report

Support requirements and accommodation options for people in the ACT with high and complex service needs

Final report

PREPARED FOR THE AUSTRALIAN CAPITAL TERRITORY GOVERNMENT, COMMUNITY SERVICES DIRECTORATE

THE UNIVERSITY OF QUEENSLAND
AUSTRALIA

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Acknowledgements	We thank the ACT Government for the opportunity to carry out this important research, and Housing ACT for its guidance and support. We also wish to acknowledge the contribution of the stakeholders from the ACT public and community sectors, as well as the people with lived experiences of homelessness or the risk of homelessness, for contributing their time and insights to the study—their input was invaluable.
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Date prepared	August 2018
ISSR Project number	ISSR121932

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
ACGA	Australian Common Ground Alliance
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
CURF	client confidentialised unit record file
DSS	Department of Social Services
HCSNs	high and complex service needs
NDIS	National Disability Insurance Scheme
NGO	non-government organisation
PSH	permanent supportive housing
SHS	specialist homelessness service
SLK	statistical linkage key
VI-SPDAT	Vulnerability Index—Service Prioritization Decision Assistance Tool

EXECUTIVE SUMMARY

This report presents findings from a study into support requirements and accommodation options for people in the ACT with high and complex service needs (HCSNs). Using a mix of qualitative and quantitative methods, the study:

- compares the cohort of people with HCSNs to the broader population of people who present to homelessness services
- identifies the homeless cohort's need, met demand and unmet demand for services
- describes the experience of accessing services and accommodation in the ACT and how the existing service system responds to the needs of people seeking homelessness assistance
- evaluates support and housing models that effectively meet the needs of the homeless cohort.

Drawing on administrative data from specialist homelessness service (SHS) providers in the ACT for the six-year period from 2011–12 to 2016–17, we identified people as having HCSNs if they identified any one of the following as their main reason for seeking assistance:

- mental health issues
- medical issues
- drug/substance use
- alcohol use
- transition from custodial arrangements
- transition from foster care / child safety placement
- transition from other care.

Findings

We found that, on average annually, almost two-thirds (63%) of people were homeless when they presented to an SHS, and 38% were at risk of homelessness. Around 383 people (10% of clients) who sought assistance had HCSNs. Of these, around 200 (8.3% of the total number of people who were homeless) had HCSNs, and around 183 (12.6% of the total number of people who were at risk of homelessness) had HCSNs.

Compared to all clients, the study found that those with HCSNs were more likely to:

- be male
- be single and unemployed and have no dependent children
- be provided with short-term rather than long-term housing options (that is, they had a high unmet need for long-term accommodation)
- have their non-accommodation needs (including assistance with mental health, drug and alcohol, domestic violence, legal/financial services, immigration/cultural services, family services and general services) met, rather than their accommodation needs.

The research also found that:

- Indigenous people were far more likely to have HCSNs than non-Aboriginal people and Torres Strait Islanders.
- Over the six-year period, the percentage of females with high and complex service needs increased.

- Consistent with the trend for the ACT, there was a decline over time in the proportion of those with HCSNs who were homeless when they first presented.

Accommodation and support services in the ACT

The research also identified gaps in existing homelessness accommodation and support services, in particular for:

- couples
- pet owners
- women and families not escaping domestic violence
- single fathers
- people with a criminal history
- people who are Indigenous
- people with a mental illness
- people with disability.

There are a number of systemic challenges in the ACT housing and homelessness service system:

- There is a lack of affordable and accessible housing options in the ACT, resulting in people with HCSNs being unable to exit crisis accommodation, meaning that some live in shared accommodation for the homeless for several years.
- In shared homeless accommodation, people reported constrained capacities to control their day-to-day lives and to improve the conditions of their lives (for example, shared homeless accommodation was experienced as a barrier to recovering from addiction or participating in paid employment).
- People who were homeless frequently praised SHS providers; however, they saw the service providers as largely unable to help them to access housing quickly.
- Most accommodation and support services in the ACT have adopted an explicitly conditional approach, which can create an additional barrier to engaging with services and exiting homelessness.
- There is evidence to indicate that the social housing allocation system places a disproportionate burden on people with HCSNs to demonstrate their housing readiness.

Models of supportive housing for people with high and complex service needs

The study found that the best outcomes for those with HCSNs come when permanent supportive housing meets the following criteria:

- It is owned or rented through a formal lease held in a tenant's name.
- There is a legal and functional separation between the landlord and the support provider.
- The housing is integrated into the community/neighbourhood.
- It is affordable.
- There is access to voluntary services.
- The housing is not contingent on behaviours (other than standard tenancy obligations).
- The resident has choice in housing and services.
- Services are community based, with no live-in staff.

1 INTRODUCTION

This report has been prepared for the Australian Capital Territory (ACT) Government and presents analyses and findings from the study titled 'Support requirements and accommodation options for people in the ACT with high and complex needs' (the Cohort Study).

The aim of the Cohort Study is to 'contribute to the development of a conceptual framework which can guide future asset and service planning and delivery for homeless and at-risk people in the ACT community with particular attention to people with high and complex needs'. The study is intended to:

1. provide an overview and profile of the greater 'at-risk' and homeless population in the ACT, including different groups within that population
2. identify the specialist care, support and accommodation requirements of at-risk and homeless people within that population, based on their identified risks and needs and with particular attention to the needs of people who may require tailored and sustained support
3. evaluate support and accommodation models and program initiatives in terms of their suitability and success in addressing those requirements
4. review and assess a range of assessment tools for conceptualising need and appropriate responses and for understanding the status and needs of individuals who require support, and make recommendations regarding the suitability of those tools for the ACT context.

The study scope includes:

1. an analysis of currently available qualitative and quantitative data on the at-risk and homeless population in the ACT (including people currently supported in long-term accommodation who have experienced homelessness) and the identification of significant issues (such as data linkages) or gaps which may have implications for the effective design and delivery of support and housing responses
2. a profile of the characteristics of the at-risk and homeless population and of the different groups that make up that population, including an analytical framework for cohort segmentation (for example, by age, gender, race, ethnicity, socio-economic status, physical and mental health status, history of substance abuse, or traumatic life experience, including domestic violence or imprisonment, or foster care)
3. an analysis of current and future 'demand', and of 'unmet' demand, for services and accommodation by the at-risk and homeless population, including the impact on demand of the ACT as a regional centre
4. an analysis of the specific support and accommodation needs and requirements of the identified cohort segments, including factors such as the duration of the need for support, and with particular attention to the needs of people with complex needs who may require tailored and sustained support of the sort sometimes called 'permanent supportive housing'
5. a conceptualisation of 'high and complex needs' and the identification or development and evaluation of useful tools (for example, for prioritising assistance based on a vulnerability index) and measures for understanding the status and needs of individuals who require support
6. a general overview of specialist support and accommodation (built environment and tenancy) models such as MyHome, Common Ground and various congregate and other types of supported accommodation arrangements in Australia and overseas, and

an assessment of their suitability and effectiveness in terms of articulated outcomes for particular cohort segments

7. a detailed overview of specialist support services and accommodation options currently available in the ACT and an evaluation of those options in relation to projections of current and future demand, identified gaps in service provision and accommodation options, and success indicators such as housing stability and community integration
8. a conceptual matrix of needs and responses that can guide future accommodation planning and service provision, along with visualisations and infographics of key findings and data analyses to help communicate key messages arising from the study
9. a general overview of other specialist program initiatives and community collaborations, such as 'Registry Week', which may have a role in identifying and responding to the needs of people who are homeless or at risk of homelessness.

The intention of the study is to develop a current picture of the homeless and at-risk population in the ACT, identify a range of models and options for responding to the needs of that population, and contribute to the development of methodologies and a suite of tools to create a real-time evidence base to underpin tailored responses to the needs of people on the ground.

1.1 HOMELESSNESS IN THE ACT

Every five years, the Australian Bureau of Statistics (ABS) undertakes a national census of the population. The ABS then derives point-in-time estimates of the prevalence of homelessness, which are important in understanding the overall scale of homelessness and who is homeless in the ACT.[1]

In contrast to overall homelessness in Australia (which increased from 102,439 homeless people in 2011 to 116,427 in 2016). Census estimates for homelessness in the ACT point to a decrease of 8.2% in the homeless population—from 1,738 people in 2011 to 1,596 in 2016. In 2016, the homelessness rate was lower in the ACT (40.2 homeless people per 10,000) than in the Northern Territory, New South Wales, Victoria and Queensland. Nationally, the homelessness rate was 49.8 per 10,000.

The Census data also recorded an increase in rough sleepers in the ACT from 28 people in 2011 to 54 people in 2016. This increase follows a national trend, although the ACT had the lowest rate of rough sleepers in Australia (1.4 people per 10,000, compared the national rate of 3.5 per 10,000).

The 2016 Census also told us that, of the ACT's homeless population, 60% were male, 6% were Indigenous, and 21% were aged from 25 to 34 years. Ninety-nine people (6.2%) who were homeless had a disability, as measured by their report of a need for assistance with core activities of daily living.

The Census provided evidence of increasing homelessness among older people Australia wide. Nationally, 16% of the total homeless population was aged 55 or older. Of those, the number of older homeless females increased by 29% and of males by 23.5% from 2011. In the ACT, homelessness among people who were 55 or older increased by 35.2% from 2011. Homelessness among older females in the ACT rose by 23.9% and among older males by 42.2%.

[1] The ABS (2012) defines a person as homeless if they do not have suitable accommodation alternatives and their current living arrangement:

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

Importantly, around 50% of those who were homeless (793 people) were in supported accommodation on Census night. Those numbers were down from 62% (1,103 people) in 2011 and were consistent with the decrease over the previous five years in the number of specialist homelessness service (SHS) clients who needed accommodation assistance. The services are funded by the ACT Government through service agreements administered by Housing ACT.

But the Census is not able to tell us much about why people were homeless and their needs for services. To get a better understanding of what services people need, what services they get and the outcomes of support and accommodation provided, client data collected by SHS providers for the six years through to 2016–17 was analysed for this study.

1.2 CONCEPTUALISING HIGH AND COMPLEX SERVICE NEEDS

This study is about people experiencing or at risk of homelessness *with high and complex service needs*. The phrase 'high and complex needs' is used to denote complexity in the lives, service needs, or both, of particular groups of marginalised people. Other terms used by researchers in this field include 'multiple and complex needs', 'multiple disadvantage', 'multiple exclusion homelessness' and 'high support needs').[2] This diversity in terminology reflects an ambiguity in the academic and policy literature about what is meant by a term such as 'high and complex needs'. Many authors take its meaning for granted and thus fail to provide a clear and consistent definition. Moreover, it is used in a range of academic disciplines and service/policy areas that all bring to bear different orientations and perspectives.

While there is no consistent definition of the term, there have been attempts to document its most common uses and their consistent or contrasting features (Johnson 2013a, 2013b; Rosengard et al. 2007). Rosengard et al. (2007) note that most uses of terms such as 'high and complex needs' imply a simultaneous 'breadth' and 'depth' of need. By breadth, they mean that a person is experiencing multiple needs simultaneously and that those needs are interconnected in some way. The interconnection between needs is particularly important because, as Johnson (2013a:128) points out, it is not merely the co-occurrence of different types of needs that is important but also that there is 'something in the interlocking nature of these needs that made them particularly hard to address'. Depth of need, on the other hand, refers to the seriousness, intensity or long duration of the particular needs in question—a seriousness that is often amplified by the interconnected nature or 'breadth' of a person's needs.

This raises the question of how depth and breadth of need are operationalised in this study. Given the focus of the study on homelessness, our definition of high and complex service needs applies for any person who is currently homeless and experiencing one or more needs additional to their need for housing (for example, mental illness or substance abuse), and where a person's housing and other needs exacerbate one another (AIHW 2010).

High and complex needs are not merely a characteristic of homeless people but also a reflection of structural and institutional factors (Rosengard et al. 2007). While the term implies a focus on individuals and their problems, it originally emerged in response to concerns about the narrow and delineated (or 'siloed') focus of service systems (that is, health services focused only on medical needs, social work focused only on psychosocial needs, and so on) and the subsequent failure of such service systems to assist people whose needs defy easy categorisation (AIHW 2010, Johnson 2013a).

The term 'high and complex needs' therefore tends to be used as a framework for providing support rather than as a description of an individual's characteristics and has been tied to personalisation and integration of services (Johnson 2013a, Rosengard et al. 2007). To make this explicit, we use the phrase 'high and complex *service* needs' (HCSNs) in this report.

[2] See, for example, Rosengard et al. (2007), Fitzpatrick et al. (2011).

1.3 METHODOLOGY

The research drawn upon in this report used a mixed-methods design to generate and analyse data within the scope of study. This recognises that the provision of support to, and access to support by, people who are homeless or at risk of homelessness is a complex and multifaceted phenomenon that cannot be completely understood through a single perspective or research approach. In this section, we describe how we deployed different methods to capture different aspects of this complex problem, as well as how we integrated them to produce a coherent set of findings.

Given the relatively short time frame in which the primary data collection and the analysis of administrative data were conducted, we employed a 'concurrent' mixed-methods research design (Cresswell 2003). Statistical analysis of quantitative data was conducted alongside in-depth qualitative field work on the characteristics, cohorts, support requirements and accommodation options for people in the ACT with HCSNs.

1.3.1 Quantitative component

The quantitative component of the study entailed the statistical analysis of SHS data (client confidentialised unit record files, or CURFs) for the financial years 2011–12 to 2016–17. This data is collected by agencies specialising in the delivery of SHSs to specific target groups (such as young people or people experiencing domestic violence), as well from agencies that provide more generic services to people facing housing crises (AIHW 2018a).

SHS data has been collected since 1 July 2011. In 2016–17, there were 42 SHSs in the ACT delivering services to 4,585 clients. They varied in size, but most of them (57%) assisted fewer than 100 clients a year (AIHW 2018a).

The SHS data contains information on client characteristics (for example, demographics, housing status, employment and homelessness history), services provided by the agency (such as client needs, services provided, service referrals and unmet needs), as well as client outcomes (for example, housing status) at the end of the support period. The data is based on the periods of support provided to the clients.

We obtained data on six client CURFs, which were appended to form a rectangular dataset containing information for more than 20,000 clients, including their personal characteristics, reasons for seeking assistance, needs identified by the service provider, and indicators of whether or not those needs had been met at the conclusion of the support period.

The 20,000 clients included in the dataset are not necessarily 20,000 unique individuals. Each financial year, clients requesting or receiving support from SHS agencies are assigned new unique identifiers. It was therefore not possible, with the data that was available within the time frame and resource constraints of this study, to ascertain how many of the 20,000 records included the same people but with new unique identifiers.

This quantitative analysis focuses on adult clients (18 years of age and over) and young people aged 15–17 years who presented alone.

More information on the availability of data for the ACT and the choice of the SHS CURF data for analysis is in Appendix 1.

1.3.2 Conceptualising and identifying cohorts

For the purpose of this study, we identified four cohorts:

1. homeless without HCSNs
2. at risk of homelessness without HCSNs
3. homeless with HCSNs
4. at risk of homelessness with HCSNs.

The arrangement of the four cohorts is shown in Figure 1.

Figure 1: Cohort segmentation

The working definition for each cohort is as follows:

1. A person is identified as being *homeless* if they are reported as being homeless at the beginning of a support period or during any month of the support period during the reporting period ('homelessness ever reported').
2. Consistent with the definition outlined in the SHS data collection manual (AIHW 2017), in our analysis a person is identified as being *at risk of homelessness* if they seek assistance from an SHS agency and they are not homeless (AIHW 2017:11).
3. A person is identified as being *homeless with HCSNs* if they are identified as homeless based on the first working definition for *homeless* and their main reason for seeking assistance is stated to be any of:
    a. mental health issues
    b. medical issues
    c. drug/substance use
    d. alcohol use
    e. transition from custodial arrangements
    f. transition from foster care / child safety placement
    g. transition from other care.
4. A person is identified as being *at risk of homelessness with HCSNs* if they are identified as being at risk of homelessness based on the second working definition and their main reason for seeking assistance is stated to be any of:
    a. mental health issues
    b. medical issues
    c. drug/substance use
    d. alcohol use
    e. transition from custodial arrangements
    f. transition from foster care / child safety placement
    g. transition from other care.

The cohorts of people with HCSNs are drawn from those people identified as being homeless and those people identified as being at risk of homelessness. The working definition of HCSNs used in this study is adapted from Fitzpatrick et al.'s (2011:502–503) definition of 'multiple exclusion homelessness':

> People have experienced [multiple exclusion homelessness] if they have been 'homeless' (including experience of temporary/unsuitable accommodation as well as sleeping rough) and have also experienced one or more of the following additional domains of deep social exclusion—'institutional care' (prison, local authority care, psychiatric hospitals or wards); 'substance misuse' (drug problems, alcohol problems, abuse of solvents, glue or gas); or participation in 'street culture activities' (begging, street drinking, 'survival' shoplifting or sex work).

Disability is not consistently reported in the SHS dataset, so disability is not included in our definition of HCSNs.[3] Extending Fitzpatrick et al. (2011), however, we have added medical issues to our definition, as they are a key risk factor for homelessness (Henwood et al. 2013). The data does not permit us to address street culture activities, so this is not included in our definition for the purposes of analysing the SHS CURF data.

1.3.3 Limitations of the SHS dataset

While the SHS dataset is the most appropriate data source for addressing the aims of the Cohort Study, it has important limitations for the identification of cohorts of people who are homeless or risk of homelessness in the ACT, as well as the analysis of their future needs for accommodation and services. The SHS data is produced when people request or are provided with services, so not all people who are homeless or at risk of homelessness are included. For example, people in health or corrections facilities who have not requested assistance from SHS agencies are not included. Furthermore, even though people ageing out of the out-of-home care system or exiting incarceration are at risk of homelessness (Australian Government 2008), they will be included in the data only if they have requested or received assistance from SHS agencies. Thus, the numbers generated from this dataset may under-represent the entire homeless or at risk population in the ACT.[4]

1.3.4 Qualitative component

The qualitative component of the study entailed semi-structured interviews with a range of stakeholders in the government and non-government sectors, including peak bodies; providers of crisis, community and specialised housing and SHSs; and users of those services who have a lived experience of homelessness or risk of homelessness.

The stakeholder interviews were carried out in April 2018. They included both one-on-one interviews and larger group interviews or 'focus groups' involving from two to eight people. In total, 24 semi-structured interviews were carried out with 54 people representing 27 organisations. The interviews with service representatives provided information about cohort needs that we were not otherwise able to be discern because of the limitations in the administrative quantitative data available to the study.

Interviewees were selected to ensure that a range of perspectives was included in the study and to reflect the diversity of stakeholders engaged with the HCSNs cohorts. The large number of stakeholders included mean that the qualitative data provided a broad picture that sat alongside the quantitative data to achieve triangulation. The sampling strategy meant that the

[3] Nonetheless, insights into the met and unmet demand for services of people with disability can be gained from the data and are discussed in Chapter 3.

[4] We asked stakeholders from the health and corrections sectors about access to administrative data that could supplement the SHS data (such as counts of people living in such institutions who are at risk of homelessness). Such data was either not available or not accessible within the time frame of the study. A more general discussion of data on homelessness is in Appendix 1 (Data audit).

qualitative data is not statistically representative. Further discussion of the recruitment of interview participants and the interview approach is in Appendix 2.

Stakeholder interviewees were selected from each of the following areas of the ACT service system:

- SHSs (including tenancy sustainment services)
- public and community housing
- the public health system (including mental health)
- the justice system
- Indigenous services
- youth services
- women's services (including domestic violence services)
- the alcohol and other drugs sector
- the disability sector
- other community service providers.

To ensure confidentiality for contributors to the study, the organisations and people interviewed are not identified in this report. The names of those quoted have been replaced with pseudonyms, and potentially identifying information, such as the organisation that a participant represents, has been altered or omitted.

In May 2018, we also conducted interviews with people with a lived experience of homelessness or risk of homelessness. Sixteen one-on-one interviews were carried out with people who were receiving or had recently received support from an accommodation and/or support service in the ACT for reasons related to their homelessness or risk of homelessness. As for the stakeholder interviews, the participants were selected to ensure that a diverse range of experiences was reflected in the study. The final sample comprised 11 men and five women. Two interviewees identified themselves as Indigenous.

Participants with lived experiences of homelessness were recruited with the assistance of stakeholder organisations that had participated in interviews. This strategy generated a sufficiently diverse sample of service users for the purposes of the study in a relatively short time. It also meant that interviewees were able to reflect on their experiences in accessing a range of different types of accommodation and support services, including:

- drop-in centres
- crisis accommodation
- transitional accommodation
- long-term shared accommodation for the homeless
- permanent supportive housing
- services provided by community-controlled Indigenous organisations
- women's services (including domestic violence services)
- other SHSs.

Participants also discussed their experiences of engaging with a range of other support providers, including government housing and health providers and drug and alcohol services, although none of the participants was recruited through those agencies.

In total, this report draws on 40 semi-structured interviews with 70 people (16 people with lived experiences of homelessness or risk of homelessness and 54 government and NGO

stakeholders). Further information on the qualitative component, including topics addressed in interviews and how the qualitative data was analysed, is in Appendix 2. Copies of the participant information sheets and consent forms used in the study are in Appendix 3.

2 DESCRIBING THE COHORTS

This chapter profiles the characteristics of the at-risk and homeless population in the ACT based on our analysis of SHS CURF data. It segments the SHS client population into four cohorts, which comprise people who are:

1. homeless without HCSNs (homeless non-HCSNs)
2. at risk of homelessness without HCSNs (at-risk non-HCSNs)
3. homeless with HCSNs (homeless HCSNs)
4. at risk of homelessness with HCSNs (at-risk HCSNs).

Our aim is both to provide a general overview of the ACT homeless and at-risk population and to identify how people with HCSNs differ from that broader population.

The chapter begins by discussing the number of people with HCSNs relative to the broader homeless and at-risk population. It then describes the composition of the four cohorts in terms of key demographic and other characteristics, and how their composition has changed between 2011–12 and 2016–17 (that is, over the study period). Lastly, the chapter examines what is unique about the HCSNs cohorts by comparing them to people who are homeless or at risk on a number of key characteristics.

2.1 HOW MANY PEOPLE HAVE HIGH AND COMPLEX SERVICE NEEDS IN THE ACT?

The number of people who are homeless or at-risk HCSNs in the ACT is small compared to the number of people who are homeless or at-risk non-HCSNs.[5] Table 1 demonstrates that, over the study period, 63%[6] of all SHS clients were identified as being homeless and 38%[7] were identified as being at risk of homelessness. Of those who were homeless or at risk of homelessness, 10%[8] or 383 people (on average each year) were identified as clients with HCSNs.

The 383 clients with HCSNs comprised 200 people who were homeless and 183 people at risk of homelessness. The 200 homeless HCSNs made up 8.3% of the total number of people who were homeless (*n* = 2,418). Similarly, the 183 at-risk HCSNs were 12.6% of the total number of people who were at risk of homelessness (*n* = 1,453).

Table 1 also illustrates changes over the study period in the numbers of homeless or at-risk HCSNs. For example, the number of homeless HCSNs in the ACT decreased from 216 in 2011–12 to 186 in 2016–17. The decrease was small but occurred in a consistent downward trend over the six years. During the same period, there was an increase in the number of at-risk HCSNs in the ACT. In 2011–12, there were 140 at-risk HCSNs, whereas there were 246 in 2016–17.

[5] Data in the tables in this report is adjusted for non-response using the weighting strategy outlined in AIHW (2017). Data in the text is usually rounded to the nearest whole number.

[6] 5.2% (homeless HCSNs) + 57.3% (homeless non-HCSNs) = 62.5%.

[7] 4.7% (at-risk HCSNs) + 32.8% (at-risk non-HCSNs) = 37.5%.

[8] 5.2% (homeless HCSNs) + 4.7% (at-risk HCSNs) = 9.9%.

Table 1: Number of people in each cohort in the ACT over the study period, adjusted for non-response

		11–12	12–13	13–14	14–15	15–16	16–17	Avg.	Avg. (%)	Avg. (as % of all clients)
Homeless	HCSN	216	192	209	213	183	186	200	8.3%	5.2%
	Non-HCSN	2,275	2,527	2,357	2,178	2,115	1,856	2,218	91.7%	57.3%
	Total	**2,491**	**2,719**	**2,566**	**2,391**	**2,298**	**2,042**	**2,418**	**100%**	
At risk	HCSN	140	136	202	189	185	246	183	12.6%	4.7%
	Non-HCSN	1,271	1,369	1,371	1,333	1,131	1,149	1,270	87.4%	32.8%
	Total	**1,411**	**1,505**	**1,573**	**1,522**	**1,316**	**1,395**	**1,453**	**100%**	
Total		***3,902***	***4,224***	***4,139***	***3,913***	***3,614***	***3,437***	***383***		

Source: SHS CURF data.

In addition to changes over the study period in the numbers of people with HCSNs, Table 1 demonstrates changes in the overall population of people who were homeless or at risk of homelessness in the ACT. For instance, the total number of people who were homeless or at risk of homelessness—as measured through SHS data—decreased over the period from 3,902 in 2011–12 to 3,437 in 2016–17. The 3,902 clients in 2011–12 included 2,491 homeless clients and 1,411 clients at risk of homelessness; the 3,437 clients in 2016–17 included 2,042 homeless clients and 1,395 clients at risk of homelessness. This overall decrease is consistent with the decrease in the homeless population recorded in the 2016 Census data (ABS 2018).

