Rough sleeping in Victoria

Situation appraisal – May 2017

Foreword

The number of people sleeping rough, including those sleeping in parks, on the streets, in cars and derelict buildings, has increased in Victoria in recent years. A subset of the broader population of people experiencing homelessness, those who are on the streets are among the most vulnerable in the state.

In response to this concerning situation, in January this year the Premier of Victoria announced the *Towards Home* program, an investment of close to $10 million to prioritise housing for vulnerable people sleeping rough in inner Melbourne and provide them with targeted supports to maintain their housing. The *Towards Home* program is part of the government's previously announced $799 million investment and $2.1 billion in financial instruments as part of *Homes for Victorians* to support the most vulnerable in our community to create new and permanent housing and provide the necessary wrap-around support services for people who are experiencing, or at risk of, homelessness. This includes a $109 million homelessness package to intervene early and provide targeted support to help get people back on their feet.

I accepted an invitation from the Victorian Minister for Housing to oversee the delivery of the *Towards Home* package and to lead the development of a long-term strategy to tackle rough sleeping through more effective, better tailored responses so we can meet people's needs sooner and over the longer term.

This situation appraisal is the first phase in the development of a state-wide Rough Sleeping Strategy. Its aim is to document what is currently known about rough sleeping in Victoria in order to inform the strategy. Utilising a variety of data sources, research, international evidence and insights from key stakeholders, it attempts to provide a comprehensive snapshot of the prevalence and characteristics of rough sleeping as it is currently experienced in Victoria.

Your feedback is invited on the contents of this situation appraisal as a key contribution to the development of a Rough Sleeping Strategy. You are invited to tell us whether this is an accurate representation of rough sleeping in Victoria, to identify any errors or gaps that you see and to alert us to any insights that we may have missed. In particular, your feedback on the general principles at the end of the situation appraisal will be invaluable, as these are intended to form the basis of the strategy.

Please take the time to read this situation appraisal, and send your feedback to roughsleepingstrategy@dhhs.vic.gov.au by Monday 10 July 2017.

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Introduction

Purpose

This situation appraisal documents what is currently known about street homelessness in Victoria, commonly referred to as rough sleeping, with a view to informing discussion and development of a long-term strategy to reduce it. The situation appraisal will inform discussions with stakeholders during mid-2017, prior to the development of advice on a Rough Sleeping Strategy to be provided to the Minister for Housing by the end of October 2017.

Approach

In order to document what is currently known about people sleeping rough in Victoria, a variety of perspectives were sought. These came from three key sources:

- **data** – analysis of point-in-time data, service usage data and service-specific data
- **discussions** – meetings between the project team and selected key stakeholders involved in service delivery or support of people sleeping rough in Victoria
- **research** – an extensive literature review and analysis of approaches to rough sleeping in other Australian jurisdictions and internationally.

This information is drawn together in this situation appraisal to provide a comprehensive and nuanced understanding of rough sleeping in Victoria. It has informed the principles (at the end of the document) that will in turn guide the advice on a Rough Sleeping Strategy.

Background

From both a social policy and a service delivery perspective, homelessness is a complex problem. The Australian Bureau of Statistics (ABS) defines a person who does not have suitable accommodation alternatives as homeless, if their current living arrangement:

- is in a dwelling that is inadequate;
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations (ABS 2012).

This operationalises homelessness as a situation that lacks one or more of the elements that represent 'home'. In this context people who are sleeping rough (that is, homeless and staying in improvised homes, tents or sleeping out) experience the most extreme and literal form of homelessness. Other forms of homelessness include 'couch-surfing' or living in severely overcrowded dwellings. Service usage data demonstrates the number of people sleeping rough is a small subset of the broader population of people who experience homelessness. Fewer than 10% of people assisted by specialist homelessness services (SHS) in 2015-16 were sleeping rough when they began receiving support (AIHW 2017). It is this group of people with which this paper is concerned.

Rough sleeping

For the purposes of this document, people sleeping rough includes people with no shelter, who don't have access to conventional dwellings. They may sleep in parks; on the streets; in cars, railway carriages, or derelict buildings; or in improvised dwellings such as tents.

Prevalence and characteristics of people sleeping rough

What does the data tell us?

Collecting data about people experiencing homelessness presents unique challenges. People who lack an identifiable dwelling, or whose living situation is hidden, are difficult to count. The problem of establishing reliable figures is compounded by the fact that people enter and leave homelessness over time, as well as moving between different locations while homeless. Most of the data used in this document is specific to people who have slept rough in the 19 months from July 2015 to January 2017. However, this data is often part of a broader homelessness data collection. If a broader collection (for example, data about all homeless Victorians) is used this will usually be noted in the commentary.

There are a range of data sources on rough sleeping, differing in their primary purpose, scope, definitions, coverage, collection method and reference period. They include point-in-time collections, service usage data, and data from specific trials and demonstration programs.

Point-in-time approaches provide a snapshot at a particular time. They may not collect information on the dynamics of homelessness such as duration or repeat periods of homelessness. Service usage data can provide more personal detail (including longitudinal data) on people experiencing rough sleeping or other forms of homelessness, but only includes those who seek services and become clients, not all of those sleeping rough. Trials and demonstration projects may provide very detailed data on participants, but by their nature will capture a smaller group of people, usually in a specific geographical area. Data from a diverse range of sources is considered in this document to establish a reliable picture of the prevalence and characteristics of rough sleeping in Victoria.

Point-in-time data

Census of Population and Housing

The Census of Population and Housing (the census) takes place every five years and provides a snapshot of household circumstances on one day of the year. The census is national, including rural and regional Australia as well as metropolitan areas. Homelessness statistics are derived through a process of estimation across a number of relevant datasets.

The approach of the ABS is informed by a broad understanding of homelessness as *home*lessness, not simply being without shelter. Rough sleeping is operationalised in the census using the category 'improvised homes, tents and sleepers out'. In 2011, 550 specialist field staff were recruited to help count people sleeping rough, working with service and accommodation providers (ABS 2012a). The census provides the best data that we have on the homeless population at a point in time, with a snapshot of where people are staying on census night in August. However, in practice there is some undercounting of rough sleeping and some permeability between the categories used to estimate the homeless population on census night (for example, those in caravans, boarding houses and hotels) (ABS 2012b).

Nationally in 2011, people sleeping rough accounted for 6% of the homeless population. In Victoria, the census found that there were 1,092 homeless people in improvised dwellings, tents or sleeping out, making up 5% of the estimated state homeless population.

To date three sets of data over successive censuses have been analysed to yield homeless counts. Data for Victoria is shown in Table 1. The number of people sleeping rough decreased between 2001 and 2006, but rose in 2011 (from 786 in 2006), returning to a level similar to 2001 (ABS 2012a).

The following key points from this data can be reliably made.

- The number of people sleeping rough on any night is a very small percentage of all those experiencing homelessness.
- The largest cohort of people counted as homeless are those being directly assisted with accommodation (refuge, short-term or transitional)—and this group has been increasing in line with increased capacity in the service system.
- There has been a sharp recent increase in the number of people living in severely overcrowded conditions.
- There has been a decrease in the number of people in boarding houses.

Table 1: Homeless persons in Victoria, 2001, 2006, 2011, number and percentages

Source: ABS Census of Population and Housing: Estimating Homelessness (2012)

Type of homelessness	2001		2006		2011	
	No.	%	No.	%	No.	%
Sleeping rough	1,018	6	786	5	1,092	5
In supported accommodation for the homeless	5,146	28	6,929	40	7,845	34
Staying temporarily with another household, including friends and families	3,546	20	3,227	19	3,324	15
Boarding house	5,144	28	3,050	18	4,397	19
Other temporary lodgings	43	-	73	-	90	-
Severely overcrowded dwellings	3,257	18	3,345	19	6,041	27

The 2016 census data estimating homelessness is not expected to be available until at least October 2017 (Liu 2017 personal communication ABS, February 2017).

City of Melbourne StreetCount

The City of Melbourne's StreetCount is a point-in-time method for capturing information on people who are sleeping rough through direct observation and a verbal survey. The StreetCount began as an annual exercise in Melbourne's CBD, but more recently has been carried out every two years. While it can provide relatively detailed information on people sleeping rough in the central city area, it covers only about 20% of the City of Melbourne and excludes other municipalities where rough sleeping is known to occur, such as Yarra and Port Phillip. People sleeping rough who speak with StreetCount volunteers may choose to undertake a survey. In 2016 the response rate was 49%; it is unclear how representative this group is of the broader cohort.

In 2016, 247 people sleeping rough were recorded by StreetCount—a 74% increase in two years. Of these:

- 78% were aged between 26 and 60 (192 people), with 57% of that group aged under 40 (110 people)
- 79% were male (195 people) and 14% were female (35 people) with the remaining 7% recorded as unsure
- 72% presented as single (176 people)
- 75% were sleeping rough in the central city (186 people)

- 49% were sleeping rough on the street (122 people), 20% in parks (50 people) and 31% in other locations (75 people) (City of Melbourne 2016, p. vii).

Melbourne Street to Home (MS2H)

Melbourne Street to Home was based on the Housing First approach developed in the United States in the 1990s, and incorporated a point-in-time survey. It explicitly targeted people sleeping rough who were at risk of premature death, by using a tool known as the Vulnerability Index (VI). The VI generates a score from 0 to 8 across the following questions:

- more than three hospitalisations or Emergency Department (ED) visits in a year
- more than three ED visits in the previous three months
- aged 60 or over
- cirrhosis of the liver
- end stage renal disease
- history of frostbite, immersion foot or hypothermia
- HIV+/AIDS
- tri-morbidity: co-occurring psychiatric illness, substance abuse and a chronic medical condition.

Intake for MS2H was initially achieved through a sustained assertive outreach effort known as Registry Week, during which people sleeping rough would be surveyed for their housing and health needs using the VI. Melbourne's first Registry Week took place in October 2010; the most recent count was undertaken in 2013. Client data from the first four Registry Weeks is shown below. The data for successive Registry Weeks is difficult to compare, given that in some years it included people surveyed at breakfast programs and day centres, in addition to those observed sleeping rough. However the numbers seen sleeping rough give some indication of relative numbers from year to year over the period 2010–2013.

Table 2: Number of people seen sleeping rough during Registry Week

Source: City of Melbourne, StreetCount 2014 Final Report

Year	Number of people seen sleeping rough
2010	190
2011	182
2012	82
2013	124

Point-in-time counts and transience

For both StreetCount and MS2H, few people have been counted in consecutive years. In MS2H, eight of the same people were surveyed across 2010 and 2011. In 2012 and 2013 there were just ten 'repeat' clients. The number of people detected across 2011, 2012 and 2013 was two.

This seems to confirm the highly dynamic nature of the rough sleeping population, and is consistent with the reports of outreach teams who contact people sleeping rough on a daily basis, and the service data that records relatively small numbers of people who experience rough sleeping for more than a year.

Service usage data

National Specialist Homelessness Services Collection

All government-funded specialist homelessness services (SHS) in Victoria contribute service usage data to the national Specialist Homelessness Services Collection (SHSC) administered by the Australian Institute of Health and Welfare (AIHW). The SHSC describes the characteristics of clients, the services requested, outcomes achieved, and unmet requests for services. Funded agencies collect and submit homelessness service usage data for the SHSC minimum dataset using the Specialist Homelessness Information Platform (SHIP) or other accredited agency specific client management systems.

While SHS client data provides the most comprehensive profile of people using services, it cannot yield a complete picture of rough sleeping because some people do not approach services for housing assistance, and services are not provided across all communities and geographies in Victoria.

Prevalence

During 2015–16, 38% of people who presented to a SHS in Victoria were homeless at first presentation (33,968 people). Of this group, 5,855 (6% of all those presenting) had their living situation recorded as sleeping rough: that is, they were without shelter or living in an improvised dwelling such as a tent without an alternative (AIHW 2017a and 2017c). In terms of their homelessness in the month prior to their first period of SHS support, 10,957 people (12%) reported sleeping rough or in non-conventional accommodation. This suggests that in addition to people rough sleeping at the time of contacting a service, others had done so episodically prior to seeking assistance.

Trends over five years

Analysis of the AIHW client dataset for the five years to 2015–16 shows a substantial increase in the number of clients of specialist homelessness services in Victoria who were rough sleeping at first presentation (see Figure 1). In 2011–12 there were 3,685 rough sleeping clients, rising to 5,855 clients in 2015–16, a 59% increase.

Figure 1 Clients at Victorian homelessness services rough sleeping at first support, 2011–12 to 2015–16

Source: SHS data cubes 2011–12 to 2015–16 (Housing situation cube). Accessed from the AIHW website http://www.aihw.gov.au/shs/data-cubes/ on 24 May 2017
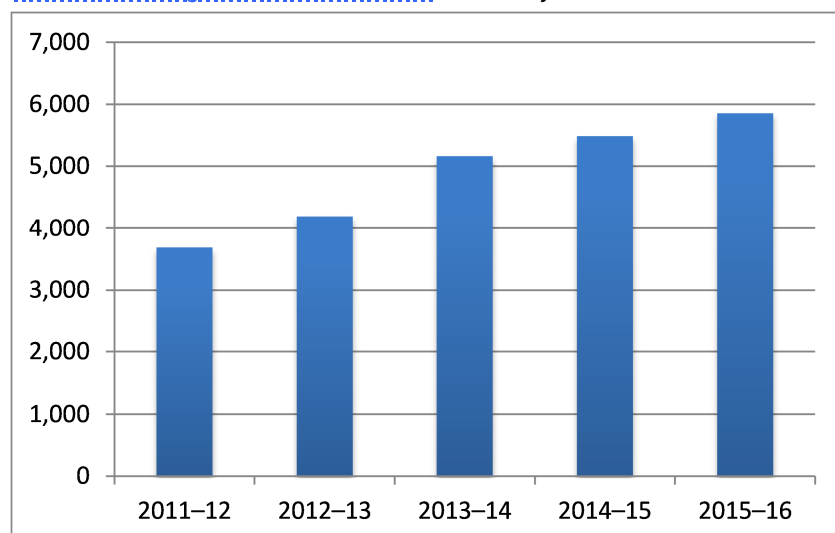
Service outcomes

Service outcomes for rough sleeping clients appear to be poor. Almost half of those who were sleeping rough at the beginning of support from SHS were still sleeping rough when support ended (45% or 2,799 people). Some 21% were in short-term temporary accommodation (1,287 people) and 7% and 11% respectively were in public/community housing (415 people) or private/other housing (688 people). The

remaining housing exits were to couch surfing (4%) or institutional settings (1%), with 11% not stated (AIHW 2017a).

This data suggests that the system is struggling to provide a housing outcome for people sleeping rough, with four out of five still classified in some form of homelessness at the conclusion of the service provided.

Victorian Homelessness Data Collection

Since July 2015, Victorian homelessness agencies send the same data to the Victorian Department of Health and Human services (DHHS) that they report through the SHSC to AIHW. This data, called the Homelessness Data Collection (HDC), provides DHHS with quick access to information about homelessness services. Although AIHW provides data back to all jurisdictions regarding the SHSC, there can be a substantial delay while data cleansing and other processes are undertaken nationally.

Data from the HDC is not directly comparable to SHSC data published by the AIHW. The AIHW weights annual data for agency non-response before it is published on the AIHW website or data cubes, but DHHS does not weight the HDC data. Also, the deadlines for data to be provided varies in each collection.

HDC data on people sleeping rough covering the period July 2015 to January 2017 was analysed for this appraisal. This subsection of the paper (pages 9 - 15) draws on detailed analysis of this data regarding 13,617 people who slept rough in this 19-month period, and this is the data source unless otherwise stated (DHHS 2017a).

The analysis includes 7,822 people who were already sleeping rough when they first sought assistance. The remaining 5,795 people experienced rough sleeping either during or between periods of support within the 19 months. This indicates the current SHS has limited capacity to resolve rough sleeping, for a range of reasons considered later.

