in Chapter 5.

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34 Note, however, that the model does not exclude the possibility of other steps or activities which may be equally effective but are not currently documented in the evidence-base, or were not identified in the research synthesis process.
Figure 13: Keeping housing outcomes model

Each element has significant breadth and complexity and is described in more detail in the following chapters. In summary, these elements are:

- **Homelessness prevention**: Active and passive tenancy management strategies including systematic arrears monitoring; provision for gradual adjustment to housed living and flexibility and contingency planning for behavioural health relapses; strong coordination between tenancy and health management supports.

  Accountability for **housing sustained** client outcomes could provide a key strategy to drive effective homelessness prevention interventions from both housing and mainstream support providers.

- **Economic and social participation**: Increasing economic capabilities and resources through social re-integration initiatives; recreation and community engagement; specialist education, training and employment programs; and connection to mainstream education.
Complex health management: Specialist support and treatment for problematic drug and alcohol use, mental health issues including trauma recovery; ongoing disability support if required.

The chapters present the research findings identifying the significance of each element for sustaining housing and the evidence-based strategies that contribute to outcomes in these areas. Each individual or family will require their own combination and weighting of these elements, and the effectiveness of interim outcomes is ultimately represented in the outcome of sustained housing.

The capacity to deliver these elements relies on the availability of appropriate services and programs, some of which do not currently exist in Australia or even internationally. The research evidence identifies some promising effective interventions but demonstrates the need for further investment and innovation in this area. The research also provides consistent evidence for the need for an increased supply of specialist support, in particular drug and alcohol treatment and mental health specialists.
10 HOMELESSNESS PREVENTION

Homelessness prevention is defined here as one of the three critical elements to achieving the outcome of keeping housing. Homelessness prevention works interdependently with the interventions identified under Economic and social participation and Complex health management in order to achieve Sustained housing.

In addition, the synthesis implies that accountability for housing sustained client outcomes could provide a key strategy to drive effective homelessness prevention interventions from both housing and mainstream support providers.

The following chapter presents the key elements of homelessness prevention identified in the research literature. They encompass strategies for housing and tenancy management as well as strategies for support providers.
It is clear from the homelessness research that the prevention step in the outcomes model is absolutely critical, yet it is both under-practised and under-researched, and covers a diverse set of possible interventions.

This chapter provides evidence from 13 empirical studies including five quantitative and seven qualitative research designs, and one review. Research was conducted in North America (five), Europe (two) and Australia (six).

10.1 Primary, secondary and tertiary prevention

Burt, Pearson and Montgomery (2007) review the research literature on homelessness prevention and conduct some small-scale qualitative evaluation of three prevention programs. European researchers have provided alternative typologies of homelessness prevention (Busch-Geertsema & Fitzpatrick 2008; Pawson & Davidson 2008).

Burt et al. distinguish between primary, secondary and tertiary prevention (Burt, Pearson & Montgomery 2007, p.215):

- Primary prevention is preventing new cases of homelessness and stopping people from ever becoming homeless.
- Secondary prevention focuses on intervening early and effectively during a first experience of homelessness.
- Tertiary prevention seeks to end long-term homelessness.

In some cases, the approach for primary prevention is the same as the tertiary prevention program, for example in the use of a combination of permanent supportive housing and intensive support services for people with severe mental illness (Burt, Pearson & Montgomery 2007, p.218).

They identify the following evidence-based primary, secondary and tertiary prevention strategies (Burt, Pearson & Montgomery 2007, pp.219–20):

- Housing subsidies to ensure housing affordability.
- Supportive services coupled with permanent housing for adults with complex needs, alone or in families.
- Mediation in tenancy matters.
- Cash assistance for rent or mortgage arrears.
- Rapid exit from shelter into permanent housing, with supports as needed.

Burt et al. highlight the challenge of efficiency in prevention approaches. While effective prevention approaches have been identified, it is correct targeting to the most at risk which poses the most difficulty and is essential for cost-effectiveness.

The authors conclude that ‘secondary prevention and institutional discharge options offer the highest degree of appropriate targeting coupled with acceptable success rates’. These effective strategies include rapid exit from shelter for both families and single adults with serious mental illness, and community-based supportive housing for people with serious mental illness exiting psychiatric and correctional facilities (Burt, Pearson & Montgomery 2007, p.227).

10.2 Adjusting to housing

National and international research consistently demonstrates that the process of keeping housing after an experience of homelessness involves a significant physical, emotional and social adjustment, particularly following chronic or long-term
homelessness. A range of national and international sources demonstrate that long-term experiences of homelessness cause profound changes to people’s habits and social networks which can then create their own barriers to maintaining housing.

To successfully keep housing requires a successful adjustment, and the research identifies particular vulnerable groups and effective strategies to assist this adjustment. Groups who are known to be particularly vulnerable in the adjustment phase:

→ People who have experienced long-term or chronic homelessness.
→ People with serious mental illness.
→ People with significant problematic drug or alcohol dependency.
→ People who are transitioning to independent living for the first time or after a period of dependency—for example young people leaving care to live independently for the first time, women who have left a violent partner, persons exiting from psychiatric or correctional institutions.

In this section and the following one on critical transitions, research shows that a successful adjustment can be effectively supported through flexibility, active support—particularly in considering the role social networks—and well-thought-out contingency management. A detailed example of the challenges and facilitators of adjusting to housing is provided by a 12-month longitudinal, qualitative study of 16 residents of a transitional shelter in Boston (Lincoln, Plachta-Elliott & Espejo 2009). The study confirms again findings of the evidence-base that respect, flexibility and patience are important for a successful transition out of homelessness.

The authors describe key aspects of the Boston Safe Haven shelter model that make it successful in assisting chronically homeless people to come in and stay in. These were ‘a place that feels like home,’ a service delivery model that ‘respects personhood’ and the flexibility to accommodate the challenges of coming in and staying in (p.239). The shelter provides a low demand model which allows for a gradual adjustment to living inside, and to the slow development of trust in service staff (pp.241–2).

The Safe Haven shelter program was designed with a Housing First philosophy to assist people experiencing chronic homelessness with both mental illness and substance abuse problems to ‘come in’ from the streets. Unlike conventional US shelters which typically admit people on a nightly basis, the Safe Haven provided accommodation with 24-hour access, no maximum length of stay. It has private or semi-private accommodation options, and provides a low-demand service and referral model (p.236).

The shelter is linked to a medical centre in Boston and is intended to serve homeless people who were unwilling to utilise traditional treatment-first programs. While formal medical evaluations were not required upon entry to the shelter, the medical staff attended meals at the shelter on a weekly basis, spending informal time with residents. This unique model allowed residents to build trusting relationships and facilitated engagement with appropriate medical treatment later on (p.239).

The study investigated the factors to explain why this particular group of residents had chosen to come in off the streets, despite having refused multiple other opportunities to enter other shelters. A ‘place that felt like home’ was demonstrated in having a bedroom with a key, a private room where residents could go to ‘rest, gather their thoughts and feel safe’, a peaceful environment, being able to decorate and personalise their room and make it ‘homey’, and pleasant staff and facilities (p.239, p.241).
One of the most critical features of the model cited by residents was the demonstrated ‘respect for personhood’. As residents were moving in, they said it was important to have minimal rules, to be treated as an adult, and allowed the freedom to maintain a sense of independence (p.240). The Safe Haven shelter operates with a ‘no-barriers-to-entry model’ and maintains minimal rules required for safety (p.240).

Residents are only required to spend a minimum of two nights per week at the shelter in order to maintain their place. This flexibility gave residents the freedom to come off the streets at their own pace and adjust gradually to living inside.

Residents nonetheless frequently reported having difficulty adjusting to living inside. In particular, adjusting their routine to living inside meant getting used to a new sleep schedule, new social interaction with others, learning to trust staff and other residents, and coping with congregate living (p.241). These were the most commonly cited stresses for the chronically homeless as they moved into the shelter. They generally dealt with these stresses by either ‘keeping to themselves [or] … asking staff to mediate if a particular resident was bothering them’ (p.242).

Similar findings of the importance of incremental change is provided from the perspective of young people transitioning from the street in Canada. A Canadian study provides a strong and detailed analysis of young people’s transition pathways off the street (Karabanow 2008). Karabanow conducted qualitative research with 128 young people living on the street in six Canadian cities (90 males, 38 females) and 50 service providers (Karabanow 2008, pp.772–3).

Karabanow identifies six steps in the process of young people exiting street life: precipitating factors—courage to change—securing help—transitioning from the street—change in routine—successful exiting (Karabanow 2008, p.780). He also finds that most young people made repeated attempts to disengage from street life: six tries was average for the sample (Karabanow 2008, p.775).

Successful exiting involved both tangible and intangible aspects (Karabanow 2008, p.785). Housing, a return to employment or education and moving away from street culture are the common tangible elements, while hope, spiritual or emotional growth and a sense of control, stability and belief in the future were important for many young people (Karabanow 2008, pp.784–5).

The study particularly identifies the importance of economic and social participation factors. The ‘changing routine’ phase was characterised by ‘replacing street activities with formal employment and returning to school’ (Karabanow 2008, p.783). Employment and the accompanying routines of daily working life marked re-integration with mainstream society and enabled young people to see street life at a distance as ‘an unhealthy, destructive environment’ (Karabanow 2008, p.784). Safe and sustainable housing was a critical starting point for seeking employment (Karabanow 2008, p.787).

As other studies agree, street culture provides aspects of supportive community for young people and this can subsequently create a barrier to exiting homelessness (Johnson, Gronda & Coutts 2008; Karabanow 2008; Kidd & Davidson 2007; Rice et al. 2005). ‘Transitioning from the street’ is a challenging phase because it involves breaking with the very support network that enabled the young person to survive homelessness. As also found in other studies, becoming pregnant and other forms of

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35 Further information on this framework and how it can be applied to engaging young people in education, employment and training, see Grace, M., H. Gronda, & L. Coventry. (2009) Education, Employment and Training for Young People Experiencing Homelessness: Outcome Dimensions. Parity (September (Youth Homelessness Conferences)).
increased responsibility supported young people’s motivation to change (Karabanow 2008, p.778; Wingert, Higgitt & Ristock 2005b) (Keys 2007a).

Of particular importance, this phase requires rebuilding relationships with mainstream society and this is equally as difficult as breaking the street ties. A comment from one young woman exemplifies this challenge:

‘I think it’s really hard because I’m, like, in between right now because a lot of my friends still live street lives. They’re all about partying and panning and I’m just not, so I guess it’s a kind of lonely time because you’re figuring out yourself and what you want to do. (Heidi, age 19, Halifax)’ (Karabanow 2008, p.783).

Unsurprisingly, the data showed a strong correlation between the length of homeless experience and the difficulty of making this transition (Karabanow 2008, p.781). Dealing with drug addictions is a decisive part of this phase.

10.3 Critical transitions

In addition to the findings about processes of exiting homelessness and adjusting to housing, the research synthesis found evidence relevant to interventions targeting specific critical transitions in people’s lives—both developmental (e.g. school-age young people) and situational (e.g. leaving an institution). This section highlights interventions that target particular developmental or situational transition moments that represent a high-risk moment, or threshold change in someone’s experience of housing vulnerability.

Practice, policy and some research suggests that intervening effectively at these critical transitions may prevent a first experience of homelessness, reduce the harms associated with the experience and has the potential to reduce the likelihood of further experiences of homelessness.

This section presents studies most directly focused on critical transitions, though there is certainly indirect evidence also included in other chapters. The critical transitions identified in the research and discussed here are:

- Ageing.
- Young people leaving care.
- Family violence related housing-risk and homelessness.
- Exiting institutional healthcare institutions, for example medical and psychiatric hospitals; substance treatment centres.
- Exiting correctional institutions.

The over-arching common theme of this research echoes the findings presented in elsewhere in the synthesis: the need for access to affordable housing and comprehensive support to address mental and physical health needs, and build vocational and social connections. There is also a body of research evidence about keeping young people engaged in education which could also be framed as a critical transition but has been presented in Chapter 12 on economic and social participation.

The evidence in Chapter 4 on pathways and sub-groups indicates that there are at least two distinct sub-groups of young people who will need different levels of support and a different approach.

These two sub-groups are not exact types, and perhaps better thought of as ends of a continuum. One end is most likely to be reconciled or reconnected with family, and have a greater likelihood of staying engaged with education. The other end of the
continuum is young people who have experienced significant traumatic childhood experiences and may have been in State care, as described in the evidence on grief and suicidality in Chapter 11.

This chapter contains evidence relevant to the second group, through studies of young people exiting State care. Evidence relevant to the first group is presented in Chapter 12 on economic and social participation, focusing on reconnection with education, employment and training.

10.3.1 Ageing

There is currently limited research on the prevention of homelessness that is related to ageing, though older Australians’ housing vulnerability is expected to be an increasing phenomenon over the coming years.36

A study from the UK identified a number of concrete prevention strategies for older people at risk of homelessness (Crane, Warnes & Fu 2006). The strategies were derived from evidence in a study of 131 people, aged over 50, who had experienced homelessness in England. The study identified the following five ‘pathways’ that described distinctive processes leading to homelessness:

1. Mobility or functioning difficulties that derived from physical and mental health problems.
2. Financial problems and rent arrears, often due to Housing Benefit renewal or payment delays.
3. The death of a relative or close friend.
4. The breakdown of a marital or cohabiting relationship.
5. Disputes with co-tenants and neighbours. (p.158).

Bereavement led to a characteristic sequence of subsequent events: first there was a change of tenancy or of the person paying the rent, followed by social isolation and either deepening depression or rent defaults, and sometimes both (p.160).

A consultation paper based on the pathways research was circulated to housing, social services and health staff in London and Sheffield, and followed by three workshops with 41 participants. The following prevention strategies were identified (pp.162–3):

- Housing agencies to adopt systematic monitoring of rent arrears for signs of exceptional risk or vulnerability. Warning signs include changes in the pattern of rent payments and uncharacteristic defaults, particularly if a person has recently taken over a tenancy, lives alone or is known to be vulnerable.
- Housing staff to provide a more individualised, case-work approach to addressing rent arrears.
- Introducing an assessment for housing vulnerability in primary healthcare settings. Primary healthcare providers could pay attention to housing issues, particularly for older patients with declining health or bereavement/marital breakdown as clear ‘red flags’ to investigate housing vulnerability.

Greater information sharing about clients at risk and coordination of services.

The authors find that homelessness prevention is a challenging policy area because of the difficulty of identifying households who are at risk and secondly because of the poor evidence-base on effective interventions. They identify two major current approaches:

- Individual-focused interventions targeting vulnerable sub-groups (e.g. bereaved older persons) or high-risk situations (e.g. discharge from institutions)
- Universal or systems-monitoring such as rent arrears management.

The researchers conclude there is clearly scope for further research and policy development in homelessness prevention (Crane, Warnes & Fu 2006).

10.3.2 Housing for young people leaving care

A recent Australian study in this area has made a significant contribution to a largely poorly understood area of homelessness prevention (Johnson et al. 2010). This evidence is supplemented here by details from an innovative, long-running program in the US which successfully uses private rental housing to transition young people to independence (Kroner 2007; Kroner & Mares 2009).

Johnson et al.’s Australian research explored the experience of 77 out-of-home-care leavers from Western Australia and Victoria and found two distinct sub-groups, with one group at significantly higher risk of long-term homelessness (Johnson et al. 2010). Three-quarters of the study participants experienced a volatile transition from care (n=59) and experienced periods of homelessness as well as acute housing instability (Johnson et al. 2010, p.40). Two-thirds of the ‘volatile transition’ group did not have a leaving care plan (Johnson et al. 2010, p.42). The study also found that reliable, sustainable social relationships were just as important as access to adequate housing for a successful transition from out-of-home-care.

The study describes how a volatile transition became a pathway to homelessness and for some, long-term homelessness. About half of the volatile transition group (n=32) were able to move on with their lives, but the rest of the group (slightly less than half; n=27) remained in unstable housing and damaging circumstances including rough sleeping even after five years (Johnson et al. 2010, p.48).

Characteristic of this group was that they left care earlier and in crisis; they typically had been through many foster care placements and distrusted the system and other people. Most experienced housing instability and homelessness (Johnson et al. 2010, p.54). If homelessness persisted and was combined with problematic substance use, it was a process leading to rough sleeping:

Over time as their accommodation options dwindled and their substance abuse problems became more pronounced, people came to rely on the streets more and more (Johnson et al. 2010, p.46).

Just over half the study participants reported a lifetime problem with substance use, confirming other research findings of high levels among care leavers. This study also found that lifetime substance use was starkly correlated with their care leaving experience: affecting 61 per cent of those with a volatile transition and only 28 per cent of those who experienced a smooth transition from care (Johnson et al. 2010, p.45).

In particular the research emphasised a critical link between reliable social relationships and housing stability:
A lack of connection had material consequences for housing: many care leavers had no-one from whom they could borrow money, receive household goods, seek advice and emotional support and ask for accommodation when their own housing broke down—housing instability and homelessness are common outcomes (Johnson et al. 2010, p.4).