These figures do not include people living in government facilities—such the Alexander Maconochie Centre (a prison)—who are at risk of homelessness upon release, as that data was not available to the study. Therefore, the numbers of homeless and at-risk HCSNs presented here should be taken with some caution, as they are likely to underestimate the size of those cohorts.

2.2 THE COMPOSITION OF THE FOUR COHORTS

In this section, we describe the composition of each cohort in terms of key demographic and other characteristics, including gender, age, employment status, Indigenous status, country of origin and living/family arrangements, among other things. We also describe key changes in the composition of each cohort over the study period.

Given the relatively small numbers of people identified with HCSNs (on average, 200 clients in the homeless HCSN cohort and 183 clients in the at-risk HCSN cohort), the data for each cohort was not disaggregated into sub-cohorts, as the results from doing so would be very sensitive to random changes and would therefore not be reliable.

2.2.1 Homeless people with high and complex service needs

Table 2 shows characteristics of the *homeless HCSNs* cohort. On average, homeless HCSNs (Column 7) were more likely to be:

- male (65.2% or 131 people)
- Australian-born (78.0% or 156 people)
- aged between 25 and 44 years (51.8% or 103 people)
- unemployed or not in the labour force (87.5% or 175 people)
- not enrolled in educational institutions (90.0% or 180 people)
- living alone (71.1% or 142 people)
- receiving government income (67.5% or 135 people).

Table 2: Profile of the characteristics of people in the homeless HCSN cohort

		(1) 11–12 *n* = 216	(2) 12–13 *n* = 192	(3) 13–14 *n* = 209	(4) 14–15 *n* = 213	(5) 15–16 *n* = 183	(6) 16–17 *n* = 186	(7) Annual average *n* = 200
Sex	Male	69.3%	59.0%	72.9%	66.7%	68.6%	54.8%	65.2%
	Female	30.7%	41.0%	27.1%	33.3%	31.4%	45.2%	34.8%
Country of birth	Australian-born	77.4%	76.2%	81.8%	80.8%	75.9%	75.7%	78.0%
	Overseas-born	22.6%	23.8%	18.2%	19.2%	24.1%	24.3%	22.0%
Indigenous status	Indigenous	14.2%	16.6%	13.9%	16.0%	14.6%	20.8%	16.0%
	Non-Indigenous	85.8%	83.4%	86.1%	84.0%	85.4%	79.2%	84.0%
Age	Under 18	12.6%	3.2%	3.9%	4.8%	6.0%	3.5%	5.6%
	18 – 19	10.8%	13.0%	7.7%	9.7%	6.3%	7.6%	9.2%
	20 – 24	17.6%	16.7%	14.5%	10.2%	12.7%	13.4%	14.2%
	25 – 29	10.6%	16.8%	12.0%	12.7%	8.6%	15.3%	12.7%
	30 – 34	8.5%	18.1%	15.6%	17.1%	17.2%	16.7%	15.5%
	35 – 39	12.3%	9.0%	10.9%	12.1%	16.0%	13.9%	12.4%
	40 – 44	12.6%	8.0%	10.4%	13.0%	9.1%	14.0%	11.2%
	45 – 49	5.3%	3.3%	10.0%	8.3%	10.4%	7.0%	7.4%
	50 – 54	4.9%	4.2%	7.4%	8.3%	4.6%	5.9%	5.9%
	Over 54	4.7%	7.8%	7.7%	3.8%	9.2%	2.7%	6.0%
Labour status[a]	Not in labour force	38.9%	47.3%	31.7%	36.3%	50.1%	33.9%	39.7%
	Unemployed	40.4%	35.4%	53.9%	54.8%	40.9%	61.1%	47.8%
	Employed	8.1%	4.3%	3.4%	5.5%	6.6%	1.6%	4.9%
Education enrolment	Student	14.8%	9.5%	6.3%	14.5%	8.5%	6.4%	10.0%
	Not student	85.2%	90.5%	93.7%	85.5%	91.5%	93.6%	90.0%
Living arrangement[a]	Alone	60.0%	64.2%	75.0%	82.9%	77.1%	67.5%	71.1%
	Single w/children	7.4%	10.1%	5.4%	4.7%	4.9%	2.7%	5.9%
	Couple w/children	2.5%	1.6%	1.1%	0.5%	1.1%	3.5%	1.7%
	Couple wo/children	2.2%	0.5%	2.9%	1.4%	0.5%	2.2%	1.6%
	Family group	5.6%	5.6%	4.5%	4.4%	4.3%	8.0%	5.4%
	Other group	16.2%	13.2%	5.9%	5.1%	8.9%	16.1%	10.9%
Income type[a]	Government income	58.7%	51.6%	71.2%	74.4%	74.9%	74.1%	67.5%
	Employee income	5.9%	3.2%	1.9%	1.9%	2.3%	1.6%	2.8%
	Business income	0	0	0.5%	0	0	0	0.1%
	Other income	0	0	0.5%	0.9%	1.1%	1.2%	0.6%

a Due to missing values and 'don't know' answers, the total is not equal to 100%.

Note: Labour status, education enrolment, living arrangement and income type are recorded as 'first reported'. Data is adjusted for non-response.
Source: SHS CURF data.

Over the six-year study period, there was a notable *decrease* in the percentages of younger clients (15–24 years) who were homeless HCSNs (24.5% in 2016–17, compared to 41.0% in

2011–12). However, as shown in columns 1 and 6, there were notable *increases* in the percentages of homeless HCSNs who were:

- female (45.2% in 2016–17, compared to 30.7% in 2011–12)
- Indigenous (20.8% in 2016–17, compared to 14.2% in 2011–12)
- unemployed (61.1% in 2016–17, compared to 40.4% in 2011–12)
- receiving government income (74.1% in 2016–17, compared to 58.7% in 2011–12).

2.2.2 Homeless people without high and complex service needs

Table 3 demonstrates that, on average, *homeless non-HCSNs* (Column 7) were more likely to be:

- female (55.7% or 1,234 people)
- Australian-born (69.3% or 1,539 people)
- aged between 20 and 39 years (56.4% or 1,250 people)
- unemployed or not in the labour force (73.8% or 1,637 people)
- not enrolled in educational institutions (84.1% or 1,865 people)
- living alone (46.8% or 1,038 people)
- receiving government income (64.1% or 1,422 people).

These characteristics remained relatively stable over the study period, with the exception of a notable *decrease* in Australian-born clients (67.8% in 2016–17, compared to 71.4% in 2011–12) and younger clients (15–24 years) (39.2% in 2016–17, compared to 45.4% in 2011–12). However, as shown in columns 1 and 6, there were notable *increases* in clients who were:

- Indigenous (16.2% in 2016–17, compared to 14.4% in 2011–12)
- not in the labour force (34.3% in 2016–17, compared to 26.4% in 2011–12)
- receiving government income (71.2% in 2016–17, compared to 48.9% in 2011–12).

Table 3: Profile of the characteristics of people in the homeless non-HCSN cohort

		(1) 11–12 *n* = 2,275	(2) 12–13 *n* = 2,527	(3) 13–14 *n* = 2,357	(4) 14–15 *n* = 2,178	(5) 15–16 *n* = 2,115	(6) 16–17 *n* = 1,856	(7) Annual average *n* = 2,218
Sex	Male	42.7%	45.8%	45.7%	45.6%	43.8%	41.9%	44.3%
	Female	57.3%	54.2%	54.3%	54.4%	56.2%	58.1%	55.7%
Country of birth	Australian-born	71.4%	70.2%	68.6%	69.0%	68.9%	67.8%	69.3%
	Overseas-born	28.6%	29.8%	31.4%	31.0%	31.1%	32.2%	30.7%
Indigenous status	Indigenous	14.4%	13.8%	14.2%	16.3%	16.6%	16.2%	15.2%
	Non-Indigenous	85.6%	86.2%	85.8%	83.7%	83.4%	83.8%	84.8%
Age	Under 18	12.6%	9.8%	6.2%	6.6%	6.7%	6.5%	8.1%
	18 – 19	12.4%	11.8%	11.0%	9.8%	10.8%	10.1%	11.0%
	20 – 24	20.4%	19.6%	20.8%	21.9%	18.3%	22.6%	20.6%
	25 – 29	14.4%	14.2%	17.4%	14.4%	13.6%	11.8%	14.3%
	30 – 34	10.6%	11.3%	10.3%	10.7%	12.6%	12.7%	11.4%
	35 – 39	8.1%	9.6%	10.6%	11.5%	10.6%	10.4%	10.1%
	40 – 44	7.4%	8.4%	8.1%	9.5%	8.9%	10.6%	8.8%
	45 – 49	5.7%	5.3%	5.5%	5.5%	7.0%	6.3%	5.9%
	50 – 54	2.7%	4.5%	3.3%	3.5%	5.0%	3.4%	3.7%
	Over 54	5.6%	5.5%	6.8%	6.5%	6.6%	5.7%	6.1%
Labour status[a]	Not in labour force	26.4%	30.4%	27.1%	27.7%	35.0%	34.3%	30.1%
	Unemployed	29.9%	36.9%	47.4%	53.2%	48.0%	47.0%	43.7%
	Employed	11.6%	14.1%	13.0%	12.4%	12.3%	15.0%	13.1%
Education enrolment	Student	16.5%	15.5%	13.8%	15.1%	16.9%	17.7%	15.9%
	Not student	83.5%	84.5%	86.2%	84.9%	83.1%	82.3%	84.1%
Living arrangement[a]	Alone	38.8%	48.2%	47.6%	51.6%	49.5%	45.3%	46.8%
	Single w/children	20.2%	20.7%	23.2%	25.0%	23.9%	24.7%	22.9%
	Couple w/children	5.3%	5.9%	7.3%	7.0%	6.9%	7.8%	6.7%
	Couple wo/children	2.9%	4.7%	4.2%	5.1%	5.0%	4.2%	4.4%
	Family group	4.8%	5.2%	5.5%	4.6%	6.3%	6.9%	5.5%
	Other group	5.8%	5.1%	5.7%	5.7%	7.4%	10.4%	6.7%
Income type[a]	Government income	48.9%	58.5%	65.0%	70.6%	70.3%	71.2%	64.1%
	Employee income	8.3%	10.8%	10.0%	8.5%	9.2%	10.0%	9.5%
	Business income	0	0	0.1%	0.2%	0	0	0.0%
	Other income	0.6%	1.1%	0.7%	1.1%	1.0%	1.2%	1.0%

a Due to missing values and 'don't know' answers, the total is not equal to 100%.

Note: Labour status, education enrolment, living arrangement and income type are recorded as 'first reported'. Data is adjusted for non-response.

Source: SHS CURF data.

2.2.3 People at risk of homelessness with high and complex service needs

The results in Table 4 (Column 7) show that, on average, *at-risk HCSNs* were *more likely* to be:

- male (52.7% or 95 people)
- Australian-born (66.6% or 122 people)
- aged between 25 and 44 years (54.5% or 100 people)
- unemployed or not in the labour force (85.7% or 157 people)
- not enrolled in educational institutions (96.9% or 177 people)
- renting (56.3% or 102 people)
- living alone (68.6% or 126 people)
- receiving government income (63.0% or 116 people).

Over the study period, there was a notable *decrease* in the percentages of younger (15–24 years) at-risk HCSNs (17.7% in 2016–17, compared to 24.2% in 2011–12; see columns 1 and 6). In addition, there were notable *increases* in the percentages of at-risk HCSNs who were:

- female (62.2% in 2016–17, compared to 42.7% in 2011–12)
- Australian-born (79.8% in 2016–17, compared to 57.7% in 2011–12)
- Indigenous (22.5% in 2016–17, compared to 11.0% in 2011–12)
- enrolled in educational institutions (3.4% in 2016–17, compared to 1.7% in 2011–12).

Table 4: Profile of the characteristics of people in the at-risk HCSN cohort

		(1) 11–12	(2) 12–13	(3) 13–14	(4) 14–15	(5) 15–16	(6) 16–17	(7) Annual average
		n = 140	*n* = 136	*n* = 202	*n* = 189	*n* = 185	*n* = 246	*n* = 183
Sex	Male	57.3%	53.2%	59.8%	53.1%	55.1%	37.8%	52.7%
	Female	42.7%	46.8%	40.2%	46.9%	44.9%	62.2%	47.3%
Country of birth	Australian-born	57.7%	60.2%	64.2%	66.9%	70.8%	79.8%	66.6%
	Overseas-born	42.3%	39.8%	35.8%	33.1%	29.2%	20.2%	33.4%
Indigenous status	Indigenous	11.0%	12.7%	12.4%	10.6%	15.0%	22.5%	14.0%
	Non-Indigenous	89.0%	87.3%	87.6%	89.4%	85.0%	77.5%	86.0%
Age	Under 18	1.5%	0	1.5%	1.1%	1.9%	2.6%	1.4%
	18 – 19	2.5%	8.2%	5.7%	1.1%	2.2%	2.8%	3.8%
	20 – 24	20.2%	9.2%	6.8%	10.0%	10.7%	12.3%	11.5%
	25 – 29	13.4%	12.0%	16.0%	16.5%	18.7%	18.8%	15.9%
	30 – 34	9.6%	11.2%	12.3%	15.0%	15.5%	13.8%	12.9%
	35 – 39	9.4%	9.6%	9.0%	14.2%	15.2%	15.8%	12.2%
	40 – 44	9.0%	15.1%	16.4%	15.5%	16.4%	8.7%	13.5%
	45 – 49	16.3%	12.9%	12.5%	10.1%	5.1%	9.2%	11.0%
	50 – 54	7.4%	10.9%	7.3%	5.8%	4.0%	8.2%	7.2%
	Over 54	10.7%	10.9%	12.6%	10.7%	10.3%	7.8%	10.5%
Labour status[a]	Not in labour force	40.5%	54.7%	54.2%	48.5%	45.9%	47.8%	48.6%
	Unemployed	36.9%	31.2%	36.2%	38.3%	40.6%	39.7%	37.1%
	Employed	8.4%	7.5%	3.0%	7.2%	7.8%	9.1%	7.2%
Education enrolment	Student	1.7%	1.5%	3.2%	4.9%	4.0%	3.4%	3.1%
	Not student	98.3%	98.5%	96.8%	95.1%	96.0%	96.6%	96.9%
Living arrangement[a]	Alone	60.0%	66.5%	76.8%	71.2%	72.3%	64.7%	68.6%
	Single w/children	8.0%	10.4%	8.8%	9.7%	5.2%	7.5%	8.3%
	Couple w/children	0.8%	6.8%	4.1%	7.1%	3.4%	8.6%	5.1%
	Couple wo/children	7.2%	1.6%	2.5%	0.0%	1.6%	3.3%	2.7%
	Family group	9.9%	0.8%	1.5%	2.8%	0.5%	4.0%	3.2%
	Other group	9.5%	9.5%	3.6%	9.2%	16.4%	9.7%	9.6%
Income type[a]	Government income	58.3%	59.6%	68.1%	70.0%	63.1%	58.7%	63.0%
	Employee income	6.7%	7.5%	1.5%	4.4%	6.6%	6.0%	5.4%
	Business income	0	0	0	0	0	0.4%	0.1%
	Other income	0.8%	2.2%	1.0%	1.7%	0.5%	0.4%	1.1%

a Due to missing values and 'don't know' answers, the total is not equal to 100%.

Note: Labour status, education enrolment, living arrangement and income type are recorded as 'first reported'. Data is adjusted for non-response.

Source: SHS CURF data.

2.2.4 People at risk of homelessness without high and complex service needs

Table 5 (column 7) demonstrates that, on average, *at-risk non-HCSNs* were *more likely* to be:

- female (63.4% or 804 people)
- Australian-born (65.2% or 830 people)
- aged between 20 and 39 years (51.6% or 656 people)
- unemployed or not in the labour force (63.9% or 811 people)
- not enrolled in educational institutions (89.1% or 1,134 people)
- renting (68.4% or 867 people)
- living alone (31.8% or 404 people)
- receiving government income (56.9% or 720 people).

As illustrated in Table 5 (columns 1 and 6), there was a notable *decrease* in the percentages of younger (15–24 years) at-risk non-HCSNs (29.0% in 2016–17 compared to 25.2% in 2011–12). In addition, there were notable increases in the number of people at-risk non-HCSNs who were:

- not in the labour force (35.6% in 2016–17, compared to 29.0% in 2011–12)
- unemployed (37.1% in 2016–17, compared to 21.9% in 2011–12)
- enrolled in educational institutions (14.9% in 2016–17, compared to 5.7% in 2011–12)
- living alone (36.0% in 2016–17, compared to 27.5% in 2011–12)
- receiving government income (64.3% in 2016–17, compared to 45.2% in 2011–12).

Table 5: Profile of the characteristics of people in the at-risk non-HCSN cohort

		(1) 11–12 *n* = 1,271	(2) 12–13 *n* = 1,369	(3) 13–14 *n* = 1,371	(4) 14–15 *n* = 1,333	(5) 15–16 *n* = 1,131	(6) 16–17 *n* = 1,149	(7) Annual average *n* = 1,270
Sex	Male	33.0%	37.8%	38.4%	38.6%	35.1%	36.8%	36.6%
	Female	67.0%	62.2%	61.6%	61.4%	64.9%	63.2%	63.4%
Country of birth	Australian-born	63.8%	67.0%	67.5%	66.4%	64.7%	61.7%	65.2%
	Overseas-born	36.2%	33.0%	32.5%	33.6%	35.3%	38.3%	34.8%
Indigenous status	Indigenous	10.3%	9.3%	10.2%	9.3%	9.8%	9.2%	9.7%
	Non-Indigenous	89.7%	90.7%	89.8%	90.7%	90.2%	90.8%	90.3%
Age	Under 18	2.6%	4.9%	3.9%	2.9%	3.7%	4.3%	3.7%
	18 – 19	6.6%	5.0%	5.3%	6.2%	4.7%	4.4%	5.4%
	20 – 24	16.0%	14.6%	12.5%	12.6%	10.7%	12.1%	13.1%
	25 – 29	12.8%	12.4%	13.1%	12.1%	11.4%	12.3%	12.4%
	30 – 34	14.8%	15.8%	13.9%	14.2%	12.0%	14.1%	14.1%
	35 – 39	11.9%	11.7%	10.8%	11.5%	13.0%	13.1%	12.0%
	40 – 44	11.6%	11.6%	12.9%	12.1%	13.4%	10.3%	12.0%
	45 – 49	9.2%	8.9%	9.9%	10.1%	11.3%	9.7%	9.9%
	50 – 54	5.0%	7.2%	9.1%	8.4%	7.4%	7.7%	7.5%
	Over 54	9.5%	7.9%	8.5%	9.9%	12.4%	12.0%	10.0%
Labour status[a]	Not in labour force	29.0%	27.1%	33.3%	33.2%	36.0%	35.6%	32.4%
	Unemployed	21.9%	29.3%	30.5%	34.4%	35.8%	37.1%	31.5%
	Employed	15.7%	19.7%	19.7%	23.6%	22.9%	23.2%	20.8%
Education enrolment	Student	5.7%	7.8%	10.2%	13.5%	13.2%	14.9%	10.9%
	Not student	94.3%	92.2%	89.8%	86.5%	86.8%	85.1%	89.1%
Living arrangement[a]	Alone	27.5%	28.5%	33.1%	31.4%	34.0%	36.0%	31.8%
	Single w/children	25.5%	26.9%	27.3%	31.3%	31.8%	27.1%	28.3%
	Couple w/children	11.5%	15.6%	14.8%	18.4%	17.8%	15.7%	15.6%
	Couple wo/children	4.9%	3.5%	4.4%	5.9%	4.6%	5.8%	4.8%
	Family group	4.0%	5.4%	5.4%	7.0%	6.3%	9.0%	6.2%
	Other group	1.9%	2.1%	2.1%	3.4%	3.8%	5.0%	3.1%
Income type[a]	Government income	45.2%	50.3%	58.5%	61.4%	61.5%	64.3%	56.9%
	Employee income	10.3%	15.4%	15.1%	19.5%	18.8%	18.7%	16.3%
	Business income	0.4%	0.6%	0.9%	0.5%	0	0	0.4%
	Other income	1.0%	1.3%	0.9%	1.9%	2.0%	1.9%	1.5%

a Due to missing values and 'don't know' answers, the total is not equal to 100%.

Note: Labour status, education enrolment, living arrangement and income type are recorded as 'first reported'. Data is adjusted for non- response.

Source: SHS CURF data.

2.3 WHAT IS UNIQUE ABOUT PEOPLE WITH HIGH AND COMPLEX SERVICE NEEDS?

It is possible to gain a deeper understanding of the HCSNs cohorts by identifying how they differ from the homeless and at-risk population more broadly. We therefore analysed the percentage differences between homeless and at-risk people with and without HCSNs in a range of key demographic and other characteristics. Table 6 shows the results of the analysis; Figure 2 summarises key comparisons.

Compared to homeless non-HCSNs (Table 6, Column 2), homeless HCSNs (Column 1) were *more likely* to be:

- male (65.2%, compared to 43.3%)
- Australian-born (78.0%, compared to 69.3%)
- Indigenous (16.0%, compared to 15.2%)
- aged between 30 and 54 years (52.4%, compared to 39.9%)
- unemployed or not in the labour force (87.5%, compared to 73.8%)
- not enrolled in educational institutions (90.0%, compared to 84.1%)
- living alone (71.1%, compared to 46.8%)
- receiving government income (67.5%, compared to 64.1%).

In addition, younger clients (15–24 years) were less likely to be homeless HCSNs than homeless non-HCSNs (29.0% compared to 39.7%), and older clients (50 years or over) were more likely to be homeless HCSNs than homeless non-HCSNs (11.9% compared to 9.8%).

Similarly, compared to at-risk non-HCSNs (Column 4), at-risk HCSNs (Column 3) were *more likely* to be:

- male (52.7%, compared to 36.6%)
- Australian-born (66.6%, compared to 65.2%)
- Indigenous (14.0%, compared to 9.7%)
- aged between 25 and 29 (15.9%, compared to 12.4%), and between 35 and 49 (36.7%, compared to 33.9%)
- unemployed or not in the labour force (85.7%, compared to 63.9%)
- not enrolled in educational institutions (96.9%, compared to 89.1%)
- living alone (68.6%, compared to 31.8%)
- receiving government income (63.0%, compared to 56.9%).

In addition, younger clients (15–24 years) were less likely to be at-risk HCSNs than to be at-risk non-HCSNs (16.7%, compared to 22.2%), and older clients (50 years or over) were more likely to be at-risk HCSNs than to be at-risk non-HCSNs (17.7%, compared to 17.5%).

Table 6: Profile of the characteristics of people in each cohort (annual averages)

		Homeless (1) HCSN *n* = 200	Homeless (2) Non-HCSN *n* = 2,218	At-risk (3) HCSN *n* = 183	At-risk (4) Non-HCSN *n* = 1,270
Sex	Male	65.2%	44.3%	52.7%	36.6%
	Female	34.8%	55.7%	47.3%	63.4%
Country of birth	Australian-born	78.0%	69.3%	66.6%	65.2%
	Overseas-born	22.0%	30.7%	33.4%	34.8%
Indigenous status	Indigenous	16.0%	15.2%	14.0%	9.7%
	Non-Indigenous	84.0%	84.8%	86.0%	90.3%
Age	Below 18	5.6%	8.1%	1.4%	3.7%
	18 – 19	9.2%	11.0%	3.8%	5.4%
	20 – 24	14.2%	20.6%	11.5%	13.1%
	25 – 29	12.7%	14.3%	15.9%	12.4%
	30 – 34	15.5%	11.4%	12.9%	14.1%
	35 – 39	12.4%	10.1%	12.2%	12.0%
	40 – 44	11.2%	8.8%	13.5%	12.0%
	45 – 49	7.4%	5.9%	11.0%	9.9%
	50 – 54	5.9%	3.7%	7.2%	7.5%
	Over 54	6.0%	6.1%	10.5%	10.0%
Labour status[a]	Not in labour force	39.7%	30.1%	48.6%	32.4%
	Unemployed	47.8%	43.7%	37.1%	31.5%
	Employed	4.9%	13.1%	7.2%	20.8%
Education enrolment	Student	10.0%	15.9%	3.1%	10.9%
	Not student	90.0%	84.1%	96.9%	89.1%
Living arrangement[a]	Alone	71.1%	46.8%	68.6%	31.8%
	Single w/children	5.9%	22.9%	8.3%	28.3%
	Couple w/children	1.7%	6.7%	5.1%	15.6%
	Couple wo/children	1.6%	4.4%	2.7%	4.8%
	Family group	5.4%	5.5%	3.2%	6.2%
	Other group	10.9%	6.7%	9.6%	3.1%
Income type[a]	Government income	67.5%	64.1%	63.0%	56.9%
	Employee income	2.8%	9.5%	5.4%	16.3%
	Business income	0.1%	0.0%	0.1%	0.4%
	Other income	0.6%	1.0%	1.1%	1.5%

a Due to missing values and 'don't know' answers, the total is not equal to 100%.