Demographics: birthplace, gender, household, age

Most people sleeping rough in Victoria were Australian born (74%). People from New Zealand accounted for 2% of the cohort. People from Sudan, Iran, Vietnam and Somalia were the next most common nationalities (all less than 1%). Aboriginal Australians made up 8% of the total (DHHS 2017a).

The majority of the cohort (66%) were male. The vast majority (84%) were aged between 20 and 54 years. Over three-quarters of people presented as single persons (77% of support periods), 11% presented as a couple without children, and 8% were parents accompanied by their children (70% of these were one parent households).

Children aged under ten years accounted for 3% of people sleeping rough, with children aged 10-14 years making up a further 1%. Overall, 580 children aged up to 14 years slept rough during this period (DHHS 2017a). Care and protection orders were in place for 75 children aged up to 17 who slept rough, including 65 children aged 14 and under.

Reasons for seeking assistance

The main reasons for seeking assistance were recorded on each occasion a service provider commenced a support period. Not surprisingly, housing crisis and inappropriate shelter were the predominant reasons recorded, together accounting for main reasons in 67% of support periods (DHHS 2017a). Perhaps more surprising was the relatively low level of other personal client factors that often are considered contributing elements to the housing crisis. Even allowing for significant underreporting, factors such as family violence, poor physical or mental health and problematic alcohol or drug use—which could be seen as underlying reasons for housing issues—were not often recorded as the main reason for presenting to services.

Factors personal to the client become more prominent when data about health-related factors contributing to their homelessness, rather than their main reasons for seeking help, are examined. Here family violence was a factor in the homelessness of 14% of people sleeping rough, either driving them directly into rough sleeping or occurring at another time during the reporting period. Significantly, two-thirds recorded no health-related factors. Mental illness was the most prominent health-related factor contributing to homelessness, with more than one in four people experiencing mental health issues. Some form of disability was reported in 11% of cases, and 5% recorded drug or alcohol use as a contributing factor (see Table 3).

Table 3 Health-related factors contributing to homelessness for people sleeping rough, July 2015 – January 2017

Source: DHHS 2017a

Health-related factors contributing to homelessness	Number	Percentage
No health-related factors	8,976	65.9%
Mental health only	2,624	19.3%
Disability only	721	5.3%
Mental health and disability	584	4.3%
Mental health and drug/alcohol	388	2.8%
Mental health, disability, drug/alcohol	157	1.2%
Drug/alcohol only	144	1.1%
Drug/alcohol and disability	23	0.2%
Total	**13,617**	**100.0%**

Once again, even allowing for a significant level of underestimation, this data presents an aggregate picture of the inability to secure housing as the primary cause of the homelessness of the majority of people sleeping rough across Victoria.

Institutional history

The HDC includes data on clients' stays in institutional settings within the previous 12 months. Nearly one-quarter of people sleeping rough (23%) had stayed in at least one category of institution: 1,474 individuals in hospital, 1,142 in adult or youth correctional facilities, 914 in psychiatric settings and 261 in rehabilitation (DHHS 2017a). Note there is a substantial level of missing data for this variable, so the number of people with recent stays in institutional settings is probably higher.

This aggregate picture indicates that many people who resort to rough sleeping across Victoria may not have multiple or complex health or justice-related problems that contribute to their housing crisis, as two-thirds did not report any health-related issues during their support. However, the level of previous stays in institutional settings suggests that there is potential to intervene and engage people earlier in these settings in order to prevent people falling into rough sleeping upon their discharge or release. There is some predictable 'churn' between institutions such as correctional facilities and homelessness.

Duration of homelessness

For most, the experience of rough sleeping is not a long-term or semi-permanent experience. While this observation does not diminish the risk of harm, the data suggests that one in four seeking help were newly homeless, with less than one week since having their last permanent address (see Table 4 below). For a further 20%, the time since last permanent address was also relatively short—from one week to

one month. A small percentage of people sleeping rough (10%) reported that it had been more than one year since they last had a permanent address.

While there may be some underestimation of their duration of homelessness recorded by service providers (time since last permanent address was not recorded for all clients), the data indicates that a minority of people sleeping rough can be categorised as long-term homeless.

Table 4: Time since last permanent address by rough sleeping clients July 2015 – January 2017

Source: DHHS 2017a

Time since last permanent address*	Number	Percentage
Less than 1 week	3,450	25.3%
1 week to 1 month	2,673	19.6%
More than 1 month, to 6 months	2,657	19.5%
More than 6 months, to 1 year	1,034	7.6%
More than 1 year, to 5 years	1,083	8.0%
More than 5 years	259	1.9%
Not applicable	513	3.8%
Don't know	1,948	14.3%
Total	**13,617**	**100.0%**

* Client is asked how long it has been since they last had a place to stay for more than three months and were not homeless (i.e. not rough sleeping, couch-surfing or in other short-term/emergency accommodation)

Previous use of social housing

A small proportion of people sleeping rough did so after they lived in public housing. Some 2.4% of people sleeping rough in the period July 2015 to January 2017 had been in public housing and were nominated on the lease, immediately prior to a period of rough sleeping (DHHS 2017a).

There appears to be a significant number of unplanned exits from social housing due to remerging personal problems and/or financial crises. Eight per cent (8,500 people) of all clients assisted annually across the Victorian homeless services are in public or community housing when they first present for help (AIHW 2015-16 data: AIHW 2017a). This group are considered to be 'at risk' of becoming homeless when they first become clients. This number does not include people who subsequently spiral into rough sleeping at some interval after an unplanned exit from social housing and subsequently seek help.

Although definitive data on the pathways from social housing into rough sleeping is not available, it is apparent that many vulnerable households assisted into social housing remain at risk of repeat episodes of homelessness despite it providing tenure security and affordability. This points to the need for more effective supports to build resilience and so prevent crises for highly vulnerable households prioritised into social housing.

Source of income

Not surprisingly, the vast majority of people rough sleeping receive their main income from Centrelink, and for most this would be their sole income. However, the data reveals a picture concerning their labour market status that is quite different from that often portrayed in the public domain. Nearly half (46%) were receiving either Newstart or Youth Allowance payments. This means that they were actively in the labour market, deemed by Centrelink to be ready for work and subject to all the activity tests applied by

Centrelink[1]. As few as 3% recorded some form of employment income and 23% were on a disability support pension (from Centrelink or the Department of Veterans' Affairs) (DHHS 2017a).

Significantly a further 14% were recorded as having no income at the time of contacting the service. People who had experienced a very recent crisis in their living situation and not yet sought assistance from Centrelink could be part of this group. So could people temporarily not eligible for a Centrelink payment due to having failed to meet a Centrelink obligation and people who, having registered with Centrelink, were fulfilling a required waiting period before receiving income support.

The large number of people sleeping rough and deemed to be in the labour market and job ready appears to reflect a trend in the broader population of those considered to be experiencing some form of homelessness. Analysis of SHSC client data over the three years to 2015–16 shows a substantial increase in demand for services from people, particularly males, who are in the labour force. The number of unemployed homeless clients has increased by 23%, from 19,703 (2013–14) to 24,127 in 2015–16. As a share of all clients (aged 15 years plus) this group rose from 35% in 2013–14 to 37% in 2015–16. Over the same period, the number of clients on 'nil income' has increased by 43% to 6,636 individuals: this represents an increase from 8% to 10% of all clients over the past three years . It is not surprising that several service providers have noted this trend.

Variation between income support types and duration of homelessness

Labour market status showed little variation according to the time since the person last had a permanent address: 45% of those who had been homeless for more than a year were in the labour force (Figure 2) (DHHS 2017a).

Those who were newly sleeping rough (<1 week) were slightly more likely to be without any income (16%) than the long-term homeless cohort (>1 year), 11% of whom were reported to be without income.

The newly homeless people sleeping rough were more likely to be in caring roles, receiving Parenting or Carer Payments/Allowances (9%), than the long-term homeless cohort (4%). Those in receipt of a disability support pension made up 31% of the people sleeping rough long term, pointing to the association between duration of homelessness and multiple disabling issues.

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[1] Youth Allowance assists young unemployed people, and also full-time students or apprentices. It is possible, though perhaps unlikely, that some people sleeping rough are full-time students or apprentices, and this too differs from stereotypical depictions of people sleeping rough.

Figure 2: Selected main sources of income by duration of homelessness
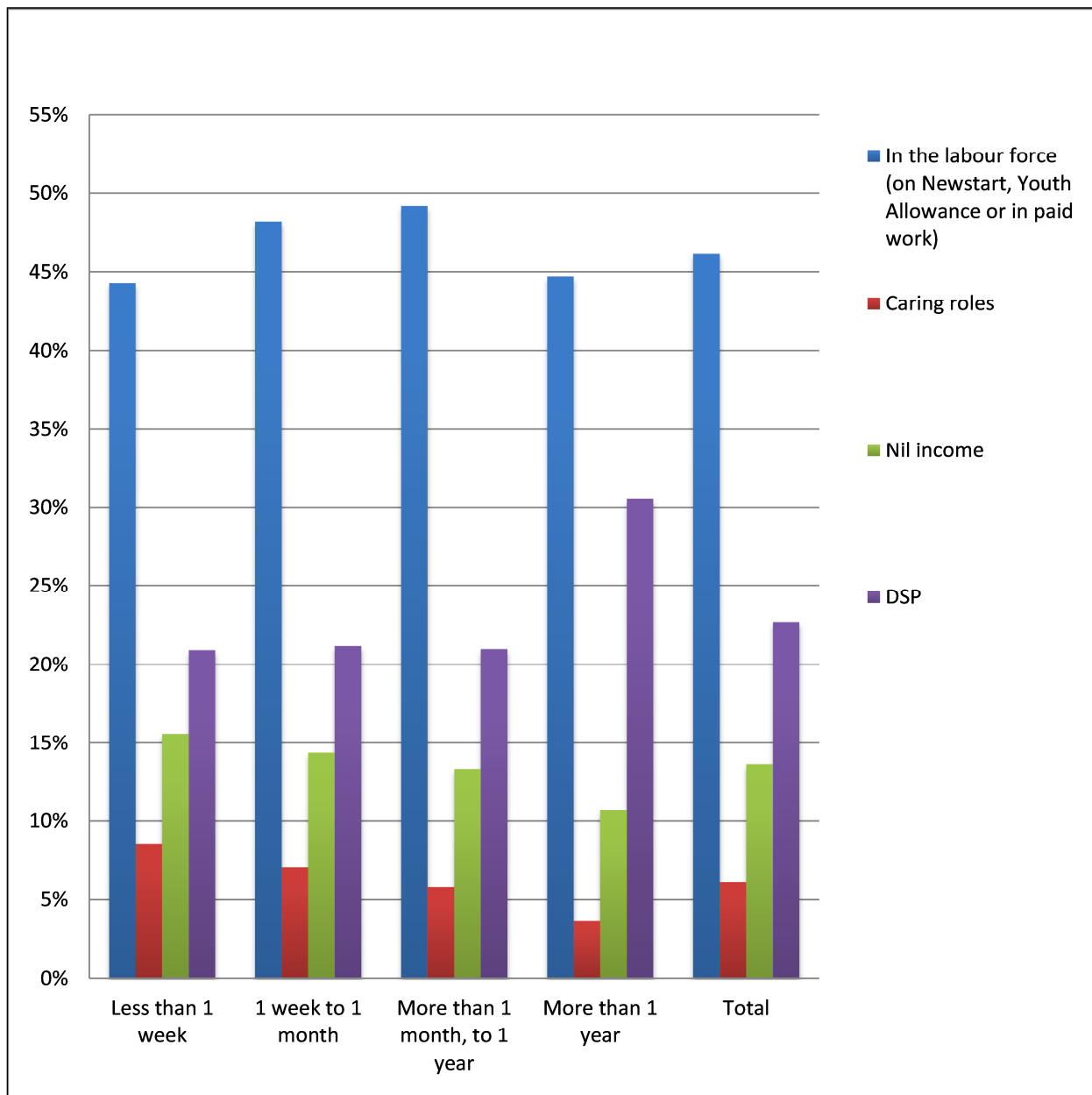
Clearly the inadequacy of Centrelink payments, particularly for the unemployed, the regulations concerning waiting periods, the mutual obligation requirements imposed on them, and the inadequate employment assistance available to them, are significant factors faced by many people sleeping rough. These matters are discussed further when considering causal factors in detail.

Reasons for presenting to SHS by duration of homelessness.

Selected reasons reported for seeking assistance show some variance with time interval since clients last had a permanent address (Figure 3). As expected, a larger proportion of the 'newly homeless' reported family violence issues as a reason for seeking help. By contrast the prevalence of health-related issues (physical health, mental health, alcohol and other drug use (AOD)) increases with duration of homelessness.

The increased health-related factors reported by people sleeping rough long-term using services reflects their complex circumstances and hence the challenges of achieving positive housing outcomes. The percentage of rough sleeping clients who have been in institutional settings in the past 12 months also

increases with the duration of homelessness—from 21% of the newly homeless cohort to 46% of those homeless for over a year (DHHS 2017a).

This correlation should be considered in the context of the evidence that homelessness, particularly rough sleeping, undermines individual health and wellbeing due to increased exposure to harm, violence, poor diet and the effects of untreated health conditions. Living in the homeless subculture for an extended period invariably leads to tensions and hostility (Johnson & Chamberlain 2012). While health conditions such as mental illness and substance abuse can result in housing crisis and homelessness, episodic and long-term homelessness also leads to poor health. There is a clear imperative to resolve rough sleeping as quickly as possible to prevent costly accumulation of trauma and poor health conditions.

Figure 3: Reasons for seeking assistance by time since last permanent address
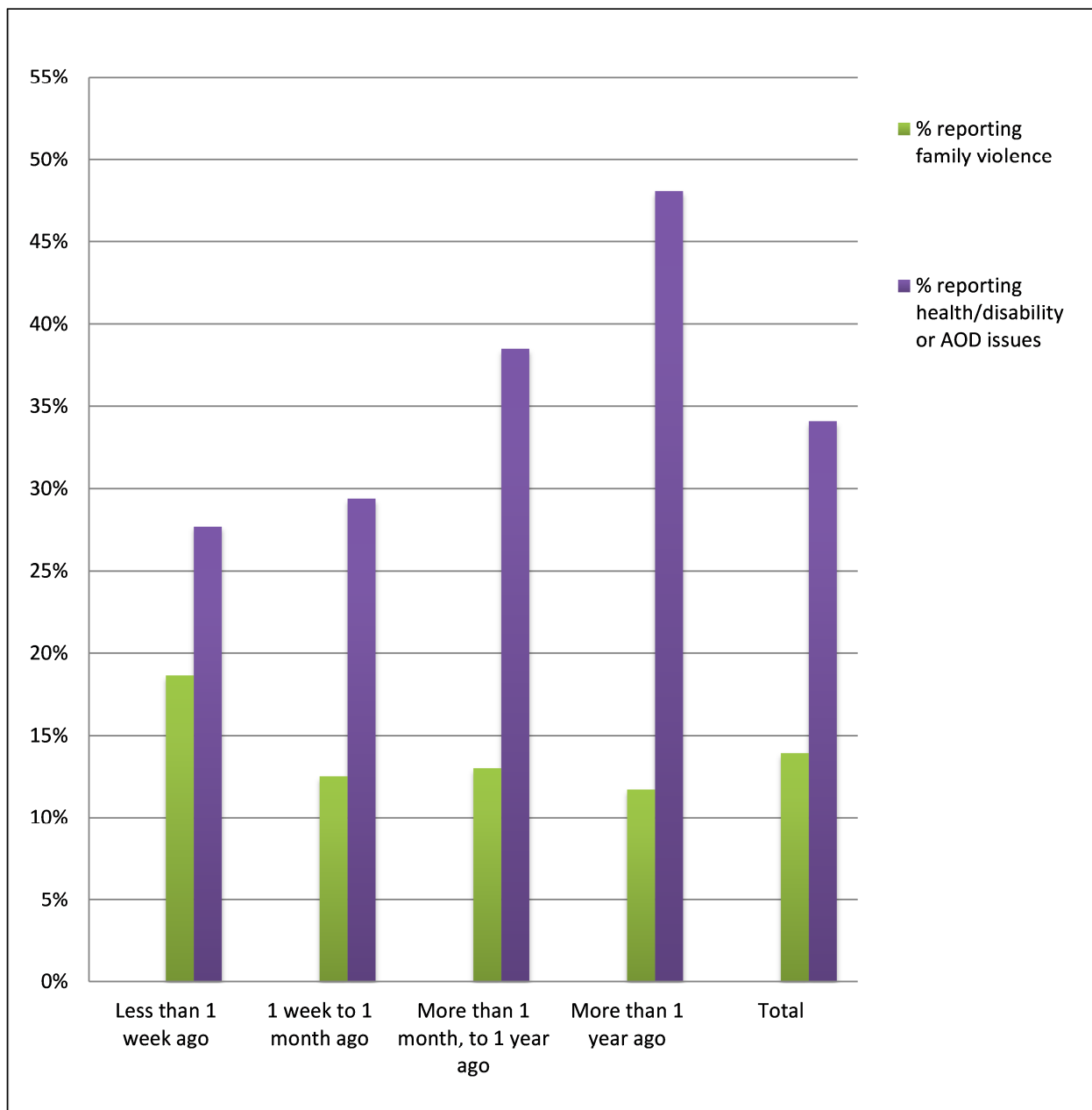
Note that 'other', 'don't know' and 'not applicable' responses were excluded from calculations

Service utilisation

Number of support periods

Almost two-thirds (64%) of the group had only one support period[2] in the 19 months analysed (July 2015 – January 2017), with a further 18% having two support periods and 7% having three. Only 218 (1.6%) clients in this period averaged more than one period of support every two months (=10 or more support periods) and might be considered 'frequent service users'.