The research identified key characteristics of the volatile transition experience and also a range of elements which assisted young people to overcome these challenges (Johnson et al. 2010, p.3).

The volatile transition was characterised by:

- Negative experiences in supported/transitional accommodation, particularly associated with shared living arrangements.
- Accommodation which lacked privacy, safety and did not allow the young person to control their environment.
- Inadequate professional support.
- Accommodation loss caused by harassment, violence or relationship breakdown.
- Absence of positive social networks and consequent lack of access to resources that could support stable housing situations.
- Difficulties with maintaining relationships and significant mistrust of care and welfare systems.
- Substance abuse and mental health issues which interfered with housing stability.
- Difficulties coping with autonomy and independence.

Just over half the group who experienced a volatile transition had been able to overcome these challenges and appeared to be successfully finding their way to independence. The key element was being able to address problematic substance abuse issues. The research finds that this group had typically:

- Addressed substance abuse issues.
- Developed improved relationships with their family.
- Found the right sort of support.
- Found work (Johnson et al. 2010, p.3).

The findings of this research strongly indicate that the complexity of practical and emotional issues faced by some care-leavers will require a long-term support commitment. The researchers conclude:

When support is sensitive to individual circumstances and has the capacity to ‘hang in there’, rather than being structured around arbitrary time frames, the chances of care leavers moving on is considerably higher (Johnson et al. 2010, p.50).

The research suggests that effective responses to young people leaving care will require coordination and persistence with a combination of practical housing support and reliable social connection strategies. This Australian empirical research supports the need for comprehensive and practical approaches to homelessness prevention for young people leaving care. An effective approach for homelessness prevention during this critical transition is demonstrated in a US program with 20 years of practice in transitioning young people from care to independence (Kroner 2007). The Lighthouse Youth Services program in Ohio in the US operates under the assumption that:
... housing-based independent living programs must be designed to accommodate the full range of mistakes which their clients will make, despite the best efforts of program staff to minimize such mistakes (Kroner & Mares 2008)

Key elements of the program include (Kroner 2007; Kroner & Mares 2009):

- The program uses private rental properties and therefore is not limited by available ‘bed spaces’.
- Young people are involved in selection of the property, which is chosen for location and affordability. The intention is that the young person may continue to live there after the program’s conclusion.
- The agency rents the property, pays the bond, and covers utilities and phone for the initial period and takes full responsibility for the young person’s behaviour.
- If the young person is employed at discharge and has proven responsible, they are able to take over the lease and keep the furnishings, supplies and security bond.
- The program has a range of alternative supervised housing options to provide ‘time-out’ and preserve neighbourhood relationships, but the property is kept for the young person as an incentive to moderate their behaviours.
- Young people complete a Life Skills curriculum through 12 projects at their own pace covering skills in living independently, employment and social development.
- Each young person has an intensive case worker (case loads of 8–12).
- Staff are available for emergency response 24 hours, seven days a week.

A recent program evaluation analysed outcome data for 455 youth admitted to the Lighthouse program between 2001 and 2006 and found overall outcome rates of 60 per cent school completion, 31 per cent employment and 33 per cent independent housing, with significant variability by risk factor groups, age at admission and length of stay (Kroner & Mares 2009).

The study found that young people of ages 19 to 20 generally achieved better outcomes than those younger clients who entered at 16 to 18. The older group were more likely to have completed high school, be employed and be living independently (Kroner & Mares 2009).

As a rule, clients who stayed longer than six months in the program were more likely to be employed and independently housed, however clients who left within six months were more likely to have completed high school. The authors attribute this to the known fact that some young people expressly enter the program to finish their final year of school (Kroner & Mares 2009).

It is noted that restricting program entry to young people with high risk factors would most likely increase the overall outcomes. However the agency has a policy to provide services to ‘last chance’ youth.

10.3.3 Preventing domestic violence related homelessness

Domestic or family violence accounts for a very significant proportion of homelessness assistance sought by women in Australia. The Australian Institute of Health and Welfare reports that 40 per cent of single women over 25, and 49 per cent of women with children identified domestic or family as the main reason for seeking assistance from specialist homelessness assistance services in 2008–09 (Australian Institute of Health and Welfare 2010, p.36). Overall, family violence was the most
common ‘main reason for seeking assistance’ in that period, reported for 22 per cent of all SAAP support periods (Australian Institute of Health and Welfare 2010, p.30).

There is not a strong evidence-base on preventing domestic violence related homelessness, although the fundamental relevant elements are clear:

- Increased access to affordable housing
- Multi-faceted options to ensure safety and security (including police and legal actions/physical security measures such as home modifications or high security refuges).

A review of Australian and international literature and program evaluations combined with targeted interviews with 32 service providers, peak advocacy bodies and client representatives finds that the lack of affordable housing options is the key barrier to an effective service response to women escaping family violence and a reason why women escaping domestic violence are forced to experience homelessness (Tually et al. 2008, p.45). Tually et al. (2008) find that domestic violence is a key cause of homelessness for women in Australia. Women with little financial independence, who are Indigenous or come from a CALD background, are overrepresented in this group (Tually et al. 2008, p.19).

Short-term refuges can provide essential, immediate safety. However, without secure, affordable ongoing housing options, women may return to dangerous home environments. Tually et al. highlight the importance of minimising the number of times a woman must move, noting the disruption this has particularly for children at school, and consequently find that transitional housing options are less suitable than permanent housing (Tually et al. 2008, p.46).

The review also finds that the use of motels as temporary emergency accommodation is considered to be particularly inappropriate due to the lack of security and lack of support, the inappropriateness for children, the inadequate cooking and laundry facilities. In addition they are seen as an expensive and wasteful use of limited brokerage funds (Tually et al. 2008, p.47).

Domestic violence affects women’s sense of belonging, self-worth and self-confidence, often resulting in isolation and disconnection from community, which undermines their capacity to participate in the workforce and secure financial independence (Tually et al. 2008, p.16). The researchers cite poverty and a lack of independent financial resources as a key cause of homelessness for this cohort (Tually et al. 2008, p.18). According to SAAP data 82.8 per cent of women are on some form of government benefit with 5.7 per cent reporting no income at all (Tually et al. 2008, p.18).

A recent innovation in family violence practice has been approaches which try to allow women to stay in the homes, while perpetrators are required to find other accommodation. This approach is only possible for a sub-group of women for whom safety can be achieved without the high security of a hidden refuge.

The approach developed in the UK has been trialled and evaluated in Australia. Research in the UK has assessed the advantages and disadvantages of the Sanctuary Model, in which additional security is added to the woman’s current home to prevent the entry of a violent (ex) partner (Netto, Pawson & Sharp 2009) (Jones et al. 2010). The evaluations demonstrate that the model is effective at reducing incidents of domestic violence and preventing homelessness.

The Sanctuary Model (or Sanctuary Schemes) combines added security features in the home with the provision of legal advice, alteration of tenancy agreements, a more joined-up approach to wrap around support services for victims, and exclusionary
orders to keep the perpetrator out of the home and surrounding neighbourhood. These schemes have been highly beneficial for some women as well as service providers (Netto, Pawson & Sharp 2009):

- They allow continuity of community connections, as well as access to important health, education and other services.
- They are cost-effective compared to the costs associated with refuges and finding new, permanent housing (p.728).
- In smaller cities and towns, moving to a new house as a means of fleeing a violent partner is pointless. They can be readily found by the perpetrator (p.731). Improved security at home can prevent needless, disruptive moves.

A large-scale qualitative evaluation of the Sanctuary Model in the UK found it to be effective at providing immediate safety for families, and cost-effective because it reduced incidents of domestic violence and prevented homelessness (Jones et al. 2010).

Netto, Pawson and Sharp did identify some disadvantages of the model and suggest that for some women the model was not appropriate for the following reasons:

- The legal system in the UK is not victim-centred, so exclusionary orders may be difficult or impossible to enforce (p.727).
- The added security can make the home feel like a prison, as one scheme participant reported in one case study cited (p.731).

The authors note that Sanctuary schemes can place ‘the onus of the victim to protect themselves …’ which ‘entails a shift to increasing individual responsibility’ rather than State responsibility for providing support (p.732). They highlight the importance of addressing broader community safety issues, particularly in relation to the stigmatisation of council estates (p.731).

The authors conclude that the sanctuary model should only be one part of a more comprehensive approach which includes other forms of housing, as well as improved multi-agency work at both the ‘policy and operational level’ (p.733), more effective policy and legislative responses to the perpetrators, and addressing the root causes of women’s domestic violence-related homelessness (p.734).

In Australia, research has documented a program to assist women to stay at home that was piloted in Bega, NSW, following research which identified the factors which assisted women to stay. This small qualitative study identified factors which could enable women in violent relationships to stay in their home (Edwards 2004). The study involved 29 women, nine of whom remained at home when ending the violent relationship. Four critical factors enabled those nine to stay in their homes:

1. The women had a strong attachment to their home and felt entitled to stay.
2. Their partner had been removed by police or had left voluntarily because he had other housing options.
3. The women were able to develop strategies that allowed them to feel safe in their home.
4. The perpetrator was intimidated by police or the courts, or felt obliged to abide by the law.

For the women and their children this resulted in stability of accommodation and security, less disruption to their lives, a sense of justice (the violent party had to leave
while the victim was able to stay in the home) and a shift in power relations as the women experienced empowerment by being able to reclaim their homes.

Most of those who left their homes reported that they would have preferred to remain. The women reported that the following factors would have assisted them to do this:

- Removing the man from the home immediately following the violent incident.
- Keeping the perpetrator away from the home.
- Actually charging the offender with assault or a breach of court order if this occurs.
- Improving the safety of the home (i.e. security doors, panic alarms, greater bail and reporting requirements).
- Providing alternative housing for the perpetrator.

The women reported that this would help reduce stigma and shift the blame and responsibility on to the perpetrator as he, not the woman, bears the consequences and leaves the home (Edwards 2004).

Consequent to Edwards' (2004) research, NSW piloted the program Staying Home Leaving Violence. The evaluation found that the majority of clients (59%) reported positive outcomes from the pilot and that those who had experienced negative outcomes also reported more complex situations (i.e. mental health or drug and alcohol issues) (Bega Women's Refuge Incorporated 2007).

The evaluation found that interagency cooperation and service coordination, the provision of outreach services, the development of individualised safety plans for women and their children, and community education were key factors in mitigating homelessness resultant from domestic violence. However, organisational and staffing instability were factors that reduced collaboration and negatively impacted client outcomes (Bega Women's Refuge Incorporated 2007, p.10).

10.3.4 Exiting hospital

The review of homelessness prevention strategies cited above by Burt, Pearson and Montgomery (2007) concludes that community-based supportive housing for people exiting institutions is a proven and cost-effective strategy for homelessness prevention. As shown in chapter 6, the studies of Housing First provide a very significant evidence-base for effective interventions for people exiting psychiatric hospitals.

10.3.5 Exiting corrections

There is some evidence of the importance of housing services at this critical transition in order to prevent homelessness and also reduce recidivism. A significant Australian study has examined the pathways of people with mental health disorders and cognitive disability in the NSW criminal justice system (Baldry 2010). It found that homelessness and housing disadvantage were strongly implicated in people’s housing pathways, and that individuals with complex needs (more than one diagnosis) were particularly susceptible to housing crisis.

A purposive sample of 2731 individuals was created by combining administrative data from the human services and criminal justice systems. Twenty-five per cent of the sample had an intellectual disability, 29 per cent a borderline intellectual disability, 35 per cent were diagnosed with a mental health disorder and 47 per cent had a substance use disorder.

The study found that individuals with complex needs (greater than one diagnosis) experienced significantly greater homelessness and housing disadvantage than those with only one or no diagnosis. The majority of those with complex needs (over 80%)
had sought assistance with housing, and between 60 to 78 per cent had been assisted. Public housing tenancies had a high rate of ending in eviction or termination (over 50%), and the rate was higher for those with complex needs. Forty-two per cent of evictions were the result of incarceration.

An earlier housing focused Australian study of people released from prison found that being homeless and not having effective accommodation support were both strongly linked to returning to prison (Baldry et al. 2003b). It also highlights the importance of social connections in avoiding poor housing outcomes.

Baldry et al. (2003) conducted a longitudinal study in NSW and Victoria which interviewed participants pre-release and then three, six and nine months post-release. The initial pre-release sample was 355 people, and 70 per cent (238 participants) were followed up post-release, a very high study retention rate for this kind of research (Baldry et al. 2003a, p.8). This sample was statistically valid, and the findings reported here are statistically significant correlations.

On the most conservative estimate, the study found that homelessness increased from 18 per cent prior to incarceration to 21.4 per cent post-release, and that homelessness was significantly associated with recidivism. Sixty-one per cent of those homeless on release returned to prison, compared to 35 per cent of those with accommodation (Baldry et al. 2003a, p.12). Interview data indicated that up to half of the participants experienced episodes of homelessness over the follow-up period (Baldry et al. 2003a, p.12).

Housing stability, measured by the number of moves between interviews, was strongly associated with recidivism. Only 22 per cent of those who did not move or moved only once returned to prison compared to 59 per cent of those who moved twice or more (Baldry et al. 2003a, p.11). Half of the sample moved more than twice between interviews, and 15.5 per cent moved more than four times (Baldry et al. 2003a, p.11).

The study found that the two factors most strongly predictive of returning to prison were moving often and worsening problems with heroin (Baldry et al. 2003a, p.22). Problematic substance use of all kinds was found to be associated with increased likelihood of returning to prison (Baldry et al. 2003a, p.19).

The housing situation most associated with staying out of prison was living with parents, partners or family members. Only 23 per cent of this group returned to prison, compared to 52 per cent of those living with others or alone (Baldry et al. 2003a, p.13). The qualitative data indicates that relationships with family could be a significant source of support. However troubled relationships equally could lead to homelessness (Baldry et al. 2003a, p.21).

The study also found that participants’ own assessments of post-release housing support and other services were reliably accurate for predicting prison return outcomes (Baldry et al. 2003a, pp.15–7). Eighty-two per cent (n=62) of those who reported that housing support was helpful stayed out of prison, while 69 per cent (n= 52) of those who reported unhelpful support did return to prison (Baldry et al. 2003a, pp.15–6). This indicates that program design could be significantly improved using the input of prisoners and ex-prisoners.

Overall, women, Aboriginal or Torres Strait Islanders, and people with debts were significantly more at risk of returning to prison. A particularly disadvantaged sub-group in this study was Indigenous women from NSW. They experienced the highest rate of re-incarceration and homelessness. These women did have a dedicated support worker pre- and post-release. However the fundamental problem was an inability to
find suitable housing. Most of this group were cycling in and out of prison on short sentences. They were often unable to live with family, needed accommodation for their children and had debts to the Department of Housing (Baldry et al. 2003a, p.25).

The study found a severe lack of services compared to the need. None of the study participants found accommodation in specialist post-release residential services. There was also a distinct lack of coordination and integration between services and programs (Baldry et al. 2003a, p.24).
### 10.4 In brief: Homelessness prevention

- The key elements of homelessness prevention identified in the research include:
  - Active and passive tenancy-risk management strategies.
  - Provision for gradual adjustment to housed living.
  - Flexibility and contingency planning for behavioural health relapses.
  - Strong coordination between tenancy and health management supports.
  - Specific strategies for known high-risk transitions.

- The most effective way to ensure the client outcome of sustained housing is a tailored package of homelessness prevention strategies along with economic and social participation and complex health management, designed in collaboration with an individual or a family.

- Homelessness prevention services could be delivered by mainstream or specialist homelessness services. The key element is that agencies delivering homelessness prevention are held accountable for housing sustained outcomes.

- This report recommends the use of shared accountability for sustained housing as a mechanism to ensure continuity and collaboration between the housing and support services which work most effectively together to prevent further homelessness.

- For some groups of people, for example in the case of severe mental illness, known to recur with sporadic episodes of unwellness, cognitive disability or acquired brain injury, support may need to be ongoing for the rest of the person's life.

- For those with or serious substance use issues, support may require significant intensity and assertive tenancy management to prevent future homelessness.

- For other people, homelessness prevention may be a shorter-term case-management response, ideally the continuation of the housing-focused support which assisted the person or family to get housing to assist with settling into a new neighbourhood and getting access to any services.
The synthesis identifies that complex health management is a critical element of achieving the outcome of Sustained housing. Complex health management works together with Homelessness prevention and Economic and social participation interventions in order to ensure that a person or family who gets housing is able to keep it.

The research synthesis identifies three major elements of complex health management. These are:

- Managing mental health issues and substance use issues.
- Increased self-efficacy.
- Improved safety and reduced risk of harm.
Of course, as discussed in Chapter 4, Understanding homelessness, the synthesis does not imply that all people or families experiencing homelessness have complex health needs, or of the same intensity. The research does support, however, the role of individualised case-management as part of Housing-focused support to ensure nuanced assessment and referrals.

This chapter firstly presents evidence from 18 studies, including nine quantitative and nine qualitative research designs. This research was conducted in North America (nine), Europe (four) and Australia (five).