Note: Labour status, education enrolment, living arrangement and income type are recorded as 'first reported'. Data is adjusted for non-response.

Source: SHS CURF data.

Figure 2: Cohort characteristics, 2011–12 to 2016–17, annual average (%)

Characteristic	Homeless HCSN	Homeless non-HCSN	At-risk HCSN	At-risk non-HCSN
Male 	65%	44%	53%	37%
Female 	35%	56%	47%	63%
Age 	57% aged 15–34 43% aged 35 or over	65% aged 15–34 35% aged 35 or over	46% aged 15–34 54% aged 35 or over	49% aged 15–34 51% aged 35 or over
Indigenous 	16%	15%	14%	10%
Australian-born 	78%	69%	67%	65%
Living alone 	71%	47%	69%	32%
Employed 	5%	13%	7%	21%
Student 	10%	16%	3%	11%

2.4 CONCLUSION

This chapter has presented the numbers, demographics and characteristics of homeless and at-risk HCSNs in the ACT and analysed how those cohorts differ from the homeless and at-risk non-HCSNs cohorts. The data reveals that the cohorts of homeless or at-risk HCSNs in the ACT are small compared to the broader homeless and at-risk population. Specifically, on average annually over the study period, 8.3% of people who experienced homelessness in the ACT had HCSNs. Further, 12.6% of people who were at risk of homelessness in the ACT had HCSNs.

Consistent with the trend identified in the point-in-time estimates of the overall homeless population in the 2016 Census, the total number of people who were homeless or at risk of homelessness decreased over the study period from 3,902 in 2011–12 to 3,437 in 2016–17.

The analysis showed that, compared to the broader homeless and at-risk population, people in the homeless and at-risk HCSNs cohorts were more likely to be single, male, Australian-born, Indigenous, unemployed, not enrolled in educational institutions, living alone, and receiving government income support. The composition of these cohorts is more or less consistent with that of other high-needs groups, such as the 'chronic homeless' and rough-sleeper populations, as described in the Australian and international research literature (Fitzpatrick et al. 2011, Flatau et al. 2018, Parsell et al. 2016).

The analysis also found that between 2011–12 and 2016–17 there were notable *increases* in the percentages of homeless HCSNs who were female, Indigenous, unemployed or receiving government income.

Reflecting national trends, Indigenous people were notably overrepresented in all four cohorts. This is particularly true of the HCSNs cohorts. While Indigenous people make up 1.64% of the ACT population, they make up 16% of homeless HCSNs in the ACT and 14% of at-risk HCSNs. There have also been increases in the proportion of Indigenous people in each cohort, except for at-risk non-HCSNs, over the six years of data analysed in this study.

3 UNDERSTANDING DEMAND AND UNMET DEMAND FOR SERVICES AND ACCOMMODATION IN THE ACT

This chapter examines demand, met demand and unmet demand for accommodation and support services in the ACT in relation to the homeless and at-risk client population of SHSs. It outlines the types and quantities of service need that each of the four cohorts experiences and analyses the extent to which the ACT service system is addressing those needs. The chapter presents an analysis of the overall demand for services, and the extent to which it is met, for the four cohorts, followed by separate analyses for three different groupings of service need: accommodation, health services and social services.

Using the definition used by the Australian Institute of Health and Welfare (AIHW), the demand for services is measured by the presence of identified need. The demand is identified as met when an SHS agency provides the needed service or refers the client to a different agency by the end of the support period. SHS agencies directly provide some services, such as short-term accommodation and tenancy support, or refer clients to other agencies for issues such as addiction or mental illness and the need for legal advice.

Unmet 'needs are those that a client identified in a particular support period, but which were either not provided or for which the client was not referred to a different agency' (AIHW 2018b). The AIHW estimates unmet demand from two perspectives: unassisted requests for services and unmet need. Unassisted requests for services captures information on people who have not received any assistance from the SHS provider. Unmet need captures clients who had some but not all of their identified needs provided by the SHS provider (AIHW 2018b). In this report, demand and unmet demand are measured only from the second perspective, as unassisted requests for services are not captured in the SHS CURF data.

3.1 TOTAL NEEDS MET AND UNMET

This section examines overall demand, met and unmet, across the four cohorts. Unsurprisingly, people with HCSNs had a higher average number of identified needs than people without HCSNs (Table 9, Appendix 3). For example, homeless HCSNs had an average of 5.0 needs identified, whereas homeless non-HCSNs had 4.8. The difference was similar between at-risk HCSNs and at-risk non-HCSNs; the former had an average of 3.2 needs identified, whereas the latter had 2.8. These results lend confidence to the definitions for HCSNs provided in Chapter 1.

On average annually, 3.7 of homeless HCSNs' 5.0 identified needs were met at the end of their support periods. Of at-risk HCSNs' 3.2 identified needs, 2.6 needs were met at the end of their support periods. People who are homeless—both those with and those without HCSNs—had the highest number of unmet service needs (1.3 and 1.6, respectively, compared to 0.6 for at-risk HCSNs and 0.8 for at-risk non-HCSNs).

3.2 NEEDS FOR ACCOMMODATION AND TENANCY SUSTAINMENT SERVICES

This section analyses the accommodation and tenancy support needs of people in the ACT who are homeless or at risk of homelessness and who are clients of SHSs. For people experiencing homelessness—that is, people without accommodation—we examine met and unmet demand for short-, medium- and long-term accommodation, comparing people with HCSNs to those without when it is meaningful to do so. For people at risk of homelessness—that is, people at risk of losing their tenancy—we examine met and unmet demand for tenancy

sustainment services, again comparing people with HCSNs to those without when it is meaningful to do so. Table 10 (Appendix 3) provides an overview of the findings of this analysis. It shows the total number of needs and the percentage of those needs for which services were met, referred or unmet.

3.2.1 Short-term accommodation needs: homeless cohorts

Three in four homeless people (76%), both with and without HCSNs, were identified as having a need for short-term housing.

Of those needing short-term housing:

- 64% of homeless HCSNs were provided with it, compared to 45% of homeless non-HCSNs
- 6% of homeless HCSNs were referred to another service provider, compared to 9% of homeless non-HCSNs.

3.2.2 Medium-term accommodation needs: homeless cohorts

Two-thirds (67%) of homeless HCSNs were identified as having a need for medium-term housing, compared to 71% of homeless non-HCSNs.

Of those needing medium-term housing:

- 15% of homeless HCSNs were provided with it, compared to 19% of homeless non-HCSNs
- 31% of homeless HCSNs were referred to another service provider, compared to 16% of homeless non-HCSNs.

3.2.3 Long-term accommodation needs: homeless cohorts

Sixty-nine per cent of homeless HCSNs were identified as having a need for long-term housing, compared to 76% of homeless non-HCSNs.

Of those needing long-term housing:

- 10% of homeless HCSNs were provided with it, compared to 8% of homeless non-HCSNs
- 36% of homeless HCSNs were referred to another service provider, compared to 29% of homeless non-HCSNs.

3.2.4 Tenancy support needs: at-risk cohorts

Just over one-third (36%) of at-risk HCSNs were identified as having a need for assistance to sustain housing, compared to 52% of at-risk non-HCSNs.

Of those identified as needing assistance to sustain housing:

- 89% of at-risk HCSNs were provided with it, compared to 88% of at-risk non-HCSNs
- 3% of at-risk HCSNs and 3% of at-risk non-HCSNs were referred to another service provider.

3.2.5 Regression analysis of accommodation needs

To get a deeper understanding of the differences in needs identified, we also performed regression analyses.[9] Regression analysis allowed us to estimate probabilities for each need being identified, provided or referred on, depending on whether or not a person was identified

[9] Calculations are provided in Appendix 5.

as having HCSNs, being homeless, or both. The results of the analyses confirm the findings presented above. In particular, the results indicate the following:

- Homeless HCSNs had a higher likelihood of being provided with short-term housing and a lower likelihood of being referred to another agency for short-term accommodation, compared to the rest of the homeless population.
- Homeless HCSNs had a lower likelihood of being identified as needing medium-term housing, a lower likelihood of being provided with it and a higher likelihood of being referred to another service provider, compared to the rest of the homeless population.
- Homeless HCSNs had a lower likelihood of being identified as needing long-term housing and a higher likelihood of being referred to another service provider if that need had been identified, compared to the rest of the homeless population.
- At-risk HCSNs had a lower likelihood of being identified as needing assistance to sustain housing tenure, compared to the rest of the at-risk population.

3.3 NEEDS FOR HEALTH SERVICES

Table 11 (Appendix 3) provides an overview of the demand and unmet demand for health services (mental health, disability, drug/alcohol and other specialist services) for different cohorts.

3.3.1 Mental health support needs

Almost one in five clients (18%) had a need for mental health services; 41% of those needs were provided, and 32% were referred to another service provider.

Thirty-five per cent of homeless HCSNs were identified as having a need for mental health services, compared to 21% of homeless non-HCSNs.

Twenty per cent of at-risk HCSNs were identified as needing mental health services, compared to 11% of at-risk non-HCSNs.

Of those identified as needing mental health services:

- 39% of homeless HCSNs were provided with them, compared to 41% of homeless non-HCSNs
- 59% of at-risk HCSNs were provided with them, compared to 40% of at-risk non-HCSNs
- 36% of homeless HCSNs were referred to another service provider, compared to 33% of homeless non-HCSNs
- 19% of at-risk HCSNs were referred to another service provider, compared to 32% at-risk non-HCSNs.

3.3.2 Disability support needs

About 3% of all clients had a need for disability services; 41% of those needs were provided for, and 23% were referred to another service provider.

Four per cent of homeless HCSNs were identified as needing disability services, compared to 3% of homeless non-HCSNs.

Four per cent of at-risk HCSNs were identified as needing disability services, compared to 2% of at-risk non-HCSNs.

Of those identified as needing disability services:

- 43% of homeless HCSNs were provided with them, compared to 44% of homeless non-HCSNs

- 51% of at-risk HCSNs were provided with them, compared to 32% of at-risk non-HCSNs
- 19% of homeless HCSNs were referred to another service provider, compared to 28% of homeless non-HCSNs
- 20% of at-risk HCSNs were referred to another service provider, compared to 14% of at-risk non-HCSNs

3.3.3 Alcohol and other drug support needs

Almost one in 10 clients (9%) had a need for drug/alcohol services; 55% of those needs were met, and 20% were referred to another agency.

Twenty-eight per cent of homeless HCSNs were identified as needing drug/alcohol services, compared to 10% of homeless non-HCSNs.

Eleven per cent of at-risk HCSNs were identified as needing drug/alcohol services, compared to 3% of at-risk non-HCSNs.

Of those identified as needing drug/alcohol services:

- 66% of homeless HCSNs were provided with them, compared to 56% of homeless non-HCSNs
- 51% of at-risk HCSNs were provided with them, compared to 34% of at-risk non-HCSNs
- 15% of homeless HCSNs were referred to another agency, compared to 19% of homeless non-HCSNs
- 19% of at-risk HCSNs were referred to another agency, compared to 32% of at-risk non-HCSNs.

3.3.4 Other specialist service support needs

Three in 10 clients (30%) had a need for other specialist services (health/medical services, specialist counselling services and other specialised services); 65% of those needs were provided for, and 24% were referred to another agency.

Forty-eight per cent of homeless HCSNs were identified as having a need for other specialist services, compared to 32% of homeless non-HCSNs.

Forty-three per cent of at-risk HCSNs were identified as having a need for other specialist services, compared to 23% at-risk non-HCSNs.

Of those identified as needing other specialist services:

- 57% of homeless HCSNs were provided with them, compared to 62% of homeless non-HCSNs
- 77% of at-risk HCSNs were provided with them, compared to 73% of at-risk non-HCSNs
- 32% of homeless HCSNs were referred to another agency, compared to 27% of homeless non-HCSNs
- 14% of at-risk HCSNs were referred to another agency, compared to 15% of at-risk non-HCSNs.

3.3.5 Regression analysis of health service needs

The results of the regression analyses confirm the findings presented above. In particular, the results indicate the following:

- Homeless HCSNs were more likely to be identified as having a need for *mental health services* compared to the rest of the homeless population.
- Homeless HCSNs were more likely to be identified as having a need for *drug and alcohol services*, and that need was more likely to be provided for, compared to the rest of the homeless population.
- Homeless HCSNs were more likely to be identified as having a need for *other specialist services* and more likely to be referred to another agency, compared to the rest of the homeless population.
- At-risk HCSNs were more likely to be identified as having a need for *mental health services* and less likely to be referred to another agency, compared to the rest of the at-risk population.
- At-risk HCSNs were more likely to be identified as having a need for *disability services,* compared to the rest of the at-risk population.
- At-risk HCSNs were more likely to be identified as having a need for *drug and alcohol services*, compared to the rest of the at-risk population.
- At-risk HCSNs were more likely to be identified as having a need for *other specialist services*, compared to the rest of the at-risk population.

3.4 NEEDS FOR SOCIAL SERVICES

For the four cohorts, Table 12 (Appendix 3) provides an overview of the demand and unmet demand for social services, including family, legal/financial and immigration/cultural services, domestic violence services and general services.

3.4.1 Family services support needs

More than one in eight clients (13%) had a need for family services; 68% of those needs were provided for, and 18% were referred to another agency.

Ten per cent of homeless HCSNs were identified as having a need for family services, compared to 15% of homeless non-HCSNs.

Eleven per cent of at-risk HCSNs and 11% of at-risk non-HCSNs were identified as having a need for family services.

Of those identified as needing family services:

- 73% of homeless HCSNs were provided with them, compared to 67% of homeless non-HCSNs
- 80% of at-risk HCSNs were provided with them, compared to 68% of at risk non-HCSNs
- 19% of homeless HCSNs and homeless non-HCSNs were referred to another agency
- 7% of at-risk HCSNs were referred to another agency, compared to 17% of at-risk non-HCSNs.

3.4.2 Legal and financial service support needs

Almost one in eight clients (12%) had a need for legal/financial services; 65% of those needs were provided, and 20% were referred to another agency.

Twelve per cent of homeless HCSNs were identified as needing legal/financial services, compared to 11% of homeless non-HCSNs.

Eight per cent of at-risk HCSNs were identified as needing legal/financial services, compared to 14% of at-risk non-HCSNs.

Of those identified as needing legal/financial services:

- 58% of homeless HCSNs were provided with them, compared to 57% of homeless non-HCSNs
- 52% of at-risk HCSNs were provided with them, compared to 80% of at-risk non-HCSNs
- 23% of homeless HCSNs were referred to another agency, compared to 26% of homeless non-HCSNs
- 19% of at-risk HCSNs were referred to another agency, compared to 12% of at-risk non-HCSNs.

3.4.3 Immigration and cultural support needs

Almost one in 14 clients (7%) had a need for immigration/cultural services; 73% of those needs were provided for, and 18% were referred to another agency.

Seven per cent of homeless HCSNs were identified as needing immigration/cultural services, compared to 9% of homeless non-HCSNs.

Four per cent of at-risk HCSNs and at-risk non-HCSNs were identified as needing immigration/cultural services.

Of those identified as needing immigration/cultural services:

- 60% of homeless HCSNs were provided with them, compared to 72% of homeless non-HCSNs
- 76% of at-risk HCSNs were provided with them, compared to 80% of at-risk non-HCSNs
- 30% of homeless HCSNs were referred to another agency, compared to 19% of homeless non-HCSNs
- 11% of at-risk HCSNs and at-risk non-HCSNs were referred to another agency.

3.4.4 Domestic violence service support needs

Almost one in six clients (16%) had a need for domestic violence services; 74% of those needs were provided for, and 9% were referred to another agency.

Fourteen per cent of homeless HCSNs were identified as needing domestic violence services, compared to 19% of homeless non-HCSNs.

Eight per cent of people at-risk HCSNs were identified as needing domestic violence services, compared to 11% of at-risk non-HCSNs.

Of those identified as needing domestic violence services:

- 72% of homeless HCSNs were provided with them, compared to 76% of homeless non-HCSNs
- 73% of at-risk HCSNs were provided with them, compared to 69% of at-risk non-HCSNs
- 15% of homeless HCSNs were referred to another agency, compared to 9% of homeless non-HCSNs
- 2% of at-risk HCSNs were referred to another agency, compared to 99% of at-risk non-HCSNs.

3.4.5 General services support needs

More than nine in 10 clients (92%) had a need for general services,[10] and almost all of those needs were provided for (99%).

Ninety-seven per cent of homeless people with and without HCSNs were identified as needing general services.

Ninety-five per cent of at-risk HCSNs were identified as needing general services, compared to 82% of at-risk non-HCSNs.

Of those identified as needing general services:

- 99% of homeless HCSNs and homeless non-HCSNs were provided with them
- 99% of at-risk HCSNs were provided with them, compared to 98% of at-risk non-HCSNs.

3.4.6 Regression analysis of social service support needs

The results of the regression analyses confirm the findings presented above. In particular, the results indicate the following:

- Homeless HCSNs were less likely to be identified as having a need for *family services*, compared to the rest of the homeless population.
- Homeless HCSNs were less likely to be identified as needing *domestic violence services*, and that need was more likely to be referred to another agency when identified, compared to the rest of the homeless population.
- Homeless HCSNs were less likely to be provided with *immigration/cultural services* and more likely to be referred to another agency when that need was identified, compared to the rest of the homeless population.
- At-risk HCSNs were less likely to be identified as needing *legal/financial services*, and that need was less likely to be provided for, compared to the rest of the at-risk population.
- At-risk HCSNs were less likely to be identified as needing *domestic violence services*, compared to the rest of the at-risk population.
- At-risk HCSNs had higher likelihood of being provided with *family services* and a lower likelihood of being referred to another agency, compared to the rest of the at-risk population.
- At-risk HCSNs were more likely to be identified as needing *general services*, compared to the rest of the at-risk population.

3.4.7 Comorbidity analysis

Given the divergence in stakeholder accounts on the issue of comorbidity discussed in Chapter 4, we undertook further quantitative analysis to assess whether people with comorbidities did indeed struggle more to access services (see Appendix 5 for details).

The results demonstrate that people with comorbid drug/alcohol and mental health service needs had a 15.4% *lower likelihood* of their mental health service need being met, compared

[10] General services include assertive outreach; assistance to obtain or maintain government allowances; employment assistance; training assistance; educational assistance; financial information; material aid/brokerage; assistance for incest/sexual assault; assistance for domestic/family violence; family/relationship assistance; assistance for trauma; assistance with challenging social/behavioural problems; living skills / personal development; legal information; court support; advice/information; retrieval/storage/removal of personal belongings; advocacy/liaison on behalf of client; school liaison; child care; structured play / skills development; child contact and residence arrangements; meals; laundry/shower facilities; recreation; transport; and other basic assistance.

to people who had a need for mental health services but not for drug/alcohol services. The results also indicate that there was no difference in the likelihood of drug/alcohol services needs being met between people with comorbid drug/alcohol and mental health service needs and people who had a need for drug/alcohol services but not for mental health services. This suggests that people experiencing comorbid mental illness and drug and alcohol issues struggle to access mental health supports, compared to people experiencing mental illness alone.

3.5 CONCLUSION

This chapter has presented an analysis of demand for accommodation and services from SHS providers, and whether or not the demand was met. In line with the AIHW definition, met need includes both the direct provision of a service and referral to another agency. Demand and unmet demand were analysed in relation to the four cohorts identified through the SHS client data.

Demand for support services (health and social) was met in the majority of cases, either through direct provision or through referral. This was the case for people both with and without HCSNs, although some differences between the cohorts were identified.

In contrast, demand for accommodation services went unmet in most cases. There were also important differences between people with, and those without, HCSNs in the type of accommodation that they were identified as needing and that was subsequently provided. People with HCSNs were more likely to be provided with short-term accommodation, whereas those without HCSNs were more likely to be provided with medium-term accommodation (although still at relatively low rates). Rates at which long-term housing needs were met for those two cohorts were very low.

Demand for tenancy sustainment services was the exception. People at risk of homelessness had their need for tenancy sustainment support provided for by the SHS provider in most cases. Analysis of the qualitative data presented in Chapter 5 in particular, but also in Chapter 4, provides some insight into why demand for accommodation services was largely unmet.

4 ACCOMMODATION AND SUPPORT SERVICES IN THE ACT: WHAT IS AVAILABLE AND WHAT ARE THE GAPS?

The ACT Government funds a range of services for people experiencing homelessness or at risk of homelessness.[11] In 2017–18, 45 funded SHSs were delivered through a range of providers (listed in Appendix 7). The funded services included 321 accommodation places, along with funding for some additional motel accommodation, and ranged from drop-in centres and crisis and transitional accommodation to tenancy sustainment services. There are also two shared accommodation sites managed by registered community housing organisations, which provide 273 accommodation places, and a 40-unit Common Ground development providing permanent supportive housing based on 'Housing First' principles.[12] In addition, support and accommodation places are provided through other programs across the ACT Government and by the Australian Government. Examples include CatholicCare's Reconnect program for under 16-year-olds and the Richmond Fellowship Residential Recovery Program, which provides a range of supported accommodation for people with severe and enduring mental illnesses and associated psychosocial disability.

This chapter provides an overview of service options, types of accommodation and support, and the groups targeted. It then describes gaps in the accommodation and support available identified by stakeholders from the government and non-government sectors. In the following chapter, these options are evaluated in relation to client need/demand and the achievement of long-term housing outcomes for people with HCSNs.

4.1 ACCOMMODATION AND SUPPORT SERVICES FOR PEOPLE IN THE ACT WHO ARE HOMELESS OR AT RISK

4.1.1 Drop-in centres

Drop-in centres are low-threshold services that seek to meet the basic sustenance needs of people who are experiencing homelessness and other vulnerable and impoverished people. The centres are often run by church organisations and offer traditional forms of charity, such as by providing hot meals and beverages, warm clothes, blankets and bedding, hygiene facilities, and moral and emotional support (Cloke et al. 2010). Drop-in centres also serve as conduits through which people access other kinds of support services, such as medical check-ups, alcohol and other drug services, and welfare services.

The most well-known drop-in centre in the ACT is the Early Morning Centre, operated by the Uniting Church, which provides hot breakfast between 7:30 am and 8:30 am on weekdays and light lunches three days per week. The centre operates as a 'community hub' where people have access to computers and the internet, telephones, newspapers, and recreational activities such as board games. It also has showers, toilets and lockers, and offers a place to which people can have mail delivered. The Centre is also a site and conduit for other services and activities, including the OneLink referral service (described below), a drop-in medical clinic, drug and alcohol counselling,

[11] See, for example, ACTCOSS (2017) for a compilation of services in the ACT.

[12] Housing First models, which are widely used worldwide, are based on immediate access to secure long-term housing (Padgett et al. 2016).

legal services, welfare support, and a current affairs discussion group hosted by political science academics from the Australian National University.

The Red Cross Roadhouse drop-in centre provides lunch on days that the Early Morning Centre does not, and provides information and referrals to support services. The Missionheart drop-in centre in the Griffin Centre offers food, hot beverages and spiritually oriented moral support. Blue Door, which is operated by St Vincent de Paul at Ainslie Village and used primarily by residents of the village, provides breakfast and lunch, as well as clothing and furniture vouchers, and information, advice, advocacy and referrals.

4.1.2 Service hubs

It is increasingly common for homelessness services to be coordinated through service hubs, which act as central access points for people experiencing or at risk of homelessness. In the ACT, the central access point for homelessness services (as well as other human services, such as family support services) is OneLink, operated by Woden Community Services. OneLink provides homeless people with a 'one-stop shop' for the city's diverse array of homelessness supports. To streamline the referral process and prevent duplication, all referrals for support must pass through OneLink. OneLink maintains a central database of information on people seeking homelessness support in the ACT and the services that have been provided to them (or not).

4.1.3 Crisis accommodation

Crisis accommodation is low-threshold, short-term accommodation (usually for a maximum of three months) provided to people who are experiencing a housing crisis and who are, or are soon to be, without any other form of accommodation. It provides an important alternative to street homelessness for people in the process of securing more stable, long-term housing. Crisis accommodation often entails shared living arrangements, for example in homeless shelters and refuges. It is not suitable as, nor is it intended to be, a long-term housing option.

In the ACT, there are separate crisis accommodation options for men and women. For single men, there is one homeless shelter that is open all year round called Samaritan House (operated by St Vincent de Paul). Occupants are provided with their own rooms as well as shared kitchen, bathroom and recreation facilities. During the winter months, additional crisis accommodation is supplied through the Safe Shelter program, which entails three inner-city church halls opening their doors to provide homeless men with somewhere safe and warm to sleep, and complimentary hot beverages. Unlike in established homelessness shelters such as Samaritan House, people accessing Safe Shelter do not have access to cooking or hygiene facilities.

A number of organisations provide crisis accommodation to women with or without children escaping domestic violence. They include refuges operated by Toora Women Inc., Beryl Women and Doris Women's Refuge. These services provide shared living arrangements to women and families, as well as access to support services. Women who are not experiencing domestic violence can access crisis accommodation through the Toora House Supported Accommodation program (operated by Toora Women Inc.), which also services women escaping domestic violence.

Karinya House Home for Mothers & Babies Inc. provides crisis and transitional housing and outreach services to pregnant and parenting women and their families who are in crisis and often homeless.