Table 5: Number of support periods for people sleeping rough, July 2015 – January 2017

Source: DHHS 2017a

Number of support periods	Number of clients	Percentage
1	8,730	64.3
2	2,382	17.6
3	969	7.1
4	487	3.6
5	321	2.4
6–9	468	3.4
10–19	177	1.3
20 +	41	0.3
Total	**13,575**	**100.0**

Note: Missing data excluded

Length of support

Of all rough sleeping clients, most received only short-term support: 57% for up to 1 day, 14% for 2 days to 1 week, 7% for 8 days to 2 weeks and 7% between 15 days and 4 weeks. One in ten periods of support lasted between 1 and 3 months and 5% were longer than 3 months.

Duration of homelessness was associated with increased length of support: 76% of the newly homeless received short-term assistance (up to a week), compared with 58% of those who had been long-term homeless. Nevertheless nearly half (46%) of long-term rough sleeping clients received assistance lasting one day or less.

Accommodation provision

Only 28% of support to rough sleeping clients included direct provision of accommodation. Over two-thirds of accommodation lasted for less than a week: 39% was for only one night and 31% for two to seven nights. There was no significant correlation between accommodation provision and time since last permanent address: one-third of those considered long-term homeless (34%) received accommodation.

However, those who were newly homeless were provided with shorter accommodation (45% for 1 night) compared to the long-term homeless cohort (28% for one night).

Housing outcomes

Very few rough sleeping clients (6%) were assisted out of homelessness at the end of their support.

Half were reported as still rough sleeping. One-quarter were in short-term, temporary accommodation and still homeless. A small number (169 clients or 1.4%) were in institutional settings. Among the newly

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[2] A support period is the period of time that a client receives services from an agency.

homeless cohort, a slightly higher proportion (2%) exited into short-term, temporary accommodation. Only 5% of rough sleeping clients who had been homeless for over a year exited to public or community housing; and 3% were in private (or other) housing: thus 8% of this cohort were no longer homeless at the end of support—a marginally better outcome compared to the newly homeless or medium-term homeless cohorts.

This relatively poor level of accommodation support and housing outcomes achieved reinforces the earlier aggregate data on client housing outcomes at exit showing that the current mainstream support system is failing to resolve rough sleeping for the majority of people seeking help, including both newly homeless people sleeping rough and those who have become long-term homeless.

Service-specific data

The small number of service-specific data sets on people rough sleeping tend to reflect the particular categories of people each service assists. Consequently, compared with the broader cohorts captured in the SHS and census data sets, they present a profile of people who have been rough sleeping for longer periods and who have significant physical and mental health problems.

Rough Sleeper Initiative (RSI)

The Rough Sleeper Initiative (RSI) is an assertive outreach, initial engagement and short-term support program across the cities of Melbourne, Port Phillip, Stonnington and Yarra, with exits to other support programs at Launch Housing or other organisations.

Data from the RSI relates to all its clients over the 19 months from July 2015 to January 2017 (329 individuals). The profile of people sleeping rough is as follows:

- 75% were male
- Their mean age was 40 years, with 83% aged between 26 and 55 years
- Most (81%) were Australian born
- 13% were of Aboriginal background
- In terms of income source, 46% were on Newstart, 34% on Disability Support Pension, 5% with no income
- The majority (71%) were in the labour force, including 6% in paid work.

The average duration of support for these RSI clients was less than two months. Indicative outcomes data from Launch Housing shows that 63% moved out of rough sleeping, with most provided with short-term or emergency accommodation either in SHS accommodation or in hotels or rooming houses.

The overall picture of the duration of homelessness for those people sleeping rough assisted as clients by Victorian SHS services contrasts with the equivalent data for the RSI client cohort (Figure 4). A far higher proportion (42%) of the RSI cohort largely assisted through central Melbourne entry points —— were long-term homeless, compared with 12% among the entire cohort of people sleeping rough.

Figure 4: Rough sleeping clients (RSI and all Victorian SHS) by time since last permanent address, July 2015 – January 2017 (%)
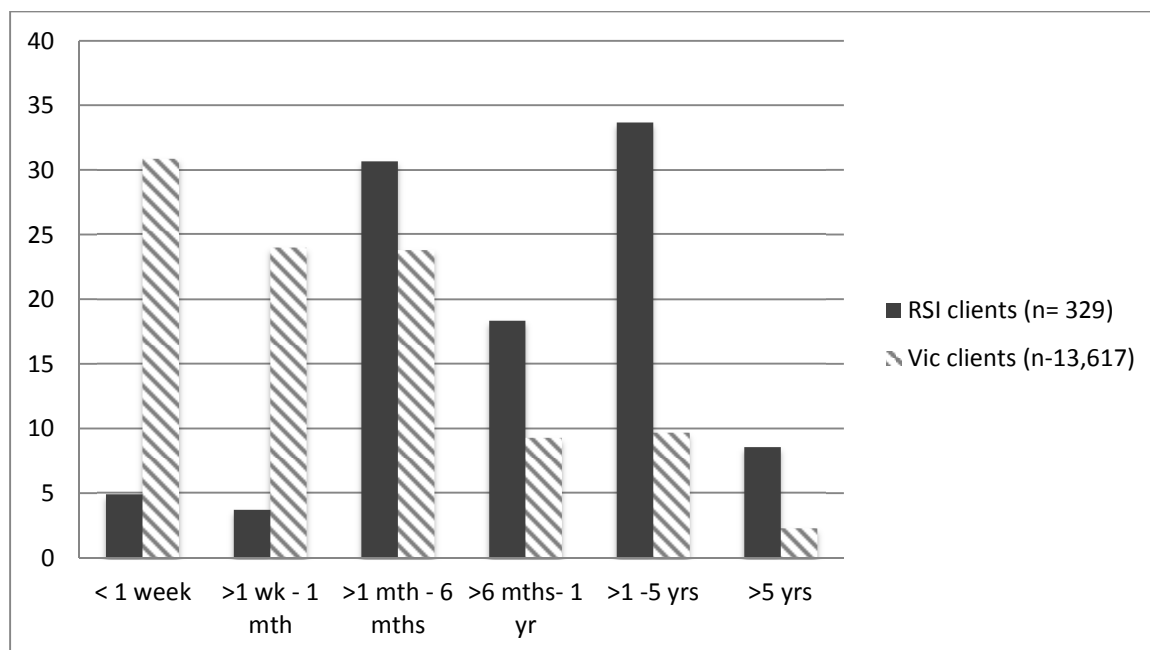
There were high rates of prior mental health diagnosis (64% of RSI clients) and much higher rates for women (80%) than for men (59%).

Subsequent data provided by Launch Housing from case file analysis of a sample of 60 RSI clients from 2016 sheds more light on the complexity of issues faced by those rough sleeping for extended periods in the inner city:

- 41% had been in prison in the past
- One in five had experienced abuse or neglect as a child
- Nearly half (44%) had completed Year 10 or less education (Launch Housing 2017 unpub.)

Journey to Social Inclusion (J2SI)

Journey to Social Inclusion was a three-year pilot of intensive support designed to break the cycle of long-term homelessness. J2SI did not directly provide housing to participants but offered intensive case management which included advocacy to access permanent housing. This Sacred Heart Mission initiative was evaluated by RMIT using a randomised control trial over four years from inception (2009–12).

J2SI selection criteria targeted people who had experienced long term chronic homelessness—including sleeping rough—as a marker of social exclusion and disadvantage. Referral criteria specified that participants:

- had slept rough continuously for more than twelve months in the past, and/or
- had been in and out of homelessness for at least three years in the past; and
- were aged between 25 and 50 years at commencement of the trial.

After three years, 85% of JS2I participants were stably and suitably housed, compared with 41% of the control group. Over four years the average use of emergency departments and average number of days hospitalised in general and psychiatric hospitals declined by about 80% (Johnson et al. 2014). The profile of participants shows a much higher rate of long-term health-related factors, as well as a high rate of incarceration). The gender split of participants was almost even. Most (81%) were single; 96% were on government benefits. Experiences of childhood trauma were evident among 87% of study participants, 95% had experienced one or more traumatic event in their lifetime, 87% had been charged with criminal

offences and more than 60% did not feel accepted by family or society (Johnson & Wylie 2010). This was a cohort with multiple and complex issues together with a history of long-term or episodic homelessness.

Elizabeth Street Common Ground (ESCG)

Elizabeth Street Common Ground is a supportive housing model for people with a history of long-term homelessness. Based on the US Common Ground model, it uses a congregate facility of 131 units with on-site concierge support (24/7) and a range of co-located services and recreational opportunities for residents. While ESCG has many core elements in common with Housing First, there are significant differences in the provision of permanent tenure, affordable housing and support through ESCG (McDermott et al. 2013).

An independent evaluation was based on 110 residents who stayed in ESCG over a two-year period up to mid-2012. The initial intake was chosen through a referral process followed by a selection panel, with the aim to focus on those with a long history of homelessness and highly vulnerable health and wellbeing. The resident profile reflects this recruitment process, with high rates of mental illness (96%), substance misuse (46%) and repeat involvement with police and justice systems (79% including 27% ex-prisoners). In the latter case, 35% of residents were nominated by the Department of Justice, an arrangement that is no longer in place.

Changes have been introduced in selection procedures since start-up to reduce the level of anti-social behaviour and ensure a safe living environment for residents. However, the profile of residents in ESCG clearly shows the multiple and complex issues experienced by people with long histories of homelessness (typically over five years) including rough sleeping. In addition to other issues, 60% of residents required ongoing support in relation to acquired brain injury, neurological disorder or intellectual disability, and 78% lacked any personal supports (McDermott et al. 2013).

Summary: service-specific data

Selected data from Victorian interventions produces a picture of people sleeping rough in central Melbourne who are largely single adult men, reliant on income support and with a high prevalence of health, mental health and substance use issues (see Table 6 of comparative data below)[3]. While Aboriginal people form less than 1% of the Victorian population, they are overrepresented in homeless populations, including rough sleeping cohorts. The high levels of complex issues faced by those sleeping rough in inner Melbourne have been exacerbated and in some cases caused by long periods of homelessness and an itinerant life. As a consequence they have made frequent use of health, justice and welfare services, often over many years (see, for example, Baldry et al. 2012).

It appears that single adult men may not be currently well served by the system. The need to prioritise scarce resources may mean that this sub-cohort is less likely to be assisted out of rough sleeping. Over time, therefore, their issues may become more complex and successful intervention may become more difficult.

There is significant variance in both demographic and contributing factors between the client cohorts of the above programs. The profile of clients of these relatively small-scale or time-limited interventions is not necessarily representative of the broader population of people rough sleeping across Victoria over a given period.

It appears that the RSI cohort have a higher labour market connection (46% on Newstart) than the other intervention client cohorts. This may reflect an emerging trend of more unemployed homeless people discussed earlier.

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[3] The demographic profile reflects the part of the service system accessed by participants (that is, inner city homeless service clients) as well as varying selection criteria adopted by services. The data is incomplete, as not all services collect all variables and definitions are not consistent.

MS2H participants are more likely to be male (89%), older (mean age 46 years), single (86%) and not in the labour force (69% on a disability support pension) than participants in other Melbourne interventions.

Table 6: Comparison of selected Victorian data on people rough sleeping in Melbourne

Variable	RSI (Jul 2015 – Jan 2017)	MS2H (2013)	J2SI Trial (2010)	StreetCount (2016)	Elizabeth St CG (2012)
Total participants	329	124	83	247	110
Male	75%	89%	48%	85%	71%
Female	25%	11%	52%	15%	29%
Age: Mean (yrs)	40 yrs	46 yrs	36 yrs		37 yrs
% aged 26–55 yrs	83%	73%*		70%**	
Country of birth: Australia	81%			69%	85%
Aboriginal	13%	12%		14%	9%
Presenting alone / single	67%	86%	81%	72%	-
Income source: Employed	6% #	-	0%	-	0%
Disability support pension	34%	69%	61%	-	61%
Newstart	46%	25%	-	-	30%
Labour force participation rate	71%	-	28%	-	0
Experience of domestic/family violence (%)	24%			-	-
Chronic physical ill health	19% ##	86%	78%	-	40%
Substance misuse	30%	72%	89%	-	46%
Mental health issue	34%		60% ***	-	96%
Previously in prison	2% ###	80%	52%	-	27%****

* Age cohort 25–55 yrs

** estimated from reported data

*** identified as 'mental health disorder'

**** 79% contact with police/justice system (note 35% of residents selected by Department of Justice)

 # Week before support

'medical issues'

reported as 'transition from custodial arrangements'.

Rural and metropolitan differences

There are strong geographical dimensions to the phenomenon of rough sleeping in Victoria. While people sleeping rough are most concentrated and visible in inner Melbourne, the majority of people rough sleeping originate from and are found in suburban Melbourne and around the state.

An analysis of the 2006 Victorian census data identified the need to separate people rough sleeping on census night from those living in improvised homes such as sheds, shack and garages that they might rent or own (Chamberlain & MacKenzie 2011). This group includes people who aim to build a house on land that they own or are purchasing, but spend a sometimes lengthy period in a shed or improvised home. For the census data analysis, they were not considered to be transient or sleeping rough.

As Table 7 shows, 153 individuals were reported sleeping rough in inner Melbourne on census night in 2006, accounting for only 30% of the total estimate. The large majority of people sleeping rough (70%) were counted not in inner Melbourne but in middle/outer suburbs (30%), rural areas (30%) and regional centres (9%).

Table 7: Distribution of people sleeping rough across Victoria, 2006 Census

Source: Chamberlain & MacKenzie (2011): Table 11 using 2006 census data

	Inner Melbourne	Suburban Melbourne	Regional Centres	Rural	Total
Number	153	154	46	151	504
Percentage	30%	31%	9%	30%	100%

In rural and regional Victoria, people sleeping rough were found in small numbers, spread thinly across a wide area. Numbers were believed to be slightly higher in areas where work such as fruit-picking is seasonally available.

A similar analysis of more recent census data has not been found. However, the analysis of 2006 data demonstrates that the numbers of people sleeping rough on any one night were broadly consistent across inner Melbourne, outer Melbourne and in country Victoria. In the absence of evidence to the contrary, it is assumed that the distribution of people sleeping rough continues to be approximately 30% in inner Melbourne, 30% in suburban Melbourne and 40% in country Victoria.