11.1 Defining complex health outcomes

11.1.1 Evidence of complex health needs

There is strong and consistent evidence that people experiencing long-term homelessness have complex physical and mental health needs. In a recent example, the Michael Project published evidence about the very poor health situation of long-term homeless men in Sydney (Mission Australia 2010). Mental health needs can include serious psychological trauma, as described for example in Robinson’s recent report on the experiences of violence in the lives of people experiencing homelessness in Sydney (Robinson 2010). Similarly, Parsell’s (2010) ethnographic study of the day-to-day lives of homeless people in Brisbane found that all participants had experienced negative or traumatic childhoods, consisting of both physical and sexual abuse.

Accordingly, the outcomes of complex health management which contribute to Sustained housing can include:

- Successful referrals and engagement with specialist support services, if required.
- Improvements in mental and physical health, including self-efficacy and functional behaviours.
- Trauma recovery including from child abuse and family violence.
- Addiction recovery or drug use harm minimisation.

11.1.2 Complex health management enables sustained housing

The research synthesis indicates that health management outcomes are a secondary outcome measure. In other words, health outcomes contribute to Sustained housing but they should not be targeted in isolation. In fact, Canada and US research has established that without housing, the long-term outcomes achieved by specialist health services will be limited (Hwang et al. 2009; Meschede 2010). The relevant point for the outcomes model is that complex health management outcomes contribute to a person’s ability to sustain housing. Accordingly the model recommends that improvements in mental and physical health are tightly linked to a shared accountability for the outcome of Sustained housing.

The evidence consistently indicates that complex health management must occur along with secured housing. A recent US study has shown that short-term treatment for complex health needs of the chronically homeless alone does not contribute to ending homelessness. Meschede’s (2010) three-year longitudinal study of 174 chronically homeless rough sleepers in Boston found high service use with an average of around 11 detoxification admissions over the period, but no significant correlation to housing outcomes. The study found that personal characteristics including gender were significant, with women significantly more likely to attain housing than men. Very long stays in respite care did predict a better chance at
attaining housing: the odds became positive at 292 days, while the average stay was 30 days (Meschede 2010, p.165).

Strong evidence of the contribution of complex health management outcomes to **sustained housing** is the negative impact of problematic substance abuse on tenancy retention. This finding is consistent across different countries and different target groups including single men and families.

Conversely, it is worth noting that **Housing First** studies demonstrate high housing retention rates without particular impacts on mental health symptom severity or substance use. However the model includes a very intense focus on complex health management through **Assertive Community Treatment** case-management teams.

Another connection highlighted in practice understandings, though not strongly documented in the evidence-base, is the way that physical and mental health and cognitive disability can impact on social functioning and therefore interfere with a person’s ability to get along with tenancy requirements and particularly neighbourhood relationships.

The research also highlights the importance of building trust in a support relationship to facilitate effective assessment and treatment of underlying complex health needs. In a 12-month evaluation of permanent supportive housing combined with primary healthcare and social services, the service use measures which most strongly predicted positive outcomes were improved coordination of services and positive relationships between clients and their primary mental health/substance abuse worker (Mares & Rosenheck 2007; Rickards et al. 2010).

Similarly, the evaluation of the **Sound Families** transitional housing program, discussed below, emphasises that effective assessment takes time and that complex health management requires specialist skills. The study found that complex health management issues often do not become apparent until after a family has settled in accommodation, and that inadequate support resources to manage complex mental health and substance dependency issues were a key cause of forced exits from the program (Bodonyi et al. 2006).

### 11.2 Managing mental health needs

A considerable body of US research has robustly demonstrated that severe mental illness is not a barrier to sustaining housing, if the right housing is secured and complex health management interventions are also provided. The evidence on the effectiveness of permanent supportive housing for people with severe mental illness was presented in Chapter 6, while other detail on effective support models for this group of people were included in Chapters 5 and 7 (particularly the model of case management known as **Assertive Community Treatment**).

A discussion of evidence on interventions that assist with other mental health needs, for example non-psychotic and psycho-social or behavioural challenges, is provided in the rest of this chapter.

### 11.3 Managing substance use issues

There is consistent evidence that addressing and managing substance use issues is fundamental to achieving **housing sustained** outcomes for people experiencing

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37 Commenced in 2004, the Collaborative Initiative to Help End Chronic Homelessness was a coordinated effort by three US Federal Departments and the US Interagency Council on Homelessness to house and provide comprehensive supportive services to individuals with serious psychiatric, substance use, health, and related disabilities who were experiencing long-term chronic homelessness. More detail on the evaluation is provided in chapter seven.
problematic substance use and homelessness. Problematic substance use can lead to recurrence of homelessness because the financial and lifestyle requirements can lead to failure to meet standard tenancy obligations. It can also lead to conflict with the rules of supportive accommodation. Illegal substance use adds further complications including the risk of incarceration.

An evaluation of the UK’s Coming in the from the cold (1998) Rough Sleepers Initiative found that up to 40 per cent of those assisted into accommodation eventually returned to the street, and a key reported reason was the restrictions on drug use in the accommodation which was typically low-cost rooming houses rather than permanent housing (Randall & Brown 2002).

Three follow-up studies of different European rehousing programs (Germany, Italy, Ireland) found that the key factor in the inability to sustain tenancy was the failure to keep drug and alcohol addictions under control, especially with respect to excessive drinking. However, for most participants with substance abuse issues, rehousing assisted them in keeping these addictions under control (Busch-Geertsema 2002, p.20).

Parsell’s in-depth qualitative study of rough sleepers in Brisbane found that people commonly explained that they were choosing to live on the streets in part because they required the freedom to use drugs (Parsell 2010).

An evaluation of a German supportive housing program found that most of the sample (86%) of 129 formerly homeless participants maintained their housing over three years, but that greater risk of housing breakdown was linked to high alcohol consumption (Fichter & Quadflieg 2006).

The Victorian Homeless and Drug Dependency Trial which provided around two years of continuous case management demonstrated good outcomes for the majority of clients. The Trial reported median treatment retention durations of 13 months, for example, significantly higher than comparison rates, but also reported a considerable minority who exited the Trial with continued serious problematic substance use (Rayner, Batterham & Wiltshire 2005).

Positive housing outcomes were achieved for 80 per cent (of 64) including 28 per cent public housing and 19 per cent private rental, however there was a significant minority of poor housing outcomes (including sleeping rough, eviction and rooming house) majority unplanned exits for the remaining 20 per cent.

Positive substance use outcomes were achieved for 63 per cent (of 65), including 34 per cent abstaining from all drug use. However again there was a significant minority, the remaining 37 per cent (24 participants), who continued heavy/chaotic/uncontrolled drug-use or had a relapse at the time of exit (Rayner, Batterham & Wiltshire 2005, pp.157–8).

These results may be explained by knowing that best-practice in addiction treatment literature establishes a threshold of around four to five years of continuous recovery for a person to be considered in stable recovery from a substance use disorder (Boisvert et al. 2008). It is certainly established that short-term, in-patient detoxification treatments are not effective at making a difference for people experiencing long-term or chronic homelessness and drug dependency (Meschede 2010).

A recent review of Housing First evidence challenges the suitability of non-treatment focused supportive housing for people with active substance addictions and suggests that further research and program innovation is still needed to identify the most effective combination of housing and support.
Kertesz et al. (2009) argue that most Housing First studies have not targeted heavy substance abusers and have therefore yet to be proven effective with this population. They argue conversely that many of the Housing First comparative studies have compared outcomes to ‘treatment as usual,’ which typically falls well short of substance abuse best-practice due to inadequate resourcing and this may explain their disappointing results in comparison with Housing First.

The evaluation of the Sound Families transitional housing program included a study of families who were asked to leave and provides valuable information about the limitations of the transitional housing with sobriety requirements model (Bodonyi et al. 2006). The report presents findings based on the 19 families asked to leave any of the 10 evaluation case study sites, supplemented by analysis of brief data from the 109 families in total asked to leave from any of the Sound Families Initiative sites.

The analysis clearly showed that families asked to leave had more complex needs than the comparison group. For example, at intake families asked to leave had higher rates of almost all the reported barriers, including 42 per cent reporting family violence issues, compared to 25 per cent and 47 per cent had eviction issues compared to 33 per cent (p.10). Even more telling was the rate of co-existing mental health and substance dependency issues, with 50 per cent rate of comorbidities.

The group asked to leave had a service requirement rate for mental health of 47 per cent compared to 36 per cent, services needed for alcohol abuse at 26 per cent compare to 10 per cent, and for drug abuse at 32 per cent compared to 6 per cent (p.10). The report notes also that the complexity of families' needs will often not be apparent at screening or intake. These issues may not emerge until the immediate need for shelter is resolved.

The authors find that the one to two years of the transitional program was not adequate to build trust or engage with the underlying and multiple issues faced by these families. Supportive housing and case management may need to be supplemented by comprehensive and specialist treatment supports to be effective for families experiencing homelessness and complex mental and physical health challenges (p.14). Sound Families staff interviews found that 80 per cent of staff felt inadequately resourced to respond to these higher-need families (p.17).

A promising direction for achieving sustained housing for people in recovery from problematic substance use is identified in a small study of a peer support community intervention. The program was implemented within a permanent supportive housing program in Florida that had identified high-relapse rates post-housing (Boisvert et al. 2008). The study found that an active peer support community reduced substance use relapse rates and reduced the incidence of homelessness by assisting people to manage their relapse without also losing their housing.

The study evaluated the impact of a Peer Support Community intended to reduce the relapse-related recurrence of homelessness found to occur within a permanent supportive housing program in Florida. Ten community participants of 18 were retained in the study over nine months. Relapse data from the previous year were used to provide a comparison rate. The study found that the substance use relapse rate reduced from 24 per cent of residents prior to the program, to 7 per cent for participants in the peer support community (Boisvert et al. 2008, p.213).

Even more significantly, returns to homelessness were dramatically reduced. Six months prior to the study the permanent supportive housing program had a relapse rate of 85 per cent; during the following first six months of the community, the rate was

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38 They acknowledge that Larimer et al. (2009), included in this synthesis, is the recent exception.
33 per cent of tenants returning to homelessness (Boisvert et al. 2008, p.213). The community members met almost monthly for social activities and conducted two fundraising events during the nine months of the study (Boisvert et al. 2008, p.213).

The Peer Support Community was initiated and supported by an occupational therapist and addictions professional who facilitated the first 10 weeks and then withdrew to a supportive background as the community became self-facilitating. The group was provided with training in leadership, group communication and facilitation skills (p.210). The community elected officers and conducted biweekly meetings, and the members actively organised their own social events.

This synthesis finds that there is certainly a need for more research, evaluation and program innovation in the area of achieving the outcome of keeping housing for people with drug dependencies.

Nonetheless, the evidence does support the following conclusions:

→ Dealing with problematic substance use is a significant part of achieving outcomes in homelessness. Substance use may be a cause or a consequence of homelessness, but in either case it is a significant challenge that must be met in order to achieve housing stability for many people.

→ Short-term detoxification treatments alone are ineffective.

→ Full stability and recovery from problematic substance use typically takes many years.

→ Further research into effective treatments is needed.

→ Problematic drug-use is often linked to trauma or co-exists with traumatic experience (including homelessness itself) and therefore trauma-oriented treatment is indicated.

→ Peer and community support are critical and can reduce relapse. Conversely alcohol and drug-using social networks can increase relapse and inhibit recovery.

The research does clearly indicate that intensive resources are required to effectively manage and address alcohol and drug dependency.

11.4 Self-efficacy: increased ability to care about and reach own goals

The practitioner focus groups in the first phase of the research identified a person’s ability to care about themselves and be interested in reaching their own goals as a particularly important outcome area. Practitioners commented that until a person had enough self-care capacity and hope for their own future, there was little possibility of achieving client outcomes; people could not achieve outcomes unless they wanted them for themselves.

This understanding is supported by qualitative data about how people are able to recover from homelessness. Important to making a sustainable change is a sense of belonging, meaning and purpose as well as their practical manifestations through housing, social networks, and activities like education and employment.

For example, a Canadian study interviewed 80 formerly homeless people in Vancouver to find out about the factors perceived as facilitating their transition from homelessness (Patterson & Tweed 2009). As noted in an earlier chapter, housing was rated the single most important factor. However it was followed by the following facilitators in order of importance:

→ Realising self-worth.
- Realising the negatives of the street.
- Social support.
- Dealing with past and present issues and responsibilities.
- Spiritual awakening.
- Mental health treatment, substance-use issues.
- Economics (i.e. stable employment or financial subsidy) (Patterson & Tweed 2009, p.855).

The study demonstrated that while people identified housing as a critical intervention, once they were housed, individual development, complex health management and social inclusion were all important for a successful exit from homelessness.

The studies found that were most directly relevant to this outcome area were two related studies of psychosocial interventions designed for women experiencing homelessness. Other studies included in the synthesis also provide tangential evidence about motivation and goal-orientation. It is consistently clear that the first core outcome—access to independent housing—leads to people reporting increased feelings of self-worth and hope for the future (Busch-Geertsema 2002; Hulse & Kolar 2009; Johnson, Gronda & Coutts 2008).

Building practical living skills is also a critical part of this outcome area and includes both knowledge and experience, which together enable a person’s capabilities to realise their goals. Evidence of these steps are provided under social inclusion and constitute a critical element of sustaining housing.

Synthesis of the evidence with other areas covered in the outcome framework does suggest the following effective elements:
- Patience and persistence.
- Use of psychological therapies to promote social and emotional healing.
- Integration of social and individual interventions.

11.4.1 Psychosocial interventions

The evidence about homelessness strongly indicates the importance of psychosocial outcomes to the overall goal of sustained housing. However the evaluative evidence of interventions in this area was indicative but not conclusive.

The synthesis did not find any systematic reviews of psychosocial interventions for people experiencing homelessness but did find and assess two systematic reviews on psychosocial interventions for groups known to be at high risk of homelessness (dual diagnosis or people with anti-social personality disorders).

Both systematic reviews were inconclusive and identify an overall lack of robust outcome findings. The review of 25 studies focused on dual diagnosis reported that differences in the interventions and the study designs made robust comparisons difficult (Cleary et al. 2008). Similarly, the review focused on anti-social personality disorder found very limited data (five studies with 276 participants) and inconclusive findings. Significant improvements were largely related to substance abuse outcomes, rather than social behaviours (Gibbon et al. 2010).

Some indicative qualitative evidence, consistent with the broader evidence-base on pathways out of homelessness, is presented below to demonstrate how psychosocial interventions can facilitate an individualised recovery process and why this requires time and patience to occur. It is clear from the research that this area has
considerable overlap with other dimensions of social inclusion and the critical outcomes of complex health management.

The qualitative research documents positive results from a Cognitive Behavioural group intervention and an assessment strategy for planning individual transitions from homelessness that was effective in assisting ethnic minority women to transition from homelessness (Washington, Moxley & Taylor 2009) (Washington & Moxley 2009).

**Cognitive behavioural group intervention**

A qualitative comparison study evaluated the effectiveness of a cognitive-behavioural group intervention for older minority ethnic women transitioning from homelessness (Washington, Moxley & Taylor 2009). The study followed the recovery process of 40 older, homeless African American women participating in a *Life Management Enhancement* (LME) program, and compared them to a ‘control’ group of 36 who did not participate in the program. The LME participants exhibited greater personal control and higher self-confidence following the six-week intervention.

The LME program aims to develop emotional self-management skills and build social support connections. It is described as:

> A client-oriented, multidimensional framework [that focuses on] altering, supporting or enhancing health-seeking and coping goals … includ[ing] the thoughts and behaviours that individuals engage in when confronting life’s crises and overcoming health threats (p.89).

LME utilises group work, which helps clients to ‘recognise commonalities that they share’, and ‘creates opportunities to build alliances … exercise reciprocal affirmations, and fosters mutual respect’ (p.89). The program facilitated the development of longer-term supportive relationships among participants beyond the termination of the treatment program (p.96). The study found that LME prepared the women ‘to engage in recovery activities and enhance[d] their motivation to locate resources to maximise their potential for finding appropriate housing’.

**Assessment as a tool for supporting transitions from homelessness**

An action research project conducted over 10 years in Detroit with around 550 participants has developed an effective assessment process to facilitate a successful transition from homelessness for older African American women (Washington & Moxley 2009). The strategy enabled women to tell their individual stories, and assisted them in identifying and resolving the issues that blocked their transition from homelessness.

The project found that expressing despair and frustration can generate momentum to successfully overcome barriers to exiting homelessness successfully. Creating a narrative around their own lived experience elucidated the particular set of factors leading to homelessness, and the strengths and resources each woman had utilised to cope with her circumstances (p.106). The authors estimate that 90 per cent of project participants ‘noted the cathartic benefits that they derived from their involvement’ (p.121). Catharsis allowed for the unburdening of their negative experiences, leaving more energy available to focus on resolving their current situation. In framing the issues she faced, each woman was able to move towards clarifying the barriers to stable housing and thereby create measurable goals and a ‘strong solution focus’ (p.121).