For youth, a number of crisis accommodation facilities (for example, the Youth Emergency Accommodation Network) are provided through a partnership between Canberra Youth Residential Service and The Salvation Army Oasis. These are clusters of three- and four-bedroom houses (or townhouses) that provide shared accommodation to youths with 24-hour on-site support. The

standard support period for this service is three months; however, stakeholders note that this is flexible and can be extended if there is an identified need for ongoing support.

4.1.4 Transitional housing

Transitional housing is medium-term accommodation provided to people experiencing or at risk of homelessness. It includes the provision of support services to help people acquire the skills they need to sustain tenancies and address issues such as substance misuse and mental illness. In most cases, people's access to transitional housing is conditional upon their active engagement with those supports. The tenancy for transitional housing is held by a service provider who acts as both property manager and provider of support services.

In the ACT, there is a range of transitional housing programs for different types of service users. MINOSA House (Men in Need of Supported Accommodation), run by CatholicCare Canberra and Goulburn, is a six-bed shared accommodation facility that offers transitional housing to homeless men for a period of around three months. While some stakeholders considered MINOSA to be crisis accommodation rather than transitional housing, it is included here as transitional housing because that is how MINOSA staff describe it, and because men often transition to MINOSA after a period in the Samaritan House crisis facility. MINOSA has limited on-site support (it is staffed four hours per day); however, residents receive outreach support through CatholicCare's ASSIST program, which we describe below.

Transitional housing for women with or without children is provided by Northside Community Service. Formerly focused on women and families escaping domestic violence, the service is now available to all women who are experiencing or at risk of homelessness.

Everyman Australia, through its Men's Accommodation and Support Service, provides transitional housing and wraparound support to single men who are leaving custody or involved with the criminal justice system. Toora Women's Inc. provides a similar service for women exiting the correctional system and their families through its Coming Home program. All of these transitional options provide independent (rather than shared) units to clients, as well as case management support.

4.1.5 Shared community accommodation

Many people who are experiencing or at risk of homeless in the ACT access shared accommodation through two large facilities managed by registered community housing providers: Ainslie Village, operated by Argyle Community Housing Limited, and Havelock House, operated by Havelock Housing Association. Ainslie Village and Havelock House provide long-term accommodation and are thus not formally transitional—although some stakeholders do view them as such. However, tenure arrangements (occupancy agreements) are insecure, and shared living arrangements do not meet community standards for suitable long-term housing.[13] Unlike the transitional housing options described above, the ACT's shared community housing options do not include wraparound support for people with HCSNs (although residents of Ainslie Village have access to an on-site mental health service called One Door). Nevertheless, both Ainslie Village and Havelock House provide accommodation to a large number homeless and at-risk HCSNs.

There are also shared housing options for youth funded through SHS programs. Options for youth tend to include access to support services of some kind and include Our Place, which is provided through Barnardos Australia. Our Place provides supported accommodation and educational

[13] As defined by the ABS statistical definition of homelessness (ABS 2012) and the 'cultural' definition developed by Chamberlain and Mackenzie (1992).

support to people aged 16–21 years who are at risk of homelessness. Barnardos also runs the Friendly Landlord Service, which provides shared accommodation and drop-in support services to people aged 16–23 years.

4.1.6 Permanent supportive housing

Permanent supportive housing entails the provision of secure, long-term housing, coupled with voluntary support services, to homeless or at-risk HCSNs. Unlike in transitional housing, tenancy management and support services are delivered by operationally separate entities. Some permanent supportive housing models seek to achieve a social mix through housing people who were formerly homeless alongside people with low to moderate incomes in need of affordable housing.

Currently, the ACT has one permanent supportive housing provider, Common Ground Canberra (in Gungahlin), and the development of another (in Dickson) is planned. Common Ground provides self-contained, independent units with secure tenancy arrangements (rental agreements) to 20 formerly homeless people with HCSNs (who pay rent at 25% of their income) and 20 low-income earners (who pay 75% of market rent). Voluntary on-site support services are provided by Northside Community Service and available to all tenants. Tenancy management is carried out separately by Argyle Community Housing.

4.1.7 Outreach

Outreach services play an important role in engaging people who are experiencing or at risk of homelessness and who are unable or unwilling to access traditional site-based support services. They usually entail trained case workers engaging people *in situ* on the streets, in shelters or other forms of homeless accommodation, or in their homes (for those who are at risk of homelessness or recently housed).

The ACT's Street to Home service conducts 'assertive' outreach with people who are sleeping rough in Canberra, most of whom have HCSNs. The outreach is assertive. Street to Home will be persistent in its engagement with people sleeping rough, continuing to offer voluntary support even if it is not initially accepted (Parsell et al. 2014). The aim of the program is to establish a relationship with people sleeping rough to a point where they will accept further support in relation to housing and other needs, such as mental health and drug and alcohol support.

Other outreach programs in the ACT include the ASSIST program (Aiding in Secure, Safe, Independent and Stable Tenancies) run by CatholicCare, which entails outreach to both homeless people and to people who are at risk of losing their tenancies. Outreach to homeless people includes case management support, referral to specialist support services (physical and mental health, drug and alcohol etc.) and advocacy, all of which are oriented to helping people to obtain or transition to stable independent housing. There is also CatholicCare's Youth Housing and Support Service, which supports youth (15–25-year-olds) experiencing or at risk of homelessness to access secure housing.

4.1.8 Tenancy sustainment services

Tenancy sustainment services are a form of outreach service for people who are at risk of homelessness or for those who have recently ceased being homeless and require ongoing support to adjust to their new tenancy. They provide case management support to individuals or households, offering support and advice on issues such as keeping up with rent and bills, cooking and cleaning skills, and relationships with neighbours, as well as referring people to specialist support services if necessary.

A number of services provide tenancy sustainment support to people in the ACT. Woden Community Services, through a program called Supportive Tenancy Services, provides support to anyone in the ACT who is at risk of losing their tenancy. In addition to case management support and referrals, this service will mediate and advocate with property managers on behalf of its clients.

Everyman Australia and Toora Women Inc. provide tenancy sustainment support to male and female ex-detainees, respectively. The services are provided both to people housed in the transitional housing provided by these organisations and to other ex-detainees residing in other forms of accommodation. Everyman also provides tenancy sustainment support to men who are not exiting the justice system.

Northside Community Service provides a tenancy sustainment service called Staying in Place to women and families at risk of homelessness. While this service is not exclusively targeted at women and families experiencing domestic violence, it does have the capacity to address the specific needs of clients who are at risk of homelessness due to domestic violence (for example, because of personal safety and property security concerns).

4.1.9 Accommodation and services for Indigenous Australians

A handful of services in the ACT operate specifically for Indigenous Australians who are experiencing or at risk of homelessness.[14] Everyman Australia provides the Indigenous Boarding House for Indigenous people relocating to the ACT for work, study or other reasons, as well as case management support for Indigenous families at risk of homelessness.

Two community-run Indigenous organisations in the ACT provide support to people who are experiencing or at risk of homelessness. Gugan Gulwan provides a diverse range of support services to Indigenous young people and their families, including people experiencing or at risk of homelessness. Those services include support to access or sustain housing and address a range of other issues, including family issues, mental illness and drug and alcohol issues.

Winnunga Nimmityjah Aboriginal Health and Community Service provides housing-related support to Indigenous people experiencing or at risk of homelessness through its Home Maintenance Program and its Housing Liaison Program. The Home Maintenance Program provides tenancy sustainment services to Indigenous people and families at risk of homelessness by addressing issues such as neighbour disputes, squalor and rent arrears. The Housing Liaison Program supports people experiencing homelessness to apply for social housing, deal with housing debts and access short-term crisis accommodation while they wait to be allocated long-term housing.

4.2 GAPS IN HOMELESSNESS ACCOMMODATION

Notwithstanding the array of support and accommodation services in the ACT, stakeholders highlighted a number of gaps in the options available to people experiencing or at risk of homelessness. They noted a number of groups that were often unable to access available accommodation because of eligibility criteria or the way accommodation services are targeted. The gaps in the homelessness accommodation system reported here are based on the experiences and perceptions of stakeholders interviewed in this research. As such, their experiences and perceptions do not represent an exhaustive list of all possible service and resource gaps for people in the ACT who are homeless or at risk of homelessness.

[14] The recently published ACT edition of *Parity* includes an overview of Aboriginal and Torres Strait Islander homelessness and services in the ACT (Community Services Directorate (2018).

4.2.1 Couples and pet owners

Two of the most commonly mentioned gaps concerned homeless couples and people with pets.[15] As the stakeholder quoted below explained, couples attempting to access crisis accommodation are required to split up, which most are unwilling to do:

> If a couple without children comes to us we're going to say, 'You're going to have to split up'. Again, this is a terrible thing, but there is no accommodation for couples. And the sad thing is we could usually house the guy … within a short time, but the woman has to wait. So usually guys will say, 'Well, I'm not going to be housed and leave her on the street.' (Sharon, stakeholder, NGO)

A similar situation is said to arise when people who have pets attempt to access crisis accommodation, as this interview exchange between stakeholders from a Canberra homelessness service illustrates:

> Gail: If you've been long-term homeless with your dog for five or 10 years, you're not going into any accommodation where you have to leave your dog behind.
>
> Bill: Yeah, it's very important.
>
> Lynda: There's no crisis accommodation for people with pets.
>
> Gail: No, and they won't go into it. People won't leave their pets. It's the only safe relationship they have.

One interview participant described the challenges he had faced in finding accommodation while experiencing homelessness with his two dogs. When asked if he had accessed crisis accommodation, he responded:

> No, because I had two dogs … [A woman from OneLink] would keep in regular touch with me at least once a week and just make sure I was all right and let me know that, unfortunately, because of my situation, the crisis beds weren't going to help. (Todd, service user, male)

Unwilling to part with his dogs, Todd opted to sleep rough in his car and in an illegal squat.

4.2.2 Women and families who are not escaping domestic violence

Stakeholders stated that it is often difficult to find short-term accommodation for women and families who are *not* escaping domestic violence:

> For single women or women with children that aren't escaping domestic violence, I think there's like eight beds. So Samaritan House, I think, has 12 beds … That's all men … the average wait is maybe a couple of weeks to get somebody into Samaritan House. Whereas for a woman, it's a couple of months wait. (Jessica, stakeholder, NGO)

Stakeholders reported that it is particularly difficult to find short-term accommodation for single women (that is, women without dependent children) who are not escaping domestic violence:

> So, the other group that's of interest here is the lone person, over 25, female, not domestic violence … Toora have one property, as I understand it, with six beds. They don't come up very often. When women go in there they're there for quite a while … This is the group that we really struggle with to try and help, because we're trying to stay in touch for so long [while they wait for accommodation to become available]. (Sharon, stakeholder, NGO)

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[15] In 2018, Launch Housing in Melbourne started a pilot project letting people access crisis accommodation with pets in tow (Launch Housing 2018).

One homeless single woman interviewed reported that she had spent 10 months moving between hotels and motels and sleeping rough while she worked with a Canberra-based outreach service on obtaining permanent housing:

> I'm currently living in a local motel … What was initially two days to stay there, I've been ever since. About 10 months … So, apart from having short-term accommodation in hotels, motels, accommodation places like that, I sort of slept out. I just didn't have the money. I would go through money very quickly. Bang, $100 a night. (Olga, service user, female)

4.2.3 Single fathers

Stakeholders also spoke about the difficulty of finding accommodation for single men with children. As the participant quoted below explained, single fathers in need of supported accommodation or social housing have tended to fall through the gaps:

> A lot of the accommodation for a mother and a bub [is] share accommodation … Because it's shared with other families you can't put a man in where there's women and children sharing. So, you're then looking for a man with a child, a two-bedroom property. There's hardly any two-bedroom properties … So, then you're looking at a three-bedroom house. So, would you give a man and one child a three-bedroom house when you have all these other larger families? They somehow just never get prioritised … (Sharon, stakeholder, NGO)

Blair, a participant staying in crisis accommodation after his recent release from prison, described the difficulties that he faced in finding somewhere to live with his two children.

> I've got two kids, both who are living in refuges at the moment because I don't have a house for them to come and live with … Housing wouldn't put my daughter on my housing application because I don't claim the pension for her … So, that entitles me to a one-bedroom flat. That's no good when I've got two children. (Blair, service user, male)

4.2.4 People with criminal histories

Another gap relates to people with certain kinds of criminal histories. As a stakeholder from the public health sector explained, when dealing with a person with a history of violent crime, service providers struggle to balance the safety needs of staff and other service users with a desire to not discriminate against people with a criminal history:

> I think there's a huge amount of stigma for people who have a criminal history and it's difficult for us because we can't actively conceal information about people because staff who might be coming into contact with our consumers, I believe they have a right to know at least some of the information that we hold about our consumers. For instance, if one of our consumers is wanting to access crisis accommodation and we know that they've got a history of violent offending it's very difficult for us. We walk a pretty fine line between not wanting to exclude them from support services, but also making sure that the people who are going to be working with them in the accommodation services have got all the information that they need to keep themselves safe as well. So that can definitely be challenging. (Lilly, stakeholder, public sector)

Another participant claimed that people with a history of sexual offences face acute problems in accessing housing:

> We also have an emerging problem because there's no housing policy around sex offenders. Most of the supported tenancy providers … don't take sex offenders. So that means sex offenders generally don't get released on parole because they don't have suitable accommodation. (Watson, stakeholder, NGO)

Chris, who was recently released from prison, described his experience of being turned away from supported accommodation due to his criminal history and past drug use:

> I'm grateful for Samaritan House and being able to stay here for as long as I have been, but … There's not much else around. Everywhere else I've been declined or deemed not suitable because of my criminal history … Or my drug use, which has been non-existent for some time now. It keeps getting thrown back in my face. I'm a recovering addict. I mean, how many times do you have to have a door shut in your face before you start thinking about using again? (Chris, service user, male)

4.2.5 People who are Indigenous

Stakeholders also state that there are limited suitable accommodation options for people who are Indigenous and homeless or at risk of homelessness. As the participants quoted below stated, many Indigenous people do not trust mainstream accommodation and support services due to personal and historical experiences of injustice:

> Helen: We find it quite difficult to navigate through that system, especially when our clients don't want to go there … So, there's still that fear factor for a lot of Aboriginal people.
>
> Nicola: Even if you've got a mainstream service … with Aboriginal workers the trust might be in the workers, but they won't trust because the service is not Aboriginal community-controlled. (Stakeholders, NGO)

However, there are currently no community-controlled Aboriginal or Torres Strait Islander accommodation services in the ACT for people who are homeless or at risk, and little in the way of non-community-controlled accommodation for Indigenous people (the Indigenous Boarding House run by Everyman Australia is an exception to this).

As a result, homeless Indigenous people are reported to be resorting to camping at the Aboriginal Tent Embassy on the lawn of Old Parliament House:

> Aboriginal and Torres Strait Islander people, as a cohort—there is no Aboriginal hostel here, there's no Aboriginal housing strategy, there's no plan around that. We're having people released from the AMC [prison], they'll go to [Indigenous organisation], [which] will give them a tent, and they'll go and camp at the Tent Embassy. In the national capital, that's atrocious. …. (Watson, stakeholder, public sector)

Stakeholders from an Indigenous organisation described how camping and other suboptimal accommodation options (cheap motels) are also used to meet the needs of the relatively large number of 'transient' Indigenous people who come to Canberra looking for work or to visit family:

> And all we can do is house a lot of them at the Tent Embassy, buy them a tent. That's if they haven't got little kids or if it's not a vulnerable mother that's expecting a baby that's come from a domestic violence situation in another part of the country, arrived in Canberra with nothing, and then we're trying to work with other organisations or we're putting them in the caravan park or cheap motels. It's not a good situation to be in. (Nicola, stakeholder, NGO)

4.2.6 People with psychosocial disability

Almost every stakeholder we interviewed highlighted how the rollout of the National Disability Insurance Scheme (NDIS) in the ACT had created what they perceive as conditions where people who are homeless with psychosocial disabilities experience greater challenges accessing supported accommodation. Stakeholders described how, following the roll out of the NDIS, the ACT Government stopped providing block funding for supported accommodation services for people with a mental illness (among other services), as it was believed that these would now be funded through service users' NDIS packages. However, as the stakeholders quoted below observed,

some people experiencing homelessness are unable or unwilling to access the NDIS, and are therefore no longer eligible to access these supported accommodation facilities:

> Because the ACT is a complete transition site for the NDIS, all mental health funded programs were rolled into or transitioned into the NDIS. So, a lot of the people that will never be eligible for NDIS or choose not to go down that route, find themselves with no options for support. So, we just found an increase in people struggling with mental health issues. (Jasmin, stakeholder, NGO)

According to stakeholders, the reason that some people experiencing homelessness are unable to access NDIS packages—and thus the supported accommodation now reserved for NDIS clients—is that people with severe mental illnesses and psychosocial disabilities often struggle to navigate the complex bureaucratic processes that are involved in accessing and using an NDIS package (as they similarly struggle to navigate other government process such as Centrelink and social housing applications). This is illustrated in the following quote from Lilly, who worked in an ACT Government operated mental health service:

> [The NDIS] adds another layer of bureaucracy, another host of challenges for people trying to navigate that system. It's incredibly frustrating and challenging as a professional to negotiate with that bureaucracy. Really significant waiting times, lots of cases of lost documentation, requiring huge amounts of evidence from people to demonstrate things like their mental health diagnosis. It's really challenging. And also, a lot of people who we work with don't consider themselves to have a disability. (Lilly, stakeholder, public sector)

Lily went on to provide an example of the challenges she faced in gaining access to supported accommodation through the NDIS for a person with a severe mental illness:

> [O]ne of the challenges is that with a lot of mental health diagnoses, for example, schizophrenia, one of the things that characterises that illness is a lack of insight often into the person's diagnosis. So, I can think of one client in particular who has quite severe symptoms of schizophrenia, including delusion and hallucinations and the whole bit, but he doesn't believe that he has schizophrenia. So, asking him to submit a whole lot of paperwork to a government agency—he's also quite paranoid about government agencies having written information about him. So, trying to sit with him and do—I've been working on it with him for months because he's so paranoid about the information that the government is going to end up with and he doesn't agree with anything I write. Trying to make him fit into the mould of, I guess, what's set up for—It seems that the NDIS seems to have been set up for more physical disability and intellectual disability. Trying to get mental health to fit into that is incredibly challenging and it means, for the time being, that he's not eligible. Even though I think he'd do quite well in supported accommodation, he can't access that until he has an NDIS package. (Lilly, stakeholder, public sector)

Given the difficulty stakeholders reported experiencing gaining access to supported accommodation through the NDIS, stakeholders report that the transition to the scheme has resulted in people who were formerly able to access supported accommodation for a mental illness now being forced into shared community housing, such as Ainslie Village or Havelock House:

> So there used to be this whole suite and people could actually pick which program they wanted or to focus on it and things like that. With the implementation of NDIS, Richmond Fellowship have gone to purely and simply being an NDIS program. The Lodge has become an NDIS program, Samaritan Services was defunded, Rahula is no longer taking on complex referrals, MINOSA is no longer taking on complex referrals. So that leaves us with Ainslie Village and Havelock House. Ainslie Village and Havelock House, they have accommodation management, they don't have any case management or support. (Anthony, stakeholder, NGO)

4.2.7 People with physical disability

One final gap in accommodation options raised by stakeholders relates to people with disabilities (other than psychiatric disabilities). One stakeholder highlighted problems with the accessibility of existing crisis accommodation for people using wheelchairs:

> For someone that's using a wheelchair and that's needing to be able to get in the door of a crisis accommodation facility. If that crisis accommodation facility has steps on the way up, narrow doorways, that is immediately ruled out as a possible, even just temporary, option. (Janeen, stakeholder, NGO)

People with physical disabilities who need longer term accommodation have particular difficulty accessing the private rental market due the very low proportion of physically accessible properties. As one participant put it: 'In the private market there's just no accessible houses, virtually' (Chloe, stakeholder, community sector). Stakeholders differed in their evaluations of the physical accessibility of social housing in the ACT. One stated that accessibility was very good by Australian standards:

> Well, because the ACT has had a policy for a number of years that when they build public housing, all of it will be built to the gold level accessibility under Liveable Housing Australia guidelines, and about 10% will be Class C adaptable. They're doing that and have been a leader, Australia-wide. (Chloe, stakeholder, NGO)

However, others were more critical of the available physically accessible stock. For example, the participants quoted below noted that, although new Housing ACT stock meets universal minimum design standards for accessibility, that does not mean that it is necessarily appropriate for people with physical disabilities:

> Ellen: The new stuff … is going to be at least meeting minimal universal design standards. But that doesn't mean necessarily that just because it meets universal minimum design standards that it's sufficient …
>
> Jim: There was a Housing ACT [property] that had ramps without a landing. They expected a woman with a wheelie walker to try to manage opening the door, holding tight for dear life because she was going to lose balance, and they thought that it was perfectly all right … because it had a ramp.

4.3 GAPS IN SUPPORT SERVICE PROVISION

Stakeholders highlighted perceived gaps in the support services available to people who are homeless or at risk of homeless in the ACT, and particularly those with HCSNs. Central among them is mental health support, particularly for people experiencing comorbid mental illnesses and substance abuse issues. As noted above, it should be emphasised that the gaps in the service system reported here are based on the experiences and perceptions of stakeholders interviewed in this research. As such, their experiences and perceptions do not represent an exhaustive list of all possible service and resource gaps for people in the ACT who are homeless or at risk of homelessness. It should also be noted that, while we showed in Chapter Three that people's support needs are met in the majority of cases, stakeholders highlighted what they perceived to be gaps in support experienced by groups with specific needs.

4.3.1 National Disability Insurance Scheme

The National Disability Insurance Scheme (NDIS) provides support for people with disability, their families and their carers. The NDIS is for people under the age of 65 who have a significant and

permanent disability. This may include a psychosocial disability arising from a mental health issue (noting that a person with a mental health condition will not necessarily have a psychosocial disability). By and large, the NDIS provides funding for supports that enable independent living rather than assistance with accommodation. A relatively small percentage of people with very high level of need may be able to access housing through specialist disability accommodation arrangements. The NDIS was rolled out in the ACT in 2014.

Stakeholders claimed that the implementation of the NDIS has created a gap in mental health oriented supported accommodation for homeless people in the ACT. Similarly, some stakeholders claimed that the withdrawal of block funding for services providing mental health outreach support has left some homeless people who have mental illnesses without mental health support:

> I think one of the major challenges for transitioning people with complex needs is that all the block funding has been taken away for the mental health services … If you're homeless, it's a little bit hard to go through the NDIS package. You don't have an address, you don't have a phone, so they can't send you appointment details, they can't contact you, and it's quite a process to get a package. Previously we had multiple services that we could put people into if they had complex needs. But now if they don't have an NDIS package of support they can't go to those services because they've lost their block funding. (Cassandra, stakeholder, NGO)

Victor, a homeless research participant currently living in shared accommodation, described his experience of attempting to access NDIS support for mental illness and substance abuse problems that he experiences:

> I did an interview and they've come back with, 'You're not qualified to be on the NDIS.' There's things to do with PTSD or alcoholism that they don't consider long-term, permanent. Like, say, a permanent condition would be bipolar, I imagine, or amputee or physically handicapped or requiring ongoing care and duty. (Victor, service user, male)

This highlights some of the difficulties that homeless people face in accessing NDIS support to address their mental illnesses. It similarly illustrates the challenges that people experience understanding not only the health system and the resources available, but also understand mental health diagnosis and what health and other resources are most suitable to address the health issues.

Some stakeholders thought that the NDIS reduced the availability of mental health support services and placed additional pressures on government mental health services to pick up the residual demand. The perceived changes are believed to mean that mental health services place a disproportionate focus on people in crisis.