Regional drift

No evidence was found to suggest that people rough sleeping in Melbourne's CBD or surrounding neighbourhoods have lived in the central Melbourne area, fallen on hard times and become homeless. During consultations service providers frequently reported that people gravitate to inner Melbourne, attracted by the perceived availability of services. These observations are supported by examination of the data on people sleeping rough using homelessness services looking at the duration of homelessness and the location of the most recent service they used (DHHS 2017a).

The analysis supports our understanding that rough sleeping can occur anywhere across Victoria, with less than 9% of those rough sleeping helped as clients at services located in central Melbourne (Table 8). Those who were long-term homeless (more than 1 year since last permanent address) are overrepresented at central Melbourne and inner city services, particularly the hot spots of North Melbourne, St Kilda and Collingwood. While there are limitations to conclusions drawn from this dataset alone, there is a drift effect linked to duration of homelessness. This is supported by observations from service providers suggesting that the drift to inner Melbourne occurs as a person's life circumstances deteriorate. However, this data suggests that the drift is from the outer and middle metropolitan suburbs, rather than from regional Victoria. Thus, only 5% of rough sleeping clients of services in outer Melbourne and 8% in middle suburban based services were long-term homeless, but over 12% in inner city and central Melbourne services were long-term homeless. Closer examination of the client cohort using regional services indicates a drift effect to the larger regional cities (for example, Geelong and Ballarat) from smaller and more remote locations.

Table 8: Location of most recent service providing support to rough sleeping clients by their period since last permanent address, July 2015 – January 2017

Location of most recent service	Time period since last permanent address, %		
	Newly homeless (<1 week)	Long-term homeless (>1 year)	All rough sleeping clients
Central Melbourne	9.0	12.0	8.6
Inner suburbs	22.0	34.3	26.9
Middle suburbs	18.8	14.2	18.5
Outer suburbs	23.6	10.3	18.5
Regional Victoria	26.6	29.2	27.4
Total	3,440	1,340	13,607

Missing data excluded

This drift pattern is also supported by looking at the postcodes of rough sleeping clients' last permanent addresses, compared with the location where they most recently received services.

Evidence of this drift phenomenon was first reported in Melbourne study in the late 1990s. It found a clear downward path leading to inner Melbourne characterised by a spiral from more stable accommodation (measured in duration of stay) to more temporary accommodation and then rough sleeping (Thomson Goodall Associates 1999). More recently the anecdotal phenomenon of inner city drift was examined for Mission Australia in a NSW study led by the Centre for Health Research, University of Western Sydney (Conroy et al. 2015); however the scope and timeframe of that study did not enable conclusive evidence of the prevalence of drift to be established. Like recent consultations, both these studies reported the pattern of exhaustion of financial and social capital and an increase in the complexity of need common to people's journeys to inner cities in search of services.

Young people leaving out-of-home care arrangements (or justice settings) are at particular risk of homelessness and rough sleeping. Many of this cohort who have experienced multiple placements during their childhood in care do not have an attachment to a local community in suburban Melbourne or regional areas. Episodic homelessness increases the risk of these young people becoming attached to subcultures in the inner city, with consequent negative peer pressures leading to poor choices and risks of serious harm.

Data summary

Drawing on the range of available data sources, it has been possible to build a reliable profile of rough sleeping in Victoria to inform a new strategy. The analysis shows that the number of people sleeping rough on any night across Victoria is a very small percentage (5%) of all those experiencing homelessness: just under 1,100 in 2011 (ABS 2012a). Annually, 6% of clients (5,855 people in 2015–16) assisted by specialist homelessness services are sleeping rough at the time of seeking help.

The statistics indicate a level of episodic rough sleeping for some households prior to and after seeking help and confirms the highly dynamic nature of rough sleeping as a last resort response to housing crisis.

Most people who sleep rough do so for a short period. A minority of people sleeping rough (about 10%) can be categorised as long-term or chronically homeless (over one year), with about half homeless for less than one month (see Table 4). The perception of large numbers of people entrenched in rough sleeping is not supported by the evidence. This is not to dismiss the risk of harm involved in any period of rough sleeping.

There are geographical dimensions to rough sleeping. Housing crisis, resulting in homelessness and rough sleeping, can occur across Victoria. Both the census and homelessness services client data suggest that about one-third of people sleep rough in inner Melbourne (including central Melbourne), another third sleep rough in the middle and outer suburbs and the remaining third experience rough sleeping in regional Victoria.

It is clear that people sleeping rough and unable to resolve their homelessness gravitate to central Melbourne over time from other locations (suburban and non-metropolitan). In particular the data suggests a drift from the outer suburbs to inner Melbourne, as well as a drift from regional and rural locations into major regional cities such as Geelong and Ballarat. A range of push and pull factors contribute to this movement of people rough sleeping for extended periods into inner city locations, including availability of accommodation and support services (such as emergency relief, material aid and meals services).

The majority (66%) of those rough sleeping across Victoria are male. Most (84%) are aged between 20 and 54 years. While nearly three-quarters present as single persons, 8% are accompanied by young children. However, the data on clients of inner city targeted interventions shows that people sleeping rough over the longer term are much more likely to be male, single and have multiple and complex health related issues.

A surprising finding is the high and increasing proportion of people experiencing homelessness who are in the labour market and unemployed. Of those who were rough sleeping, nearly half (43%) were in the labour market and on Newstart or Youth Allowance payments[4] and a very small number in paid work. An additional 14% of rough sleeping clients were without any income. This picture supports a conclusion that labour market conditions and low income support payments are drivers of increasing levels of homelessness and rough sleeping.

This trend can be seen in the increasing use of homelessness services over the past decade in Victoria. However, the data on service provision shows that the homelessness service system is failing to provide a housing outcome for people sleeping rough, with 4 out of 5 still experiencing some form of homelessness at the end of support. Most clients receive short-term or one-off assistance. Only 28% of support includes the provision of accommodation: in most cases this was for only a few nights (70% for 1 week or less). Only 8% of the rough sleeping clients who had been homeless for over 1 year are no longer homeless at the end of support, with 5% entering public or community housing and a smaller 3% in private (or other) housing.

While the inability to secure housing is the primary cause of homelessness for most people sleeping rough, particular groups are especially at risk, including those leaving institutional settings and survivors of family conflict and violence. About one-third of those who sleep rough have one or more health-related problems.

This profile of the population of those rough sleeping in Victoria paints a very different picture from the typical descriptions of people sleeping rough in the inner city portrayed in the public domain. The locational distribution, in particular, points to a need to intervene closer to where their housing crisis originates.

People sleeping rough cannot be considered a homogeneous group. Different needs must be considered when designing effective interventions to resolve their homelessness and, ideally, prevent housing crisis from leading to rough sleeping in the first place. The current mainstream response to homelessness is struggling to resolve rough sleeping and achieve housing outcomes for those seeking help. The consequent level of 'churn', which contributes to episodic and chronic rough sleeping, reflects the increasing challenge for clients and service providers in accessing and keeping affordable rental housing.

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[4] As noted previously, it is possible Youth Allowance recipients are in full-time study or training.

Typologies of rough sleeping

This situation appraisal seeks to organise key client characteristics and circumstances into an agreed framework or typology. Typologies can help to match clients with the most appropriate services, and inform policy, program design, and resource allocation (National Health Care for the Homeless Council 2013). The main purpose of adopting a typology for rough sleeping is therefore to provide a basis for triaging clients of homelessness services at their first point of entry to match their circumstances to the most appropriate housing and support package needed to resolve their homelessness and to sustain housing.

There are multiple typologies of homelessness, and no single approach is universally accepted, perhaps reflecting that the utility of a typology relates to context and purpose. Existing typologies tend to apply to the broad scope of homelessness, and not just rough sleeping, although there are examples of the latter (Coleman et al. 2013, Young Foundation 2011).
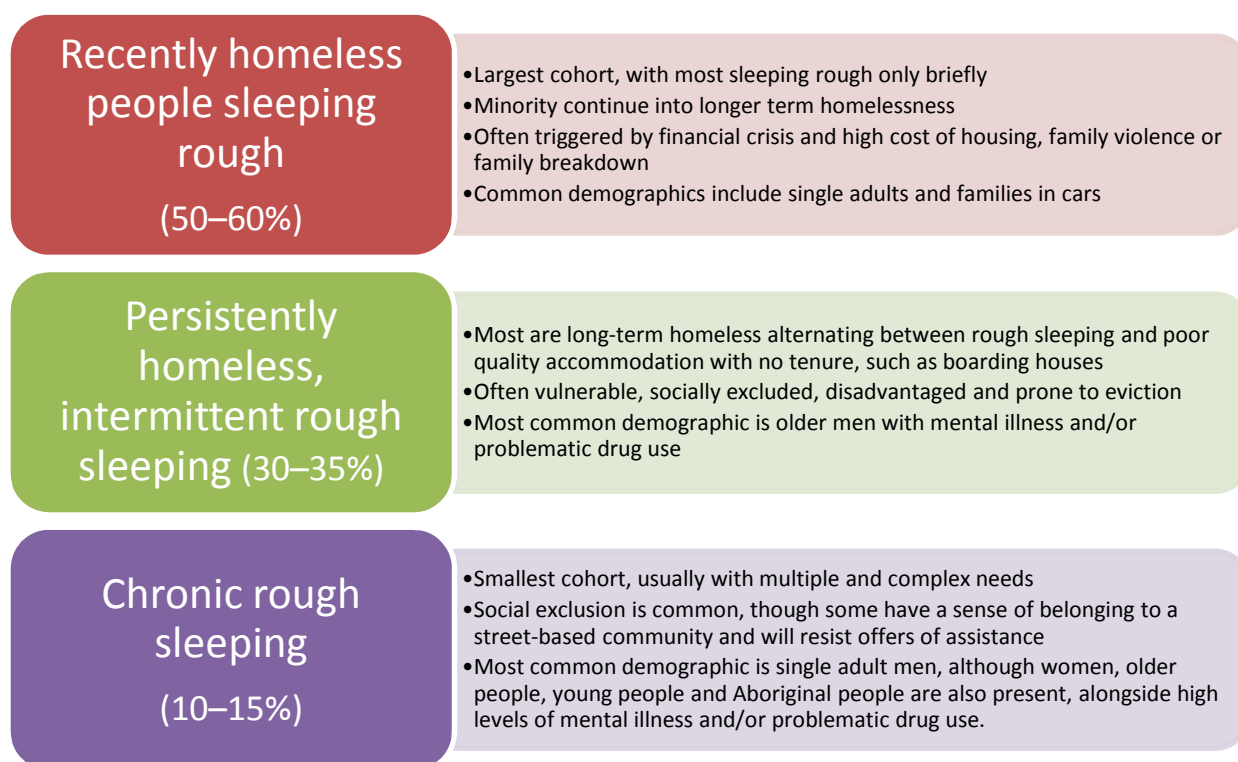
Time-based typologies

One common typology proposes three readily identifiable overarching groups within any population of people sleeping rough:

- recently homeless people sleeping rough —a small number on any one night, but a large proportion of people sleeping rough over a year
- persistently homeless, intermittent rough sleeping—who may spend the greater part of their lives in run-down boarding houses and other substandard accommodation
- chronic rough sleeping—many of whom have significant mental health and drug and alcohol issues, and may be alienated from services (Nous Group 2017, Chamberlain & MacKenzie 2011, Coleman et al. 2013, Kuhn & Culhane 1998).

Based on the data, the literature and discussion with stakeholders, and consistent with similar countries, newly homeless people sleeping rough (less than 1 month) in Victoria are the largest group of people sleeping rough. Chronic people sleeping rough, who are usually long-term homeless (for a year or more), are the smallest group. The boundaries between chronic and intermittent people sleeping rough are fluid. Based on the most recent data on the 13,617 people using homelessness services across Victoria (over a 19-month period, DHHS 2017a), approximate percentages are shown in Figure 5. However, it is not possible to be precise due to data limitations and an unknown level of undercounting (since not all those rough sleeping become clients of homelessness services).

Figure 5: Typology of people sleeping rough in Victoria

Recently homeless people sleeping rough (50–60%)	• Largest cohort, with most sleeping rough only briefly • Minority continue into longer term homelessness • Often triggered by financial crisis and high cost of housing, family violence or family breakdown • Common demographics include single adults and families in cars
Persistently homeless, intermittent rough sleeping (30–35%)	• Most are long-term homeless alternating between rough sleeping and poor quality accommodation with no tenure, such as boarding houses • Often vulnerable, socially excluded, disadvantaged and prone to eviction • Most common demographic is older men with mental illness and/or problematic drug use
Chronic rough sleeping (10–15%)	• Smallest cohort, usually with multiple and complex needs • Social exclusion is common, though some have a sense of belonging to a street-based community and will resist offers of assistance • Most common demographic is single adult men, although women, older people, young people and Aboriginal people are also present, alongside high levels of mental illness and/or problematic drug use.

Pathway typologies

Similarities between those who are persistently homeless and intermittently sleeping rough and those who are chronic rough sleeping in the typology above suggest the two groups may be the same population recorded at different points in their lives (Kuhn & Culhane 1998). This underlines the importance of understanding the client group not only from their current, point-in-time situation, but also their vulnerability and likelihood of developing longer term patterns of chronic homelessness and rough sleeping.

Young care leavers are a distinctly vulnerable group for lifelong homelessness and entrenched rough sleeping. Younger people sleeping rough are likely to include current or former out-of-home care clients, and the data suggests this group may go on to be disproportionately represented among the older chronically homeless rough sleeping cohort. Many may have never experienced 'home' in terms of supportive connection, despite being 'sheltered'. Among young people generally, even a short period of sleeping rough may be likely to develop into long-term homelessness, due to limited living skills to negotiate an exit from homelessness.

Considering people's pathways in and out of homelessness over the course of their lives makes for a richer understanding not only of their complex issues and needs, but also of their personal resources, strengths and resilience (Brady & Flatau 2007). Bringing such information to bear in homelessness responses and prevention strategies can improve the capacity to meet people's needs.

Pathways data offers other typologies upon which to base preventative responses to rough sleeping. Although more complex, grouping people according to their 'pathways in' can inform their 'pathways out', and offers the potential for more nuanced, effective and appropriate interventions to assist them in that journey. Pathways can also reveal the combination of structural, systems and individual factors that cause and compound homelessness. These issues are specifically addressed in a later section (see *Factors affecting prevalence*).

In their evaluation of Melbourne Street to Home, Johnson and Chamberlain found that close to half the participants had first experienced homelessness when they were 18 years or younger, with their average age when first homeless of just 13 years (2015). The common experiences on this pathway tended to be a history of child protection (40%), low educational attainment and the attendant disadvantage, dysfunction and poverty. All these factors culminate in a lack of 'cultural capital' to reconstruct a 'normal life' following street homelessness. Outcomes data for this group reflects this challenge.

In contrast, those on the 'adult pathway' (who had first experienced homelessness at age 18 or older) tended to have more to fall back on in terms of previous housing and family experiences and living skills. Many of them had enjoyed stable housing, relationships, employment and good health prior to entering homelessness due to one or a combination of housing crisis, marriage breakdown, job loss or the onset of mental illness.

A study of pathways into 'multiple exclusion' homelessness (including sleeping rough, substance misuse, institutional care and 'street culture activities' such as begging and shoplifting) in seven British cities adds depth to the pathways analysis. Fitzpatrick, Bramley and Johnsen (2013) identified a high degree of overlap between multiple needs, forming five broad clusters of experience. Furthermore they could identify a common sequence in the emergence of these issues or behaviours across all clusters, as people followed trajectories of disadvantage into chronic homelessness. The experience clusters were:

• barriers to obtaining secure tenure housing (availability, cost, discrimination)
• homelessness and mental health
• homelessness, mental health and victimisation/incarceration
• homelessness and street drinking
• homelessness and hard drugs.