### 11.5 Improved safety and reduced risk of harms

Practitioners consulted for this project identified that for some people, working towards outcomes of reduced risk of harm and self-harm may be the only feasible outcome
and of critical importance. The following two in-depth qualitative studies of young people from Australia and Canada provide strong evidence of the depth and complexity of the emotional, psychological and social damage associated with homelessness, indicating the likely need for long-term therapeutic interventions for recovery.

11.5.1 Youth suicidality and self-harm linked to grief and trauma

Australian ethnographic research by Robinson finds that grief is a significant dimension of young people’s experience of homelessness, both an obstacle to sustaining housing and an important target for specialist therapeutic interventions (Robinson 2002, 2005).

Robinson’s study combined observation and in-depth interviews with 36 young homeless people (aged 16 to 26) over a period of eight months at an inner-city Sydney homelessness services. Robinson also spent 18 months as a youth refuge worker (Robinson 2005, p.50).

This research demonstrates that while assisting young people to negotiate housing and labour markets is important, just as important is the provision of safe spaces to make sense of things, and support to grieve in a healing way. Robinson identifies ‘the importance and possibilities for young people of finding places … in which to be—to think, talk and relax’ (Robinson 2002b, p.27). The right to these places is lost when the young person’s living situation (housed or homeless) includes the threat of violence.

Robinson confirms that many young people experiencing homelessness are grappling with the impact, memories and trauma of failed and often abusive homes. She finds that:

... grief over past home experiences was lived in terms of the continuing negative relationships with new homes they established (Robinson 2005, p.52)

Robinson finds that excessive drug use and self-harm were the two main coping strategies for the young people in her study. She also confirms that while the practices of grieving through drug-numbing and self-harm helped young people manage their traumatic histories, these are ‘precisely the practices which reinstigated and reinforced homelessness’ (Robinson 2005, p.54). Nonetheless Robinson finds that young people consistently ‘searched for and found particular places of “connectedness” in which they felt emotionally and physically safe, supported or simply free to think and talk’ (Robinson 2005, p.55).

These ‘spaceful’ places, as one research participant described them, were sometimes service sites such as drop-in centres and refuges, and sometimes private or secret places within the city. A critical dimension of these places is that the young person could exert control over themselves and their environment. One young woman explained that home means you are ‘able to be whoever you are, instead of having to put on this big staunch front’ (Robinson 2002b, p.34). This ability to be oneself, safely, was in contrast with the inability to control what occurred in their family home, and in subsequent living arrangements (Robinson 2005, p.52).

This research highlights the importance of understanding the grieving process involved in homelessness and how it can affect young people’s experiences and behaviours with often self-destructive consequences. Robinson identifies the importance of places which young people can make their own, and can enact forms of control over their environment, safe places where grieving and processes of making home can be supported as they occur over time.
While focused more narrowly on suicide risk and experiences, a strong Canadian study describes a very similar nexus between youth homelessness, difficult and traumatic experiences and self-destructive behaviours including problematic drug use. Kidd (2004) reports on an in-depth qualitative study of 80 young Canadians living on the streets in Toronto and Vancouver and found that suicidality was very prevalent (Kidd 2004). Participants linked suicide to feelings of being trapped in a cycle of homelessness and drug use, and to feelings of loneliness, worthlessness and hopelessness (Kidd 2004, p.34).

Participants included 49 young men and 31 young women and are described as ‘visible street youth’ (Kidd, 2004, p.36) who were openly asking for change on sidewalks etc. Nearly half of the participants indicated that they had attempted suicide at least once (n=37; 45%). Of this group, 23 indicated that they had made multiple attempts.

Suicide was strongly associated with drug addiction in the young street homeless: 53 of the 80 participants indicated that drug addiction was linked with suicide. Participants intimated that feelings of being trapped and also worthlessness were related to being identified as a drug addict. The negative feeling that this inspired would often lead to turning to drugs to ease the physical and emotional burdens of homelessness:

I hear about people overdosing on purpose because they just finally get disgusted with themselves for what they are doing. So what better way to get rid of myself than how I put myself here. Cause sometimes it is just peaceful. Dying from a heroin overdose … you can just lay there and just fade away. Just pass right out and you are dead (young man, 17) (Kidd 2004, p.43).

Feelings of ‘being trapped,’ defined as feeling ‘unable to reduce negative feelings and unable to escape intolerable situations,’ were specifically raised by 27 participants, who identified the relationship between being trapped and suicide as a ‘process’. This process involved entering into homelessness, feeling trapped in a physically and emotionally dangerous situation and recognising suicide as the only way out. Factors that influenced participants’ feelings of being trapped were:

- Drug addiction.
- Lack of social/government services.
- Societal prejudice/oppression.
- Unsupportive street life.

The following quote from a young woman participant illustrates the sense of being trapped in a cycle of drug use and homelessness:

We smoked crack a couple of times and stuff … and all of a sudden we were in that same stairwell, and the walls were closing in, and we were trapped, and that stairwell felt like a trap, man. … That is what gets me thinking about suicide. Half the time there was so much shit happening. I was just thinking it is just a trap; no matter what I do I always end up back on drugs. Back on the street. Dumped again. Just go in circles, it doesn't matter how many steps forward you go, you end up taking more steps backwards (young woman, 17) (Kidd 2004, pp.38–9).

Thirty-three of the 80 participants indicated that suicide for a young person on the street was a symbol of ‘giving up’. This is preceded by apathy regarding their own person and their peers: they become in a sense defeated by their problems. The
following comments from one young man indicate how feelings hopelessness and loss of belief in your own future lead to suicidal thoughts:

When you are younger you can actually visualise yourself doing all this stuff 30 years from now but when you are on the streets for a while you begin to lose that. You can’t visualise yourself any further than a day or two away. That’s usually where the drugs come in, and the suicide usually comes after the drugs because they have found that they are hopeless and have nowhere left to go. And then when they are on the drugs they realise ‘I am still wandering around in a circle but now I am addicted to drugs so I can’t get off. That is usually when it happens’ (Kidd 2004, p.39).

Many participants indicated that traumatic life events such as childhood abuse, neglect and the deaths of family and friends had direct links to attempted suicide or suicidal thoughts. Kidd concludes that the high rates of suicidal tendencies in the sample suggest that this needs to be taken into consideration and monitored by service providers when providing interventions to young homeless people.
11.6 In brief: complex health management

Complex health management is a critical element of achieving the outcome of *Sustained housing*. Complex health managements work together with Homelessness prevention and Economic and social participation interventions in order to ensure that a person or family who gets housing is able to keep it. Complex health management outcomes which contribute to *Sustained housing* include:

- Successful referrals and engagement with specialist support services, if required.
- Improvements in mental and physical health, including self-efficacy and functional behaviours.
- Trauma recovery including from child abuse and family violence.
- Addiction recovery or drug use harm minimisation.

The research indicates that improved safety and reduced risk of harms is a critical part of complex health management, however it is not a direct focus of the evidence-base. An exception is research on young people which links high suicidality with homelessness and highlights the need for rigorous, specialist support.

Dealing with problematic substance use is identified as a significant part of achieving outcomes in homelessness. Substance use may be a cause or a consequence of homelessness, but in either case it is a significant challenge that must be met in order to achieve housing stability for many people.

There is a clear need for more research, evaluation and program innovation in the area of achieving the outcome of *keeping housing* for people with drug dependencies. The existing evidence supports the following conclusions:

- Short-term detoxification treatments alone are ineffective.
- Full stability and recovery from problematic substance use typically takes many years.
- Further research into effective treatments is needed.
- Problematic drug-use is often linked to trauma or co-exists with traumatic experience (including homelessness itself) and therefore trauma-oriented treatment is indicated.
- Peer and community support are critical and can reduce relapse. Conversely alcohol and drug-using social networks can increase relapse and inhibit recovery.

The research does clearly indicate that intensive resources are required to effectively manage and address alcohol and drug dependency.

Overall, the research synthesis finds that health management outcomes are a secondary outcome measure for homelessness. In other words, health outcomes contribute to *sustained housing* but they should not be targeted in isolation. The evidence consistently indicates that complex health management occurs most effectively in conjunction with secured housing.
Participation is defined in this synthesis as economic and social participation. Participation works with Homelessness prevention and Complex health management to assist a person or family in sustaining their housing, once it has been secured.

The research synthesis identifies three main categories of economic and social participation interventions. These are:

- Improved economic resources: income level, savings, employment.
- Improved access to education and training.
- Increased positive social connections.
The research also identifies some of the significant challenges that people who have experienced homelessness may face in participating socially and economically. These findings imply that economic and social participation interventions require persistence and adequate investment to have the best chance of securing successful outcomes.

The evidence is this chapter relates to improving the capabilities of people who have experienced homelessness to participate in social, economic and political life, specifically through:

- Improved income level—reduced poverty and improved access to material necessities.
- Access to welfare benefits.
- Improved access to employment.
- Increased mainstream social networks and connectedness.
- Maintenance or re-engagement in education.
- Literacy and numeracy.
- Political participation—voting, public life.

Economic and social participation strategies are defined here broadly to encompass interventions that aim to increase a person’s capabilities in the sense identified by the work of Amartya Sen as ‘a person’s being able to do certain basic things’ (Sen n.d.), and interventions which are designed to increase a person’s social connectedness. This broad definition is in line with the way the Australian Government defines its social inclusion agenda:

The Australian Government’s vision of a socially inclusive society, is one in which all Australians feel valued and have the opportunity to participate fully in the life of our society.

Achieving this vision means that all Australians will have the resources, opportunities and capability to:

- Learn, by participating in education and training.
- Work, by participating in employment or voluntary work, including family and carer responsibilities.
- Engage, by connecting with people, using local services and participating in local civic, cultural and recreational activities.
- Have a voice, in influencing decisions that affect them.

Access to housing can be considered highly relevant to Sen’s concept of capabilities (McNaughton 2010), and clearly the foundation for social inclusion. However, homelessness research has shown that housing alone is not adequate to facilitate the broader aspects of economic and social participation for many people who have experienced homelessness. The research has also established that lack of social inclusion can be a barrier to sustained housing, and may trigger further experiences of homelessness.

Australian and international research and policy analysis is increasingly promoting greater integration of education and vocational services into programs for addressing homelessness and early outcome findings are promising. The research findings that

are relevant to this area demonstrate the importance of economic and social participation interventions, broadly defined, to achieving the outcome of sustained housing.

There is not a strong body of evaluative research in this area, so the chapter firstly discusses evidence of the challenges that effective interventions must overcome, and then presents exploratory research on three critical areas of economic and social participation:

- Improved economic resources: income level, savings and employment.
- Improved access to education and training.
- Increased positive social connectedness.

This chapter presents evidence from 21 studies, including 12 quantitative and 9 qualitative research designs. The research was conducted in North America (11 US/Canada), Europe (six) and Australia (four).

12.1 Economic and social participation challenges

The research overall demonstrates that assistance with housing is a critical step in social reintegration but for people with significant behavioural health challenges or even simply grappling with poverty, other supports are needed to promote economic and social participation. The evaluations demonstrate consistent findings for both individuals and families.

12.1.1 Working with individuals and long-term homelessness

Evidence of the need for post-housing economic and social participation emerged from the US Housing First evaluations discussed in Chapter 6, and these findings are congruent with European research.

A European evaluation review study provides a rare, international comparison of the experiences and outcomes from rehousing programs in Germany, Ireland and Italy (Busch-Geertsema 2002). All three programs targeted marginalised single persons who had been homeless for more than half a year and who, with the support of rehousing services had secured normal, permanent housing. The review included three follow-up studies with a total sample of 36 people. Eighty per cent of them had successfully retained their tenancies for 12 months.

Participants reported improved health outcomes and a sense of autonomy, security, privacy and normality. The study also identified persisting issues including poverty, unemployment and substance addictions which posed an ongoing challenge to social reintegration and housing stability. The study identified the importance of social ties and personal relations in sustaining housing and reintegration. Participants reported a need to ‘break ties with their “networks” from the past, i.e. with other homeless people’ but this had the consequence of increasing their social isolation.

The German program found that participants benefitted if they were rehoused away from communities where they had experienced conflict, or would be socially isolated. Formal support from program workers was found to be important particularly in the initial period of being rehoused. However in the long-term, successful reintegration depended on the development of new, or renewal of old, informal connections:

For many formerly homeless people, contact with new friends or friends and relatives from ‘old times’ or even the beginning of a new intimate partnership was at least as important—and in some cases much more important—than any formal support (Busch-Geertsema 2002, p.22).
The studies found limited evidence of employment reintegration, with many participants unlikely to reach economic independence through work. The most successful reintegration was found in individuals with educational qualifications or job experience.

Barriers to employment were both individual (ill health, advanced age and low levels of education, training and experience) and structural (poor labour market opportunities and conditions). However the research in Dublin identified a lack of vocational focus from support agencies as a reason for low levels of employment and training participation in the rehoused rough sleepers (Busch-Geertsema 2002, p.20).

The study concludes that ‘material support (access to housing, financial assistance) is essential, but not sufficient, in most cases’ (Busch-Geertsema 2002, p.25). Personal support is also needed in order to:

- Develop motivation, a sense of responsibility and resilience in crisis.
- Provide emotional support to combat isolation and provide assistance in developing new social networks.
- Develop functional ways of relating to authorities including asserting their rights and coping with the responsibilities of being a tenant (Busch-Geertsema 2002, p.25).
- ‘The results from the Hanover and Dublin programs also showed that those who did not succeed in sustaining their tenancies were persons with a particularly long history of homelessness and often with extreme health and addiction problems, while those reaching an advanced stage of integration were “privileged“ in terms of a better education and work experience’ (Busch-Geertsema 2002, p.18).

Researchers note that although the study supports the importance of housing on the path to social reintegration, the findings indicate that simple rehousing was not sufficient for people who had experienced long-term homelessness and that post-housing support is a crucial factor in successful rehousing.

12.1.2 Economic and social participation for families

The significant challenges of economic and social participation are confirmed in findings from three US evaluations of transitional housing programs for families. These studies demonstrate the need for the full range of steps in the outcomes model, from Housing work to Complex health management.

One study examined the operation of five years of a program targeting first-time single mothers, including data from nearly 100 families (Fischer 2000). The program provided 12 months supported accommodation and another year of follow-up ‘aftercare’. However the study found that nearly a third of the participants continued receiving support after this time (p.405).

The program had a significant focus on employment preparation and the study reports that after the supported accommodation period, 76 per cent had either completed or made reasonable progress in their chosen program (p.410).

At the follow-up survey, the study found that 61 per cent of participants were employed and 11 per cent were in school or training (p.411). The average income of program participants was often higher than outcomes for other federal job training programs, and a higher proportion also had incomes exceeding the federal poverty line (p.412). Nonetheless, participants had difficulty in securing stable affordable housing, although the author suggests this is largely due to a decrease in both the amount of affordable housing and Section 8 voucher funding (p.413).
Fishcer finds that extended case-management was beneficial in providing support for the maintenance of employment stability. However, the study finds that while the program did increase the economic self-sufficiency of participants, few women were able to become completely self-reliant, and needed some level of ongoing public assistance to maintain a stable and reasonable standard of living (Fischer 2000, p.417).

Another US study of transitional housing for families identified the importance of the comprehensive and practical range of skill development and support provided by the program (Washington 2002). The study conducted qualitative follow-up interviews with 10 former residents who had sustained self-sufficiency for six to 12 months after graduating from the program. Alongside housing for up to 12 months and case management, this Tennessee program provided ‘life skills … (e.g. parenting, budgeting), financial counselling, school enrolment, job training, day care, after-school programs, mental health counselling, and case management’ (p.184). The target group was lower needs families and applicants were excluded for drug use and previous felony convictions.

Former residents identified that the most helpful services were ‘focused on budgeting, job training, and leadership skills’ (p.185):

- All the interview participants reported very low or non-existent budgeting skills prior to living at Estival Place. They were given instruction in prioritising bills and responsibilities, and how to manage expenses rationally on a low income (p.185).

- The type of families living at Estival Place frequently lacked qualifications and other skills such as career planning, grooming and application writing. The job skills training at Estival Place assisted residents to develop a realistic plan and then gain the necessary skills and training to achieve it.

A unique and valued feature of the program was the leadership opportunities provided to residents (p.186). They could elect to become a coordinator for a program, which involved ‘set[ting] an agenda, decid[ing] what should be done, and delegat[ing] responsibilities’ (p.186). Interview participants felt these life skills classes and the leadership opportunities provided were beneficial in increasing their self-confidence (p.186).

Counselling was also viewed as highly valuable by residents in learning the skills needed for self-sufficient lives. The most important skills cited were anger management, problem-solving skills and the enhancement of self-esteem. Group counselling sessions at the residence also facilitated mutual support between residents.

The author suggests a number of other factors that contributed to the success of Estival Place (pp.186–7):

- The existence of strong networks between staff at Estival Place and a range of other community and private organisations. These allowed staff to refer residents to a wide range of resources and services, as well as helping them locate appropriate housing and employment. Recommendations from staff were often crucial to residents gaining jobs.