4.3.2 Comorbidity

Another potential gap in mental health services for people who are homeless or at risk of homelessness is the purported difficulty that people with comorbid mental illness and drug and/or alcohol dependence face in accessing support. Many stakeholders raised this issue, although there was some ambiguity about the nature and extent of the gap. As the stakeholders quoted below described, the issue here is that, on the one hand, drug and alcohol services such as rehabilitation facilities are not capable of accepting clients with severe mental illness, and, on the other hand, mental health services are often reluctant to diagnose or treat someone if they believe their issues are related to their drug and alcohol use:

> So, I think a big problem in the ACT is a lot of other organisations will separate out drug and alcohol and mental health … So, you'll have a lot of people unable to manage a tenancy and then we're trying to get them into facilities. Drug and alcohol rehab will go, 'Well, we don't take people with mental

> health.' Mental health services don't take people [with drug and alcohol problems]. (Annette, stakeholder, NGO)
>
> Comorbidity or the places for people with comorbidity issues is even more difficult. So, someone that's struggling with drugs and alcohol, but also mental health issues, which, in my experience, I haven't found anyone that's not struggling with both at the same time; however, places [for] people with drug and alcohol and mental health issues are even scarcer. So, that's really difficult. (Jasmin, stakeholder, community sector)
>
> I mean, it's interesting that there's a lot of talk about comorbidity and the fact that drug and alcohol and mental health issues often go together. We still do find that there will be services that say, 'No, you can't have mental health support until drug and alcohol is taken care of,' or vice versa. So, that's still an ongoing [issue]. (Sharon, stakeholder, NGO)

Other stakeholders sought to moderate these concerns by pointing out the steps taken within the mental health and drug and alcohol sectors to address the problem. For instance, when asked whether people with comorbidities struggle to access services, a stakeholder from the public health system provided the following response:

> Not so much. Definitely not here. Most of our consumers have comorbidities. I guess there's a bit of an ongoing discussion between us and Drug and Alcohol. I guess you just work out who's doing what and who's having the main support role … So, I think it can work really well. I don't think that consumers should be having the experience where they're turned away from services. Yeah, I'd be really surprised. Maybe it is happening, but I haven't seen so much of that. (Lilly, stakeholder, public sector)

Similarly, a stakeholder from the drug and alcohol sector stated that work has been done within that sector to close the gap on comorbidity, although she admits that it continues to be a problem for those with the most acute needs:

> We've worked pretty hard over the last 15 years or so to integrate mental health care as a core business to drug and alcohol. So, we've got screening, suicide risk assessments, have kind of worked out how to do it in a scope of practice way. But when people kind of talk about the gap between drug and alcohol and mental health, it tends to be, I'm obviously generalising here, for people that have really acute mental health problems and really acute drug and alcohol problems, which is a smaller subset, and that's the group of people that really fall through the gaps of both systems. (Karen, stakeholder, NGO)

As noted in Chapter 3, there is a divergence in stakeholder accounts on the issue of comorbidity. Our analysis suggests that people experiencing comorbid mental illness and drug and alcohol issues struggle to access mental health supports, compared to people experiencing mental illness alone.

4.4 CONCLUSION

This chapter has provided an overview of specialist accommodation and support services for people experiencing or at risk of homelessness in the ACT. There is a range of short- and medium-term accommodation options for homeless people, many of which entail (or indeed mandate) access to support services, and one long-term accommodation option with accompanying supports. There is also a range of services that provide alcohol and substance use treatment services, case management and conduits and referrals to specialist support services (medical, legal etc.) to people who are homeless or at risk of homelessness. Drawing primarily on the first-hand knowledge of stakeholders and people with experiences of homelessness, we have highlighted a number of

potential gaps in accommodation and support services available to people in the ACT. This suggests that, while a substantial range of services exists, there are some groups that do not fit the allocation criteria for those services or that have service needs that are not met by current arrangements.

Chapter 5 sets out a more holistic assessment of how these services operate together as a service *system*, and the outcomes for people experiencing or at risk of homelessness, particularly those with HCSNs.

5 SYSTEMIC CHALLENGES

Chapter 4 described a number of accommodation and support services available to people in the ACT who are homeless or at risk of homelessness. In this chapter, we take a more holistic perspective and examine how those services and resources function as a service system. Specifically, we evaluate the capacity of existing services to meet the demand for support from people with HCSNs and we provide insight into the levels of unmet demand identified in Chapter 3.

We highlight two systemic challenges faced by the homelessness service sector in the ACT. Those challenges include a lack of exit points in the form of secure, long-term housing, particularly for people with HCSNs. They also include the conditional approach to service provision in the ACT homelessness services sector, in which people who are homeless are expected to transition through short- and medium-term accommodation and comply with a range of therapeutic–behavioural conditions before they are able to access social housing. We also examine the impact that these challenges have on public institutions, such as the public hospital and prison systems, and on the homeless people who are engaged with those institutions.

5.1 BACKLOGS AND BOTTLENECKS

Our analysis reveals that a lack of affordable and accessible housing options in the ACT means that people are often unable to access homelessness accommodation at times of crisis, and when they are able to access accommodation they find themselves stuck in those situations for extended periods, sometimes indefinitely.

5.1.1 Lack of permanent housing options

As we showed in Chapter 3, only 8–10% of homeless people who have a need for permanent housing have that need met. The qualitative data provided insight into why that is the case.

A consistent theme in our interviews was that the private rental market in the ACT is out of reach for most people who are homeless or at risk of homelessness, particularly those with HCSNs. Participants said that most homeless people are reliant on government income support, which is not sufficient to cover rent in the private market in most cases, particularly if people are receiving the Newstart allowance:

> Generally a lot of the clients that we work with—because we are working with those that are really, really vulnerable—don't necessarily have a source of income. So, their income will be Centrelink, which is too low to actually pay the rent in many instances. (Ellen, stakeholder, NGO)

> The private rental in Canberra is pretty high. It's almost the same level as Sydney prices. So, it's pretty expensive, which excludes a lot of people that might be on a lower income or, unfortunately, receiving benefits and that's it. (Jasmin, stakeholder, NGO)

> The other interesting thing is, there's just not enough money. Newstart is not enough. Even I was talking to a fellow today with [Disability Support Pension] and he said the housing market's too competitive. (Stewart, stakeholder, NGO)

The issue of affordability was also raised by people with a lived experience of homelessness, such as Brock, who was unemployed and living in shared homeless accommodation at the time of his interview:

> Private rentals—I'm unemployed now, again—it's just not doable. The options available for someone if you want to go into the private rental market, you have no chance of getting a one-bedroom flat or

> a studio flat. That's just simply not going to happen. So, you have to look at sharing a house with other people that you more often than not don't know and the rents that are charged, plus electricity on top, plus phone bills, plus all the rest of it. Just the rent will wipe out the Centrelink payment, even with rent assistance, like that. So, by the time you pay all those bills, you've probably got about $20 a fortnight for food, which is just not going to happen.

People who receive income support find that their income restricts their ability to access even shared living arrangements in the private rental market without compromising their ability to purchase basic necessities. The accounts of those participants are consistent with the data presented in a recent housing affordability snapshot produced by the ACT Council of Social Services, which shows that 'there is almost no housing in this city which is affordable to anyone on any kind of income support or a minimum wage' (ACTCOSS 2018:1).

Stakeholders also reported that, even when people with HCSNs can afford to move into a private rental property, they are usually unable to access such properties due to the level of competition and the stigma associated with their situations:

> So, people on Centrelink can only go into private rental if they're share housing. The problem here is, when you go to view the houses, you're up against public servants who have a secure income. And if you own a house, who are you going to rent to? A public servant or a group of people on Centrelink benefits? (Annette, stakeholder, NGO)

> In the ACT, again, we've talked about [people] having significant incomes, young couples, and all the rest of it; it's much easier to give a unit to a dual income family than it is to a person who is on a pension. So, instantaneously a person is stigmatised and they're discriminated against because they don't have the job, they're the more complex option, and it's rampant through the sector. (Anthony, stakeholder, NGO)

As these participants suggested, homeless people, particularly those with HCSNs, are at a disadvantage in the extremely tight private rental market in Canberra. For these people, social housing is often the only option. However, as of May 2018, people in the two highest priority categories for social housing (Table 7)—where most people with HCSNs would fall—wait on average between 8 months for priority housing and 21 months for high needs housing.[16]

Table 7: ACT social housing waiting times, May 2018

Application category	Average waiting time (days)
Priority housing	232
High needs housing	625
Standard housing	998

Source: ACT Government Community Services Directorate's website.

These waiting times might be considered modest by current Australian standards. However, interviewees observed that social housing applicants often wait for significantly longer periods than

[16] Figures retrieved from the ACT Government Community Services Directorate's website (online) on 29 May 2018.

the official waiting times suggest. A participant from an accommodation provider supporting a large number of people with HCSNs noted that his service sees very few people transition to social housing, and those that do access social housing wait for substantial periods of time:

> I wouldn't say a lot of people [move to social housing], but we do have [some]. In fact, we had one last week. Someone who'd been on the register for, I think, nine years had a property offered, a suitable offer. It was a second offer, and [s/he] accepted and moved into it. It's not a high number. There's not a lot of people. (Simon, stakeholder, NGO)

Some participants with lived experience of homelessness described waiting even longer than this. As the example provided by the participant quoted below illustrates, this occurs because people move on and off the waiting list for various reasons, such as a failure to respond to correspondence from Housing ACT:

> Now, I'm on the ACT Housing list, and I have been for quite some time, probably about eight or 10 years. I was on it, but unfortunately they voided my position on the waiting list because they'd sent out some documentation which I'd never received, but they might have sent it to an old address or something. So, I had to go and reapply. Yeah, which is one thing. I know the waiting lists here go for years [anyway]. Obviously, I know. (Victor, service user, homeless)

Others explained that they were taken off the waiting list because they declined offers for housing in areas that they considered dangerous or otherwise undesirable. One participant, Brock, described how he declined two offers for housing he considered dangerous and is now no longer on the list:

> I got offered a bedsit at Stuart Flats[17] … Stuart Flats is quite possibly one of the worst places on planet Earth. Think downtown Johannesburg on a Friday night and that's the sort of place. Really violent and really bad … The Stuart Flats place that I got offered, when I got offered, my first option was Kanangra Court, the white flats down the road here. It's a bedsit probably three times the size of this room and, yet again, it's a zoo. A lot of drug issues … There was some guy—the day I went to have a look at the place—that was having a psychotic episode in his flat smashing something up. That was always a good indication. (Brock, service user, homeless)

These participants' accounts highlight some of the ways in which people with HCSNs wait substantial periods of time for social housing, to the point where some simply give up.

These perspectives help us understand why in Chapter 3 we found that so few people are able to access permanent housing, despite having an identified need. As we will now show, the difficulties that people face in accessing permanent housing mean that many remain in the homelessness service system for long periods, often cycling between unsuitable, insecure and/or temporary accommodation, couch surfing, and sleeping rough.

5.1.2 Unsuitable accommodation

Many people who experience homelessness in the ACT, and particularly those with HCSNs, find themselves stuck in transitional housing or other insecure accommodation options. In some cases, this means that they remain for long periods in environments that, both homeless people and NGO stakeholders report, exacerbate their service needs and retard their efforts to improve their situations.

[17] The Stuart Flats complex in Griffith are due to be demolished and all tenants have been relocated (https://www.canberratimes.com.au/national/act/stuart-flats-residents-relocated-as-government-prepares-to-demolish-it-20180418-p4zadx.html).

As detailed in Chapter 4, some services in the ACT provide transitional accommodation for homeless people, the aim of which is to assist them to locate and prepare for permanent housing. However, stakeholders described how providers of transitional housing are finding it increasingly difficult to achieve transition due to the lack of permanent housing options. For example, two staff involved in the provision of transitional housing described their experience as follows:

Bill: We can't transition people or refer them on to another housing because there's just nothing. Everything is chock-a-block full at the moment …

Leah: There's no exit point, that's right. I mean, the case managers do a great job of getting them ready, and when they're ready they put in their forms to try and get them onto a certain priority, that they might get housed quicker through ACT Housing. But that's as far as we can go. Once all of that is submitted then you've got to sit back and wait for that person's name to come up, really.

The inability of transitional housing providers to transition people means that there is lower turnover in this accommodation, which in turn means that others are unable to access it.

Those who do not make it into transitional accommodation find themselves with very few options. Many of them are referred to the shared accommodation options described in Chapter 4, such as Ainslie Village and Havelock House. Those options are described by stakeholders and homeless people alike as sites of concentrated disadvantage that are not conducive to addressing people's complex needs or ending their homelessness. According to stakeholders, homeless people are aware of this, and many therefore resist accessing those options unless they have no others:

> So, the only option for these people … is Ainslie Village and Havelock House. Even our guys don't want to go there. You have to insist and insist and insist until the last minute sometimes and then they will fill it. They don't want to go in these places … (Dianne, stakeholder, NGO)

> The reality is that they're 50-year-old buildings. You've got to share with other people who have high rates of mental health, [alcohol/drug] issues, and then you put them in a tiny little village—in the sense of Ainslie Village—and Havelock, in one little building, and you've got a couple of hundred people with [alcohol/drug] issues, mental health issues, sharing accommodation. Nobody wants to go there. (Stewart, stakeholder, NGO)

Consistent with stakeholders' claims that the ACT's shared accommodation facilities are not conducive to addressing people's complex needs, people who live in shared accommodation characterised them as sites of social exclusion. They explained how living in these environments meant chronic exposure to drug and alcohol misuse and violence. Indeed, people expressed the view that living in some shared accommodation in the ACT put people into close contact with others misusing drugs and alcohol, and it was drug and alcohol misuse that explained their ongoing exposure to violence. Referring to shared accommodation close to the Canberra CBD, Vladimir described it as:

> A drug haven. Yeah, I'm going to be honest. Straight up. It's a drug haven here, mate. People go off their [deleted] dials. (Vladimir, service user, male)

After living in shared accommodation for six years, Vladimir explained how what he described as a 'drug haven' directly fuelled violence and dysfunction among other residents. He believed that the high rates of drug use coincided with drug dealing, leading to violence and associated problems:

> Someone owes $10 for a deal or whatever they do and people owe money around here all over to different people and the next thing, 'They're not going to pay me.' They've got a broken window in their room. They'll throw a brick through it. Every weekend here, on average, you'd probably get two windows broken. (Vladimir, service user, male)

Victor also lives in one of the ACT's shared accommodation settings, and has done so for around 12 years. His experiences resonate with Vladimir's. He described the issues at the accommodation in terms of 'drugs and violence'. He said that in order to survive in the shared homeless accommodation you had to 'know how to keep your head down and just survive'.

Maree described how living in shared accommodation meant she lacked the privacy and feeling of safety that come with independent living. She survived multiple violent relationships, including with former partners and her father, before moving into shared homeless accommodation. For 10 years since then, she has lived in shared homeless accommodation, which she describes as 'awful':

> There's only two women's blocks. We're just surrounded by male blocks. There's nowhere you can go and be private outside or anywhere really, because we've got the laundry next to us and about six blocks use that one laundry. I always feel like it's not completely private. … Can't we have just a little bit of space where I don't have to worry about whether I've got clothes on or not or whether my hair is up here or out there? (Maree, service user, female)

The accounts of Vladimir, Victor and Maree illustrate the significant challenges faced by people living in the ACT's shared accommodation options. Yet, despite their clear dissatisfaction with these arrangements, they have each lived in this accommodation for extended periods due to a lack of viable alternatives.

According to some stakeholders, people's reliance on shared accommodation in lieu of suitable long-term housing exacerbates their service needs and contributes to their ongoing homelessness. As one stakeholder put it: '[W]e are… forcing people into places like Ainslie Village and Havelock House because they have no other choices, which is then perpetuating that cycle in the sector' (Anthony, stakeholder, NGO). That perspective is consistent with the experiences of at least some of the people living in shared accommodation. Brock, who lived in shared accommodation for around 14 years, claimed that the conditions undermined his and others' ability to improve their circumstances:

> It's really destabilising for people who are trying to get [themselves] back together. If you're trying to maintain employment and you've got someone who's on the ice … three or four days straight screaming and carrying on in their room until the wee hours of the morning, you can't sleep. If you can't sleep and you go to work the next day and you're trying to function you're not going to do a very good job and eventually you won't have a job. (Brock, service user, male)

Brock also stated that the concentration of people with complex needs in shared accommodation made it difficult for people trying to address substance abuse issues:

> If people have had drug issues in the past they'll be enticed with free shots and free weed and whatnot. Even just simple things like bang on their windows at 4:00 am in the morning and, yet again, affecting their sleep saying, 'Look, we want to go along and have a party. Come and have a party,' and continually coming back. They just won't take no for an answer. (Brock, service user, male)

Research has shown that concentrations of disadvantage can create 'area effects', increasing barriers to overcoming disadvantage (Cheshire et al. 2014). The experiences of Brock, and other people living in shared accommodation, resonate with the finding that shared accommodation denies people privacy and prevents them from living apart from others with whom they share basic amenities, such as bathrooms, toilets and kitchens. It should be noted that a media article from 2017 did show that some people in Ainslie Village, who were concerned that the village would be demolished and that they would be evicted, expressed a view that there was a sense of community at the village (Baker, 2017).

5.1.3 Inability to access crisis accommodation

Despite the suboptimal conditions that characterise the ACT's shared accommodation, people are still trying to access it. Coupled with the backlog in transitional housing options cited above, this is reported to have a flow-on effect.

A number of stakeholders lamented the scarcity of crisis beds. For example, Jessica, an NGO stakeholder, stated that, 'I think that we really need more crisis accommodation beds in Canberra. We seriously need more crisis accommodation beds. I think that is a massive gap'. However, others claimed that the problem was not merely a lack of crisis beds; rather, it was that people using crisis accommodation had nowhere else to go. For example, Watson, a stakeholder from the ACT public sector, said:

> [T]he transitional housing system, where people are supposed to stay short-term, your refuges and so on and so forth, what's happening is the people in the refuges aren't able to then move to more stable accommodation because there is none of that that's currently available. So they're staying and they're actually blocking up that transitional housing system. So that then has a flow-on effect, which means that people who would normally be in that transitional system are now stuck in the crisis system and it's just getting worse. The answer is not just more crisis beds, because you actually need the flow through, you need the throughput.

One result of this is that people experiencing a housing crisis often have to *wait* for crisis accommodation.

Service providers cited cases in which users of their services were unable to access crisis accommodation. In one instance, staff from a specialist support service described how they received a call for assistance from a client who had been unable to get crisis accommodation through OneLink (the central access point for crisis accommodation and community services) due to a lack of vacancies:

> Ellen: We had one [woman] relatively recently where they'd basically been given the push off by Gateway Services [now called OneLink] and so then they contacted us. And you [Natalie] were involved in trying to find—
>
> Natalie: Yeah. So, my main concern was that she had linked in with the homelessness, like Gateway, and they said, 'Thanks for registering. Nothing we can do presently.' … The client then was sleeping in her car with two children as well. So, they were aware of that, and there was just, at the time, nothing else that they could offer … I was told that there were lots of women in her position in Canberra. (Stakeholders, NGO)

Another stakeholder, from the ACT's public hospital system, described his observations of emergency department staff providing swags to homeless people who were leaving hospital and who were unable to access crisis accommodation:

> So, I can speak on behalf of the social workers at the main hospital in ED. If they can't find, and they're having 30 to 40 presentations a day for mental health, and they're sometimes having to discharge people with a swag. When there's nothing else available, the social work department is giving people a swag … from the emergency department, because there is no crisis accommodation available. (Gerry, stakeholder, public sector)

5.1.4 Challenges for people exiting hospitals and prison

Interviews with government and NGO stakeholders suggested that the backlogs and shortages in the ACT homelessness accommodation system have an impact on people with HCSNs who are leaving prison and hospital. This also places additional burdens on those institutions. Stakeholders

stated that, because of what they understood to be the ACT Government's aspiration not to move people from institutions into homelessness, institutions keep working with people because those people have nowhere else to go.

In the case of prisons, a stakeholder with direct experience working in the ACT Corrective Services claimed that people who would otherwise be released on parole are kept in custody:

> Now, people who are being released by the Parole Board, part of that is they must have what the Parole Board consider to be a suitable address … The unintended consequence of that means that we actually have people who are in custody who have participated in their rehabilitation programs and, [because of them] having a lack of suitable accommodation available in the local community, actually remain in custody. (Watson, stakeholder, public sector)

Similarly, this participant stated that people are sometimes refused bail on the basis of their homelessness and held on remand:

> There's people that are being held on bail [because] there's no accommodation. If there was a bail support house, they would have 15 people who are in custody now could be supported in a bail support house. It is just a lack of accommodation to be able to provide that sort of support.

Stakeholders described how people who have served their full sentences cannot legally be held in custody until suitable accommodation is found, regardless of whether or not they will be homeless upon release. This means that some are released into homelessness, despite the best efforts of prison staff:

> They actually do their best out there, the case managers at the AMC [Alexander Maconochie Centre], to house people before they are exited, the ones coming out on parole … But a lot of the time it's time served and they know that it's coming up and they work very hard with the client again to try and get them housed. But they can't stop them leaving if it's time served if they haven't found them somewhere to live. They have to release them. (Leah, stakeholder, NGO)

Stakeholders acknowledged that there are supported accommodation programs for people exiting prison, some of which have been shown to be effective in helping people transition back into life in the community. They include the Coming Home program for women, operated by Toora Women Inc., and the Men's Accommodation Support Service, operated by Everyman Australia. However, stakeholders stated that these programs simply did not have sufficient capacity to accommodate all of the people who required their support:

> Interviewer: So, as far as you've seen, have those programs been—
>
> Watson: They are wildly successful. Wildly successful. There's no two ways about it.
>
> Interviewer: The problem is there's just not enough space?
>
> Watson: Indeed. The demand outstrips the supply, and the supply hasn't increased. (Stakeholder, public sector)

ACT Corrective Services also runs a program called Extended Throughcare, which provides intensive case management to people leaving prison. A recent evaluation of the program found that it produced positive accommodation outcomes and reduced rates of reoffending for those who were able to access it (Griffiths et al. 2017). However, at least one stakeholder reported that, despite being effective, 'the Throughcare system just isn't resourced' (Kevin, stakeholder, NGO), meaning that some of the demand for the service goes unmet.

Canberra's hospitals are also reported to be experiencing challenges related to discharging homeless clients.[18] Stakeholders reported that health facilities in the ACT were also committed to the aspiration to not exit people into homelessness. However, stakeholders claim that, with the limited accommodation options available to homeless patients, health institutions often experience delayed patient discharge, despite the patient's need for acute care having been met. Stakeholders reported that the problem is particularly pronounced for inpatient mental health services, as a stakeholder from the public health sector stated:

> So, we're a funded, 37-bed, acute mental health ward at the hospital. We actually have 40 beds … Out of our 40 patients there's [a considerable number] … either homeless and they're ready for discharge and we've put in OneLink referrals and we're waiting for OneLink, which is the crisis accommodation service, to get back to us … So, we've got a real issue with accommodation at the moment. There's probably [several people] waiting for accommodation as we speak. (Gerry, stakeholder, public sector)

This highlights the difficult situation that inpatient health institutions find themselves in. These services have the difficult task of providing acute services with a limited set of resources/beds, and the fact that they accommodate people who no longer need those services means that their ability to meet demand for their services is reduced.

Stakeholders who described the practices of public institutions holding people for longer than necessary all identified those practices as suboptimal. Those exiting institutions into homelessness or unsuitable situations, or without sufficient support, also face poor outcomes. Indeed, stakeholders highlighted how transitioning into these situations can undermine the positive outcomes achieved while a person has been in institutional care:

> So, the issue about housing and stable housing has a core part of drug and alcohol work because, for example, say you spent an entire year in a residential rehabilitation service, the idea of exiting someone into homelessness after that, after they've done this incredible, superhuman feat—and it's such hard work—it's impossible to retain those drug treatment outcomes without somewhere to live that's safe and stable and supporting of their amazing achievements that they've done. So that's a real barrier in terms of people exiting out of treatment, particularly residential treatment. (Karen, stakeholder, NGO)

Karen went on to explain how exiting people into unsuitable accommodation also undermines their rehabilitation:

> Say someone has undergone a treatment program and they've decided they don't want to use whatever kind of substance, we should be supporting them to live somewhere where they're not exposed to people that use that. That's a pretty reasonable thing and, in a really crass kind of way, we've actually invested a bunch of resources in them, in terms of the treatment system, and then we're putting the people in an environment where they're highly likely to fail, and that's our fault. That's a systems problem and we frame it as an individual failure. But it's a total systems problem.

Similar observations were made about people exiting prison into accommodation without access to adequate ongoing support:

> [It's] recognised everywhere that a lot of people go to jail, they get off the drugs, they get healthy, they get fit, they put on weight, they start to fit into their clothes again, they get cleaned up, they get their relationship back on track, they get access to counselling … Now, the issue that we have from there is, whilst those people are quite well supported whilst they're in custody, when they move back

[18] See Gerry's comment (above) about swags.

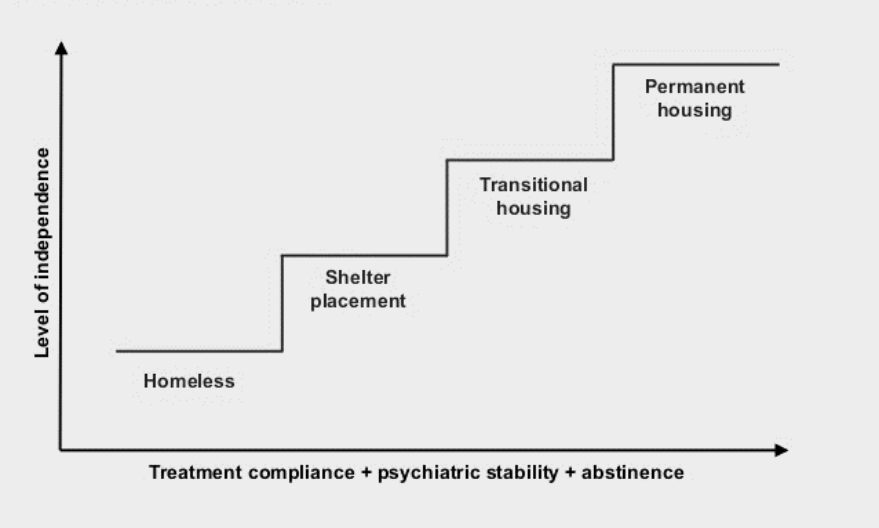
into the community, if those supports aren't maintained, very quickly they deteriorate. So that's where you get that horrible cycle of reoffending and reincarceration. (Watson, stakeholder, public sector)

5.2 CONDITIONALITY AND THE STAIRCASE MODEL OF SUPPORT

Another systemic factor limiting the ability of the ACT's homelessness services to address the needs of people with HCSNs is the conditional nature of the housing and support that is available.