The individual sequences of experience that held true across the clusters were:

• leaving home/care, using solvents and other drugs and alcohol
• mental health problems, street survival crime with associated victimisation and incarceration, and increasing itinerancy
• sleeping rough, begging, injecting drug use, hospitalisation with mental health needs (in a recently homeless population this coincided with sudden crises such as bankruptcy or divorce)
• use of crisis accommodation (signalled in recently homeless people with later life eviction, repossession, death of spouse).

The striking consistency of these pathways could assist planning of service responses, including across universal or specialist platforms where earlier intervention may be possible. In Victoria a more effective intervention within three main areas— corrections, in-patient health settings and out-of-care arrangements for young people—would have a substantial impact on reducing homelessness and rough sleeping.

The Victorian HDC data analysis indicates that 3,157 clients who slept rough in the period July 2015 to January 2017 had been institutionalised at least once in the previous 12 months. The most common institutions were general hospitals, adult correctional facilities and psychiatric hospitals. Four per cent or 563 people had been in more than one type of institution (DHHS 2017a).

Homelessness and time in prison are related—both before imprisonment and after release. Former prisoners in unstable housing circumstances are more likely than other former prisoners to return to prison, and those who are homeless are significantly more likely to be re-incarcerated. The most recent report detailing national prisoner health indicators found that 43% of prisoners said they were going to be homeless on release (AIHW 2015).

In 2015, one in four Australian prisoners were homeless in the four weeks prior to incarceration, including one in 16 who were sleeping rough (AIHW 2015)[5]. In 2015–16, 2% of Victorian specialist homelessness services clients (2,145 people) had exited from a custodial setting, including prison, youth justice detention centres and immigration detention centres. Nationally, the majority are men (78%), are aged 25–44 years and they are more likely than other homelessness services clients to require drug and alcohol counselling (11% compared with 4% of all clients) (national data AIHW 2017b). Increasing imprisonment rates in the future necessitates a focus on more effective reintegration programs that prioritise housing and support to reduce pathways from prison into homelessness.

Young people leaving out-of-home care arrangements are at particular risk of homelessness and rough sleeping. Approximately 500 young people exit care settings in Victoria each year, and the number of children in out-of-home care in the state is steadily increasing (AIHW 2016, Table 5.7). A range of research has pointed out the high probability of this group experiencing homelessness and its long-term impact on their future. It is estimated that at least one-third of young care leavers experience an episode of homelessness within one year of their transition to 'independence' (McDowall 2009). A recent study found that nearly two-thirds of a sample of 300 homeless young people had been in out-of-home care, with half having slept rough before the age of 18 years (MacKenzie et al. 2016). Many of this cohort who have experienced multiple placements in care do not develop a sense of home in a local community or neighbourhood. Episodic homelessness increases the risk of these young people becoming attached to sub-cultures in the inner city, with consequent negative peer pressures leading to poor choices and risks of serious harm.

Understanding these typical pathways into homelessness and rough sleeping identifies opportunities for more effective early intervention aimed at key risk groups, including those about to be released from prison, discharged from in-patient health facilities or leaving out-of-home care settings. The challenge is to strengthen assessment (prior to exit) of their probability of becoming homeless and rough sleeping, and intervene successfully.

Demographic typologies

In addition to the above main typologies, it is important to consider particular subgroups within the rough sleeping population who may require modified forms and levels of support. At a service delivery level, housing and support packages should meet best practice principles, that is, be tailored to the individual's circumstances, capabilities and aspirations. However, recognising significant subgroups within the broader homelessness population is necessary to configure interventions that match resources with client housing and support needs (Johnson et al. 2011).

The following sub-groups have been identified for particular attention:

(i) **Aboriginal people:** this group make up over 8% of those rough sleeping who become clients of homelessness services, although Aboriginal people are less than 1% of the Victorian population (DHHS 2017a; ABS 2011). A different cultural lens is needed to understand and respond to rough sleeping by this group. Nationally, many Aboriginal people who are public 'place dwellers' and may appear to be homeless in a conventional sense, consider themselves not to be homeless. Rough sleeping is sometimes an expression of connection to land (AHURI 2004), and is a particularly frequent occurrence in warmer parts of Australia. In practice, however, the group of Aboriginal rough sleeping clients who have sought and received support at Victorian homelessness services suggests involuntary homelessness requiring an effective form of support that meets their needs.

Victorian data shows that Indigenous people sleeping rough have a longer duration of homelessness than non-Indigenous people sleeping rough (DHHS 2017a). There is a higher proportion of women amongst Aboriginal clients (41% versus 34% non-Indigenous clients), and family violence is more often identified (20% versus 14%). Overall, it is more common for Aboriginal clients who have slept

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[5] Note that the number of respondents was small. http://www.aihw.gov.au/prisoner-health/

rough to have spent time in an institution than non-Indigenous clients. However this is less commonly a hospital or psychiatric service (compared to non-Indigenous clients), and more commonly adult corrections (34% versus 27%). A higher proportion of children aged 14 or under is evident in comparing Aboriginal and non-Indigenous clients (6% versus 4%).

(ii) **Men:** males constitute the majority of people sleeping rough in Victoria (66%). However, the inner city program data shows that an even higher percentage of long-term homeless people sleeping rough are males. There is also a strong correlation of male rough sleeping with incarceration and health related issues.

(iii) **Women:** women make up a minority of those rough sleeping (34%) and are less likely to be long-term homeless and hence to drift into the inner city. Those who are long-term homeless have multiple and complex issues which affect their capacity to sustain independent living. Research has shown that this cohort have often experienced family violence either as a child or from a partner, often compounded by substance misuse. However, many women resort to rough sleeping as an immediate response to domestic violence and therefore require a different form of housing and support.

(iv) **Families (with accompanying children):** while the majority of those rough sleeping are living as single persons, 8% of those assisted by homelessness services have children in their care (580 children aged under 15 over the 19 months of HDC data analysed). Configuring support to resolve this group's homelessness is critical to minimise the trauma and adverse impact on these children.

(v) **Young people:** the Victorian data indicates that young people (15–24 years) account for 17% of those rough sleeping. If not helped early, young people are particularly vulnerable to becoming long-term homeless where their issues become more complex and costly to resolve (Johnson, Cook & Sesa 2016). Young women make up nearly half of this group (45%). Early school leaving, out-of-home care backgrounds and emerging health issues contribute to this group's lack of social capital and resources to sustain independent living. Responding effectively to young people rough sleeping requires specifically designed interventions and opportunities based on evidence of their positive impact.

(vi) **Older people:** The Victorian HDC data indicates that while only 4% of those rough sleeping are aged over 60 years, another 10% are aged 50–59 years. Researchers have argued that 50 years is a more appropriate age for defining older people experiencing homelessness (Judd et al. 2004) and this has been acknowledged to some extent through their lower age of eligibility for aged care support. Rough sleeping older clients of SHS services are more likely to be long-term homeless than younger age cohorts. Again, the design of housing and support should reflect this group's particular circumstances and capacity for independent living.

The above demographic typology draws attention to the specific circumstances of these subgroups of the rough sleeping population—firstly to ensure that the design and resourcing of future interventions takes into full account their needs and capabilities and secondly to enable outcomes monitoring that ensures these groups are not left behind.

In summary, the best available data on rough sleeping across Victoria shows there is real potential to significantly reduce the extent of rough sleeping, particularly the drift into inner-city areas. This could occur through more effective entry points and outreach services that focus on assessment of key risk factors leading to rapid triage of clients to assessment for an offer of housing and support. Knowledge of the main pathways into rough sleeping should be used to design more effective interventions *before* individuals at risk exit institutional settings. This could suggest use of a short screening tool to identify likelihood of rough sleeping, with a priority referral to housing and support integrated into transition arrangements prior to release or discharge.

Themes from stakeholder meetings

Stakeholder engagement to inform this document took the form of a series of stakeholder meetings with service providers, funding providers, government departments and experts around Victoria. A summary of the themes that emerged is included in this chapter, and stakeholders consulted are listed in the Appendix.

Service response

Assertive outreach

The vast majority of stakeholders agreed that persistent assertive outreach is the most effective way to engage people sleeping rough, and is often the only way to engage those who are chronic rough sleeping. However, there is some diversity in assertive outreach practice, especially in central Melbourne—some services are acting on referrals while others are seeking people out, with some workers more assertive than others.

Outreach services to people who are homeless and dwell in public places have a long history in Australia. Services may include different types of support, such as the provision of meals, clothing, accommodation and support, as well as counselling, advice on legal issues, transport and support for substance use issues (Phillips et al. 2011). Outreach workers make contact with people sleeping rough and endeavour to build relationships to link them to services. Some outreach programs target formerly homeless households who are staying in hotels, boarding and rooming houses—for example, through the Royal District Nursing Service or the Community Connections Program.

Outreach has been one element of Victoria's specialist homelessness services delivery in the inner city. It aims to engage people where they are sleeping rough to offer access to emergency or short-term accommodation as part of the continuum of care or 'stepping stone' design of the support system.

More recently this outreach has been integrated with some form of Housing First response (see next section), and may be characterised by: 1) its aim to permanently end homelessness for clients through sustainable resources; 2) its integrated approach drawing on multidisciplinary teams and 3) its persistent, long-term engagement with clients to ensure transition between rough sleeping and stable housing (Phillips et al. 2011). The difference between assertive outreach and traditional outreach approaches may be more based on priority access to (or lack of access to) resources including housing options (Coleman et al. 2013).

The assertive outreach approach is used in other countries including the UK and Canada. People sleeping rough may be disconnected and alienated—not only from mainstream services and supports, but also from services targeting homeless people. The shift overseas from low-key ameliorative forms of outreach to proactive, 'interventionist' approaches has been driven by factors including increasing vulnerability and risk of harm to those on the streets; increasing local community and business concerns about anti-social behaviours and greater acceptance of conditionality obligations and income support sanctions. Recent UK discussion on the most effective balance between supportive, low level outreach and strongly assertive 'enforcement' approaches has warned of the unintended consequences of the latter: rather than achieve positive outcomes for those rough sleeping, they shift rough sleeping to other locations (Johnsen S 2016). In the UK the acceptance of assertive approaches to outreach has been linked to the increased risks of harm due to violence and ill-health from prolonged periods of rough sleeping—in effect an overriding duty of care for workers to be more persistent. The challenge for 'on the ground' practice is how outreach should balance this duty of care against the need for optimal therapeutic support that emphasises individual choice and readiness to make changes.

An emerging consensus in the UK emphasised ensuring that the 'offer' made to those rough sleeping is sufficient, genuine and timely. This has led to proactive interventions such as the 'No Second Night Out' strategy in London (and more recently across England) that includes a Single Service Offer to resolve their sleeping rough, albeit with a strong message that new people sleeping rough are expected to accept it (No Second Night Out 2013). This is consistent with feedback from stakeholders in Melbourne who expressed concern as to what accommodation outreach workers can offer people sleeping rough— many people sleeping rough do not want to go to motels or rooming houses due to poor previous experiences, and adding them to a waiting list for crisis accommodation is inadequate. It is difficult for workers to persist when there is a limited choice and supply of accommodation available to people sleeping rough.

Some stakeholders suggested assertive outreach teams should have priority access to housing, so that an immediate solution to rough sleeping can be provided. Others disagreed, however, believing that people sleeping rough must be subject to the waiting list prioritisation system like others at risk of homelessness, and that it is not ethical to 'hold' vacant beds for people sleeping rough that others could utilise.

Workforce capacity was cited as a factor in the ability to build a trusting relationship with people who have been sleeping rough for long periods. It was suggested that the workers are not resourced for enough hours to build such relationships, and to continue to provide support. And while it is agreed that engagement must begin at outreach, a balancing act is required to build an effective relationship, without creating a dependence that is unsustainable and detrimental to the client in the long term.

Several stakeholders supported the Street to Home model, which includes teams of skilled people that conduct assertive outreach, build relationships, case manage and support those with multiple and complex needs for a long period until they are settled in stable housing. It appears that while a relatively small cohort require this intensive, expensive support, all people sleeping rough would benefit from more assertive outreach accompanied by an adequate offer of support that includes rapid entry into permanent housing.

Housing First or transitional housing?

Housing First, which originated in the United States, is 'a complex clinical and housing intervention comprised of three major components, a) program philosophy and practice values (referred to as "shared ethos'" by Pleace), b) permanent independent housing, and c) community-based, mobile support services' (Tsemberis 2012, p. 169). Based on a belief that housing is a basic human right, the Housing First approach can be understood as a broader assertive outreach program that emphasises rapid access to permanent housing as its first priority. Other diverse support needs can then be addressed (Coleman et al. 2013). Coleman et al. note that the literature identifies key elements of Housing First as: choice and options for clients (both about housing and when or how to address other issues); a mix of scattered and single-site housing; and intensive support beginning with assertive outreach. Housing First models developed primarily to address the housing needs of patients of mental health services who were becoming homeless following deinstitutionalisation. There is a strong evidence base that shows the benefits of the core elements of Housing First for people with complex and long-term issues (for example, Mental Health Commission of Canada 2014 on Chez Soi).

Stakeholders had varying understandings of Housing First. It appears that there is little practice in Victoria that achieves a genuine Housing First approach, with very few people sleeping rough placed into long-term housing immediately: most service providers have to utilise temporary options pending more permanent housing. This may exhaust the support that needs to be available for an eventual transition to permanent housing. Johnson et al. (2012) make the point that Australian initiatives that identify as Housing First do not have the resources required to meet the basic criterion of rapid access to housing: this is a particular challenge in Australian cities because of the lack of affordable private rental stock compared with the USA.

Similarly, there are differing views about the term 'rapid rehousing', and even in successful programs in Canada and the UK, there are often lengthy periods before clients are housed permanently. A distinction here is between immediate assistance to minimise the time spent 'on the street' by vulnerable people (such as No Second Night Out, with its focus on reconnection) and rapid entry into affordable, secure tenure housing.

Many stakeholders expressed support for the Housing First philosophy, provided this approach involves assertive outreach coupled with access to permanent housing and flexible, long-term support for the client needs. Tsemberis (2012) notes that programs defined as Housing First vary in the fidelity with which they meet Housing First model criteria of program philosophy, housing and services. This 'program drift' has occurred in several countries, and as Johnson et al. note, no Australian Housing First program can or should be an exact replica of the original Pathways to Housing program:

> it is not fruitful to engage in a protracted discussion of whether a policy or program should be defined as Housing First or not. What is most important is that the policy focus in the area of homelessness be directed towards assisting chronically homeless individuals obtain the most suitable housing quickly and providing the support that enables them to stay housed (Johnson, Parkinson & Parsell 2012, p. 2).

However, several stakeholders noted that Housing First may not be as effective for young people as for other cohorts. For many young people, permanent housing is not their aspiration or appropriate for their stage of life. Those who have not completed formal schooling or acquired vocational skills are at particular risk of long-term homelessness and social exclusion. The 'out-of-home care' cohort of young people who are considered to lack the foundational capabilities for independent living require a transitional model of housing and support, which prioritises their education and employment pathway integrated with building their foundational life skills (for example Education First Youth Foyer: see Horn et al. 2015).

Finally, a common theme arising in discussion was that the current service system in Victoria has evolved to rely heavily on crisis and transitional housing. Johnson, Parkinson and Parsell (2012) have observed that some of the philosophical tenets of the Housing First approach already exist in the service system and as such it does not represent a radical change. However, the problem remains that the system is predicated on the assumption people will be able to exit services into permanent housing in the social or private housing markets. It appears that enhancing the existing system by unblocking the pathways to permanent housing ought to be a key component of any strategy to get greater numbers of people sleeping rough into permanent housing.

Access points

Reforms to the Victorian HSS in 2008 established service access points centralised within regions with the intention of enhancing efficiency in dealing with a large and growing number of people seeking help with their housing problems. These access points were underpinned by a state-wide policy and practice framework to assess need and match people to available resources. The practice framework guides the prioritisation of people who are homeless or at risk of homelessness, such as parents accompanied by children, who are identified as particularly vulnerable.