- Staff referrals to permanent, affordable housing. Residents were assisted with locating housing, and then provided with ongoing support beyond the life of the program to help them maintain stable tenancies.

The author concludes that transitional housing programs which offer a range of life skills and other training alongside stable accommodation are effective in assisting homeless families into stable housing and self-sufficient lives (p.188).
The Sound Families transitional housing program, discussed in previous chapters, also had a significant focus on social inclusion interventions and outcomes (Bodonyi et al. 2006; Northwest Institute for Children and Families 2008).

The evaluation reports a strong focus on social networks. The aim was to enhance families’ social support, and create a sense of belonging and sense of place to increase engagement and reduce social isolation.

Many programs actively built relationships between families resident in a housing complex, both permanent and transitional residents. These community building interventions were effective and families’ strong sense of belonging was evidenced by their participation in community-building activities, many of which were resident-driven and included community gardens, potlucks and barbeques, and after-school homework clubs.

The program reported a positive impact on income and employment. Forty-eight per cent of families increased their income between entry and exit and employment rates improved. Overall employment (including full- and part-time) among primary caregivers increased from 22 per cent at entry to 45 per cent at exit, and full-time employment tripled (p.15).

Sound Families provided a very comprehensive range of supports in addition to case management. The following list of services were most often mentioned by families as helpful or needed (2008, p.46):

- Credit counselling and budgeting guidance; life skills classes including cooking, nutrition and cleaning; permanent housing information; on-site childcare and play areas for children; job assistance; food assistance and material aid; counsellors; legal assistance; transport assistance; and community meetings.

Also worth noting to indicate the connection between housing and social inclusion was that the Sound Families Initiative encouraged transition-in-place models wherever possible to allow families to either stay living in the same unit or at least in the same housing complex upon exiting the program. Sixteen per cent of exiting families were able to transition-in-place (p.13).

12.2 Improved economic resources: income level, savings, employment

The research found evidence of three types of interventions that are effective at improving a person’s economic resources. They include:

- Integration of vocational interventions within homelessness programs.
- Intensive, structured job skills training and providing job placement, settling in and mentoring support.
- Practical assistance and motivation in saving or otherwise earning the resources needed to establish an independent household.

Potential outcomes in this area include improving a person’s income level through ensuring they have access to benefits they are entitled to, and increased access to employment and/or work-readiness skills and resources, as well as programs to increase a person’s financial and material resources through savings-assistance or housing-establishment programs.

12.2.1 Vocational outcomes for adults and families

While people recovering from homelessness face many significant challenges, there is consistent evidence that providing vocationally focused, appropriately delivered
support can improve social inclusion outcomes and as a consequence lead to greater likelihood of **sustained housing**. The large-scale evaluation of the *Access to Community Care and Effective Services and Supports* (ACCESS) trial, discussed in Chapter 5, examined vocational outcomes data from 4778 participants in the program (Cook et al. 2001).

The study found that vocational outcomes increased modestly over a year of receiving ACCESS services. The proportion that had worked at all increased slightly but significantly from 18 per cent at baseline, to 19 per cent at three months and 22 per cent at 12 months. Amongst the group who worked, the proportion in full-time employment rose from a quarter at baseline to a third at three months and greater than a third by 12 months. Mean monthly earnings rose from $259 to $469 over twelve months (Cook et al. 2001, pp.1077–8).

The study found that people receiving job training and job finding assistance were two-and-a-half times more likely to be employed at 12 months, even after controlling for diagnosis, mental health and substance abuse treatment, education level and other variables. It also found that only 10 per cent of participants reported receiving vocational and educational services (Cook et al. 2001, p.1078).

As this was not a randomised experimental comparison of vocational programs, it is possible that those who were more motivated to work selectively pursued vocational assistance. However the association remained significant after controlling for important personal characteristics, and does robustly indicate both the potential for this group of people to achieve employment outcomes over time, and to benefit from vocational services (Cook et al. 2001, p.1079).

Another innovative practice-reflection similarly suggests that a directed focus on vocational interventions within homelessness services has the potential to improve employment and social inclusion outcomes. Shaheen and Rio (2007) provide a set of concrete strategies that agencies can use to embed vocational interventions at the centre of a response to homelessness, and argue for a ‘work first’ rather than a ‘work readiness’ approach.

Shaheen and Rio present practice-derived principles for engaging in employment-oriented support for people experiencing chronic homelessness (Shaheen & Rio 2007). They state:

> … experience in employment and training programs that target homeless job seekers is starting to show that offering work at the earliest opportunity when people ask for help motivates people who are chronically homeless to seek connections with service providers and address treatment issues (Shaheen & Rio 2007, p.348).

The authors recognise that mainstream employment services are not demonstrating effectiveness with people experiencing homelessness. This may reflect performance targets which lead to exclusion of clients with complex barriers to employment (Shaheen & Rio 2007, p.347).

Fundamentally committed to the value of paid work, Shaheen and Rio advocate that ‘the opportunity to perform some kind of work should be offered at the soonest possible moment rather than treated as an outcome of recovery’ (Shaheen & Rio 2007, p.347). They identify a set of concrete actions to provide more effective integration of vocational services with homelessness assistance:

- Change service delivery culture: embed a focus on helping people access employment opportunities as part of all elements of service-delivery, recognising that change takes time, motivation and patience.
For example, outreach workers could provide information about employment services; drop-in centres could post job offers; supportive housing staff provide job search resources and access to work clothes and phones.

While housing workers and case managers cannot be expected to also be vocational specialists, a general understanding of effective employment support and interest in vocational outcomes can slowly build clients’ interest and hope for employment. In addition, practitioner alliances between homelessness and employment services are very useful (Shaheen & Rio 2007, p.351).

Challenge traditional assumptions about ‘work readiness’, particularly by acknowledging the resilience and creativity required to survive homelessness.

The authors note, ‘People who are homeless are resilient and creative in finding sources of income. They may not report to an office at 8am everyday, but they do adhere to their own ‘work schedules’ (Shaheen & Rio 2007, p.349).

Shaheen and Rio suggest establishing an in-house peer advisory committee with authority to make decisions about employment services as a method to demonstrate commitment to client empowerment.

‘Make a credible standing offer of work’: not-for-profit and social service agencies themselves can provide work-opportunities with flexible readiness criteria to take advantage of moments when job-interest is expressed; such experience may avoid the need for lengthy job preparation programs.

In conclusion, Shaheen and Rio describe how they believe vocational interventions contribute to the goal of sustained housing:

The objective is to help people realise how important a job is to them so that the desire to keep a job builds determination to address their issues of substance use or access to mental health treatment (Shaheen & Rio 2007, p.350).

They identify a link between employment and the motivation to address complex health management issues which is a consistent finding in both UK and US research on this topic.

12.2.2 Building young people’s capacity for economic independence

The research suggests that economic and social participation interventions are particularly important for young people. This focus on the capabilities for young people experiencing homelessness reflects the impact on future life chances. For example, Wingert et al. (2005) note the critical impact of homelessness on the life-course. Youth homelessness disrupts the educational achievement and life-skill development necessary for economic participation and adult independence. Without educational credentials, the young adult is then at higher risk of being trapped in low-paid work and continued economic and social marginalisation (Wingert, Higgitt & Ristock 2005, p.57).

An approach to building young people’s capabilities through a Social Enterprise intervention presents evidence of an innovative and successful model for working with street-involved young people. Ferguson (2007) and Ferguson and Bin (2008) report on an evaluation of a program designed to compete with the income-opportunities of street-based, often illegal money-raising activities. This program is targeted at the group Project i, identified as the ‘transgressive homeless.’ It combines vocational training for street-based youth with support from clinically trained mentors to address mental health and health issues (Ferguson 2007, p.110). The program engaged youth
by developing their capability for accessing economic resources and produced improvements in social connectedness, health and wellbeing.

The Social Enterprise Intervention (SEI) model includes four months’ vocational training and three months’ business skills seminar, followed by up to 12 months’ continued mentoring to establish a cooperative business venture hosted by a local agency (Ferguson 2007, pp.108–9). The business venture was selected based on the skills and resources available in the host agency and the local labour market conditions (Ferguson 2007, p.106).

An innovative model for engaging street-based young people in employment and education was designed to address both the challenges and the disincentives for homeless young people to leave street life. Ferguson argues that not only do homeless young people negotiate barriers to employment like a lack of contact details, laundry, shower facilities and secure storage of belongings, but the mainstream labour market has to compete with existing methods of raising money (Ferguson 2007, p.106). These methods have been described in a Melbourne context by Johnson as the ‘business of raising money’ (Johnson, Gronda & Coutts 2008, pp.76–80).

Ferguson conducted a 12-month comparative study of 28 street homeless youths (18 to 24), of whom 16 participated in the SEI pilot, along with a control group of 12 who were accessing the host agency drop-in centre. Participants in the SEI program showed significantly increased life satisfaction and family contact (a large effect size) along with increased peer social support and reduced depressive symptoms (moderate to strong effect size) (Ferguson & Bin 2008, p.14).

Other US-based research examined the outcomes of an intensive employment preparation, training and job placement program for young people who had experienced homelessness (Lenz-Rashid 2006; Rashid 2004). Outcomes were also assessed for a sub-group of care leavers who also accessed a transitional housing program.

The study included 251 young people who graduated from an EET program called Hire Up Job Ready Certification class, in San Francisco between 1999–2003. There was an 83 per cent graduation rate during this period (Lenz-Rashid 2006, p.241).

The Hire Up program includes a three-week, three hours per day, five days a week Job Readiness Class which includes exploration of the young person's interests and strengths as well as job skills, visits to employers, homework and final presentation. Youth are paid a progressively increasing stipend each week and receive a free haircut and new outfit on completion (Lenz-Rashid 2006, p.240). The job skills course concluded with a graduation ceremony and presentation of a certificate, which was the first such experience for many participants (Rashid 2004, p.244).

The study found that approximately 60 per cent of participants found employment within three months of the training (Lenz-Rashid 2006, p.242). The mean hourly wage for the employed sample was higher than the current Federal and State minimum standard, and high enough to be considered a 'living wage' in San Francisco (Lenz-Rashid 2006, p.249).

Mental health issues were the most significant barrier for all young people, and were correlated with lower rates of employment and lower hourly wage (Lenz-Rashid 2006, p.251). Substance use, while high among the study participants was not a significant factor in determining employment outcomes (Lenz-Rashid 2006, p.253).

Within this study, there was a sub-group analysis of 23 young people with previous involvement in the State care and protection system who also accessed a transitional living program. The analysis compared the employment outcomes for 10 young
people who joined the residential program prior to the *Hire Up*, with 13 who participated in the comprehensive employment training program.

The program required residents to obtain full-time work, and included the support of an employment coordinator to find positions and provide comprehensive post-placement support, and a career mentor program. The research found that participants in the *Hire Up* program had significantly higher hourly pay rates, and longer mean durations in employment and program stay (Rashid 2004, p.245).

The sub-group’s median age was 19 years. All had experienced homelessness from ages 18 to 22 after leaving State care and subsequently joined the transitional living program (Rashid 2004, p.243). Participants were asked to make a commitment for 6 months and could stay up to 18 months. Mean length of stay was 7.3 months, and longest 18 months. The mean length of employment was 6.1 months which correlates with the mean program time and shows that participants found work quickly and maintained it while in the program (Rashid 2004, p.244).

Only 13 per cent were employed at entry to the program but 100 per cent were employed at exit, and 83 per cent maintained the same employment on exit, while the remaining 17 per cent moved interstate after giving appropriate notice (Rashid 2004, p.244). At discharge, all the youth exited to stable housing, and at six months, of the 20 who were contactable, 90 per cent were living in stable housing independently or with family while one person was incarcerated and another had returned to the streets (Rashid 2004, p.246).

Of interest in understanding how the program promoted the economic resources outcomes, the housing program charged a rent of 30 per cent of income which is saved on behalf of the youth, to be used on exit as savings to purchase household items and security deposit. The length of stay was directly related to the amount of savings and 70 per cent of the sample saved more than $1100, and 56 per cent with more than $1800 (Rashid 2004, p.244). The amount saved was not found to be related to the level of independent living skills at entry to the program (Rashid 2004, p.244).

12.3 Improved access to education and training

12.3.1 Individualised learning support

An innovative UK model for assisting people who have experienced homelessness to engage with education and training uses a one-to-one learning support model closely integrated with the housing assistance provided. Crisis, the prominent UK charity for single people experiencing homelessness, has focused over the last decade away from crisis interventions and toward social inclusion programs. Strategic priorities for Crisis include:

... engagement, education, employment and empowerment, and the elimination of barriers that can prevent homeless people achieving rewarding lives within mainstream society (Luby & Gallagher 2009, p.3).

*SmartSkills* is the name given by Crisis to a model of working which delivers personalised support for learning alongside access to private rented accommodation for homeless people (Luby & Gallagher 2009).

The *SmartSkills* model includes a dedicated *SmartSkills* worker who provides one-to-one learning support to people who have sought help with their housing. Group learning is also employed where appropriate for the learner, and the program is designed to enable the learner to achieve an accredited qualification. The program was designed to create ‘bridges’ to more formal learning opportunities.
SmartSkills was an initiative designed by Crisis after research showed that many people experiencing homelessness had interest in education (more than half surveyed, while less than a fifth were able to do so) (p.4). The evaluation carried out research at the seven sites which delivered the pilot program and interviewed 39 learners and 16 staff. Program data was also used to assess outcomes, although the data quality was not strong. SmartSkills was informally targeted at people considered relatively stable but at risk of homelessness recurring.

Boredom was the most commonly cited motivation for engaging in the SmartSkills program. Participants’ comments indicated they were trying to address their isolation and create purpose: ‘I wanted to meet new people and not be stuck in a flat, staring at four walls’. Another wanted to ‘do something rather than sit watching TV’, while another person linked their motivation to addressing substance use: ‘something to occupy myself to keep me off the drink’ (p.10).

SmartSkills was ‘marketed’ to potential learners through their housing worker, and a close working relationship between the housing and learning programs was key to successful recruitment and retention in the program. A gradual, informal engagement approach was used to overcome people’s fears and lack of confidence (pp.11–3).

A high proportion of learners progressed to some further education or adult learning. A small number enrolled in university, while many others progressed to further training courses; progression to literacy and numeracy courses was common. There was very little progression to employment. However some sites offered volunteering opportunities and these were successful and appreciated by the learners. Some learners reported valuable improvements in their independent living skills, including budgeting and cooking, which were the focus of some learning modules (pp.13–7).

The intense personal support (in some cases a 1:5 case load) was reportedly a very positive factor and learners most often cited the skills and qualities of their worker as the key to the program (p.31). SmartSkills was implemented within a ‘strengths based’ support paradigm, meaning that it focused on building a person’s strengths rather than diagnosing their deficits (p.29).

The evaluation found the program had a significant positive impact on people recovering from substance abuse. This seemed to be because of the multiple benefits: one-to-one support, the structure and routine, which provided an alternative to substance use habits and the opportunity to build self-esteem and confidence (p.18). Increase in self-respect was also linked by some learners to a reduction in their criminal or anti-social behaviour, and by others to gaining the confidence to reconnect with family (pp.21–3).

The primary aim of the program was to integrate housing and learning support. While the outcomes analysis was constrained by limitations in the available data, the evaluation makes the following comparisons to demonstrate the program impact (p.35):

➔ Between half and a third of participants went on to further learning compared to a reported rate of less than a fifth of people experiencing homelessness.

➔ Between 25 and 40 per cent of participants engaged in volunteering, compared to a reported rate of 13 per cent of people experiencing homelessness.

In conclusion, the evaluation finds strong qualitative evidence from the learner’s themselves that the program was successful and effective at enhancing participant’s self-esteem, building concrete practical skills and providing a ‘bridge’ to further learning (p.39).
12.3.2 Integrated housing and education for young people (Foyers)

Another influential practice model and source of evidence on housing-integrated employment and education programs derives from the Foyer model of integrated accommodation and learning support for young people experiencing homelessness or disadvantage.

Foyers are a European model of providing transitional housing for young people integrated with support emphasising education, employment and training. The UK adopted and developed the model from France in the 1990s. In the UK, integrated learning and accommodation centres for vulnerable young people now operate in over 130 urban and rural communities across the UK.40

The Australian Government’s White Paper on Homelessness specifically identified Foyer models in addressing the need for more supportive housing for young people that connects accommodation to education, training and employment (FAHCSIA 2008).

The first Australian Foyer opened in 2003 in NSW, and while no longer funded as a Foyer, had demonstrated promising outcomes (Randolph & Wood 2005). The Australian Foyer Foundation41 was established in April 2008 and there are currently many Australian jurisdictions that have either launched or are considering establishing Foyers. The most advanced include Victoria, South Australia and Western Australia.

There is little Australian evaluative evidence of Foyer client outcomes. However the UK research has shown both the benefits and limitations of the model (Lovatt, Whitehead & Levy-Vroelant 2006; Quilgars et al. 1997; Smith 2004). Synthesis of the UK evidence finds that the model has excellent potential because it provides housing and integrates comprehensive support with targeted employment and education assistance. However its effectiveness reduces without adequate individualised case-management support.