Conditionality in the homelessness sector is associated with the 'staircase' approach to housing support (Padgett et al. 2016). In that approach, people who are homeless are required to move through crisis and transitional accommodation before being provided with access to permanent housing (see Figure 3). The aim is to ensure that people are capable of sustaining permanent housing when it is eventually provided to them. To progress from one step to the next, people are required to comply with various conditions, such as abstaining from drug and alcohol use and engaging with support services (particularly for substance use and mental illness). Research shows, however, that people with HCSNs struggle to comply with those conditions precisely because of the depth and breadth their needs and the fact that those needs are exacerbated by their ongoing homelessness (Padgett et al. 2016, Parsell et al. 2017). This in turn means that this cohort is often unable to progress 'up' the staircase towards permanent housing.

Figure 3: The staircase approach to homelessness services



Source: Padgett et al. (2016:7).

No homelessness service system operates exactly the way that the staircase approach implies. This is true of the ACT, where there are exceptions and alternatives to the staircase model. However, the linear and conditional logic of the staircase approach is clearly discernible in the way accommodation and support are provided in the ACT. This can produce poor outcomes for people with HCSNs; people may relapse into homelessness during the transition, and proportionally few progress successfully into secure housing.[19]

[19] See Padgett et al. (2016) for a review of the international research literature on the staircase approach.

5.2.1 Conditionality and the allocation of social housing

To an extent, the conditional approach to accommodation and support provision in the ACT begins with the way social housing is allocated. Housing ACT has a housing allocation instrument that assists it to prioritise those most in need: the *Housing Assistance Public Rental Housing Assistance Program (Housing Needs Categories) Determination 2011 (No. 2)*.[20] This instrument groups applicants into three categories: (1) priority housing; (2) high needs housing; and (3) standard housing. Categories 1 and 2 capture people with HCSNs.

To make it into the priority housing category, which has the shortest waiting time (232 days in May 2018; see Table 7), people must not only demonstrate 'exceptional, urgent and critical needs', but must also demonstrate that they are capable of maintaining a tenancy. This is made explicit in one of the 'supplementary principles' for priority housing in the allocation tool, which states that:

> Inclusion will be confined to applicants who are currently capable of independent living and with the capacity to undertake a housing tenancy to address their longer term housing needs. A clear distinction will be made between applicants who meet these requirements and *those for whom crisis or short-term housing is more appropriate to their needs* [italics added].

The conditional logic of the staircase approach informs this principle: priority housing will be provided only to people with HCSNs who can demonstrate that they can live independently and maintain a tenancy. Those who are not able to demonstrate this must return to 'crisis or short-term housing'—that is, the bottom of the staircase—until they are housing ready.

Stakeholders from Housing ACT explained that an applicant's capacity to live independently and maintain a tenancy is assessed in two ways. First, Housing ACT assesses whether there is evidence that the applicant can pay the rent for the property:

> Certainly one of the criteria for the priority housing list is that somebody can afford to pay rent to sustain their tenancy. So, where they've lived in the past, any particular community housing property, that's not necessarily true. It's just the record-keeping that can demonstrate a person can pay. (June, stakeholder, public sector)

As a stakeholder from the community sector explained, the requirement for a demonstrated ability to pay rent functions to usher people with HCSNs into the crisis and short-term accommodation system:

> For most of them it's six to 12 months in a car or couch surfing or whatever it is. So, for them to prove that they can pay their rent on time, Housing will push them to access refuges, crisis accommodation. (Stewart, stakeholder, NGO)

The second way in which an applicant's ability to maintain a tenancy is assessed is by considering whether they are engaged with support services to help them manage their complex needs and meet their obligations as tenants. As a stakeholder from Housing ACT put it:

> The ability to sustain and manage is broader than just, 'Can you pay rent?' It's whether or not you have a need for services to provide you with assistance to manage the day-to-day management of a property and your own needs within that property. (Terence, stakeholder, public sector)

This requirement relates to Housing ACT's desire to ensure that people with HCSNs are not left to fend for themselves once they are securely housed:

> From a tenancy perspective, we want to give the new tenants the best chance of succeeding in their tenancies. Particularly for new tenants who do have high and complex needs, having some

[20] Notifiable instrument NI2011-507, online.

> confidence that they've got the necessary community supports around them is an important factor in terms of helping them to sustain tenancies on a long-term basis and hopefully not placing them at risk of losing their tenancies down the track because they're not able to sustain it. (Loretta, stakeholder, public sector)

As discussed in Chapter 6, research confirms the assertions of stakeholders that people with HCSNs will require support linked to their housing for them to sustain their tenancies. However, making timely access to secure housing contingent upon engagement with support imposes additional burdens on people who are by definition highly vulnerable, and whose vulnerability is exacerbated by their homelessness (Padgett et al. 2016, Parsell et al. 2017).

Stakeholders from NGOs described some of the challenges people with HCSNs face in qualifying for priority housing. The conditions of homelessness make it difficult for people with HCSNs to sustain engagement with support:

> When we're talking about the high and complex needs, it's very hard for a lot of these people to go through the process of even getting to the stage where they can put in an application, let alone then maintaining [support] while they're waiting for their application. (Anthony, stakeholder, NGO)

These difficulties result in people with HCSNs being relegated to short-term homeless accommodation, some for indefinite periods. This goes some way to explaining our finding in Chapter 3 (Section 3.1) that homeless people with HCSNs are more likely to be assessed as having a need for short-term accommodation than are other groups.

5.2.2 Conditionality in crisis accommodation

The provision of accommodation and support at the crisis level is also conditional. The conditions are intended to assist people to progress towards housing readiness and to prepare them for the medium-term accommodation options that constitute the next step in the staircase:

> So, there's a chores list and then a follow-up of their chores, and they're required to clean up any mess and things like that themselves … So, the majority of their opportunities are going to be in group housing or even shared accommodation. So, if they don't have those basic skills they're going to struggle when they move on from here … We can write a support letter saying that they've been able to pay their rent for so long. They're are able to show that they're able to live in a group environment, that they've been able to maintain a basic level of hygiene, that they've been able to meet minimum requirements for cleaning up their rooms, maintaining their rooms, and cleaning up their own dishes, and those type of things, and we're able to show if they've got basic living skills like cooking and cleaning and all those type of things. (Anthony, stakeholder, NGO)

Conditional arrangements for crisis accommodation services give people the opportunity to demonstrate their ability to pay rent and live independently. However, those conditions also lead to the exclusion of people who are unable or unwilling to abide by the rules:

> The crisis accommodation, they have really strict intake criteria. People can't be intoxicated, they need to have their mental health under control or be stable on medication just because the service just can't have people who are intoxicated or people who are going to have a psychotic episode. So there's a lot of people who are not eligible. They're just not going to get into that crisis accommodation. They're not even going to get on the waiting list for it. (Jessica, stakeholder, NGO)

Another condition for living in crisis accommodation is that people actively endeavour to transition to the next step:

> So, because we are crisis accommodation, and based off the White Paper documentation, we can't just kick a person out because they've got no accommodation. So, in other words, technically their

> stay while they're here is indefinite. However, there is a caveat around that, that they must be abiding by the house rules. One of the house rules is looking for long-term accommodation, permanent and long-term accommodation. (Anthony, stakeholder, NGO)

In a sector in which there are limited accommodation options, this condition often functions to funnel people into shared accommodation options such as Ainslie Village and Havelock House. Anthony went on to explain:

> So that's where we run into a lot of difficulties in working with our residents here, is that if a person doesn't identify Ainslie Village and Havelock House as being suitable accommodation due to perceived personal risk, risks of relapse with regards to drug and alcohol and those type of situations, and they therefore don't want to apply for that, we're really in a tight—because they're technically in breach of their house rules and their occupancy agreement with us … What do we do then? Because, in other words, we'd be full and no one would be able to come in from the street and things like that.

The qualitative data therefore suggests that conditionality in the provision of crisis accommodation reduces people's ability to exit homelessness, as many people are either excluded from crisis accommodation due to their complex needs or are funnelled from crisis accommodation into shared accommodation. Neither of those outcomes helps people to move 'up' the staircase. This is further evidenced by the finding (Chapter 3, Section 3.1) that homeless people with HCSNs have a lower likelihood of being provided with medium-term housing, compared to the rest of the homeless population.

5.2.3 Conditionality in transitional and shared homelessness accommodation

Most of those who make the ostensible step 'up' the staircase to transitional housing or long-term shared accommodation face another layer of conditional support. Despite the lack of affordable and accessible permanent housing options, both transitional housing providers and at least one shared accommodation provider aim to move people up the final step of the staircase to permanent housing. In most cases, their method of doing that is to mandate engagement with support services as a condition of people accessing or retaining accommodation through their services. For instance, one provider of transitional housing stated that:

> When they come to [our] program they have to agree to participate in the program. So, they're not just getting a place, they need to agree to have regular visits from their caseworker and to participate in the design of the implementation of their case plan. (Kevin, stakeholder, NGO)

Similarly, while the long-term shared accommodation options in the ACT do not include their own support services, at least one of them requires that people with HCSNs be engaged with support services before they are accommodated:

> When we're going through that [intake] process … somebody might be identified with particular needs, and if they've got supports for those needs and they're connecting to support services, we will record that down there and we'll take them in. But if we've got people with identified issues, say, substance abuse types of issues, we could potentially not take them in until they connected up to some type of support service. (Alan, stakeholder, NGO)

The conditions are similar to those applied to social housing applicants seeking priority housing status. The difference is that the requirement for support is not only about maintaining a tenancy—although that is an aim—but also about preparing people to move to permanent housing.

The research literature questions this kind of conditional approach to service provision. The evidence suggests that the effectiveness of support is attenuated when it is made a condition of accessing housing (Watts & Fitzpatrick 2018). This is particularly the case when the person's service provider is also their tenancy manager (Padgett et al. 2016), which is the case in all of the

transitional housing provided for people who are homeless or at risk in the ACT (although not the long-term shared accommodation options).

A key issue with combined tenancy management and service provision arrangements is that people have no choice about who provides services to them, meaning that they are stuck with a service provider regardless of whether the relationship is working for them or not:

> Well, the thing that I was thinking that does impact on housing is options that have been offered where it is the same organisation being asked to be both landlord and also support service. Because, for people with the most complex needs, you've suddenly lost a housing option if your relationship with that service provider isn't good. You can't just, as anyone else would do, go, 'Okay, I want to change my service provider,' if it's conditional that it's a package, that you have to do both. (Janeen, stakeholder, NGO)

There are also issues related to the capacity of service providers to develop a necessary rapport with people with HCSNs when those people have no choice about engaging in the relationship. The problem of rapport also often emerges when the organisation providing support is also the tenancy manager who collects rent from service users and has the potential to sanction them for poor behaviour.

Transitional housing, and the staircase model generally, can create a state of limbo and uncertainty about the future. While the people living in transitional housing to whom we spoke stated that they did not feel pressured by service providers to move on, the temporary nature of their accommodation was a source of ongoing stress and concern for them. One participant expressed concern that the challenges she faces in accessing permanent accommodation are preventing others from accessing the service:

> Again, it's not long term. Women who come through with the domestic violence, there's a big turnover. You're in the program and they kind of get you on your feet and then you kind of exit the program. But I can't exit the program because I don't have the accommodation to exit … I know that there's other people that are needing to come through. (Jacinta, service user, female)

Another participant raised concerns about changing her children's school when she moves from her transitional property:

> Kate: I would like to stay here now because the kids have already moved school once. I don't really want to move them again. [With Housing] you sort of can just say what suburb that you want, but Belconnen, Gungahlin is a pretty big [area]…
>
> Interviewer: So is there a chance you would move too far away from the school?
>
> Kate: There is. Because I don't have a car at the moment either, so this house has been good because there's a bus stop just at the end of the street that goes straight to their school. (Service user, female)

In these examples, the participants express anxieties related to the transitional and therefore temporary nature of their accommodation. This reflects another important challenge related to the ACT homelessness service system's adherence to a staircase model that requires that people move through transitional housing in order to access permanent housing.

5.3 CONCLUSION

This chapter has highlighted the systemic challenges that the ACT homelessness service sector faces and the impact that those challenges have on people experiencing homelessness. Central to the challenges is the fact that the lack of affordable and accessible long-term housing means that

there are limited exit points for people engaged with the homelessness service sector. In addition, the conditional staircase approach to homelessness support in the sector makes it difficult for people who have HCSNs to be deemed 'ready' for long-term housing. In the next chapter, we discuss how permanent supportive housing may offer the ACT an important way to address these challenges.

6 SUPPORTIVE HOUSING MODELS FOR PEOPLE WITH HIGH AND COMPLEX SERVICE NEEDS

Although the principles of supported housing and permanent supportive housing (PSH)—which include housing affordability, tenant control, choice, a separation between tenancy manager and support provider, and normality—are critical to success, they can be actioned through a diverse suite of PSH models. This chapter examines those models and evidence about the efficacy of PSH over transitional and conditional models of accommodation and support for homeless HCSNs.

6.1 WHAT IS PERMANENT SUPPORTIVE HOUSING?

The Corporation for Supportive Housing in the United States defines supportive housing as combining 'affordable housing and services that help people who face the most complex challenges to live with stability, autonomy, and dignity' (CSH n.d.). Importantly, supportive housing is directed towards people with needs in addition to their need for housing.

While there is no unanimously agreed definition of PSH (Farrell et al. 2010), it significantly involves long-term housing. Henwood et al.'s (2013) review of supportive housing in the United States referred to 'permanent supportive housing' to distinguish it from shelters and other forms of non-permanent homeless accommodation. In an overview of supportive housing in the United States, Hannigan and Wagner (2003:4–5) identified the core principles that have guided its development and effectiveness:

1. Permanence and affordability; a key priority is to increase the supply of affordable housing. Affordability is typically defined with rents not exceeding 30% of income.
2. Safety and comfort; tenants should feel safe and comfortable in their homes. Supportive housing buildings must at a minimum comply with building codes, and every effort must be made to provide security measures to meet tenants' needs, including the promotion of tenants taking collective control over their environment.
3. Support services are accessible and flexible, and target housing stability; support services not only cater for tenants' diverse needs, but also retain flexibility to cater for changing needs over time. Tenancy sustainment is fundamental.
4. Empowerment and independence; supportive housing is purposefully designed to promote tenants' empowerment and to foster tenant independence. Tenants are in their homes and service providers are there to be supportive.

These principles share similarities with the views of people with mental illness about their housing preferences and their need to live independently (O'Brien et al. 2002). Although PSH is an initiative broader than the mental health field, the literature focuses specifically on mental health because, in the United States at least, having a disability—very often a psychiatric disability—is a requirement for accessing PSH (Burt 2006). This mental health focus has shaped the supportive housing practice and research agenda. A large part of the research considers the appropriateness and nature of supportive housing vis-à-vis mental health institutions and involuntary patients' experiences of healthcare provision. In this respect, the supportive housing literature is often presented and examined in contrast to health care that is inpatient based and often restrictive.

O'Brien et al. (2002) identified housing characteristics important to people with mental illness as including:

1. independence and choice
2. convenient location
3. safety and comfort
4. affordability
5. privacy
6. social opportunities.

Using almost identical principles to the literature defining PSH, a body of literature—also predominantly from the United States—defines 'supported housing'. The Center for Mental Health Services in the United States identified eight characteristics of the ideal model of supported housing:

1. owned or rented through a formal lease held in a tenant's name
2. a legal and functional separation between the landlord and the support provider
3. housing that is integrated into the community/neighbourhood
4. affordability
5. availability of voluntary services
6. resident choice in terms of housing and services
7. community-based services with no live in staff
8. crisis services available 24 hours a day, seven days per week (cited in Rog 2004:340).

Tabol et al. (2010) analysed peer-reviewed literature on both supportive housing and supported housing published between 1987 and 2008. They focused on housing interventions for homeless populations with serious mental illnesses, substance use disorders, or both, and identified five overarching criteria of supported housing:

1. Normal housing: affordable; integrated with non-consumers; long-term / potentially permanent; normal tenancy agreement; appearance of tenancy fits neighbourhood norm; privacy over access to unit
2. Flexible supports: individualised and flexible services; crisis services available; resources in close proximity
3. Separation of housing and services: absence of requirements as condition of stay; housing and service agencies legally and functionally separate; no live-in regular housing staff
4. Choice: in housing options and shared decision-making
5. Immediate placement: not preparatory settings.

While the literature on supported housing and PSH defines those two models separately, they share philosophical premises. Housing affordability, tenant control, choice, a separation between tenancy manager and support provider, and normality are all key features of both supported housing and PSH.

6.1.1 What is the evidence for permanent supportive housing?

There is a large body of research on the outcomes attributed to PSH, which demonstrates that the provision of affordable housing with some form of voluntary support services is a successful means to enable people with experience of homelessness and mental illness to sustain housing. In this section, we review the evidence base for the housing, health and cost offset outcomes of supportive housing.

Housing

Longitudinal research and randomised control trials indicate that affordable and secure housing with voluntary linked support services is successful in enabling people to exit chronic homelessness and sustain housing. Much of this research has been conducted from mental health perspectives.[21] In a review of the latest evidence from Canada, Goering and Streiner (2015) say that the most important finding about Housing First PSH is that the model is 'very successful, most especially regarding the primary outcome of enabling people with a mental illness who are homeless to find and maintain stable housing for an extended period of time'.

The Housing and Accommodation Support Initiative in New South Wales is an example of PSH. The program is focused on people with mental illnesses rather than homelessness (recognising that they are often the same group). The evaluative research demonstrates that it has achieved excellent housing access and housing retention outcomes (Bruce et al. 2012).

Other Australian evidence on PSH models in Brisbane, Sydney and Melbourne has shown that people with HCSNs with long histories of homelessness are able to make immediate exits from homelessness into secure housing and that the majority—between 80% and 90%—sustain their housing for at least one year.[22]

Health and healthcare access and supportive housing

People who are homeless experience poorer physical and mental health than the broader population. They are also at greater risk of having unmet healthcare needs and are disproportionate users of emergency health services. Drawing on administrative data, Australian research shows that people who move from chronic homelessness into supportive housing use less emergency health care and that reduced health care offsets the costs of supportive housing.

[21] See, for example, Pearson et al. (2009), Rog et al. (2014), Salyers & Tsemberis (2007), Siegel et al. (2006), Tsai et al. (2010), Busch-Geertsema (2013a), Fitzpatrick et al. (2012), Johnsen & Teixeira (2012), Johnson et al. (2012), Pleace & Bretherton (2013).

[22] See, for example, Brisbane Common Ground (Parsell et al. 2016); Street to Home in Brisbane (Parsell et al. 2013a) and Melbourne (Johnson & Chamberlain 2015); Way2Home in Sydney (Parsell et al. 2013b); and Journeys to Social Inclusion in Melbourne (Johnson et al. 2014).

Integrated health care and supportive housing:
a case study of Brisbane Common Ground

Brisbane Common Ground is an example of the integrated health care and supportive housing model in practice (Parsell, C. et al. 2016). A multidisciplinary team of health, psychosocial, and housing professionals works together to achieve interdependent objectives while, at the same time, maintaining clear and established professional boundaries. In this model, an on-site team works cooperatively and collaboratively with external service providers.

The model enables tenants' needs to be identified, external resources accessed and a coordinated response delivered by external and on-site providers in a way that realises tenant-identified objectives. Tenant needs and tenant choices underpin the model. Tenants are free to engage or disengage with service providers. Refusal to engage with the health or psychosocial providers has no impact upon the ongoing delivery of housing.

The model addresses systematic barriers to mainstream health care and social services access, assisting tenants to take control of their health care, support, and tenancies. Through the provision of secure and affordable housing and integrated health care, the model empowers tenants to access health care and social services through mainstream institutions.

'Tenants' experiences illustrated how the model enabled them to overcome barriers to start taking control of their primary healthcare and lifestyle needs.'

At Brisbane Common Ground, the model is resourced with four tenancy managers, two clinical nurses, and two social workers who provide psychosocial support. The three service providers—tenancy, health, and psychosocial—are all located on site.

With tenant consent, the service providers work together. If tenancy issues have the potential to lead to eviction, the health and psychosocial service providers work with the tenant and tenancy manager to address the problems that put the tenancy at risk—problems that often have a health and social basis.

An evaluation of the model (Parsell et al. 2016: p. 3) found evidence of five impacts:

- People sustained their tenancies.
- Tenants used less crisis health and criminal justice services.
- Integration of health, housing and psychosocial practices and systems was achieved.
- People overcame barriers to healthcare access.
- The health and wellbeing of tenants improved.

In their study of health care integrated with PSH at Brisbane Common Ground, Parsell et al. (2016, 2018) examined how people exiting homelessness use and benefit from integrated health care and supportive housing. In addition to the material deprivation of homelessness directly contributing to ill health, they showed how homelessness contributes to exclusions from mainstream health care. Developing the evidence about affordability barriers to accessing health care, they found that homelessness was experienced as a devalued identity with limited power to be heard and thus to access and benefit from appropriate health care. Being homeless meant that medical professionals treated the symptoms of their poverty; for example, treatment did not take account of how the social conditions of homelessness caused their ill health. Perversely, the ill health exacerbated by homelessness constituted physical, often mobility, barriers to accessing mainstream health care.

The study showed how PSH tenants actively used the resources available in supportive housing to access mainstream health care. Most participants reported improved access to medical professionals, which predicted improved physical health and life satisfaction. Coupled with the resources that housing enables—transport, access to medical practitioners, advice and understanding of healthcare directions—integrated health care created the conditions for tenants to control their day-to-day lives and healthcare needs.

Cost offsets

In Australia, the 2008 national policy statement identifying the need for governments to achieve measurable reductions in homelessness occurred alongside the need for homelessness programs to achieve client outcomes that could be measured financially (Zaretzky & Flatau 2013). Augmenting notions of social justice, contemporary advocacy to end homelessness draws on the proposition that it is more expensive to keep an individual homeless than it is to provide formerly homeless people with housing and linked support. The Australian Government (2008:10) refers to ending homelessness as a 'good investment of public money' that delivers 'whole-of-government savings in avoidable health, justice and police outlays'.

Ending homelessness, rather than just managing people who are homeless, has become a matter of fiscal governance. Providing long-term housing and linked support—as opposed to crisis accommodation and the myriad health and criminal justice services that people who are chronically homeless disproportionately use—constitutes a whole-of-government cost offset.

Parsell et al. (2016) linked government administrative data from tenants of Brisbane Common Ground PSH to develop evidence about the costs and cost offsets of addressing chronic homelessness. The tenants used fewer services, often considerably fewer, in their first year living in supportive housing compared to the year before they began their tenancy, when they were homeless. The reduced costs were directly associated with reduced service use. The tenants used health, criminal justice and homelessness services that cost the Queensland Government $1,976,916 (an average of $48,217 per tenant) in the year they were homeless. The cost of services they used in the year they were supportive housing tenants was $852,314 (an average of $35,117 per tenant), resulting in an overall cost reduction of $1,124,602.

These figures included health, criminal justice and homelessness services and the tenancy and support costs of supportive housing. Compared to the costs of a person being chronically homeless for 12 months, a 12-month supportive housing tenancy reduced the average tenant's use of state government services by $13,100.

Reduced service utilisation and cost offsets are only one reason for responding to people who are chronically homeless with supportive housing. Parsell et al.'s (2016) analysis supports more fundamental arguments for enabling chronically excluded individuals to participate in society. The research provides further evidence that the provision of supportive housing demonstrably changed which services people used and how they lived their lives. They went from being homeless clients, patients, offenders and inmates to being supportive housing tenants.

Different models

Recent debates in the PSH literature have turned to the form of housing and the nature of linked support that are most effective for people with chronic experiences of homelessness and high vulnerabilities. The debates centre on the design of the built environment, how it facilitates wellbeing and how disadvantaged people leaving homelessness can experience home and community. They have also raised important questions about whether housing should be concentrated in one building or scattered throughout neighbourhoods. The Pathways to Housing approach, which has achieved outstanding results in housing retention (Tsemberis 2010), strongly advocates scattered-site

housing. The program limits leases to no more than 20% of the units in any one building. The push towards scattered-site supportive housing is based on the argument that housing should be indistinguishable and should facilitate people's reintegration into and inclusion in society.

Supportive housing delivered by scattering properties throughout buildings and neighbourhoods is common beyond the Pathways to Housing program in the United States, in Australia and in the United Kingdom, and is advocated in Europe, where it is argued that the provision of scattered-site housing for people exiting homelessness is associated with a desire to achieve normalisation of living conditions and a move away from place-centred support to person-centred support.[23]

In contrast, single-site supportive housing congregates independent tenancies within one building. Social and health services are often located on site. Some single-site supportive housing has services available 24 hours a day, seven days per week. Salyers and Tsemberis (2007:632) noted that the constant presence of services, while potentially effective in meeting people's needs, can be intrusive when such services are 'out of sync with consumers' needs'. Weiner et al. (2010) hypothesised that normalised independent forms of supportive housing create the conditions for tenants to express autonomy, which acts to protect against reduced quality of life.