Several service providers have suggested that people prone to rough sleeping have not fared well under these arrangements. The necessary bureaucracy involved at these access points, and the inability to respond to particular needs within a relationship rather than a relatively brief transaction, were seen to alienate people sleeping rough. The prioritisation approach that ranks needs, risks and vulnerability lacks nuance, and may fail to respond to single adults when considered against the needs of families with children. Significant support was found for the establishment of an assertive outreach capacity, involving a distinctive practice and resourcing model, at key access points.

While people under 25 years form a small minority of the people recorded as sleeping rough in the various data sets, some stakeholders suggested that several regional entry points are not 'youth friendly' and as a consequence the resolution of young people's homelessness is delayed. Others reported on local collaborations between youth-specific services and the intake points that largely overcome such problems. In some cases the intake functions for youth have been split off and placed within a youth-specific service that offers a broad range of services. These diverse approaches suggest that careful consideration needs to be given to the most appropriate response in each regional setting.

Assessment tools and client data collection

Assessment tools

The standard assessment framework across Victorian homelessness services remains the Opening Doors prioritisation matrix, that builds upon a narrative assessment approach. However consultations indicate that a range of ancillary assessment and triage tools have been developed or adopted by agencies in order to identify or prioritise people who are in specific circumstances such as rough sleeping (for example, the VincentCare Streaming Tool, the Vulnerability Index and newer VI_SPDAT). These are variously used to manage demand, identify target cohorts or stream clients to specific service responses.

Most of these tools are based on a combination of risk assessment and personal circumstances with a health focus. As they are initial assessment mechanisms, they do not identify other critical aspects of the individual's prospects for resolving their housing crisis, such as income support, employment, skills or capabilities. In addition, these tools overlap with the existing SHS program's core data collection, which is primarily used for monitoring and reporting performance. The development of these tools has been accompanied by significant investment in software, staff training and analytical capacity.

New research has utilised the Journeys Home project dataset on Centrelink clients at risk of or experiencing homelessness to better understand the likelihood of client contacts either achieving a positive housing outcome or becoming long-term homeless. Their analysis used longitudinal data to predict entries into and exits from homelessness. This research has found that it is important to distinguish between 'private' and 'public' in the information that people in housing crisis hold, with 'private' information more useful for predicting a person's odds of becoming homeless[6].

There are two clear implications from this study for considering more effective assessment processes:

1. Collecting detailed data covering the full range of health and other issues at first contact is not necessary, as it is not a good predictor of future homelessness. This suggests reducing initial intake procedures to a short core set of pertinent information. Screening the individual sleeping rough for eligibility and for the most appropriate housing and support should be separated from the deeper engagement and assessment as part of case management and support.

2. A common screening tool could be applied across those sectors that have been shown to be high-risk pathways into homelessness and rough sleeping. A simple question asking individuals in these risk populations whether they are likely to become homeless on discharge from institutional settings or in the near future seems to have merit as part of a stronger effort to prevent homelessness among these groups—prisoners, patients, out-of-home care youth, etc.

The Opening Doors assessment framework at SHS intake points is not considered an adequate tool for flagging rough sleeping. This limitation reflects in part the multiple purposes of the SHSC data collection, including primarily monitoring and reporting program outputs at an agency or aggregate level. There needs to be a short common data set that supplements the existing SHSC data collection. Its express

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[6] Public information is the sort of intake data that Centrelink collects to determine eligibility for income support and other supports. Private information is the more subjective opinion and other personal details or experiences that people hold and may not disclose in assessment/intake processes for a variety of reasons (O'Flaherty et al. forthcoming)

purpose would be to rapidly identify rough sleeping and assess people sleeping rough on their immediate circumstances and risks of harm to triage clients on the urgency and level of support required.

The Nous Group (2017) report on coordination in central Melbourne proposes a three-tier model of client circumstances to determine the most appropriate housing and support response. The three tiers are based on their analysis of recent data on people sleeping rough in the inner city through the Rough Sleeper Initiative, which groups demand using a single criterion of the number of 'discrete issues' disclosed by people sleeping rough. The set of issues covers health, abuse/trauma, alcohol and other drugs (AOD), gambling, relationship breakdown and unemployment. Their assumption is that people with multiple issues are less able to live independently and therefore require long-term, more intensive support. Applying this measure to people sleeping rough in the inner city, they apportion 60% to Tier 1 (0–1 issues); 21% to Tier 2 (2 issues) and 19% to Tier 3 (3 or more issues). In this, they rely on 'public information' – that is, information disclosed by clients on the issues assumed to correlate with rough sleeping.

The VincentCare Streaming Tool has adopted three priority domains: (a) housing/homelessness, (b) current support and complexity of need, and (c) risk of harm and vulnerability—with each domain having three categories of client circumstances. Based on disclosed information, clients are streamed into three levels which are used to inform the level of support provided.

The scan of current assessment tools shows that there is no consistent robust approach across the service system, to allocate the level of housing and support that can confidently expected to resolve rough sleeping and homelessness. Consultations suggest a need for a short, simple assessment tool at first contact (either through assertive outreach, at SHS entry points or 'first to know' services) to identify current or likely rough sleeping, risk of harm (to self or others) and barriers/capabilities for sustaining independent living.

Data collection

The absence of a consistent approach to client data collection and sharing between both homelessness service providers and relevant health, justice and welfare services (including Centrelink) continues to inhibit effective, timely support for vulnerable individuals with complex issues, including many of those who are sleeping rough. This challenge is driven by siloed contracting and funding arrangements that impose separate reporting obligations on providers.

Over time this has led to multiple client management systems—often with different software and varying data dictionaries—that prevent integrated case management and support. Individual agencies and providers have invested considerable resources in developing processes and systems (including staff training) to streamline internal client management and regular performance reporting.

Almost all those sleeping rough have histories of using health, welfare or justice services. The practical way forward to strengthen collaboration and integrated assistance to resolve rough sleeping appears to be the development of a short, high-level, common data set administered by 'first to know' service providers (including outreach workers) that flags rough sleeping and identifies the likelihood of long-term homelessness and risk of harm. This short set of variables (see above) could be added to existing software programs run by SHS service providers at minimal cost.

This data combined with personal identifying information on the person sleeping rough (subject to informed consent) would be used to understand the client's existing use of the relevant programs across justice, health, AOD, Centrelink and employment assistance settings through data matching. This would enable a coordinated assessment or panel review process involving representatives of all relevant services, leading to the individual being triaged to the most appropriate housing and support package.

These issues of assessment and data collection are fundamental stumbling blocks that must be tackled if we are to achieve the case sharing and coordination across services and systems that are so critical to service accountability for client outcomes.

Coordination and collaboration between service providers

Stakeholders discussed their relationships with other service providers and efforts to work in a coordinated manner. The Opening Doors framework remains the key mechanism for service coordination among homelessness providers, through Local Area Service Networks.

While examples exist of collaborative practice, both between homeless and housing specific service providers and with the broader human services systems, they appear to be inconsistent across Victoria. Where they exist they all too often to rely upon goodwill and personal relationships between practitioners rather than on any formal protocols or local agreements.

In central Melbourne, where rough sleeping is receiving priority attention by the Victorian Government, the City of Melbourne and numerous funded service providers, various coordinating mechanisms have recently been put in place. Despite differences in philosophy and practice between the service providers, these mechanisms appear to be making some headway in providing a more effective response. However, there is some evidence that progress is hindered by the lack of a high-level shared view concerning what people sleeping rough can expect. Put simply, people sleeping rough appear to be receiving mixed messages about what they can expect of the service system and what individual services can deliver.

Harnessing voluntary effort

This lack of clear expectations is exacerbated by the numerous informal voluntary efforts from community-minded organisations and individuals. Typically they bring elements of the home to people sleeping rough: food, clothing, bedding, and bathing and laundry services that make the experience of rough sleeping a little easier. In some instances they bring the offer of friendship as a means of engagement that will assist in the objective of getting people off the streets.

However, these informal service responses appear to operate in a way that is largely disconnected from the government-funded services. This compounds the mixed messages that people sleeping rough receive. Without collaboration between voluntary organisations and others with the government funding- to provide access to housing and health and welfare supports, they will be at cross purposes. As a consequence, the very real risk arises that the various voluntary outreach services become part of the problem, inadvertently leading to people being sustained in their rough sleeping and enculturated into a life style that is degrading and dangerous.

As British researchers have observed:

> Perversely, it can often be easier or more preferable for a rough sleeper to access ad-hoc services that help to maintain a life on the street, than to take up an officially-sanctioned offer of support that aims to bring them in off the street (Young Foundation 2011, p. 5)

Informal community responses to rough sleeping, with their offerings of material assistance, accommodation, care and friendship, have much to contribute to the challenge of reducing rough sleeping. They often have capabilities that, if appropriately harnessed, can significantly enhance the effectiveness of the government-funded services. But this depends upon their efforts being integrated with the formal service system to ensure that all contributions are sustainable over the longer term and that all parties are working to the one ultimate objective of getting people off the streets. Currently this is not adequately recognised in policy, practice and funding decisions. It is a challenge for the government-funded and voluntary service providers alike.

Camps

Central Melbourne has seen an increase in the number of people rough sleeping in groups, often referred to as camps. Although camps are not a new phenomenon, in recent times they have sprung up in highly visible locations and have resulted in disruption to pedestrian thoroughfares. The camps have

been accompanied by an increased amount of bedding, camping paraphernalia and personal belongings present on the streets.

Service providers have reported some success in engaging these people and establishing alternative housing arrangements for them.

Launch Housing pointed to the complexities that lay behind the existence of such camps. For some people who are homeless, such camps offer a sense of safety in numbers, as well as a sense of community and solidarity. Due to the concentration of people sleeping rough in one location they tend to be well serviced by the informal voluntary efforts. As discussed earlier, while attempting to meet the material needs of the people in the camp, these voluntary efforts can also have the unintended effect of drawing more people to the camps, including vulnerable people who have accommodation, but are attracted by the services offered and the sense of community. Others are attracted by the obvious availability of alcohol and other drugs. And the history of such camps indicates that they can attract small numbers of people intent on exploiting vulnerable homeless people. The Launch Housing experience suggests that these complexities need to be recognised in any strategy designed to appropriately assist people sleeping rough in camps.

At the time of writing, the City of Melbourne is considering proposed amendments to the *Activities Local Law 2009*, in response to the public hindrance caused by such camps. The amendments include a broader definition of camping in or on any public place, and a new clause prohibiting the leaving of items unattended in a public place, with a fee of $388 for the return of confiscated items. The statutory consultation process around the proposed amendments received 2,556 submissions from the community, with almost 90 per cent opposing the changes.

International evidence suggests that regulatory approaches are difficult to implement, do little to reduce the prevalence of rough sleeping and simply shift its location. A study of the impact of enforcement measures in five locations around England found that they led to geographical displacement and sometimes to the displacement of activity from begging to acquisitive crime. The authors concluded that enforcement is a 'high-risk strategy, only to be used as a last resort, and never with very vulnerable street users such as those with severe mental health problems' (Johnsen & Fitzpatrick 2007).

Housing supply

Most stakeholders identified a dearth of suitable housing options for people sleeping rough as a major problem. Crisis and transitional forms of accommodation were frequently reported as 'blocked' due to the lack of ongoing appropriate and affordable accommodation for people to exit to. This is the case in most of metropolitan Melbourne and in regional cities.

Social housing

All stakeholders raised the need for more social housing and greater diversity in its stock. The Victorian government has recently recognised the need for both an increase in supply of social housing and more innovative approaches to achieving this increase. Various initiatives have been introduced through *Homes for Victorians*, which commits $2.7 billion to social housing and homelessness services, with a primary aim of increasing supply. This includes the $1 billion Social Housing Growth Fund, which will provide a long-term, permanent source of capital for new social and affordable housing through investment returns in perpetuity, and the $1 billion loan guarantee program to attract investors to partner with community housing associations to grow supply. While there are long lead times in the realisation of these investments, they provide some hope that the need for more social housing and greater diversity in stock will be realised in coming years.

Private rental

Despite these social housing initiatives, given the number of people sleeping rough and the long lead times involved in bringing more social housing stock on line, many stakeholders considered private rental to be the best, or perhaps the only, permanent housing option that is likely to have a significant impact on rough sleeping in the short to medium term.

The Victorian Family Violence Royal Commission (FVRC) identified that the private rental market can provide a long-term housing option reasonable quickly, and in the location needed, if the problem of affordability is overcome through rental subsidies and barriers to access are overcome by service providers entering head leasing arrangements, Several service providers spoke positively about their experiences with the Private Rental Access Program (PRAP), a recommendation of the FVRC that is being implemented by the Victorian Government through its Family Violence Housing Blitz. Others reported success in similar private rental market arrangements that were supported by philanthropists, charitable foundations and corporations.

A key question from these discussions concerned how well those people who have been rough sleeping for a prolonged period would be able to sustain a tenancy with a private landlord. Some service providers, conscious of the imperative to maintain their good standing with real-estate agents and owners, and aware of the limited ongoing support that they can offer their client, have taken the pragmatic decision to limit the use of the private rental market to those who are 'private rental ready'. By this they mean people who will be able to sustain a tenancy without significant ongoing support.

Others suggested that the ongoing support can be lessened if the person spends a period in temporary supported accommodation so that they can plan and prepare for their move to the permanent housing. Still others asserted that the issue has more to do with the adequacy of ongoing support to meet individual needs, irrespective of whether the tenancy is with a social housing provider or a private landlord.

What has become clear is that with innovation in thinking, practice and resourcing, use of the private rental market does hold the prospect of making a significant contribution to the provision of long-term housing to people who have been sleeping rough. However, the innovation is taking place in isolation and as a consequence opportunities for sharing practice experience and building a body of knowledge about the issue are being missed. Similarly, it is not yet clear whether the type of monitoring and evaluation required to support a culture of adaptive or 'learn as you go' management is in place to enable timely adjustments to policy and practice.

Housing Establishment Fund

Some $12 million is allocated annually through the Housing Establishment Fund to service providers (HEF) to assist eligible clients to access and/or maintain private rental housing, to access emergency short-term accommodation, or for assistance relating to relocation and establishing housing. Most service providers reported that they use most of their HEF allocation in paying for temporary accommodation such as in motels, rather than contributing to longer-term solutions. The exception was in some country locations where affordable housing was less a problem. Here service providers reported that the majority of the HEF monies available to them are used in helping people into permanent accommodation. However, offsetting the benefits of a more amenable housing market is the reality that such markets tend to exist in locations where the local economy is depressed and unemployment is high.

Suitability of supply

Given that the majority of people rough sleeping are single, several providers pointed to the extremely limited supply of one-bedroom accommodation as a problem in the private and public housing sectors. It was also noted that congregate accommodation and accommodation aggregated into large-scale developments do not suit many people prone to rough sleeping and carry the risk of creating institutional

environments that hinder the development of wellbeing and the capability to participate in the broader community. Some referred to serious problems, such as a lack of safety, encountered in earlier large accommodation centres that were closed or scaled back in the 1990s. While there was strong support for the default accommodation option being 'ordinary houses in ordinary streets', stakeholders also acknowledged that ideally there should be adequate diverse long-term accommodation options to enable individual needs to be met.

Last Resort housing

The concept of last resort housing was raised in consultations with particular reference to a recent report from SGS Economics, commissioned by the University of Melbourne, titled *The case for investing in last resort housing* (Witte 2017). This report argues that last resort housing, defined as 'legal rooming and boarding houses, emergency accommodation and transitional housing', is an economically efficient homelessness intervention. Its analysis was contested in consultations. Some have posited that it reaches misleading conclusions as to the cost effectiveness of last resort housing because it conflates emergency accommodation with transitional housing and rooming houses with boarding houses, each of which have different cost bases and provide very different forms of accommodation and support. They also suggest that it fails to recognise the complexity and heterogeneity of the rough sleeping population.