12.4 Increased positive social connectedness

The following studies provide evidence about the importance of achieving social-connectedness outcomes in making a difference to people experiencing homelessness. Many of the studies presented in this and earlier chapters have identified the importance of post-housing support and a repeated theme has included the role of social reintegration to address isolation and loneliness. The studies of pathways out of homelessness note the importance of both personal connections (friendships and family) and a general connectedness to the community or neighbourhood. Conversely, studies of the homelessness experience typically identify the negative role of social stigma related to homelessness.

Social connectedness is a critical outcome area because it is linked to successfully exiting homelessness and conversely can be part of a barrier that traps people in homelessness. The research identifies two critical considerations that can shape effective service-delivery:

➔ The role of connections to other people experiencing homelessness.
➔ The importance of rebuilding connections to the mainstream including family and social networks.

12.4.1 Stigma

Economic and social participation interventions are important because the experience of homelessness is so strongly shaped by social exclusion and stigma (Hoffman & Coffey 2008; Johnson, Gronda & Coutts 2008).

This was described, for example, in qualitative, exploratory research into the experience of family homelessness in Melbourne (Hulse & Kolar 2009). The study conducted in-depth interviews with 20 women living with at least one of their children in transitional housing.

The study found that homelessness reduced women’s feeling of belonging. Hulse and Kolar write: ‘Three quarters did not feel that they belonged anywhere anymore’ (p.39). The most common response, when asked what would increase their sense of belonging, was a permanent home. As one woman explained, a home was the key to being ‘normal’ again: ‘To get me in a home where I can put my kids, normal, you know, normal again, to have that life normal again, like it used to be’ (p.40). The study highlighted the impact of the stigma of homelessness. Most women had experienced feeling looked down upon or judged by some people because of their situation (p.37).

The study also identified significant stresses created by the uncertainty and lack of control experienced in transitional housing. This was felt particularly keenly because of the impact on children and their schooling (p.15). All the women prioritised providing stability for their children and some cases this meant travelling long distances to get them to and from school and avoid moving them (p.28). This evidence underlines the interconnection of housing with all other elements of the outcomes model.

In another example, a Canadian study of 80 street youth in Vancouver and Toronto found that social stigma was a serious factor in suicidality (Kidd 2004). Participants noted that on a regular basis they would have to deal with negative public perceptions of them. This stigma was often expressed by cruel comments, physical violence, general disdain and derision from the general public. This experience of social stigma was recognised by 35 participants as a key factor in suicidal thoughts and suicide itself.

Nineteen of the 80 participants indicated that feeling worthless was linked to their feelings of suicide. Feelings of worthlessness were reinforced by internal and external factors. External factors identified by participants were people on the street reacting negatively to them and looking down on them. For example, one 20-year old male participant noted:

Sometimes a person goes out and commits suicide because they don’t feel like they are wanted. That is why a lot of people do suicide, they don’t feel wanted, they don’t feel like people … like people look at them and like ‘You know you are no good, you should go and get a job, make something of yourself.’ People came up to me lots of times, ‘You know, you should get off the streets; you are a piece of shit or you are scum.’ I heard a lot of people say, ‘Don’t give money to them, he is only a druggie, he’s scum, he’s not worth it’ (Kidd 2004, p.39).

Social isolation and loneliness was also highlighted in the study. Half of the participants identified feeling alone as a key factor in suicidal thoughts. Loneliness was often linked to worthlessness, as participants felt that if they were worthless then no one could care about them. This was often reinforced by the superficial nature of the friendships between other street homeless people. As well as leading to suicidal thoughts, Kidd finds that the absence of a ‘positive support system’ compounded the
difficulty of homelessness and drug abuse (Kidd 2004, p.41). One woman comments that at the time of her suicide attempt:

Well, I had no place to go. Like, nobody … my parents didn’t know where I was. I had boyfriends coming in and out of my life. Just people … I don’t know … I felt totally alone (woman, 18) (Kidd 2004, p.41).

12.4.2 Relationships as resource and barrier

The finding that social networks are both a protective resource and a potential challenge and barrier to recovery from homelessness is evident in many studies already cited in this synthesis. Some particular studies are presented here by way of further example.

A significant source of Australian evidence about youth homelessness is Project i, an internationally comparative longitudinal study of over 1200 homeless young people in Melbourne and Los Angeles. Project i provides evidence about the importance of social connections among young homeless people, and between young homeless people and significant positive relationships with others.

Project i’s qualitative data from Melbourne finds that better relationships with supportive partners and with family was correlated with homeless young people reducing or giving up their problematic drug use (Mallett et al. 2003, pp.62–5). Conversely, Project i found that having more injecting drug users or homeless peers in a newly homeless young person’s social network was associated with higher drug use after three months (Rice et al. 2005, p.1117). The researchers advocate ‘interventions at a street level that attempt to connect homeless youth to positive social influences’ (Rice et al. 2005, p.1119).

Related findings have emerged from studies of families experiencing homelessness. A longitudinal study of 266 families in New York City requesting homeless shelter for the first time confirmed the protective role of social networks in preventing or delaying homelessness. Almost all the study participants stayed with family or friends prior to requesting shelter (Shinn et al. 1998, p.1655). Similarly, an Australian longitudinal study of 30 families exiting from crisis support services in Melbourne over a two-year period identified the significant role of family and social support networks in the experience of these families (Kolar 2004, p.67).

In the Australian study, the majority of study participants reported receiving informal social support at both 12 and 24 months. Parents and friends were the most common sources of support. At 24 months, the kind of help included: emotional support (90%, n=27), advice (67%, n=20), childcare (53%, n=16), financial help (47%, n=14), and help with housework or transport (37%, n=11).

Conversely, two families reported they had ‘no-one’ to turn to for support and these were families that had reported multiple concerns throughout the study, with ongoing difficult circumstances. One of these families had also not accessed formal support over the last six months, suggesting isolation and vulnerability to further crisis. This indicates the way in which disadvantages are compounded (Kolar 2004, p.67).

While an Australian qualitative study with 24 young mothers (aged between 17 and 26) who had experienced homelessness found that women’s relationships with partners and ex-partners strongly correlated with their pathways in and out of homelessness (Keys 2007a). Partners’ problematic behaviour, drug use or overspending affected the young women’s ability to obtain private rentals or retain tenure in existing housing. Partner violence was experienced by a third of participants and was reported as

42 For more information, see http://www.projecti.org.au/
impacting homelessness status. However sometimes motherhood empowered women to resist controlling behaviour exhibited by their partners (Keys 2007a).

12.4.3 Strategies to improve social relationships

A UK study comparing two different approaches to post-housing support for homeless people with substance issues indicates that relationships are critical to achieving sustained housing (Bowpitt & Harding 2009). The qualitative study involved semi-structured interviews with 13 participants, including eight service users (single men and women) and five service-providers.

The study found that loneliness was a tenancy risk factor that ran deeper than financial or substance mismanagement. The study found that loneliness was one of the single largest risk factors for people returning to the streets. As one tenant put it, ‘it’s easy to revert back to old ways and back to old friends because you feel lonely [living on your own]’ (p.6).

The study found that practical risk management was a useful element of tenancy support, but that a more effective approach addressed people’s social connectedness. Risk management included assisting tenants to pay bills on time, ensuring adequate nutrition, and empowering the substance user to bring their use under control (p.6).

Social connections were differentiated into four types of important relationships—with support workers, with themselves, with the wider community and with old social networks:

- **Relationship with the tenancy worker:** the authors point to ‘the importance of achieving change in tenancy support … through mutual trust and acceptance rather than coercion. Underpinning this whole approach was a willingness to do whatever it took to effect the changes that had the best chance of ensuring [tenancy] sustainability’ (p.7). Thus, tenancy support at this level is more than just teaching the life skills needed to escape homelessness—rather it is about giving tenants a motive to work on the issues causing disruption to their lives.

- **Relationship with self (restoring self-worth):** the development of ‘positive images of themselves, other people and their circumstances was crucial to resettlement as a process of change …’ (p.7). The research described here strongly suggested ‘a correlation between a positive relationship with a tenancy support worker and an altered self-image’ (p.7). Encouragement from tenancy workers gave them a more positive view of themselves and their situation, and a successful tenancy diverted interest and energy away from substance use (pp.7–8).

- **Relationship with the neighbours and local community:** building relationships with neighbours and a new social network gave tenants a further new interest that diverted attention away from harmful substance abuse practices.

- **Relationships with family:** ‘Of all the social networks in services users’ lives, family had the greatest restorative potential’ (p.8). These relationships are the most common trigger for the homelessness in the first place, so support workers need to exercise caution in this area. ‘Tackling family issues must … be at the service user’s initiative’ (p.9). In particular, this study noted the ‘motivating effect that reconciliation with children can have on services users who are struggling to rebuild their lives’ (p.9).

The authors therefore suggest that while risk assessment models can provide some assistance, the benefits of improved relationships in a number of spheres are fundamental to restoring the lives of these people and achieving sustainable tenancies (p.9). They also suggest that tenancy support workers need adequate
training to be able to assist tenants with managing these complex sets of relationships (Bowpitt & Harding 2009, pp.9–10).
### 12.5 In brief: Economic and social participation

Economic and social participation is a significant step in the outcomes model and works with Homelessness Prevention and Complex Health Management to achieve the outcome of *Sustained Housing*.

The research overall demonstrates that assistance with housing is a critical step in social reintegration but for people with significant behavioural health challenges or even simply grappling with poverty, other supports are needed to promote economic and social participation. The evaluations demonstrate consistent findings for both individuals and families.

**Key findings on economic and social participation include:**

- Housing is itself a critical part of economic and social participation. The quality, location and permanency of the housing contributes to a sense of reclaiming a 'normal' life.
- However, housing alone may not generate employment participation or social connectedness, particularly for groups dealing with complex behavioural health issues.
- Lack of social integration, evidenced as loneliness and the impact of negative social networks is a factor in destabilising housing and triggering further homelessness.
- Homelessness is a stigmatised experience and this can create a barrier to sustaining housing.
- Meaningful occupation and structured activities are important facilitators for managing problematic substance use.
- Integration of vocational programs into homelessness services is effective for assisting even chronically homeless populations to achieve increased income and increased employment outcomes.
- Learning-oriented programs are effective at building people’s self-esteem and motivation and sense of purpose. Intensive learning support successfully leads to further engaging in education, training, volunteering and employment.

The research found evidence of three types of interventions that are effective at improving a person’s economic resources. They include:

- Integration of vocational interventions *within* homelessness programs.
- Intensive, structured job skills training and providing job placement, settling in and mentoring support.
- Practical assistance and motivation in saving or otherwise earning the resources needed to establish an independent household.
The following table summarises outcome indicators from the research literature that can be used to monitor an agency’s contribution toward making a difference in this part of the outcomes model. Both positive and negative indicators are recommended.

Table 6: Keeping housing outcome indicators

<table>
<thead>
<tr>
<th>Outcome step</th>
<th>Outcome indicators</th>
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<tbody>
<tr>
<td>Housing sustained</td>
<td><strong>Individual level</strong>&lt;br&gt;Individual who has been homeless or at risk maintains housing over 6, 12, 18 and 24 months.&lt;br&gt;Mainstream support agencies to monitor and report ongoing housing status of previously homeless clients.&lt;br&gt;National homelessness data collection records repeat episodes of homelessness.&lt;br&gt;<strong>Population level</strong>&lt;br&gt;Tenancy retention rates for social housing priority allocations.&lt;br&gt;Eviction rates and causes for social housing priority allocations.&lt;br&gt;→ Number of people who have been previously homeless presenting for assistance.&lt;br&gt;→ Private rental eviction rates for low-income households.</td>
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<tr>
<td>Homelessness prevention</td>
<td>→ Eviction rates&lt;br&gt;→ Successful arrears management</td>
</tr>
<tr>
<td>Economic and social participation</td>
<td>→ Soft skills development&lt;br&gt;→ Completion of specialist pre-employment programs&lt;br&gt;→ Enrolment in certified training and education&lt;br&gt;→ Completion of certified training and education&lt;br&gt;→ Employment rates (full and part-time)&lt;br&gt;→ Income (total, benefits, work-related)&lt;br&gt;Paid work for one or more day in the last 30 days;&lt;br&gt;Typical weekly hours of work&lt;br&gt;Average hourly rate/ estimated monthly income.&lt;br&gt;Community adjustment&lt;br&gt;Knows any neighbours well&lt;br&gt;Social support&lt;br&gt;Days in jail&lt;br&gt;Subjective quality of life&lt;br&gt;→ Locus of meaningful activity</td>
</tr>
<tr>
<td>Complex health management</td>
<td>→ Reduction in mental health symptom severity measured through clinically validated tools e.g. SF-12 mental health; Beck Depression Inventory (see Appendix A)&lt;br&gt;Observed psychotic behaviour&lt;br&gt;→ Satisfaction with primary treater&lt;br&gt;→ Substance use measures—self-report&lt;br&gt;→ Days intoxicated&lt;br&gt;→ Treatment retention duration&lt;br&gt;→ Trust in physician/ other specialist practitioner</td>
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14 A NATIONAL FRAMEWORK FOR OUTCOME MEASURES

This chapter presents the overall ‘client outcomes model’ that depicts the evidence-based steps that lead to getting and keeping housing. Rather than focus on how clients should change, the outcomes model specifies what the service system should deliver, to give individuals and families the best chance at getting and keeping housing.

This chapter includes example outcome indicators, however a key strength of the model is that it is designed to support local flexibility and the use of indicators from existing data collection infrastructure. A core finding of this research has been that nationally consistent client outcome measurement can best be achieved by simple, high-level indicators built on a robust practice model. The practice model provides the consistent logic for more detailed lower level, locally tailored outcome step indicators.

14.1 Getting housing and keeping it: a client outcomes model

This research synthesis has generated an overall model of the outcomes that make a difference and the steps that are most effective for reaching these outcomes. This client outcomes model is a significant resource for ensuring evidence-based good practice. The model is shown in Figure 17 followed by Table 7 with example outcome indicators.

The model shows how families or individuals need to be engaged in housing focused support and then identifies two phases in achieving outcomes for people experiencing or at risk of homelessness: getting housing and keeping housing.

For people currently experiencing homelessness, these are sequential phases of assistance. For people who are at risk of their first or further experiences of homelessness, the activities in the Keeping phase are needed. In some cases, people at risk of homelessness need both phases of assistance if, for example, their existing accommodation is unsafe. Perhaps most significantly, the outcomes model recommends a significant shift of focus toward the keeping housing phase of delivering and monitoring the outcome of housing sustained.

The Getting phase involves engaging a person or family in housing-focused support, securing suitable housing in a timely manner and assessing the need for specialist health supports while providing comprehensive, practical case-management. The first phase needs to be completed quickly and it crucially relies on the availability of suitable housing options. In the Australian context, and internationally, actions to increase the supply of available, affordable housing remains a critical step in achieving homelessness client outcomes.

The Keeping phase is even more critical, however, and is an area that is currently under-emphasised in the Australian service-system. It involves assisting a person or family to sustain their housing. It is clear that more research and evaluation is needed to better understand this second critical phase of achieving housing sustained outcomes.

The existing research indicates that sustained housing outcomes requires at least effective case-management, specialist health supports where needed, homelessness prevention strategies and interventions to increase economic and social participation.

43 This report draws on the outcomes theory developed by Paul Duignan. See Chapter 4.
It is not clear how long this phase will take for any given household, however longitudinal studies suggest that two to three years will be a minimum benchmark for most people (Johnson et al. 2008; Karabanow 2008; Northwest Institute for Children and Families 2008; Kolar 2004; Busch-Geertsema 2002). The research also emphasises the need for individualised ‘packages’ of interventions tailored to the individual. Some homelessness prevention strategies involve ongoing systemic monitoring and accountability for housing outcomes, for example proactive arrears management.

The evidence indicates that the Keeping housing phase requires partnership and coordination between specialist and mainstream services. And the model strongly recommends shared accountability for the long-term outcomes of sustained housing. This report recommends that accountability for housing sustained client outcomes could provide a key strategy to drive effective homelessness prevention interventions from both housing and mainstream support providers.