As well as reducing stigma and promoting wellbeing and reintegration, scattered-site supportive housing is congruent with the preferences of consumers of mental health services and people with experience of homelessness (Busch-Geertsema 2013a, Tanzman 1993). This is affirmed by evidence that people with chronic experiences of homelessness sustain their tenancies in scattered-site supportive housing (Rog et al. 2014).

Despite the unambiguous evidence for the benefits of scattered-site housing with voluntary and person-centred support, single-site housing with on-site support continues to be developed in Australia, parts of Europe and the United States (Busch-Geertsema 2013a, Parsell et al. 2014). Its advocates describe it as a means of fostering community, networks of formal and informal support, and social inclusion and as a way for people who have otherwise been socially and economically marginalised to achieve the safety and security of home (CGQ 2014).

Some forms of single-site supportive housing involve a deliberate social mix: half of the properties are allocated to low- to moderate-income employed tenants and the other half to formerly chronically homeless tenants. The mix is intended to promote positive community interactions, networking, bridging social capital, role modelling and stigma reduction (Galster 2012, Sautkina et al. 2012). Although there is little empirical evidence that single-site supportive housing achieves the purported social objectives, and little work comparing outcomes in single-site supportive housing with those in scattered-site supportive housing, inferences about the benefits of single-site housing can be made from research examining scattered-site housing.

Single-site supportive housing aims to provide an inclusive community and a means of self-improvement for people who have been marginalised and excluded as homeless and who continue to experience isolation and social exclusion after they have obtained housing. Through the design of the built environment, on-site support services and the critical mass of tenants in the one building, single-site supportive housing intends to create communities for tenants and enable them to achieve the positive non-housing outcomes that are largely absent in the evidence from scattered-site supportive housing. Siegel et al. (2006) suggested that single-site housing coupled with active assistance from support providers promotes socialisation among tenants and thus plays an important role in addressing the isolation experienced in scattered-site housing. Tsai et al. (2010)

[23] For instances in the United States, see Pearson et al. (2009) and Rog et al. (2014); in Australia, Parsell and Moutou (2014); in the United Kingdom, Fitzpatrick et al. (2012) and Pleace and Bretherton (2013); and in Europe, Busch-Geertsema (2013a).

likewise found that people in single-site and supervised housing reported a greater sense of community than did tenants living in apartments. However, the sense of community also led some tenants to complain about other tenants' alcohol and drug use, disruptive behaviour and theft (Tsai et al. 2010). In a Danish study, Benjaminsen (2013) found that some residents of a trial single-site supportive housing program were satisfied with their housing and interactions with other formerly homeless neighbours, but there were a range of conflicts and problems between tenants. Ultimately, the single-site supportive housing model was abandoned and tenants were offered scattered-site housing.

6.1.2 Permanent supportive housing in the ACT

Housing First services

Two services operating in the ACT are explicitly committed to Housing First principles—Northside Community Service and Street to Home Canberra (operated by St Vincent De Paul). Both reported that they struggle to translate their commitments to those principles into practice. As one stakeholder put it:

> We need more Housing First options … because ACT Housing doesn't support Housing First and it makes it difficult for us … Some of our clients are not going to be housing ready in the next two, three, four, five years. (Lynda, stakeholder, NGO)

Northside provides transitional housing to women with or without children through its Women's Housing First Program, and Street to Home has crisis housing for people experiencing chronic homelessness, rough sleeping, or both. The organisations are both tenancy manager and service provider to people occupying their transitional properties.

Common Ground

As noted in Chapter 4, Canberra has one Common Ground facility, and plans are underway for the development of a second. Common Ground Canberra in Gungahlin, which opened in 2015, followed the guidelines for the Common Ground model developed by the Australian Common Ground Alliance: 'The key objective of Common Ground is to house chronically homeless people through a "housing first" approach that provides permanent housing, direct from homelessness, and the support people require to stay housed' (ACGA 2011:2).[24] It offers self-contained, independent units with secure tenancy arrangements to 20 formerly homeless people with HCSNs (who pay rent at 25% of their income) and 20 low-income earners (who pay 75% of market rent). Tenant eligibility is limited to singles and couples without children and people over the age of 18 years. Voluntary on-site support services (provided by Northside Community Service) are separate from tenancy management (by Argyle Community Housing). One key difference between Common Ground Canberra and some other facilities around Australia is that concierge services are not available 24 hours a day. Nevertheless, the key features of Common Ground Canberra are consistent with the principles of PSH.

Some stakeholders expressed reservations about the Common Ground model and PSH more generally; however, in many cases, those reservations were inconsistent with the findings of research and the experiences of people living at the facility. One concern raised was that Common Ground did not sufficiently incentivise people to move on to other living arrangements. For example, one participant lamented the lack of conditionality involving service engagement:

[24] The Common Ground Community of Practice Network has replaced the earlier collaboration called the 'Australian Common Ground Alliance' and is now part of the Australian Alliance to End Homelessness.

> They do have their Common Ground site … It's a Housing First model, however it's got voluntary case management, which means these people that have come into the program three years ago are still there and they've not necessarily addressed any of their issues, or whatever it is, but they're still there, which means it's a funnel neck … I would have liked to have seen maybe engagement with case management being a part of the tenancy agreement, so at least there's an incentive to move on. (Stewart, stakeholder, NGO)

Another stakeholder raised concerns that the secure tenure available to people at Common Ground meant that they become 'too comfortable' and thus lack an incentive to move on:

> I don't think it [Common Ground] really encourages building on strengths and growing and moving out the other end. That's my opinion and from my observations … [O]nce they're there: comfort zone, safety. There's got to be a balance there, that thing about safety. Why not keep moving? (George, stakeholder, NGO)

Those observations differ from the principles and objectives of PSH as a secure, long-term home, not a stepping stone to something else. However, the second quote in particular raises the more complex issue of the personal development of those residing at Common Ground, or 'empowerment', as the participant put it earlier in the interview.

This view of PSH is challenged by our interviews with tenants and by the peer-reviewed literature. The two tenants of PSH interviewed in the ACT derived great benefit and feelings of stability and security from the non-conditional support. Moreover, both articulated aspirations for positive life changes that would lead them to move beyond PSH. Jerry's experiences illustrate those aspirations and how PSH plays a role:

> Jerry: Yeah. It's just a good place. The Argyle staff are pretty good. Security and I get along. I've always got along with the security guards here. Northside Community Service are good. Yeah, it's just sort of like it's designed as the next step. Like a step before, say, going into a house or renting a house or buying a house.
>
> Interviewer: Is that something you see yourself doing?
>
> Jerry: Yeah. I'd like to move out of here eventually. I don't want to be here forever. At the moment it's good.
>
> Interviewer: And there's no pressure on you to go or anything like that?
>
> Jerry: No, they don't put pressure on people to go. It's designed as not really temporary, but I suppose sort of temporary. After a few years, if people get on their feet they're encouraged to go to bigger and better things, like their own house.

Ricky felt similarly about his time in PSH as a means to a broader life goal:

> If I end up with a girlfriend or wife or family I would prefer to be in the suburbs somewhere. But not in an area that's just all public housing. Like private accommodation, so I can say goodbye to the world of poverty. (Ricky)

The sentiments of Jerry and Ricky illustrate how they experienced the permanence and support provided in PSH as resources to help them move forward, rather than as a disincentive, as the stakeholders quoted above implied. The experiences of the two ACT PSH tenants are consistent with research from other Common Ground facilities in Australia. As Parsell and Marston (2016:208) argued:

> Leaving supportive housing differed from the idea of churning people through a residualised social housing system. Leaving supportive housing rested on an optimistic assumption of human capacities.

> The life transformations that led to moving on highlighted a normative view that all people, even highly vulnerable people with disadvantaged life histories, can go on and flourish. The intended flourishing was not left to the individual to achieve on their own. Rather supportive housing was a significant intervention into vulnerable people's lives.

Parsell and Marston's research further showed that a move out of PSH has to be determined by the individual tenant, at a time that reflects the realities of the tenant. Imposing a time on moving is counterproductive, undermining the feelings of security that are a critical ingredient in the aspirations and experiences of improving one's life (Parsell & Marston 2016).

A number of stakeholders also expressed concerns about the cost-effectiveness of Common Ground, given its relatively high cost to build and run and the fact that the number and permanence of tenancies means that there are few vacancies for new clients:

> But $20 million to look after 20 people with services is a capital outlay, not mentioning the ongoing costs of running that building and providing those services. I just look at that and I think that's incredibly expensive … They could have looked after a lot more people for that type of money. (Alan, stakeholder, NGO)

> Just that it costs so much for one flat and this really intensive model, and apparently it does work, but it's just a really expensive model and is it really even the best model? … There's not a lot of movement. I met with a lady from Common Ground last month … and she was like, 'I'm surprised you didn't know more about Common Ground.' I was like, 'Well, you're just not relevant to us. You don't have any vacancies … (Jessica, stakeholder, NGO)

Concerns about the cost-effectiveness of Common Ground are addressed by the literature on cost offsets discussed above, which shows that housing and supporting people with HCSNs in Common Ground is less expensive to governments than keeping people in chronic homelessness (Parsell et al. 2017). Indeed, some stakeholders recognised this:

> That model is brilliant. It seems to be expensive if you look at it as a standalone. But if you look at what the costs are to the ACT community in terms of crime, policing, courts, victimisation, prisons, hospital, then it becomes an investment rather than a cost. (Watson, stakeholder, public sector)

MyHome in Canberra

The MyHome model of supported accommodation is a potential response for people homeless or at-risk HCSNs and is being proposed for a development in the ACT.[25] The proposal is based on HOME in Queanbeyan, New South Wales, which provides long-term accommodation and support to around 20 people who are experiencing serious mental illnesses. HOME is a congregate facility that includes a number of successful features of PSH highlighted in the research literature, including the provision of long-term, secure tenancies and self-contained, independent units. The facility has 24-hour security to ensure the safety of tenants (security locks, on-site caretaker). Tenants are free to come and go as they please. They also have access to on-site support provided by a team of volunteers who, like case managers at other forms of supported accommodation (including Common Ground), make referrals to external support providers.

However, some features of the MyHome/HOME model are not supported by the research literature on PSH. While stakeholders from HOME in Queanbeyan stated that people's tenancies are not contingent upon their engagement with support services, there is no formal separation between tenancy management and support provision at the facility. This means that HOME—and MyHome,

[25] MyHome in Canberra, online.

too, if it is implemented in this way—is likely to face similar shortcomings to transitional models with integrated tenancy management and support (discussed above).

HOME also lacks any form of social mixing, as all of the 20 units are occupied by people with HCSNs. However, it is possible that the proposed MyHome initiative will have affordable housing units integrated with it, in a manner similar to Common Ground. As a stakeholder explained:

> So we've got this block of land owned by the Uniting Church in Curtin and the Uniting Church is proposing to build an affordable housing development on the block to integrate it with MyHome. So, we've got to look at how best we can strategically integrate both in the MyHome model and the Uniting Church's affordable housing model together. (Rudy, stakeholder, NGO)

The integration of affordable housing units with MyHome would be consistent with the PSH principle of normality of housing.

There are also questions about whether MyHome will be accessible to those people in the ACT who have the most challenging and complex needs. Stakeholders involved in the HOME and MyHome projects explained that, along with level of need, applicants seeking tenancies at HOME in Queanbeyan are assessed on the basis of their 'compatibility' with the model and other tenants:

> I think the other aspect is, HOME in Queanbeyan is based on needs first and compatibility is the other one. So, someone might have a high need, but in terms of compatibility with the other residents, if they're not able to work together you've got to look closely. (Richard, stakeholder, NGO)

As another stakeholder explained, compatibility is assessed by a tenancy committee that considers a range of factors, including an applicant's criminal record:

> Our tenancy committee is made up of the manager of the local mental health service, the police, a community representative, myself, [a local priest], and someone from Department of Housing. So, we look at referrals. The police do police checks, and a lot of our residents have been in contact with the police during their time, particularly when they weren't well. So, it's more serious things we look at. (Christine, stakeholder, NGO)

On top of the assessments carried out by the tenancy committee, residents of HOME undergo a three-month trial tenancy to further assess their compatibility:

> They sign a tenancy agreement for three months in the beginning and then after the three months that gives them time to see if they want to be here and for us to see if we think they'll fit here as well. Then after that it's 12 months and it's just an ongoing 12 months. (Christine, stakeholder, NGO)

We do not know exactly what a MyHome model would look like in the ACT. However, we can point to the features of the PSH model that contribute to its success, and suggest that MyHome can contribute to ending homelessness in the ACT for people with HCSNs to the extent that it is brought into alignment with the critical characteristics of PSH: affordability, normality, choice, autonomy, non-conditionality, and a separation of tenancy and support providers.

What is needed: stakeholder perspectives

When asked, most stakeholders agreed that some form of PSH is required in the ACT to end homelessness for people with HCSNs:

> I think it's not just accommodation. It's permanent accommodation and I think there are lots of shelters that people may get a short stint of a roof over their heads, but I think it's looking at that long term, and that long term then allows the individuals to grow and develop. Because once you've given them that long-term surety, then there's that willingness to look and see how things are going. (Richard, stakeholder, NGO)

> Just Housing providing more houses doesn't fix it. You're providing more housing—that absolutely needs to happen—but the support services need to be around there as well … These are people with complex health needs. So, it's not just more resi-rehab beds and more counsellors. It's not just more houses. It actually needs a holistic approach where we can actually do that. (Watson, stakeholder, public sector)

By and large, stakeholders thought that a diversity of models is needed to meet the needs of people with HCSNs. As one participant put it:

> The comment I'd make is 'variety'. Your client group is so very diverse that there's not going to be one solution that is going to meet everyone's needs. It needs to be a variety of different options available because different people will need different things. (Janeen, stakeholder, NGO)

Stakeholders suggested that there is a need for both scattered-site and congregate models of PSH, such as Common Ground and MyHome. They believed that congregate models worked well for people whose needs were particularly complex, given that they provided highly responsive on-site support:

> To be eligible as a social housing tenant at any given Common Ground model, you've got to be chronically long-term homeless, rough sleeping, absolutely unable to resolve your own housing needs, and unable to sustain your tenancy without support services on site where you live. Now, that works. It is proven that it works right across the world … I know that Canberra is about to have a second Common Ground site in Dickson and I'm absolutely looking forward to it. (Arthur, stakeholder, NGO)

> It's models of housing that facilitate that on-site support … for a small group of people, I think, with the very, very high and complex needs … For others, sure, who are more independent and not at the top scale of complexity, yeah, just a different model. (Nicola, stakeholder, public sector)

Others noted that the social mix provided by the integration of affordable and social housing tenancies in Common Ground gives people with HCSNs access to social capital and role models that non-mixed environments do not:

> Things like Common Ground, that you mentioned before, that provides a fantastic example of how you can provide services, like in a geocentric location, and you also have, because it's a combination of people who are homeless and affordable housing, you provide people with opportunities to step up. You provide them with access to a different peer and social network, to co-locate Northside's case management services in the building so it's available for everybody. Not a requirement, but available. That model is brilliant. (Watson, stakeholder, public sector)

People also thought that congregate models might be more cost-effective ways to support those with the highest needs because they provide economies of scale and cut down on travel time for support workers:

> It would be more cost-effective and efficient to have 20 units together rather than separate ones. (Rudy, stakeholder, NGO)

This suggests that there is support for additional congregate models of PSH in the ACT to assist people with HCSNs. However, there is also a sense among stakeholders that, while congregate models such as Common Ground are effective for some people with particularly high needs, scattered-site models of PSH are also needed to provide people with choice and for those who require or desire more privacy and independence:

> I think there was definitely a place for [scattered-site models], because it depends upon what the actual circumstances are of that individual. If it was a high needs, intensive type of thing, then actually

> getting them together and providing that intensive type of service is actually the right thing to do. But that's not the right thing to do for everyone. There are some people that do have some degree of independence and they just need a little bit of encouragement. So, I think you really do need to tailor it to the individual's circumstances. (Alan, stakeholder, NGO)

Stakeholders noted, however, that it is imperative that scattered-site models entail adequate support to tenants to ensure that they maintain their tenancies:

> There are people who can actually still manage a tenancy and they can manage a home and they can have that level of independence and autonomy. I think if people are able to do that there should be wraparound services to allow the person to do that … I think people need quite a lot of support, particularly if they haven't run a house before or had to do any of that stuff. There's a lot to learn. I think just sticking people in a house without any of that is just setting them up to fail because there's just so much involved in it. (Lilly, stakeholder, public sector)

Others highlighted what they saw as the importance of ensuring that people in scattered-site housing are supported to integrate into the local community:

> I am a fan of the salt-and-pepper approach as well. But, again, what it requires though is community integration. So, to have public housing, like one house in every street is fine, but it's no good if that person is then not included in whatever community activities that are actually occurring in that area. (Watson, stakeholder, public sector)

Stakeholders' call for a diversity of models of PSH to support people with HCSNs in the ACT corresponds to the findings of the research literature discussed above.

On the other hand, a small number of stakeholders called for additional transitional houses and conditionality practices to support people with HCSNs in the ACT:

> I don't know whether also the option of, I guess, shorter term housing … where it's almost like a practice run where it's medium term housing, there's the wraparound support there, there's less, I guess, bureaucracy and red tape with maintaining a government housing property. You've got a trial run, I guess, of a year or two to see how you go and see if you might be able to manage a government housing property. (Lilly, stakeholder, public sector)

As we noted above, transitional housing and conditionality are ineffective at assisting people with HCSNs to exit homelessness and sustain housing. In fact, in at least some cases, people's calls for more transitional housing were informed by their observations that there was an insufficient supply of permanent housing and uncertainty about the supply increasing. For instance, one participant proposed transitional housing as a way to mitigate the impact of the lack of permanent housing:

> Once you put in your application they have two levels to place you in, like standard needs or your needs are not complex enough, urgent, high needs which is complex needs, but you still wait years before you're offered that because the stock is so limited. Then, if … you can demonstrate that your client has an urgent, critical, or complex needs, then you can apply for priority and then they have to wait again. So, transitional is essential for these clients who are couch surfing and other things. (Dianne, stakeholder, NGO)

Others explicitly acknowledged that their interest in transitional models was a product of their experiences in working with the lack of housing and the staircase approach in the ACT homelessness services system.

> Carmel: I think we're all talking from experiences where it's just not been achievable … We all know that the evidence suggested that model [Housing First] is better for long-term

> outcomes for people rather than the transitional process of having to go through crisis accommodation and then move somewhere. We know that's destabilising. It's just the reality is that maybe—I don't know if that's possible within ACT's models.

6.1.3 Permanent supportive housing and specialist programs and community collaborations

Advocacy for and the success of PSH have been linked to specialist programs and community collaborations. In Australia, the homelessness Registry Week and the recently adopted Adelaide Project Zero are examples of specialist programs and community collaborations. Registry Week was first established by Micah Projects in Brisbane in 2010. Since then, community organisations have operated Registry Weeks in other Australian cities, including Melbourne, Sydney, Hobart, Newcastle, Perth and Townsville.

Registry Week aims to survey and document the population of homeless people in a given area, including by listing their names (and photos of them if they consent) and their health, support and housing needs. Their health and housing needs are assessed to estimate who in the homeless population is at the highest risk and thus should be prioritised for housing.

Community organisations in Australia have used vulnerability index tools to identify and assess such needs, including the VI-SPAT (Vulnerability Index—Service Prioritisation Decision Tool, discussed below), and have used Registry Week to advocate for housing solutions for homeless people and, indeed, to advocate for PSH. In the simplest terms, Registry Week is a bottom-up initiative by community organisations. Such initiatives were first developed in the United States as part of the 100,000 Homes Campaign (Padgett et al. 2016), which was part of a national campaign to change the agenda from managing homelessness to permanently ending it. Registry Week is thus part of a broader strategy to lobby government to end homelessness through systematically increasing the supply of affordable housing, including PSH. One of its critical elements is to use a high-profile awareness of the nature and extent of homelessness to publicly assess the success of governments in moving people from homelessness to permanent housing, as indicated by the register.

The Adelaide Zero Project is an initiative that was launched in 2017 to end street homelessness in Adelaide. The project is driven by the premise that managing street homelessness is insufficient, and that the ultimate goal is to end it. The Adelaide Zero Project adopts a methodology that draws on the street homeless population and the number of people who access housing to count down to a functional zero, which is achieved:

> when the average capacity of [Adelaide's] housing system is greater than the existing need and this can be proven with data [and when] the number of people sleeping on the streets at any point in time, is no greater than the average housing placement rate for that same period (usually a month). (DDF 2018)

There is no published evidence to demonstrate that specialist programs such as Registry Week, or community collaborations such as Adelaide Zero Project, achieve positive housing outcomes that would not have been achieved in the absence of those measures. In the absence of clear evidence, we offer two observations.

First, the advocacy and profiling of these initiatives has the capacity to translate into additional supplies of affordable housing. Indeed, Registry Week in Brisbane was closely associated with the 50 Lives 50 Homes campaign, which sought to advocate for increased affordable housing in that city. Second, if Registry Week or Project Zero do not demonstrably contribute to an increased supply of affordable housing available to homeless people, there is no evidence-based reason for prioritising them. For example, if the housing supply limitations remain unchanged, even if these

specialist programs or community collaborations do help to enable homeless people to access housing, homelessness at the population level and the conditions that contribute to it are likely to remain unchanged.

6.1.4 Conceptual matrix

The conceptual matrix in Table 8 encapsulates the key points outlined in the foregoing discussion on PSH, and the findings of this report more broadly.

Table 8: Housing models—responding to homelessness and housing need

Model	Key features	Strengths	Limitations	Suitable for	Example
Crisis accommodation	Low threshold of access Access to case management Referral gateway for support services (mental health, alcohol/drug etc.) Short-term (usually around 3 months) Shared facilities	Provides immediate shelter for people in crisis situations Can enable people to exit violent relationships Hub for service delivery	Short-term Shared amenity subverts autonomy Stigma Successful outcomes contingent upon the existence of exit points	People experiencing housing crisis People escaping domestic and family violence	Samaritan House (ACT) Toora House (ACT) Youth Emergency Accommodation Network ('YEAN', Salvation Army, ACT)
Congregate	Secure, long-term tenure Affordable rent Independent, self-contained units in a single complex On-site voluntary support services Separated tenancy management and service provision Purposively designed communal spaces Building visual amenity consistent with neighbourhood standards On-site security (for example, concierge)	Independent living Reduced experiences of isolation Close proximity to other service users increases sense of community Social mix (if both tenants of social housing and affordable housing are included) Highly responsive support services Economies of scale Sense of safety and security	On-site support and security can be experienced as intrusive Close proximity to other service users increases risk of conflict Greater chance of place-based stigma	People with HCSNs who experience: • chronic homelessness • mental illness • drug and alcohol issues • leaving institutions • medical conditions • social isolation	Common Ground Lu'uma Aboriginal Children's Village (BC, Canada)

Model	Key features	Strengths	Limitations	Suitable for	Example
Scattered site	Secure, long-term tenure Affordable rent Independent, self-contained units Cap on number of program units in any one area Unit visual amenity consistent with neighbourhood standards Mobile voluntary support services Separated tenancy management and service provision	Independent living Normalised living conditions Reduced place-based stigma Easier integration with mainstream community Greater user autonomy and choice	Less responsive support services Risk of social isolation More resource intensive	People with HCSNs who experience: • chronic homelessness • mental illness • drug and alcohol issues • leaving institutions • medical conditions or who desire more privacy, independence and choice	Pathways to Housing (USA) Housing & Accommodation Innovation Fund ('SAIF', CatholicCare, Canberra and Goulburn)
Social housing	Secure, long-term tenure Publicly managed stock	Affordable rent (for example, 25% of income) Housing security	Possible concentration of disadvantage Limited access to support	Homeless or at-risk non-HCSNs People on income support	Housing ACT Public housing authorities (Australia)
Affordable housing	Secure, long-term tenure Privately or community managed	Affordable rent (for example, 75% of market rent) Housing security	Limited access to support	Homeless or at-risk non-HCSNs Low-income earners	Community Housing Canberra ('CHC', ACT)

6.2 A NEEDS ASSESSMENT TOOL FOR THE 21ST CENTURY

Various tools have been used to assess the needs of homeless people and to target housing services for them on the basis of the severity of those needs. According to De Jong (2017), 'a good assessment tool should:

- Be grounded in evidence and be rigorously tested.
- Be easy to administer.
- Assist with identifying different levels and types of housing supports.
- Include the voice of persons with lived experience in its creation.
- Be sensitive to culture, race, gender, and various types of homelessness.
- Reinforce a trauma-informed approach to service delivery.
- Transcend different population groups.
- Work for YOUR community, YOUR principles, and YOUR prioritization process.'

The VI-SPDAT (Vulnerability Index—Service Prioritization Decision Assistance Tool), which allows for differentiation by individual, family and age and is based on scoring self-reports, is one such tool.