Perhaps a more fundamental criticism is of the concept itself. Some suggested that the concept of last resort housing is at odds with the aspirations for mainstream social and economic participation held by most people experiencing homelessness and in particular by that half of people sleeping rough who are actively in the labour market. Legitimising it as a viable tenure risks recreating a form of housing that was often residualised, reinforcing social exclusion and poor health.

Rather than last resort housing, it is suggested that the housing needed now is the type that will support people's needs for labour market participation and their aspirations for community integration. This entails greater choice in terms of proximity to transport, education and training opportunities and areas of jobs density. And that housing needs to facilitate an ethos where mainstream economic and social participation is considered the norm.

Pop up housing

Proposals to use temporarily available buildings that might be adapted for accommodating people rough sleeping were also canvassed in discussions. Sometimes referred to as pop up housing, the ideas have ranged from use of vacant office space to the use of hotels and hostels slotted for redevelopment. Some involve the promise of substantial pro-bono contributions to the physical adaptation work required, but government funding is also required to contribute to capital works and to support ongoing operations.

Here, careful consideration needs to be given to the costs and benefits, the challenges that will be encountered in closing the accommodation and relocating people appropriately when the property is no longer available, and the opportunity costs of diverting effort and limited resources from longer-term solutions. A central issue should be the caution offered above about the re-establishment of large-scale crisis accommodation centres and the problems typically encountered in them, as well as the priority need for additional service infrastructure in key suburban and regional locations rather than in central Melbourne.

Support before and after periods of rough sleeping

Early intervention

Opportunities to intervene through other service systems

Most stakeholders supported a stronger focus on early intervention to reduce the spiral from housing crisis and secondary homelessness into rough sleeping. This could include reaching out to those being

discharged from prison, being released from hospital, or leaving out-of-home care. Additionally, there are those who have exited public housing, due to either unplanned exits and abandonments or eviction (though rates of evictions are generally quite low). People with multiple or complex issues who gain priority access to public housing are the most vulnerable to subsequent homelessness.

Early intervention could also include more effective support from first presentation at 'first to know' services other than the specialist homelessness services. The overwhelming majority of those who experience rough sleeping are on income support payments or benefits and thus are in regular contact with Centrelink. Nearly half are in the labour force and hence connected with employment assistance services. This should provide opportunities for better integrated help through Centrelink to ensure that:

- Centrelink has full information on income support recipients experiencing homelessness or rough sleeping
- those rough sleeping are assisted to obtain their income support entitlements without delay
- those rough sleeping who are eligible for employment assistance through jobactive or Disability Employment Services receive appropriate, timely support that is integrated with housing, health and justice services
- the circumstances of people sleeping rough are fully considered in assessing their capacity to actively seek employment and meet their mutual obligation requirements.

Consultations indicated that the past performance of the mainstream employment assistance programs (Job Network, Job Services Australia and Work for the Dole) has been inadequate in achieving job outcomes for highly disadvantaged job seekers. Jobactive is considered less able than its predecessors to offer meaningful assistance to homeless jobseekers, due to funding constraints, higher caseloads, lower frontline staff skills, loss of specialist services, and reliance on telephone or online interactions. A striking feature identified in these discussions was the apparent low level of collaboration between Jobactive providers and specialist homelessness services, despite having clients in common.

A specific opportunity was identified to link young people to health, housing and education support when they are deemed by Centrelink as eligible for Unreasonable to Live at Home Allowance (UTLAH). There appears to be no standard referral or support process for this, which could be a key intervention point for these young people who may be at risk of rough sleeping after leaving their home.

Homeless service providers generally recognised the potential for earlier intervention but reported having limited capacity to engage or support clients at these points.

Locational dimension of early intervention

Several service providers made the point that for early intervention to be effective, it should engage with those experiencing homelessness or newly rough sleeping in the locations where they have community connections and potential supports still available. The research data has shown the drift into inner Melbourne over time. While several providers suggested that reconnection with community should remain a focus of assistance particularly for those newly homeless, they noted that it requires timely intervention through 'first to know' local services in regional centres and middle and outer suburbs. The level of assistance should be sufficient to resolve their homelessness based on rapid assessment of their circumstances and capacity for sustaining independent living.

Maintenance of stable housing

It was generally agreed among stakeholders that sustainable long-term housing outcomes are less likely if the person formerly rough sleeping lacks the health and welfare supports they require and if they don't establish relationships in the community where their housing is located.

Two matters to do with integration into the community arise from these reports.

The first concerns the availability of the professional health and welfare supports to the person being housed. They are entitled to use mainstream professional services such as those offered by a community health service or an employment agency. Consequently, facilitating access to such services and ensuring the person builds relationship with service practitioners should be the objective of homeless service providers and the government agencies that fund them. However, for this to happen, housing needs to be carefully chosen so that it is accessible to such services.

Secondly, it was often reported that isolation, loneliness and a lack of purpose contribute to tenancies breaking down. For some people, their only sense of community derives from a shared experience of homelessness or institutional living. And in a small number of cases, people who have been housed, return by day to the street life they are familiar with, simply because they have not been able to find a way to participate in the life of the new community. This suggests that greater attention needs to be given to creating community around the people who are being housed. This task of 'community building', of building friendships and shared interests with neighbours, should be seen as central to the task of successfully breaking established patterns of rough sleeping and homelessness, not peripheral to it. As in other social programs such as the NDIS, building capability for participation in mainstream community life should be recognised in a distinctive form of practice and in the funding of assistance provided to people who have been rough sleeping. Here, voluntary groups that have strong links into local communities can play a critical role in building community around the previously homeless person.

Key factors affecting prevalence of rough sleeping

This section briefly touches on structural, systems and individual factors causing homelessness. For a new strategy to address rough sleeping to be effective, it is vital to understand the interplay of these factors leading to rough sleeping, whether it be a one-off experience, episodic or long-term (Figure 6). As recent Canadian research has shown, a stronger focus on prevention requires the design of interventions that take into account the complexity of factors that often cut across portfolios, jurisdictions and contracted providers (Gaetz & Dej 2017). The key factors associated with rough sleeping, summarised below, will be considered as levers for change in the development of the Rough Sleeping Strategy.

Figure 6: Socio-ecological model for causes of homelessness and rough sleeping

Adapted from Gaetz & Dej 2017
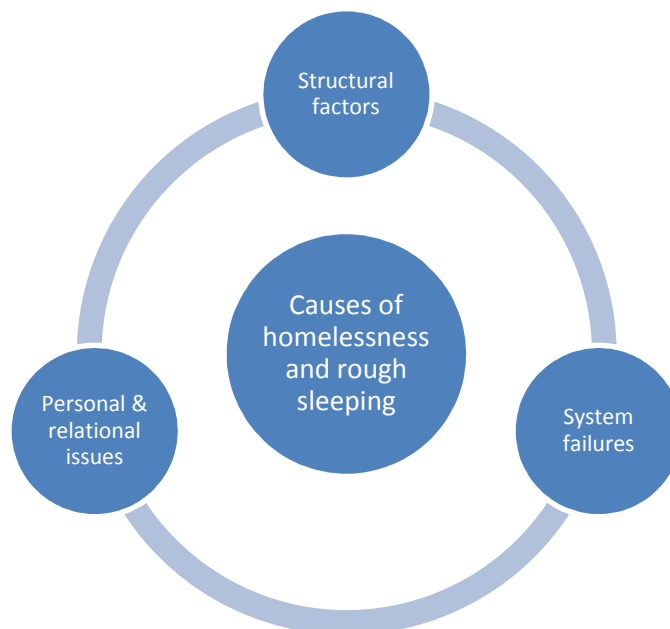
Structural factors

A range of economic and societal issues affect people's access to secure housing. Structural factors may include lack of adequate income, and limited access to affordable and available housing.

Income, labour market participation and the private rental market

The transition underway in the Victorian economy sees a decline in low-skilled, entry-level jobs as growth in employment occurs in knowledge and service sectors. In the growing sectors, employers are placing an emphasis on qualifications, skills and previous experience in these industries. In these circumstances the task of securing work faced by people who have become redundant in declining industries or those who are trying to re-enter the labour market has become particularly difficult. As a consequence, despite having one of Australia's most buoyant economies, Victoria has 202,400 unemployed (April 2017) and a further 294,300 underemployed (February data, ABS 2017). Many of these are at risk in the current housing market.

As noted earlier, the majority of people sleeping rough are reliant solely on Commonwealth government income support, with nearly half of people sleeping rough across Victoria in the labour market and receiving unemployment benefits.

While for most Australians having a reasonably paid job ensures resilience in the housing market, the unemployed and those not in the labour market rely upon Centrelink income support. As a consequence the payment levels are a critical determinant in securing and maintaining housing; and the payment levels, in particular for Newstart and Youth Allowance, are proving to be grossly inadequate. The 2016 December quarter in metropolitan Melbourne saw less than half of one per cent of all lettings in the private rental market affordable for an unemployed person solely reliant on Newstart (DHHS 2017b). The situation was only marginally better for those on a Disability or Age pension (0.5% and 0.6% respectively).

In country Victoria almost 20% of lettings were affordable for an unemployed person (DHHS December 2017b). However, the cheapest country lettings tend to be in areas of high unemployment, where, under Centrelink rules, an unemployed person would be stripped of their entitlement to income support if they relocate there.

It is now a common occurrence that unemployed people who are without the support of family or friends are resorting to rough sleeping simply because of the inadequacy of the Centrelink income available to them. They are having to choose between adequate shelter and food, transport costs and other essential living costs.

In these circumstances their ability to look for work and meet all their obligations under Centrelink rules is seriously impaired by factors beyond their control. The further tightening of Centrelink obligations with indifference to realities faced by the unemployed who have no other supports to fall back on, can be expected to result in increased levels of rough sleeping.

As discussed earlier the assistance that the Australian Government's *Jobactive* providers are obliged to deliver to these jobseekers appears to be largely ineffective. This is despite the providers' access to the Commonwealth's Employment Fund to pay for crisis accommodation and for various rehabilitative services that their unemployed and homeless clients need.

Equally concerning is the apparent lack of collaboration between the *Jobactive* providers and the specialist homeless service providers despite their common clients.

Social housing – availability and sustainability

For people who have been rough sleeping, social housing offers the attraction of a permanent tenancy at an affordable rent. However, it carries two difficulties for them.

Firstly there is simply not enough social housing that is suited to them. There were 33,940 social housing applicants on the Victorian Housing Register as at December 2016. Of these 10,849 were on the priority access list (DHHS 2017c).

Despite policy settings that expedite access by those in highest need, timely housing of priority cohorts such as the chronically homeless is slowed by a lack of stock or lack of suitably sized stock. This can mean that people are sleeping rough or being accommodated in the homelessness service system far longer than is ideal or desirable. This systemic delay has knock-on effects throughout the service system and impacts directly on people's safety and wellbeing.

Secondly, there is little choice in terms of location. People tend to be allocated to wherever vacancies occur, irrespective of their need to maintain or re-establish community connections, and access employment opportunities.

For many people who have been rough sleeping, a social housing tenancy does not guarantee the risk of homelessness is resolved. A hallmark of people with histories of chronic homelessness is that they

remain persistently vulnerable to homelessness, even when securely housed. Tenancy breakdowns and abandonment can result in a return to rough sleeping for people whose living skills, social networks, ill health or poor decision making compromise their ability to sustain independent housing.

A significant number of people in social housing seek assistance from specialist homelessness services when at risk of homelessness (as reported above). Research indicates that tenancy failures are generally heralded by standard indicators such as a lapse in property upkeep, rental arrears or difficulties with neighbours due to disruptive behaviours. Currently, reliance is placed on referrals through support from Social Housing Advocacy and Support Program providers. However a preventative focus would require existing support to respond flexibly and more intensively to changing client circumstances. Resolving chronic homelessness requires creative and flexible integration of strategies for outreach support, tenancy sustainment and eviction prevention, both systematic, and tailored to individual need with a focus on building resilience to future shocks.

Closures of untenured private accommodation

Closures of private rooming houses and caravan parks, and gentrification of the inner city and middle suburbs are contributing to a dwindling supply of marginal housing properties. Over the last three years, Melbourne has lost an estimated 460 single units of this type of accommodation, while another 110 are at risk of imminent closure (Witte 2017).

Affordability and quality considerations aside, housing options such as these do provide shelter to a significant number of marginalised people who might otherwise been sleeping rough. The dynamic of people 'cycling' between low-cost or substandard accommodation and rough sleeping is a truism in the homelessness discourse.

Systemic factors

Poor transitions

Where transitions from and between Victorian service systems directly contribute to the incidence of rough sleeping, it is important to understand these failures, and position tailored interventions at strategic points to prevent them.

Opportunities for interventions occur in court and correctional facilities, state care systems for vulnerable young people, and hospital and mental health settings.

The complex relationship between homelessness and offending is widely acknowledged, and impacts on both incarceration and reoffending. Former prisoners in unstable housing circumstances are more likely than other former prisoners to return to prison, and those who are homeless are significantly more likely to be re-incarcerated.

Research using the Australian Institute of Criminology's Drug Use Monitoring in Australia (DUMA) program shows 7% of police detainees reported living rough, having no fixed address or living in crisis accommodation at the time of their arrest. Nearly one-quarter (22%) had been living rough or in temporary or unstable accommodation for most of the preceding 30 days (Payne, Macgregor & McDonald 2015). In 2015, one in four Australian prisoners were homeless in the four weeks prior to incarceration, including one in 16 who were sleeping rough (AIHW 2015)[7].

The most recent report detailing national prisoner health indicators also found that 43% of prisoners discharged said they were going to be homeless on release (National Prisoner Health Data Collection AIHW 2015). This report also describes the link between homelessness and imprisonment.

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[7] Note that the number of respondents was small. See http://www.aihw.gov.au/prisoner-health/

In 2015–16, 2% of all clients of Victorian specialist homelessness services (2,145 people) had exited from a custodial setting, including prison, youth justice detention centres and immigration detention centres. Nationally, the proportion of clients in this cohort is growing. The majority were men (77%) and aged between 25 and 44 (58%), and they were more likely than other homelessness services clients to require assistance with drug and alcohol counselling (11% compared with 4% of all clients) (AIHW 2017b).

As stated earlier, a considerable proportion of young care leavers experience homelessness within a year of transition. Qualitative research shows that the type of care setting, length of placement and instability (multiple moves) can increase the risk of post-exit homelessness. These experiences are often associated with limited educational achievement and disengagement from training and work. Once these young people are homeless, lack of support, resources and living skills compounded by low or no income and housing discrimination can result in a rapid descent into the vulnerability of rough sleeping. For this group of young people this experience is too frequently the beginning of a lifetime of chronic homelessness Crane et al. 2014). Within the homelessness service system itself, young people may be caught in a nether world between youth services and adult supported accommodation—perceived as too old for the former, too young for the latter. Despite program reforms to strengthen leaving care transitions, critical gaps remain in the provision of support to ensure smooth transitions into independent living (McDowall 2016). This speaks to the need for fluid service criteria that better reflect people's lives and needs, and in particular for longer periods of support during these transitions.

Despite targeted approaches to homelessness prevention at intake and discharge in hospital and mental health settings, people continue to be discharged following treatment without stable housing to which they can return. The report from the City of Melbourne StreetCount in 2013, *Living rough in Melbourne*, found that participants who were rough sleeping had spent 10 per cent of the nights recorded during the study in hospital. People sleeping rough are heavy users of hospital emergency departments as a result of assaults, overdoses or acute mental illness, and perhaps also because they are safe and warm locations. They are likely to be especially prone to cycles of short-term care interspersed with a return to the streets.

Siloed systems

Service systems such as clinical mental health, homelessness and emergency departments all deliver their own specific expertise and models of practice for addressing the needs of complex clients such as frequent service users or those who are sleeping rough. However single issue systems are poorly equipped to properly resolve the complex interplay of multiple issues that perpetuates and entrenches homelessness.