More detail on each of the steps in the model is provided below at 14.5 Key Findings for each step of the outcomes model.
14.2 Client outcomes model diagram

Figure 17: Client outcomes model diagram
### 14.3 Client outcomes model indicators

**Table 7: Client outcome indicators**

**Indicators for the client outcomes model – housing secured**

<table>
<thead>
<tr>
<th>Getting housing outcome steps</th>
<th>Client outcome: housing secured</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Engagement in housing-focused support</strong></td>
<td>Individual level</td>
</tr>
<tr>
<td>→ Rate of clients engaged to number of <em>housing secured</em> outcomes.</td>
<td>→ Person or household secures permanent housing (defined by the 'cultural definition')</td>
</tr>
<tr>
<td>→ Rate of persons exiting institutions with no fixed address engaged with housing-focused support PRIOR to exit</td>
<td>OR</td>
</tr>
<tr>
<td>→ Rate of rough sleepers</td>
<td>→ No set housing standard BUT linked to accountability for achieving sustained housing situation.</td>
</tr>
<tr>
<td>→ Proportion of rough sleepers offered housing-focused support</td>
<td>→ Affordability—defined using the 30/40 rule.</td>
</tr>
<tr>
<td><strong>Housing work</strong></td>
<td><strong>Population level</strong></td>
</tr>
<tr>
<td>→ Housing secured meeting minimum standards for:</td>
<td>→ Housing availability measures:</td>
</tr>
<tr>
<td></td>
<td>→ Number of affordable and</td>
</tr>
<tr>
<td>▪ Timely access</td>
<td></td>
</tr>
<tr>
<td>▪ Suitable housing (dwelling quality standards, location, access to relevant amenity)</td>
<td></td>
</tr>
<tr>
<td>▪ Affordability</td>
<td></td>
</tr>
<tr>
<td>▪ Maximising client choice.</td>
<td></td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>→ Link to and monitor <em>housing sustained</em> outcome over time</td>
<td></td>
</tr>
<tr>
<td>→ Time elapsed between engagement and <em>housing secured</em></td>
<td></td>
</tr>
<tr>
<td>→ Proportion of people seeking assistance who secure housing within three months.</td>
<td></td>
</tr>
</tbody>
</table>
### Effective case-management
- Continuity of service delivery from engagement to housing secured and housing sustained (either direct service delivery or through successful referrals)
- Successful referrals to specialist health support
- Successful referrals to homelessness prevention, economic and social participation and complex health management providers

### Effective specialist health support
- Active assessment of homelessness risk
- Facilitate engagement in housing-focused support
- Successful referrals to homelessness prevention, economic and social participation and complex health management providers
- Continuity of service delivery from engagement to housing secured and housing sustained (either direct service delivery or through successful referrals)

### Available, affordable housing options
- Private rental vacancy rate
- Rental affordability index, monitored by location and housing type
- Social housing availability (public and community access times)
- Low-income homeownership opportunities
- Housing subsidy (e.g. CRA) availability and affordability outcomes

### Indicators for the client outcomes model – housing sustained

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Keeping housing outcome steps</strong></td>
<td><strong>Client outcome: housing sustained</strong></td>
</tr>
<tr>
<td><strong>Homelessness prevention</strong></td>
<td>Individual level</td>
</tr>
<tr>
<td>- Eviction rates</td>
<td>Individual who has been homeless or at risk maintains housing over 6, 12, 18 and 24 months.</td>
</tr>
<tr>
<td>- Successful arrears management</td>
<td>Mainstream support agencies to monitor and report ongoing</td>
</tr>
<tr>
<td><strong>Economic and social participation</strong></td>
<td></td>
</tr>
<tr>
<td>- Soft skills development</td>
<td></td>
</tr>
</tbody>
</table>
- Completion of specialist pre-employment programs
- Enrolment in certified training and education
- Completion of certified training and education
- Employment rates (full and part-time)
- Income (total, benefits, work-related)
- Paid work for one or more day in the last 30 days;
  Typical weekly hours of work
- Average hourly rate/ estimated monthly income.
- Community adjustment
- Knows any neighbours well
- Social support
- Days in jail
- Subjective quality of life
- Locus of meaningful activity

### Complex health management
- Reduction in mental health symptom severity measured through clinically validated tools e.g. SF-12 mental health;
  Beck Depression Inventory (see Appendix A)
- Observed psychotic behaviour
- Satisfaction with primary treater
- Substance use measures—self-report
- Days intoxicated
- Treatment retention duration
- Trust in physician/ other specialist practitioner

### Housing status of previously homeless clients.
National homelessness data collection records repeat episodes of homelessness.

### Population level
- Tenancy retention rates for social housing priority allocations.
- Eviction rates and causes for social housing priority allocations.
  - Number of people who have been previously homeless presenting for assistance.
- Private rental eviction rates for low-income households.
14.4 Implications of the model

14.4.1 A shift of focus for the service system

Firstly, the model implies that housing sustained is the most robust and objective indicator of the effectiveness of assistance to people experiencing homelessness. And secondly, that the right kind of housing secured outcome and the provision of Homelessness Prevention, Economic and Social participation and Complex Health Management provide the best possible chance of achieving housing sustained outcomes.

Accordingly, the report recommends a shift for the homelessness assistance system away from a focus on getting shelter and toward accountability for the long-term outcome of housing sustained which demonstrates really making a difference to homelessness. Accountability for housing sustained implies that the housing secured needs to be suitable housing that a person or household can keep, or there is management plan for securing suitable housing.

It is important to underline that the research evidence consistently shows that a proportion of people do not achieve sustained housing or other outcomes, despite receiving proven effective interventions. It is clear as a result that there are gaps in our responses that require practice and research innovation. A particular service gap evident from the research is the link between problematic drug and alcohol use and tenancy failures, indicating the need for further policy and program development in this area.

In addition, it important to acknowledge there will always be a range of individual and structural characteristics, beyond the agency or the system’s control, which influence the result. So for example, the reason a person gets housing and sustains it over time will never be purely because of an assistance agency. Nonetheless, a robust evidence-base demonstrates the overall effectiveness of the interventions which make up the client outcomes model. The research credibly establishes that prompt access to housing and sustained, comprehensive support can be considered responsible for positive client outcomes.

14.4.2 Linking detailed data to big picture outcomes

The intention of the outcomes model is to provide a conceptually rigorous, evidence-based and practice-relevant framework that convincingly links the micro-level of service delivery practice activities with the macro-level of policy outcome targets.

The purpose of structuring the outcomes model by the two simple indicators, housing secured and housing sustained, is to focus on the critical outcomes which make a difference. While many interim steps and interventions may be required for any particular individual to achieve these outcomes, if the interim steps do not lead to getting housing and keeping it, then the homelessness assistance system is not making a difference to homelessness.

The value of the model is that it provides a transparent logic that then can drive the selection of credible outcome measures or indicators. Outcome indicators are selected by mapping them onto the logic of the outcomes model. The steps that make up the outcomes model generate a set of indicators that can be used to monitor the contributions made by individual agencies. These include outcomes and interventions with demonstrated links to the achievement of sustained housing. As for all outcomes

44 Note that the evidence base does not support a general statement about the size of this group, as it varies across programs and client groups.
models, it should be subject to regular review and refinement in order to incorporate emerging research and practice innovation about what makes a difference.

Finally, all the client outcome indicators can be reported against basic demographic variables such as age, gender, cultural diversity, income and service location, which are built into the majority of minimum data sets, to determine who is being served effectively by the homelessness assistance system, and which sub-groups may be facing particular challenges.

14.5 Key findings for each step of the outcomes model

The model broadly describes the steps that lead to successful outcomes, based on the current synthesis of the evidence and practice understanding. The synthesis chapters describe in broad terms the elements of effective practice in each step. However, future research could explore each step in much more detail, to document the particular activities being delivered and the client outcomes being achieved by specific agencies working at different levels of the overall picture.

The following section provides the key findings of the synthesis for each step of the outcomes model, as presented in the ‘In brief’ summary boxes at the conclusion of the relevant chapters.

An overall understanding of homelessness from the research literature highlights the following key implications for a national client outcomes framework:

→ Adequate time is required to achieve client outcomes that really make a difference. Durations of two to three years are a realistic threshold for sustained positive change in case of people experiencing chronic or long-term homelessness.

→ Significant specialist support is needed for many people, particularly for drug and alcohol issues, trauma recovery and other mental health issues, and support for cognitive disabilities.

→ Barriers and challenges include socio-economic disadvantage, social stigma and discrimination. Accordingly, economic and social participation interventions (including vocational support and social integration) are critical for sustained recovery from homelessness.

→ The challenges and barriers to getting and sustaining housing typically worsen or become more complex, the longer someone experiences homelessness.

→ The resource requirements to achieve successful client outcomes are expected to differ because service responses are needed at two ends of a continuum of service intensity: high and low(er). Research and monitoring is needed to identify the quantitative prevalence of needs across this continuum in order to allocate resources efficiently.

→ People experiencing homelessness require access to affordable, suitable housing AND individualised assistance to ensure they can sustain it.

Engagement in housing-focused support

The research demonstrates that engaging a person in persistent and practical housing-focused support is a critical first step in securing and sustaining housing.

Housing-focused support combines housing work and effective case-management and has demonstrated potential to achieve the outcomes of getting and keeping housing:

Housing focused support = Housing work + Effective case-management
Research shows that service accessibility cannot be taken for granted and that effective homelessness assistance actively engages clients in the services they need. Experience in the US and the UK, documented in four quantitative studies, has shown that assertive outreach case-management combined with housing resources has demonstrated capacity to deliver outcomes that make a difference for people experiencing long-term homelessness.

The research synthesis suggests there are two important aspects of effective engagement:

- **Individual relationship-based engagement**—facilitated by persistence and continuity; a ‘whatever it takes’ attitude; relationship qualities of trustworthiness and respect; and strengths-focused practice to inspire self-esteem, motivation and hope.

- **Systemic and service model engagement**—facilitated by a service system model that enables reaching out and staying engaged with a person or family from initial contact through to getting housing and doing what it takes to ensure that housing is sustained.

**Effective case-management**

National and international research has robustly demonstrated the effectiveness of persistent, reliable, practical case-management support for people experiencing homelessness.

The evidence emphasises that persistence, continuity and intensity are critical effective elements: trusting relationships entail a minimum duration threshold to establish (e.g. up to six months with people experiencing complex health needs).

Case-management has demonstrated results across a diverse range of target groups including people experiencing serious mental illness, drug-dependency, young people and families.

**Housing work**

There are robust and coherent findings across the evidence-base that effective housing work secures housing options that are:

- **Timely.** The research literature on effective housing work underlines that speed is critical for housing interventions. In fact, the critical point to draw from the *Housing First* and *Street to Home* research is the importance of timely provision of permanent housing options.

- **Affordable.** The research consistently reports the importance of securing affordable housing for sustaining housing for people who have experienced homelessness. The evidence is coherent and robust from findings across countries and target groups.

- **Suitable.** As well as conventional minimum standards, there are also suitability considerations that are specific to recovery from homelessness and its associated challenges, particularly for example, substance use (e.g. proximity to substance using networks) or socio-economic disadvantage (e.g. access to transport), children’s development (e.g. maintaining continuity of schooling).

- **Supportive housing, offered in a way that maximises a person’s choices.** For example, permanent rather than transitional housing and maximised client involvement in location and housing type. Client involvement allows people to select the most suitable housing with the best chance of meeting their location and social amenity needs.
Increased housing supply and increased specialist support

Increased housing supply and increased specialist support are critical outcome steps for making a difference to homelessness.

Drawing on the broader Australian housing research evidence it is clear that Australia has a significant housing supply and affordability problem, which is particularly acute in the low-income rental market. Consequently people at risk of or experiencing homelessness confront intense competition for both social and private housing.

The evidence for increased specialist support is less direct, but recurs as a consistent theme throughout the research synthesis. It includes the findings that intensive specialist support aids in long-term tenancy retention (Housing First studies) while lack of support, particularly for drug and alcohol issues is linked to tenancy breakdown.

Homelessness prevention

The key elements of homelessness prevention identified in the research include:

- Active and passive tenancy management strategies, including systematic arrears monitoring.
- Provision for gradual adjustment to housed living.
- Flexibility and contingency planning for behavioural health relapses, strong coordination between tenancy and health management supports, specific strategies for known critical transitions where homelessness is a high risk.

The evidence indicates that the most effective way to ensure the client outcome of sustained housing is a tailored package of homelessness prevention strategies along with social inclusion and complex health management, designed in collaboration with an individual or a family.

- Homelessness prevention services could be delivered by mainstream or specialist homelessness services. The key element is that agencies delivering homelessness prevention are held accountable for housing sustained outcomes.
- This report recommends the use of shared accountability for sustained housing as a mechanism to ensure continuity and collaboration between the housing and support services which work most effectively together to prevent further homelessness.

For some groups of people, for example in the case of severe mental illness, known to recur with sporadic episodes of unwellness, cognitive disability or acquired brain injury, support may need to be ongoing for the rest of the person’s life.

For those with or serious substance use issues, support may require significant intensity and assertive tenancy management to prevent future homelessness.

For other people, homelessness prevention may be a shorter-term case-management response, ideally the continuation of the housing-focused support which assisted the person or family to get housing to assist with settling into a new neighbourhood and getting access to any services.

Complex health management

Complex health management is a critical element of achieving the outcome of Sustained housing. Complex health managements works together with Homelessness prevention and Economic and social participation interventions in order to ensure that a person or family who gets housing is able to keep it.
Complex health management outcomes which contribute to *Sustained housing* include:

- Successful referrals and engagement with specialist support services, if required.
- Improvements in mental and physical health, including self-efficacy and functional behaviours.
- Trauma recovery including from child abuse and family violence.
- Addiction recovery or drug use harm minimisation.

The research indicates that improved safety and reduced risk of harms is a critical part of complex health management, however it is not a direct focus of the evidence-base. An exception is research on young people which links high suicidality with homelessness and highlights the need for rigorous, specialist support.

Dealing with problematic substance use is identified as a significant part of achieving outcomes in homelessness. Substance use may be a cause or a consequence of homelessness, but in either case it is a significant challenge that must be met in order to achieve housing stability for many people.

There is a clear need for more research, evaluation and program innovation in the area of achieving the outcome of *keeping housing* for people with drug dependencies. The existing evidence supports the following conclusions:

- Short-term detoxification treatments alone are ineffective.
- Full stability and recovery from problematic substance use typically takes many years.
- Further research into effective treatments is needed.
- Problematic drug use is often linked to trauma or co-exists with traumatic experience (including homelessness itself) and therefore trauma-oriented treatment is indicated.
- Peer and community support are critical and can reduce relapse. Conversely alcohol and drug-using social networks can increase relapse and inhibit recovery.

The research does clearly indicate that intensive resources are required to effectively manage and address alcohol and drug dependency.

Overall, the research synthesis finds that health management outcomes are a secondary outcome measure for homelessness. In other words, health outcomes contribute to *sustained housing* but they should not be targeted in isolation. The evidence consistently indicates that complex health management occurs most effectively in conjunction with secured housing.

**Economic and social participation**

Economic and social participation is a significant step in the outcomes model and works with Homelessness Prevention and Complex Health Management to achieve the outcome of *Sustained Housing*.

The research overall demonstrates that assistance with housing is a critical step in social reintegration but for people with significant behavioural health challenges or even simply grappling with poverty, other supports are needed to promote economic and social participation. The evaluations demonstrate consistent findings for both individuals and families.

Key findings on economic and social participation include:
Housing is itself a critical part of economic and social participation. The quality, location and permanency of the housing contribute to a sense of reclaiming a normal life.

However, housing alone may not generate employment participation or social connectedness, particularly for groups dealing with complex behavioural health issues.

Lack of social integration, evidenced as loneliness and the impact of negative social networks is a factor in destabilising housing and triggering further homelessness.

Homelessness is a stigmatised experience and this can create a barrier to sustaining housing.

Meaningful occupation and structured activities are important facilitators for managing problematic substance use.

Integration of vocational programs into homelessness services is effective for assisting even chronically homeless populations to achieve increased income and increased employment outcomes.

Learning-oriented programs are effective at building people’s self-esteem and motivation and sense of purpose. Intensive learning support successfully leads to further engaging in education, training, volunteering and employment.

In addition, the research found evidence of three types of interventions that are effective at improving a person’s economic resources. They include:

- Integration of vocational interventions within homelessness programs.
- Intensive, structured job skills training and providing job placement, settling in and mentoring support.
- Practical assistance and motivation in saving or otherwise earning the resources needed to establish an independent household.

Economic and social participation interventions for people experiencing homelessness are not common as yet, and there is little evaluative evidence on successful programs. However, it is consistently clear that sustaining housing critically depends on increasing economic capabilities and resources as well as increasing social connectedness. The research documents the value of specialist education, training and employment programs—both one-to-one vocational support and tailored employment opportunities. Other effective programs include social re-integration initiatives, recreation and community engagement and connection to mainstream education.

The capacity to deliver these elements relies on the availability of appropriate services and programs, some of which do not currently exist in Australia or even internationally. The research evidence identifies some promising effective interventions but demonstrates the need for further investment and innovation in this area. The research also provides consistent evidence for the need for an increased supply of specialist support, in particular drug and alcohol treatment and mental health specialists.
15 POLICY AND PROGRAM IMPLICATIONS

The project found that a client outcomes model can provide a rigorous foundation for nationally-consistent outcome measures, and it built an outcomes model using a comprehensive synthesis of national and international research evidence.

The findings of this project have a range of implications for guiding good practice in the homelessness service system. These detailed implications are presented in the chapters and summarised in Section 14.5 Key findings for each step of the outcomes model.

Importantly, at a system level, the outcomes model recommends an overall shift for the homelessness assistance. The model recommends a shift away from a focus on getting shelter, and toward accountability for the long-term outcome of housing sustained. And secondly, it recommends shared accountability for housing sustained.

The value of this high-level, strategic approach to national consistency in outcome measures is its simplicity and adaptability. It aims to avoid the potential drawback of getting lost in the detail of individual indicators and instead seeks to provide transparency, direction and rationale. In line with principles of continuous quality improvement, the outcomes model offers a transparent framework that can be refined as new evidence comes to light.

15.1 A model for shared accountability

The evidence strongly and consistently indicates that requiring non-homelessness agencies to be accountable for housing sustained outcomes will make a difference in preventing further homelessness. The outcomes model is neither agency nor homelessness sector-specific because one of the clearest messages from the synthesis is that homelessness is not a ‘one agency’ problem. This characteristic of homelessness means that individual agencies will rarely be able to demonstrate achievement of client outcomes that make a difference from their own work alone.

Shared accountability is needed because the homelessness specialist and mainstream agencies (including housing providers) must operate together to deliver the best possible results for people seeking assistance.

Accordingly, the outcomes model includes outcome steps that demand participation from other sectors of non-government and government services. A further benefit of a cross-sector outcomes model is that it allows agencies and program areas to define their role and activities in relationship to other parts of the system.

National and international homelessness evidence establishes the importance of coordination between housing, human services, health and employment services. Monitoring and reporting outcomes across sectors is a tool for motivating coordination and will drive better results for the individuals and families experiencing or threatened with homelessness.

While the value of a shared accountability mechanism is recommended by the evidence-base and aligned with the good practice direction of whole-of-government responsibility and integration, it will require reform and cross-government cooperation to implement. Yet it is reform that is fundamentally aligned with the direction set in The Road Home, the Homelessness White Paper (FAHCSIA 2008).

15.2 Implications for data collection

The outcomes model provides a mechanism to transparently coordinate local outcome data sets by reference to national higher-level client outcomes. This
approach supports cost-effective outcome data collection using administrative systems already in place and may provide an alternative to the resource intensive and logistically complex option of a consistent data collection tool across all human services involved with homelessness.

Individual agencies may need and indeed may already have a more detailed set of specific outcome measures, developed for the particular local context and target group, and specialist practices. One example of such a resource is the recently developed national client-focused data collection, by the Australian Institute for Health and Welfare. This significant investment could be leveraged by mobilising it strategically through the clear, high-level direction and purpose of a national client outcomes model.

An advantage of this approach is that it empowers individual agencies to use their own data collection systems, by providing a mechanism to link this data to the national framework by demonstrating the relevance of the activities to the outcomes model. This approach could reduce collector burden for the many agencies funded under multiple funding agreements with different government departments.

The outcomes model can also guide further strategic development of data collection systems and data collection practices to ensure that major client outcomes and significant steps in the outcome model can be reported.

A final data collection implication is that while the two key client outcomes proposed in this project are both objective and measurable, access to the data may require both coordination and cross-departmental collaboration. It is worth noting that the often discussed difficulty of following up to determine housing sustained outcomes is not merely a data collection issue, but reflects a fundamental gap in the service system—namely there is very little resourcing of the steps which are known to enable a person to keep housing.

Shared accountability for individual level client outcomes could be implemented by requiring mainstream support agencies (e.g. mental health and disability) and homelessness prevention providers to monitor and report against housing sustained client outcomes. While at a population level, monitoring eviction rates for priority social housing allocations could provide an indicator of success or failure.
16 FURTHER DEVELOPMENT

This project contributes a conceptual framework (the client outcomes model) for a set of rigorous, evidence-based outcome measures, measuring short and long term outcomes for homeless people. The outcomes model provides the foundation for the further development of indicators and measures that can monitor rigorous, evidence-based practices that make a difference for people experiencing homelessness.

This research recommends that a national framework for monitoring homelessness outcomes is built on the client outcomes model, and anchored by the two primary, inter-linked client outcome indicators: housing secured and housing sustained. These two client outcomes have demonstrated validity for indicating successful progress toward ending or reducing homelessness.

Based on this model the project has identified a range of potential secondary outcome indicators (summarised in Section 14.3). It is expected that further development of this research will involve these being further considered and refined by policy-makers, academics and the sector, including through pilots in a range of services, as an important phase in moving towards a coherent national approach to measurement of outcomes for people experiencing homelessness.

The outcomes model needs to be understood as one piece of a larger infrastructure for outcome measurement. The findings of this project imply a number of recommendations for further development:

→ Data collection tools: the framework recommends data collection be client-based; that unique identifiers are deployed to allow data-matching in recognition that client outcomes occur over time and with the assistance of multiple agencies, usually beyond homelessness specific services.

→ This framework could efficiently leverage the investment in the new specialist homelessness data collection, developed by the Australian Institute of Health and Welfare.

→ Accountability: client outcome stakeholders can be broadened to include all agencies involved in housing and supporting people who have been or are at risk of experiencing homelessness.

→ Further targeted research and evaluations are conducted to further our understanding of how to achieve housing sustained outcomes.

The research synthesis also identifies a number of weaknesses in the Australian research evidence-base for the client outcomes model. Further research is recommended in the following particular areas:

→ Quantitative research on the intensity of need: how many people are experiencing homelessness long-term or have complex needs?

→ Evaluations of Homelessness prevention and Economic and social participation interventions.

→ Working specifically with cognitive disabilities and personality disorders.

→ Effective post-housing support for drug dependency and other kinds of addictions.

→ Psychosocial interventions to promote changes in self-efficacy and behavioural issues.

→ Evaluations of recreational programs.

→ Evaluations of programs targeting the barriers to private rental housing.
17 CONCLUSION

The purpose of this project was to provide an evidence-based, practice-relevant foundation for meaningful outcome measures for homelessness services. The project contributes to the National Homelessness Research Agenda 2009–13 objective: ‘inform and improve the service system and practice including evaluation’.

The project used the international research evidence-base to build a credible, robust and independent client outcomes model, guided, tested and refined by repeated engagement with expert homelessness practitioners to ensure practice-relevance.

The outcomes model and the synthesis report provide a guide to evidence-based good practice and a foundation for nationally-consistent client outcome measures for homelessness services.

The project has consequently answered the following research questions, within the limitations of the existing evidence-base:

1. What is credibly known about interventions that make a difference to people experiencing or at risk of homelessness?

2. Which client outcomes reliably indicate the effective performance of homelessness assistance?

3. How can the evidence most effectively contribute to a national foundation for client outcome measures?

The client outcomes model is structured around two simple indicators, housing secured and housing sustained, which the evidence demonstrates are the critical outcomes that make a difference. While many interim steps and interventions may be required for any particular individual to achieve these outcomes, if the interim steps do not lead to getting housing and keeping it, then the homelessness assistance system is not making a difference to homelessness.

The project developed a high-level model so that the core components are applicable and adaptable for use with any homeless population. The model specifies two key areas of work: work to get housing and work to keep housing. And within these broad areas, it identifies core components that will be more or less applicable in any individual circumstance. These core components form the structure of the synthesis report: Engagement with housing focused support; Effective housing work; Effective case-management; Increased supply of housing and specialist support; Homelessness prevention; Complex health management and Economic and social participation.

The core components can be adapted for use with different sub-groups by tailoring the activities conducted within the basic steps. Similarly, lower-level indicators or outcome measures in a local context can be identified and adapted as required, while demonstrating their contribution to the overall long-term outcomes sought. The model provides a way to link the micro-level of service delivery practice activities with the macro-level of policy outcome targets.

Importantly, the outcomes model recommends a shift for the homelessness assistance system. The model recommends a shift away from a focus on getting shelter, and toward accountability for the long-term outcome of housing sustained. Furthermore, accountability for housing sustained implies particular conditions on the kind of housing which is secured. Key characteristics of effective housing options include: affordable, timely availability, suitable in location and amenity, and offered in a way that maximises the choices of the client.
It may seem straightforward that *sustained housing* is the client outcome sought by homelessness services, yet at present in Australia, there is very little resourcing directed at achieving or monitoring this outcome.\(^{45}\) Homelessness services are typically funded to support a person during an experience of homelessness, while ongoing support services typically do not have a housing focus and are not accountable for homelessness prevention.

It seems that the majority of homelessness service resources are invested in the first half of the outcomes model: ‘getting housing.’ Practitioners consistently report that the housing work required to get access to affordable housing within Australia’s very constrained housing market is significant, often highly bureaucratic and can be, from the practitioners’ perspective, frustrating and at times heartbreaking.

The recommended shift in focus to *housing sustained* highlights that homelessness services acting alone cannot achieve these client outcomes. Without the critical input of increased housing supply, specialist support to manage complex behavioural health conditions, active and passive homelessness prevention strategies and social inclusion programs, the homelessness sector will struggle to achieve the outcomes which make a difference.

Consequently, the framework also recommends using outcome accountability to drive cross-sector and whole-of-government coordination because that is what the evidence suggests will really make a difference for homelessness.

The evidence-based outcomes model identifies the need for a significant reform in Australian homelessness assistance policy and practice: toward a central focus on sustaining housing, rather than simply securing shelter. The next step in developing nationally-consistent outcome measures is to use the client outcomes model to engage homelessness and mainstream agencies in a national conversation about consistent outcome indicators and measures.

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**What we already know about homelessness**

There is a rich and diverse international research literature on homelessness that identifies many of the causes and consequences of homelessness and documents successful and unsuccessful assistance approaches.

**How this study contributes to better understanding of homelessness**

This project contributes a significant integration of the research evidence on homelessness for the purpose of creating a foundation for nationally-consistent outcome measures.

It brings together a significant evidence-base on homelessness assistance practice; it presents findings from 125 empirical research studies, and conclusions from a review of the literature on outcome measurement in homelessness services.

This research contributes a rigorous ‘client outcomes model’ based on a synthesis of research evidence and engagement with stakeholders. The outcomes model provides a guide to evidence-based good practice and a solid foundation for the development of nationally-consistent homelessness client outcome measures.

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\(^{45}\) Some jurisdictions provide a type of ‘post-settlement’ support, for example SHASP in Victoria provides up to six months of tenancy establishment support.
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APPENDIX A: HOMELESSNESS OUTCOME MEASURES AT CLIENT AND SYSTEM LEVELS

The following review study is used in the research synthesis, but is provided here in more detail as a resource. The recommended outcome measures have been integrated into the outcome indicator tables provided in the report:


Crook et al. reviewed the homelessness outcome evaluation literature and made the following recommendations for consistent outcome measures (pp.387–8):

<table>
<thead>
<tr>
<th>System-level</th>
<th>Service-provider level</th>
<th>Client level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demonstrated cost-savings across systems</td>
<td>Aggregation of client-level outcomes:</td>
<td>A range of existing validated tools:</td>
</tr>
<tr>
<td>Reduction in access barriers</td>
<td>Reduced days substance use</td>
<td>Addiction recovery</td>
</tr>
<tr>
<td>Networking among community organisations</td>
<td>Increased days housed</td>
<td>Instrumental functioning</td>
</tr>
<tr>
<td>Aggregation of client-level outcomes</td>
<td>Improved employment status</td>
<td>Mental health</td>
</tr>
<tr>
<td></td>
<td>Improved family and social functioning (no existing measurement tools found)</td>
<td>Interpersonal support</td>
</tr>
<tr>
<td></td>
<td>Increased income</td>
<td>Partner violence</td>
</tr>
<tr>
<td></td>
<td>Decreased risk behaviours</td>
<td>BUT caution: These tools typically require clinical training to administer reliably.</td>
</tr>
<tr>
<td></td>
<td>Improved mental health status</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased client participation and engagement</td>
<td></td>
</tr>
</tbody>
</table>

Crook et al. identify three levels of outcome measurement (service system, service provider and client) shown in the figure below (Crook et al. 2005).

![Conceptual framework](image)

**Source:** (Crook et al. 2005, p.381)
Each level has a different kind of outcome, though they are inter-linked, with outcomes at one level affecting outcomes at others. The service system level (known as Continuums of Care in the US context) should deliver linkages and resource outcomes; the client level will include changes in behaviours, status and attitudes; while the service provider level should deliver effective services.

The review found nine empirical studies focused on the system-level of change, twelve studies reporting on service-provider-level outcomes and twelve studies reporting client-level outcomes, half of which focused on mental illness and substance abuse, a reflection of research funding in this area (pp.381-6). They find no system-level or service-provider-level outcome measurement instruments (p.386), but a significant range of validated client-outcome tools. They comment that there is no single standardised tool for client outcomes overall.

This review identified the following client outcomes measured in the literature service-program level studies (386):

- Sobriety.
- Employment (3 times).
- Housing (twice) and Housing stability following shelter stays.
- Internalised locus of control following life skills program.
- Case-manager-client agreement for independent living.
- Degree of psychiatric symptoms.
- Degree of alcohol and illegal drug use.
- Family support.
- Mental health status.
- Client participation and service utilisation.
- Research reporting client-level outcomes.
- Housed after four months.
- Increased income.
- Days spent in stable housing.
- Mental health symptoms.
- Level of substance use.

The study identifies the following clinical client-outcome tools which have been validated with homeless populations (pp.386-7):

- Centre for Epidemiologic Studies-Depression Scale.
- Addiction Severity Index.
- Alcohol Dependence Scale and Personal History Form.
- Brief Instrumental Functioning Scale.
- Modified Colorado Symptom Index.
- Interpersonal Support and Evaluation List.
- Social Network Interview.
- Short Form 12-Item Survey (SF-12).
- Partner Violence Interview.
APPENDIX B: FOUR INITIAL OUTCOME AREAS: ‘IT’S NOT JUST ABOUT GETTING HOUSING, IT’S ABOUT KEEPING IT’

The first and second stage of the project produced a framework of four client outcome areas to guide the search and selection of relevant research evidence. Analysis of material gathered in the practitioner focus groups and input from the steering group was used to generate these four broad outcome areas. These areas are described in the table below and were used to guide the search and selection of relevant high-quality research studies.

<table>
<thead>
<tr>
<th>Client outcome/area of change</th>
<th>Type of intervention (mechanisms)</th>
<th>Contexts</th>
</tr>
</thead>
</table>
| **Improved ability to care for self and others and reach own goals** | Case management or key worker (relationship)  
→ Individualised and tailored services for each person  
→ Coordinated and persistent assistance (‘whatever it takes’ and ‘sticking with it’)  
→ Modelling a positive, caring non-judgemental relationship to rebuild trust. | Individual capacity—social and cognitive abilities.  
Level of self-care ability and motivation  
Mainstream services—capacity and willingness to accept referrals  
Service Quality Frameworks |
| → Improved safety and reduced risk of harms | | |
| → Self-efficacy; emotional/cognitive development especially for children; improved socially adaptive behaviours; motivation and hope | | |
| → Practical living skills—budgeting, self-care, shopping, personal administration; improved social and personal functional behaviours | | |
| → Parenting skills | | |
| → Successful referrals and engagement with the interventions below. | | |
| Note that self-efficacy and practical living skills can be defined as ‘basic capabilities’ under Amartya Sen’s model. | | |
| **Improved health and well-being** | Clinical/specialist healthcare (range of specific medical mechanisms)  
Note that housing is also a mechanism for health improvements | Inadequate living conditions—poor housing and lack of income  
Continuing harms from substance addictions |
<p>| → Improvements in mental and physical health (link to addiction recovery) | | |
| → Trauma recovery including from child abuse and family violence | | |
| → Addiction recovery or drug use harm minimisation | | |</p>
<table>
<thead>
<tr>
<th>Improved living situation—a home!</th>
<th>Housing</th>
<th>Housing market conditions</th>
</tr>
</thead>
</table>
| ‘A housing situation that supports the person’s physical, psychological and social well-being and their ongoing growth and development’ HomeGround/Mark Planigale framework | Specific housing mechanisms from HomeGround (Mark Planigale’s) framework:  
- ‘decent appropriate accommodation  
- a good location  
- affordable  
- supportive relationships—highlight neighbourhoods  
- choice and control.’ | Highlight role of government in establishing housing market conditions—social housing ‘market’—availability, waiting lists, treatment of debt  
Housing history—rental arrears/debt |

<table>
<thead>
<tr>
<th>Improved capabilities (‘a person’s being able to do certain basic things’ Amartya Sen)—specifically:</th>
<th>Social inclusion</th>
<th>Labour market conditions</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
- Improved income level—reduced poverty and improved access to material necessities  
- Access to welfare benefits  
- Improved access to employment  
- Increased mainstream social networks and connectedness  
- Maintenance or re-engagement in education—critical for children and adolescents  
- Literacy and numeracy  
- Political participation—voting, public life |  
- Employment (placement and follow-up employment mentoring and support)  
- Education/training (placement; subsidies)  
- Recreation (structured group activities)  
- Social connectedness (family reconciliation; structured group activities)  
- Career counselling  
- Foyer model—combining accommodation and EET |  
- Industrial relations environment  
- Structural social marginalisation—stigma, racism, impact of colonisation on Indigenous people  
- Social inclusiveness context—diversity, tolerance  
- Financial mechanisms and market institutions  
- Income support system and welfare policy |