Holistic, multi-disciplinary team approaches are frequently cited as the solution to complex and long-term homelessness. As stakeholder discussions showed (see *Coordination and collaboration between service providers*) where they do exist, it frequently occurs through the determined effort of individual services to construct a bricolage of related services for a shared client group, rather than being the subject of formal protocols, or being formally commissioned across related service sectors.

Overlooked and 'underserved' sub-cohorts

This appraisal suggests that the service system, with its focus on particular forms of vulnerability, prioritises service for families with accompanying children and for young people.

Aboriginal people are over-represented among those experiencing homelessness, including rough sleeping. However, unique cultural and structural factors shape the experience and definition of homelessness for Aboriginal peoples. Rough sleeping as it is understood in conventional terms does not encompass the diverse dynamics at play for Aboriginal peoples who may appear at first glance to be without shelter (Memmott, Long, Chambers & Spring, 2003, DHS, 2013).

This complexity demands highly nuanced policy and service responses that prioritise cultural safety and respect the different ways in which Aboriginal people may use and occupy public places, and the service options offered. The language and practice of assertive outreach may be experienced or construed as a 'move-on' response, if not undertaken with requisite sensitivity and cultural knowledge. Similarly concepts such as service individualisation need to be acutely sensitive to the interplay of self-determination and community when responding to Aboriginal individuals or groups in the context of rough sleeping (Phillips & Parsell, 2012).

The prominence of single adults in the rough sleeping cohort, especially of men aged 25–50, is striking. Women, including those with children, do experience rough sleeping on a single occasion or for a short period, but single adults, particularly men, are overrepresented in the cohort of people sleeping rough long-term. This suggests the gender imbalance among people sleeping rough does not reflect the incidence of housing crisis. Instead, while some groups are successfully assisted to resolve their homelessness within a reasonable timeframe, others are not. This may relate to priority for assistance or to a lack of capacity in the service system. It is evident, however, that single men with multiple and complex issues are less likely to be successfully assisted out of homelessness.

This trend may signal a progressive systemic exclusion of homeless single adults along the prevention and response continuum. It suggests that certain services and systems are repeatedly failing to identify, prioritise or respond to the needs of this sub-cohort (for example the need for affordable single unit housing for those on income support payments).

The hidden nature of women's homelessness is acknowledged as another part of this picture: many women endure exploitation and violence in the name of shelter and survival prior to eventually sleeping rough.

Inadequacy of homeless service responses

As has been discussed throughout this document, there is a prevailing sense that existing homelessness service responses are unable to adequately engage with and support people who are rough sleeping. The services on offer, ranging from system responses such as crisis supported accommodation through to the provision of goods and services by philanthropic and faith-based organisations, result in far from optimal housing outcomes for the majority of people sleeping rough.

Individual factors

Individual factors focus on the personal experiences and circumstances of individuals or households experiencing housing crisis that may result in homelessness and rough sleeping. They may include personal attributes or relational issues. Predicting homelessness with any accuracy is problematic, as not all those facing structural or systemic barriers will become homeless or resort to rough sleeping. However, it is evident that those with one or more personal or relational issues or crises are more vulnerable to rough sleeping and often lack the capabilities or resources (including social capital) to resolve their homelessness.

As discussed earlier, the housing outcomes for those rough sleeping who become clients of SHS services have been poor, with a significant churn rate. Effective and timely resolution of rough sleeping requires assessment of all the relevant circumstances of the individual to inform and agree on an adequate package of housing and support. Too often the mainstream service response has underplayed the importance of building individual capabilities and resources to prevent a return to housing crisis and rough sleeping after support has ended. Rather, often due to resource constraints, it has focused on temporary or short-term assistance.

This points to the need for better integrated packages of housing and support that address the following factors if a higher probability of sustained positive outcomes is to be achieved.

Employability

The profile of those who resort to rough sleeping is characterised by low levels of educational achievement and of recent work experience. Just under half are looking for work (those on Newstart and many of those on Youth Allowance) or are in paid work. This excludes those on Parenting Payments or Disability Support Pension who might, with appropriate employment assistance, be assisted into a job that fits their individual circumstances. For these people, the long-term prospects of sustaining housing in the rental market are enhanced by building their capability to be employed. That requires more effective employment assistance that builds skills and qualifications, with a clear pathway to employers.

Family violence

Family violence is one of the main reasons that women seek assistance from specialist homeless services, and many of these women are accompanied by children. It is also increasingly driving the presentation of single men at crisis accommodation services after their removal from the home following a family violence incident.

Ozanam House crisis supported accommodation reports that around 40% of men presenting for emergency accommodation identify their use of violence in the home as contributing to their homelessness, and similar figures were estimated at other services. The increasing emphasis on removing men who use violence from the home will in turn drive the need for accommodation responses for this group, presenting both a demand pressure and a valuable intervention opportunity.

Ill health and disability

As the research data shows, there is a two-way association between the incidence of ill health, trauma and disability and homelessness. Prolonged rough sleeping is both a cause and consequence of health conditions becoming entrenched, with increased likelihood of violence, trauma, disease and substance abuse, which over time leads to permanent disability and social exclusion. Those who have drifted to inner city locations often accumulate multiple issues including mental disorders (Johnson et al. 2008, Johnson et al. 2011); substance misuse (Johnson & Chamberlain 2008) and acquired brain injury (Keys et al. 2006). Police statistics have shown the association between criminal behaviour, substance abuse and homelessness: police detainees are almost twice as likely to be dependent on or misusing alcohol or other drugs (Australian Institute of Criminology 2008).

This points to the need to get people off the street as quickly as is possible, address their health problems and not to inadvertently sustain them in street life.

Implications for interventions

The implications for service systems reform that can be drawn from the evidence assembled in this situation appraisal appear to be fivefold.

Firstly, they must be more effective at intervening earlier in the downward life spiral that people experience. Opportunities for earlier intervention lie in major service systems such as health, justice, Centrelink, employment services and child protection, as well as within the homeless and housing service systems. They also lie in establishing a greater capacity to intervene in key suburban and regional locations closer to the communities from which people originate (see Figure 7).

Earlier intervention should aim at:

* reducing the inflow by preventing people from sleeping rough in the first place (e.g. improved housing affordability, increased support for groups at risk leaving institutional settings)
* providing immediate assistance to newly homeless people at entry to the SHS system to prevent or resolve their rough sleeping (particularly in locations where they first experience crisis)
* increasing and accelerating the number of people moving out of chronic and intermittent rough sleeping into permanent housing with support
* reducing the incidence of recurring homelessness by people who have experienced rough sleeping.
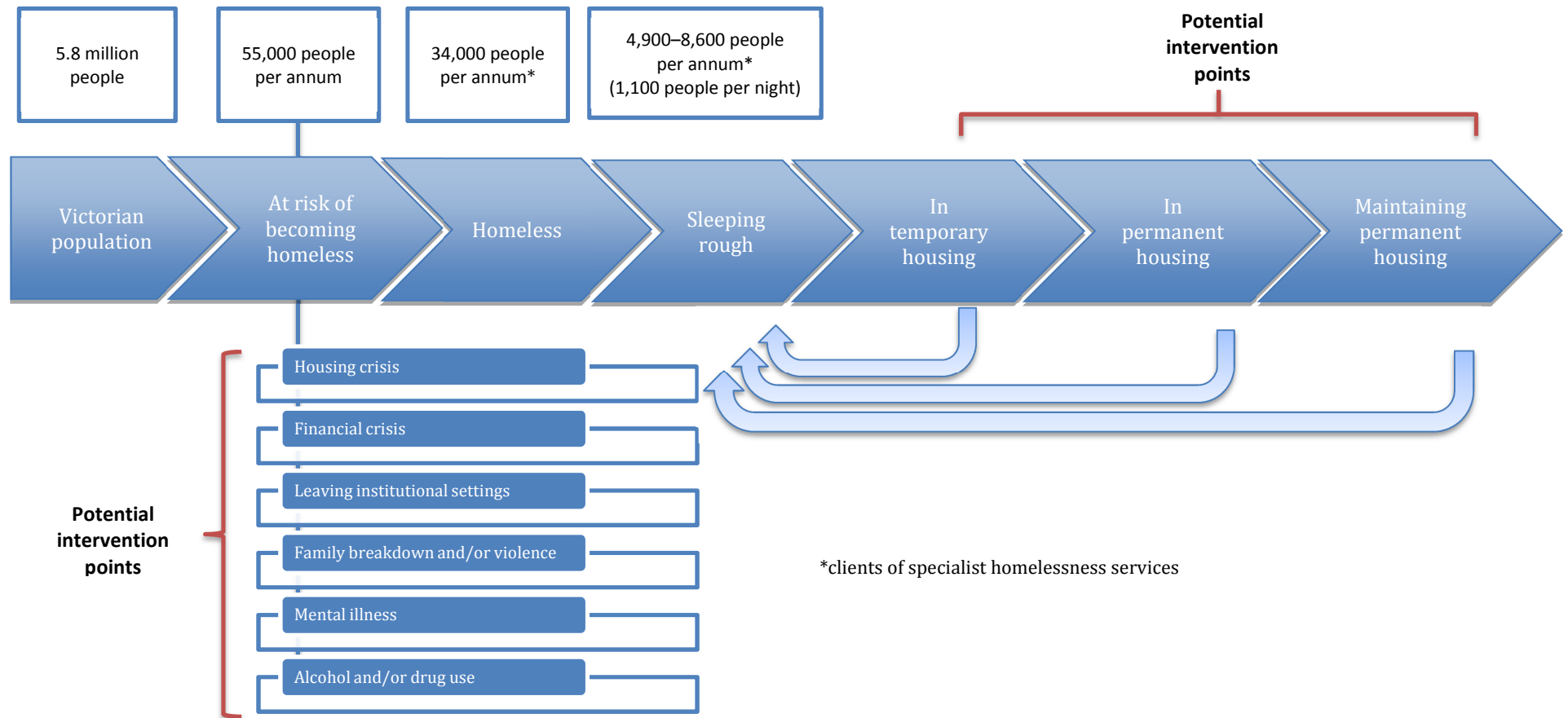
Secondly, to be effective in addressing rough sleeping, services must recognise the interdependence between the various elements of assistance that people need. This requires a level of collaboration and integration in their practice that goes beyond goodwill between practitioners and is reflected in service system governance.

Thirdly, to assist people become resilient to housing loss, models of practice need to give a greater emphasis to building the capability and creating the opportunity for people to participate in the mainstream social and economic life of the community.

Fourthly, housing and homeless services to people sleeping rough in the suburbs and in country Victoria require a form of practice and a form of resourcing that is distinctive from and additional to current intake and assessment arrangements.

And finally, the goodwill of the community expressed through numerous programs of voluntary assistance needs to be recognised within service systems, and harnessed to add value to and extend the capacity of government-funded services.

Figure 7 Potential intervention points to reduce flows in and out of rough sleeping

| 5.8 million people | 55,000 people per annum | 34,000 people per annum* | 4,900–8,600 people per annum* (1,100 people per night) |

Potential intervention points

Victorian population → At risk of becoming homeless → Homeless → Sleeping rough → In temporary housing → In permanent housing → Maintaining permanent housing

Potential intervention points

- Housing crisis
- Financial crisis
- Leaving institutional settings
- Family breakdown and/or violence
- Mental illness
- Alcohol and/or drug use

*clients of specialist homelessness services

Guiding principles

The data analysis, stakeholder discussions and research undertaken to complete this situation appraisal have led to a set of principles that are proposed to guide the development of a Rough Sleeping Strategy. These are categorised as general principles, housing principles and service response principles.

General principles

- Reduction of rough sleeping is a shared responsibility across all levels of government, service sectors and the broader community.

- The most appropriate response for a person sleeping rough should be determined with the individual, taking into account their expressed needs and reasonable aspirations.

- There is an overarching obligation to maximise the safety of people rough sleeping from risk of harm to themselves and to others.

- The provision of shelter alone is insufficient: effective responses will include help with health and welfare matters, employment support and the establishment of mainstream community ties.

- To prevent those at risk of homelessness from having to sleep rough, earlier intervention is required within certain service systems and in locations closer to the person's community of origin.

- Assertive outreach strategies are essential to engage people sleeping rough, and they need to be complemented by responsive assessment and intake at homelessness service entry points.

- Effective rapid assessment of people sleeping rough at first contact should inform triaging for immediate housing and support to reduce the risks of harm, trauma and extended homelessness.

- Research and evidence should underpin efforts to reduce rough sleeping. Action research is required to support an adaptive approach to management, inform further policy development, and enable experience and best practice to be shared.

Housing principles

- Housing provision should be planned to facilitate mainstream social and economic participation.

- Flexible forms of housing (short-term, transitional and permanent tenure) are required to meet the individual circumstances and needs of people sleeping rough, while making best use of existing housing and support infrastructure.

- Permanent housing options are ideally dispersed properties integrated with the broader community—'ordinary houses in ordinary streets'. It is preferable to offer housing that is not institutional in design or scale.

- The greatest potential in the short to medium term for securing housing for people sleeping rough is through the private rental market, requiring a combination of rental subsidies and forms of head leasing or co-leasing.

Service response principles

- Service provision must respond to the diversity of rough sleeping with offers that match the needs and reasonable aspirations of individuals and that encourage and assist the building of capability for participation in mainstream community life.

- Offers of support should take into account the potential for reconnection of people to their community of origin.

- Assertive outreach practice should be guided by duty of care principles that recognise the inherent dangers involved in rough sleeping. Consequently there is a need for persistence in engagement, balanced with a genuine offer of housing and support matching individual circumstances.

- Individual support packages, flexible in terms of intensity and duration, have a critical role to play in sustaining housing and building resilience to housing crisis.

- Integration in the design of support models needs to extend beyond the housing and homelessness service sector: it is required across the health, human services, corrections, education and employment sectors, as well as across the public and privately funded providers.

- Service responses to rough sleeping will be more effective if they are integrated, irrespective of whether they are delivered by multiple agencies. This requires consistent messages and practice through the outreach, engagement and support stages.

- A high-level, shared practice framework will assist integration of service responses, as well as create opportunities to form communities of practice.

- Communication of a consistent and clear message to people sleeping rough and to the broader community regarding the service response should be a key element of a new strategy.

Next steps

This Rough Sleeping Situation Appraisal is the culmination of extensive data analysis, discussions with stakeholders and review of literature and international practice. It is intended to document the current situation in Victoria with regard to rough sleeping and propose some guiding principles to inform the development of the long-term Rough Sleeping Strategy.

The strategy will be developed over the next three months, with an anticipated completion date of October 2017. It is envisaged that the strategy will make recommendations to government regarding evidence-based, targeted points of intervention to prevent high-risk cohorts from falling into rough sleeping, engage with those who are sleeping rough, and support the maintenance of housing once it is achieved.

Comments on this situation appraisal are invited at roughsleepingstrategy@dhhs.vic.gov.au.

Appendix

The project team would like to thank the following stakeholders who have contributed to the development of this Situation Appraisal:

300 Blankets

Australian Community Foundation

Barwon Child, Youth and Family (Geelong)

Besen Family Foundation

Brotherhood of St Laurence Coolibah members

Community Housing Ltd (Morwell)

Council to Homeless Persons

Gandel Philanthropy

George Hicks Foundation

Guy Johnson, Professor of Urban Housing and Homelessness, RMIT

Haven; Home, Safe

Incognitus

Launch Housing

Lord Mayor's Charitable Foundation

Melbourne City Mission

Melbourne Health

Myer Family Company

Mornington Peninsula Foundation

Nous Group

OneVoice

Orange Sky Laundry

Philanthropy Australia

Portland House Foundation

Reichstein

Robert Pradolin, Property Council of Victoria

Royal District Nursing Service

St Kilda Community Housing

SalvoCare Eastern, Peninsula

SalvoConnect, Geelong

Samaritan House, Geelong

Society of St Vincent de Paul (Vic)

The RE Ross Trust

The Salvation Army Crisis Services Network, St Kilda

The Salvation Army Flagstaff Crisis Accommodation

The Salvation Army Melbourne Project 614

UnitingCare Ballarat

Unison Housing

VincentCare

Youth Projects

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