VI-SPDAT is a ready-made solution that is relatively easy to deploy and administer. It was used in Australia as part of the Brisbane Street to Home and 50 Lives 50 Homes campaign to assess the needs of homeless people, to rank their needs and to prioritise a response based on the assessed needs. Micah Projects used the scores from the VI-SPDAT to estimate whether people required affordable housing, affordable housing with brief support or affordable housing with long-term support. The Australian Government funded an evaluation of Brisbane Street to Home, which found that the VI-SPDAT was used to advocate for housing for people sleeping rough, and that the information elicited with it provided the outreach team with additional information about the needs of homeless people. It is also possible that information from the VI-SPDAT could inform housing providers about the needs of tenants entering housing. However, the evaluation also found that tenancies were at risk after people exited homelessness not because of a lack of information about their support needs (as assessed through the VI-SPDAT) but because services were not available or were not linked to them.

To further extend the information that can be gained using the VI-SPDAT, a strategy based on better informed decision-making and *adaptive management* of targeted housing services could be used (Sandor 2016). Adaptive management, outlined by Holling (1978)[26] as a form of environmental management, recognises that management decisions are made with imperfect information and uses ongoing innovation (as opposed to *post hoc* revisions after implementation) to inform future decisions. We see great potential in using adaptive management to vastly improving the rigour of needs assessment.

6.2.1 Harnessing data, cutting-edge methods and technology to better target services

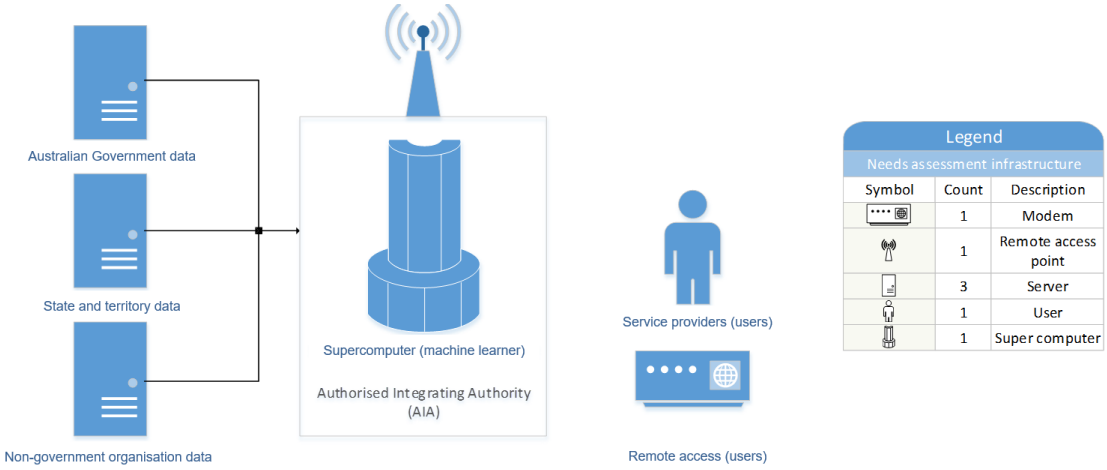
To improve the targeting of housing services, we propose the application of machine learning methods to integrated administrative data. The aim is to make more refined predictions of a person's probability of being homeless or at risk of homelessness, with or without HCSNs.

We envision that probabilities for a given person would be updated on a daily basis using integrated data held by an 'authorised integrating authority' such as the AIHW with the Sax Institute. The predicted probabilities would be available to governments and service providers

[26] To whom we can be grateful for the now ubiquitous use of the term 'resilience'.

through the Specialist Homelessness Information Platform (SHIP) hosted by Infoxchange Australia. Using this infrastructure, governments and service providers can be provided with more and better individual-level information about a person's need for housing services. Figure 4 illustrates the system.

Figure 4: Needs assessment tool infrastructure



There is a wealth of data that could reasonably be integrated to inform predictions of service need. Integrating administrative data would extend the self-reported data elicited from tools such as the VI-SPDAT. By drawing on linked administrative data, for example from health authorities, analyses of people's risk of homelessness and future needs for support would be based on verifiable clinical data and formal assessments. The integration of those data sources can be achieved through deterministic data linkage at the individual level using an SLK 581[27] or some other unique individual identifier. Where deterministic data linkage is not feasible, probabilistic data linkage methods may be possible. A full description of the data available for integration is in Appendix 8.

6.2.2 An evolving tool for better targeting housing services

Epitomising the concept of *adaptive management*, machine learning using boosted regression trees, in particular, is an adaptive method for combining many simple models to give improved predictive performance (Elith et al. 2008). From the data, it discovers nonlinear relationships and ignores unimportant variables. Also, as more data is collated and linked together over time, the accuracy of predictions improves. Hence, the case for innovation over time only becomes stronger.

6.2.3 Practical implementation

Data linkage plus machine learning is a powerful combination that takes advantage of available but underutilised data. The largest challenges in its use are not technical but cultural. On the technical side, the software to implement boosted regression trees is freely available through the 'R' statistical package (Ridgeway 2017). Moreover, within R it is also possible to draw on the significant improvements in the processing power of graphics processing units, which have become popular in recent years for computationally intensive calculations.[28] Furthermore, this functionality has become far more accessible in recent times (Determan 2016).

[27] Statistical linkage key 581: an identifier based on elements of a person's family name, given name and date of birth and their sex.

[28] Graphics processing unit: an electronic circuit designed to rapidly manipulate and alter memory to accelerate the creation of images intended for output to a display device; used in mobile phones, personal computers, workstations and game consoles.

This needs assessment tool would fit squarely with the Data Integration Partnership for Australia, which is a whole-of-government initiative to make better use of existing public data. Specifically, it aims to inform the development of emerging social, economic and environmental policy priorities and improve the delivery of government services (PM&C 2017).

7 CONCLUSIONS

There are five headline findings from this study.

7.1 COHORT POPULATION

From our analysis of six years of data on clients of SHSs in the ACT, we can infer that the population of people in the ACT who were homeless or at risk of homelessness who also had HCSNs (homeless HCSNs) was small compared to the broader ACT homeless and at-risk population. Among the client population, on average annually, 200 people were homeless HCSNs. This group made up 8.3% of all homeless people in the ACT. The number of homeless HCSNs has been trending down, from 216 in 2011–12, to 209 in 2013–14 and to 186 people in 2016–17.

Of the 1,453 people on average annually who were at risk of homelessness in the ACT over the study period, 12.6%, or 183, had HCSNs (at-risk HCSNs). The data revealed an upward trend in the number of at-risk HCSNs, from 140 in 2011–12 to 246 in 2016–17.

Limitations in the available quantitative data mean that we should be cautious in reaching conclusions about the size, characteristics and needs of these cohorts. However, our analysis of the CURF data strongly suggests that, compared to people who were homeless without HCSNs (homeless non-HCSNs), homeless HCSNs were more likely to be male, living alone with no dependent children, Australian-born, unemployed and not participating in training or education. The analysis also suggests that there were notable *increases* over the study period in the proportion of homeless HCSNs who were female, Indigenous, unemployed or receiving government income.

Compared to the general ACT population, Indigenous people were overrepresented in each of the four cohorts. They were also overrepresented in both the homeless HCSNs and at-risk HCSNs cohorts. Over the study period, there was also a notable increase in the proportion of Indigenous people in each cohort, except for the cohort of people at risk of homelessness but without HCSNs (at-risk non-HCSNs).

The characteristics of the HCSNs cohorts in the ACT closely reflected the characteristics, identified elsewhere in Australia and internationally, of people who sleep rough and experience chronic homelessness.

7.2 DEMAND, MET NEED AND UNMET NEED FOR SERVICES AND ACCOMMODATION

Multiple sources of evidence generated in this study suggest that homeless HCSNs in the ACT faced barriers to access to safe, affordable and long-term housing. Housing was the most prevalent need among people in all four cohorts. However, homeless HCSNs had a higher likelihood of being provided with short-term accommodation, compared to the rest of the homeless population. Additionally, compared to homeless non-HCSNs, homeless HCSNs were less likely to be assessed as needing medium-term housing and less likely to be provided with it. The data also revealed that both homeless HCSNs and homeless non-HCSNs had a low likelihood of being provided with long-term housing.

The qualitative evidence from homeless people and from service providers in government and NGOs suggests that homeless HCSNs accessed short-term accommodation because there is an insufficient supply of long-term affordable housing. In addition, the allocation of social housing through a system that requires people to first demonstrate housing readiness adds a further challenge for homeless HCSNs in accessing long-term housing.

The quantitative evidence demonstrates that, in contrast to their unmet need for housing, homeless and at-risk HCSNs frequently had their needs for non-housing services and resources met. For example, when they presented to SHS agencies seeking mental health, drug/alcohol, domestic violence, legal/financial, immigration/cultural, family or general services, most were likely to have had their identified need met through the direct provision of the service or through the SHS agency referring them on to another service provider.

The quantitative administrative data and the qualitative data present a synergistic picture: homeless HCSNs were unlikely to be provided with long-term housing, but most were likely to have had their needs for non-housing resources and services met.

However, there is a complex relationship between people's need for non-housing services and supports and their homelessness that we do not have the data to interrogate empirically, which limits our capacity to rigorously analyse future demand. Evidence from Australian and international peer-reviewed research demonstrates that people's needs for health and social support services are often driven by their homelessness. As their homelessness continues, their health deteriorates (Johnson & Tseng 2014) and their needs for health services increase (Parsell et al. 2017).

With the data available for this study, we are not able to determine what health and social support services homeless people will require in the future if they are provided with affordable long-term housing. For example, the evidence suggests that providing affordable long-term housing for some homeless HCSNs creates conditions in which they no longer need and use some health and social services that they need and use while homeless (Parsell et al. 2016). The evidence shows that providing housing can protect people from the physical conditions of homelessness that exacerbate poor health (Marmot 2005) and that housing provides a basis for people to manage their own health care through general practitioners rather than using crisis health services, such as ambulances and emergency departments (Padgett et al. 2016). In short, data on the services that homeless people use is not a reliable indicator of the services that they will need and use after they have moved into long-term housing.

7.3 SYSTEM AND RESOURCE GAPS

Quantitative data on unmet need for long-term housing, together with qualitative data from people who have been homeless and from representatives from the government and non-government service sectors, demonstrates that the ACT has insufficient permanent and affordable housing, with linked support services, for homeless HCSNs. Although the ACT has a well-developed SHS system—and notwithstanding the evidence showing that the system successfully meets people's non-housing needs—in the absence of a sufficient supply of affordable long-term housing, the capacity of the SHS system to meet the housing and support needs of homeless or at-risk HCSNs is compromised. As demonstrated, the absence of an adequate supply of long-term housing means that people with HCSNs are provided with crisis homeless accommodation.

At the system level, the qualitative evidence highlights an additional problem that is a consequence of an insufficient supply of long-term housing available for people with HCSNs. Stakeholders in both government and NGOs reported that, in the absence such a supply of long-term housing with linked supports, people with HCSNs unnecessarily use mainstream health and justice resources because of their unmet need for housing. Similarly, because there are insufficient exit points into long-term housing, people with HCSNs stay on in homeless accommodation. The consequence is less capacity in system to accommodate people who need crisis accommodation.

7.4 EXPERIENCES, PERSPECTIVES AND ASPIRATIONS OF KEY ACT STAKEHOLDERS

Qualitative data from at-risk HCSNs in the ACT, and from government and non-government stakeholders who work with them, highlights the need for permanent supportive housing (PSH) models. There was a convergence of opinion among all stakeholder groups that a suite of PSH models is needed to meet the needs of people in the ACT. They recognised that providing long-term housing without ongoing support would not be enough to enable some people with HCSNs to sustain housing and thus avoid future homelessness. A broad consensus held that the ACT requires PSH models that include congregate buildings, where support providers are located on site, as well as scattered-site housing, where support is linked but provided through outreach. Stakeholders similarly understood that some people with HCSNs will require ongoing support to sustain their housing. They believed that diverse PSH models are needed to meet the needs of a diverse cohort of people.

The need for models and features of PSH can also be inferred from the experiences of homeless HCSNs. Their experiences illustrate how homelessness is experienced as dangerous, through the need to interact in shared accommodation with others who are homeless, and also limits their ability to be autonomous and impose order in their day-to-day lives. When homeless people—or, indeed, people living in Common Ground Canberra who had ceased to be homeless—were asked about what they want, they described normal housing where they are socially connected and where they can bring control and order to their lives.

The experiences and aspirations identified in the qualitative data are broadly consistent with the principles of PSH in the published peer-reviewed literature. Australian and international researchers stress that PSH works as a cost-effective solution to meet the ongoing housing and support needs of homeless HCSNs when access to housing has a low qualifying threshold, access to support is voluntary and not contingent on access to housing, housing is safe and affordable, and people access housing as tenants, not program clients.

Consistent with the views of some people in the ACT, published research demonstrates the need for PSH to include models in which support services are provided through outreach in scattered-site housing so that support can be stepped up and down to match people's changing needs over time. In line with 'recovery' philosophy in mental health, addiction and chronic physical ill health, the future duration of someone's problems and thus their needs can often not be predicted based on what they currently need. The evidence demonstrates that PSH works effectively when it is flexibly designed to enable program and service delivery changes that reflect people's changing needs over time.

7.5 INNOVATIVE DATA-LINKING OPPORTUNITIES

There exists a great opportunity to link administrative data within the ACT Government, and to link that data to Australian Government datasets. Data linkage will enable a more accurate understanding of the four cohorts and an assessment of their current, future and unmet needs for housing and support, and has the potential to provide real-time evidence about their ongoing need for resources and services. Linked administrative data would allow us to objectively ascertain and assess a range of factors that contribute to HCSNs and risks of homelessness, including disability, health, child protection history, and employment and unemployment history.

APPENDICES

APPENDIX 1: DATA AUDIT

We conducted a data audit to identify qualitative and quantitative data available in the ACT and relevant to the study scope. The audit aimed to identify the cohort of people who are homeless and at-risk HCSNs, to analyse their current, future and unmet demand for services and accommodation, and to assess the strengths and limitations of the available data.

First, we identified no relevant ACT qualitative data sources. That absence drove the need for the qualitative field work conducted for this study and our decision to sample more in qualitative field work than was initially planned (discussed below).

Second, the data audit involved assessments of available quantitative data that would provide a comprehensive picture of the homeless cohorts, their characteristics and their current, future, and unmet needs for services. In the first step of the audit, the research team discussed with representatives of ACT Housing the possibility of analysing the ACT social housing register data and rental agreement records. Housing ACT advised us that the housing register data and housing agreement records do not contain detailed categorisations of housing needs, which were necessary for this study.

Next, the research team discussed the possibility of using OneLink data for the Cohort Study with the custodians of the OneLink dataset. OneLink contains episode-level data that records information on all people's requests for crisis and community services in the ACT. OneLink data has been collected since August 2016, but was not included in the analysis because it does not have data over a sufficiently long period. In the future, however, we expect that OneLink administrative data could provide a rich picture of service requests throughout the ACT.

Also included in the quantitative data audit were the 2016 Census, the General Social Survey (ABS 2015) and the Journeys Home survey (Chigavazira et al. 2014). Those three datasets provide quantitative information on the extent of homelessness in the ACT. The Census provides a point-in-time estimation of the rate of homelessness in the ACT (in 2006, 2011, and 2016). The Census data was not used in the analysis for this study, as it contains insufficient information to determine either HCSNs or current, unmet and future demand for services. The General Social Survey, run every four years, provides good detail on the multidimensional nature of relative advantage and disadvantage across Australia (including in the ACT); however, that data contains only information about past experiences of homelessness from survey participants living in private dwellings. Like the Census, the General Social Survey was not used in the analysis for this study as it contains limited information pertinent to the study scope.

The Journeys Home survey is an excellent national longitudinal dataset informed by homeless or at-risk people. The longitudinal data draws on six waves of survey data collected between 2011 and 2014. A further strength of Journeys Home is its detail about respondents' needs (including diagnoses) and use of housing and support services. However, Journeys Home was assessed as inappropriate for the Cohort Study because the number of survey respondents from the ACT was too small: only 46 people from the ACT completed all six waves.

The data audit also identified and comprehensively assessed the relevance of the SHS data (CURFs). SHS agencies collect information about all people who request and receive assistance from them. CURFs contain basic sociodemographic characteristic of the clients, as well as information on services needed, services provided and client outcomes at the end of the support period.

Informed by discussions with the ACT Government, we determined that the SHS data provided the most appropriate data source available in the short study time frame to identify homeless

and at-risk HCSNs in the ACT. Moreover, because the data was produced as a product of all people in the ACT requesting and receiving support from SHSs, we considered it to be the most comprehensive information for identifying current, future and unmet demand for accommodation and services. By using SHS data, we could identify both homeless and at-risk HCSNs, as well as the services they requested or were provided and whether their needs had been met.

While the SHS dataset is the most appropriate data source for addressing the aims of the Cohort Study, it has important limitations for the identification of the homeless and at-risk cohorts, as well the analysis of their future needs for accommodation and services. The SHS data is produced when people request or are provided with services, so not all people who are homeless or at risk of homelessness in the ACT are included. For example, people in health facilities or corrections facilities who have not requested assistance from SHS agencies are not included. Furthermore, even though people ageing out of the out-of-home care system or exiting incarceration are at risk of homelessness (Australian Government 2008), they are included in the data only if they have requested or received assistance from SHS agencies. We enquired with stakeholders from the health and corrections sectors about the possibility of accessing administrative data that could be used to supplement the SHS data (such as counts of people living in such institutions who are at risk of homelessness). Such data was either not available or not accessible within the time frame of the study.

Moreover, although the SHS data contains rich information on ACT clients, the yearly numbers of people with HCSNs are small compared to other cohort studies. In particular, this report finds that, on average annually, 200 clients in the ACT were homeless HCSNs and 183 were at-risk HCSNs. On the other hand, the most recent report by the AIHW (2018b), which provided a detailed analysis of the profiles of Australia's rough sleepers, found that there were 13,660 rough sleepers in Australia in 2011–12, of whom 1,810 were identified as persistent service users, 5,796 were identified as service cyclers, and 6,054 were identified as transitory service users. The small cohort numbers identified in the Cohort Study compared with the AIHW study of rough sleepers limited our analyses of the differences in key sociodemographic characteristics (differences by gender, age group, ethnicity etc.) within each cohort. This report compares the differences between cohorts instead.

Furthermore, the confidential nature of the SHS CURF data meant that it was not possible to identify unique individuals from year to year; as described below, our research draws on SHS data collected over six years. An identifiable version of the data using the statistical linkage key (SLK) 581 would address this limitation, but that data was not accessible within the time frame of the study. For this reason, in a given year the figures refer to people in receipt of SHSs at a given point in time. This is a 'stock', similar to the way that a social housing waiting list is a stock. For this reason, it was not possible to estimate the number of returning and new clients for each year, which makes the data unsuitable for forecasting the 'flow' of future demand.

Another limitation of the SHS data is the minimal valid information that it contains about people's future needs for accommodation and services. The needs of people requesting and accessing assistance from SHS agencies are not based on any clinical or formal assessment of their current or future circumstances. Significantly, it is not possible to rigorously infer that the need a person has identified by their request or receipt of assistance from an SHS provider predicts their future need for accommodation and services. This means that it was not possible to conduct the analysis of 'duration of need' that was outlined in Point 4 of the scope of service for this project.

It is possible for future research to overcome some of these limitations in the SHS data, provided that the researchers are given enough time to access the linked SHS CURF and SLK 581 data. That would enable an estimate of the number of returning and new clients for each year, and thus the flow of demand for SHSs. It would also allow the SHS data to be linked to other administrative datasets, such as those held by health or corrections facilities, and thus

supplement the SHS population data with data on people who are homeless or at risk but who have not had contact with an SHS provider.

Finally, although the scope of service included an analysis of the impact on demand of the ACT as a regional centre, it was not possible to access the data needed to address that question within the time and resource constraints of this study. Linked administrative data, combining ACT data with that of other states or territories or with Australian Government data, could be used to address this problem in the future.

APPENDIX 2: QUALITATIVE COMPONENT—ADDITIONAL INFORMATION

Our method of recruiting interview participants from the ACT's government and non-government service sectors was purposeful: we sampled participants based on requirements from ACT Housing and in order to achieve maximum variation. Because our sample was purposefully selected, rather than a random probability sample, the results from the qualitative interviews of service providers are not statistically representative. This is consistent with norms in qualitative research: random probability sampling is almost never used. Even though our sample was purposefully selected—and the findings are thus not statistically generalisable—the study triangulated the data from the service provider qualitative interviews with the data from the client qualitative interviews and the analysis of client quantitative administrative data. Thus, the data generated from the service provider interviews was examined alongside the data generated from client qualitative and quantitative data. The triangulation of data and methods enabled the study to generate a comprehensive picture of the ACT housing and services system.

The stakeholder interviews elicited perspectives on a range of topics relevant to the study. including:

- the role of the interviewee/s and their organisation in the provision of accommodation and support to homeless and at-risk people, particularly people with HCSNs
- the kinds of service needs that homeless and at-risk people experience, from the interviewees' perspectives
- the challenges that interviewees, their organisations or the people they represent face in assisting people with HCSNs
- strengths and limitations of the service system in the ACT in supporting homeless or at-risk HCSNs
- what is needed in accommodation and support models to improve outcomes for people in the ACT with HCSNs.

There was some variation in the topics addressed during interviews. This was in part due to the need to tailor questions to the specific roles of the interviewees and the organisations that they represented (for example, service providers were asked questions different from those asked of advocacy groups and peak bodies). It was also due to the semi-structured nature of qualitative interviewing (Mason 2002), which is intentionally flexible to allow interviewees to raise issues and topics unanticipated by the researcher. This is vital to allow for the emergence of unexpected and context-specific findings.

Interviews with service users covered a range of topics related to their housing and homelessness histories and their experiences in accessing accommodation and support services in the ACT. They were asked to reflect on their accommodation and support needs and whether the services that they were currently using, or had used in the past, satisfactorily addressed those needs. Service users were also asked what, in their view, would constitute accommodation and support that satisfactorily meets their needs. Like the stakeholder interviews, the service user interviews were carried out in a semi-structured and flexible way to enable participants to raise themes that were important to them and to allow the interviewer to record and explore unexpected themes.

The qualitative datasets produced from the two sets of interviews were analysed by two members of the research team using the methods of thematic analysis, as is standard practice in qualitative research (Holliday 2007). The findings of those analyses were then shared and discussed to identify consistent, complementary and contrasting themes, which were then synthesised.

APPENDIX 3: PARTICIPANT INFORMATION SHEETS AND CONSENT FORMS

Stakeholder information sheet

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Interview Participant Information Sheet

Support requirements and accommodation options for people in the ACT with high and complex needs

Researcher team: Cameron Parsell, Chris Ambrey, Andrew Clarke, and Margarita Vorsina

What is the research about?
The research is about people in the ACT who are homeless or 'at risk' of homelessness, with a particular focus on those who have high and complex service needs. It is particularly concerned with a) describing and segmenting this population based on types of service need; b) examining what support and accommodation options are currently available to, and used by, this population and what demand for these services might be like in the future; and c) assessing ways in which the provision of support and accommodation to this population can be improved.

Who is conducting the research?
This study is being conducted by researchers from the Institute for Social Science Research based at the University of Queensland.

How can you participate?
We wish to understand the perspectives and experiences of people who provide accommodation and/or support to people who are at risk or homeless and who have high and complex needs, as well as the perspective of advocacy/peak organisations. We therefore invite you to participate in an interview to share your views. The interview will be held at a time and location convenient to you. The interview will go for between 30 and 60 minutes. We would like to record the discussion (with your consent) to make sure we have correctly documented your views. You can also choose not to be audio recorded during the interview, in which case the interviewer will take written notes of the interview.

How will the information be used?
The information that you provide in the interview will inform the findings of the study, which will be written up in a report to be presented to the ACT Government at the end of June, 2018. The information may also be used in articles written by the research team for publication in academic journals. Any publication will be subject to ensuring privacy and confidentiality and maintained.

Voluntary participation
Your participation in an interview is completely voluntary. If you choose not to participate, this decision will not have any impact on your relationship with the ACT Government, the University of Queensland or any other people or organisations. You can also withdraw from the study at any time by contacting a member of the research team using the contact information provided. You will not be

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penalised for withdrawing from participation in this study. If you choose to withdraw, any information or data that you have provided will be destroyed and will not be used in the research.

Confidentiality
Any information that you provide to the study will be kept confidential. All audio recordings and notes about what was said in the interviews will be kept in a secure place during the course of the study, and only the researchers running the study, and a professional transcription service, will have access to them. No individual will be identified and your name will not be related to any comment. We will also remove any information pertaining to the identity of your organisation. If you like, a written summary of your interview can be provided to you after the interview has finished. You can request such a summary by e-mailing Andrew Clarke at a.clarke4@uq.edu.au.

Ethics approval
This study has been cleared by one of the human ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council's guidelines (Ethics Approval #2018000414). You are welcome to discuss your participation in this study with project staff (contactable on 07 3346 8209). If you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Officer on 07 3365 3924.

Benefits
Whilst individual participants, or the organisations that they work for, may not receive any direct benefit from the study, the information and insight that you provide will help inform policy and the provision of accommodation and support to people who are homeless or at risk in ACT.

Thank you for your help with this important piece of research.

For more information please contact:

Andrew Clarke
a.clarke4@uq.edu.au
07 3346 8209

Stakeholder consent form

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Interview Participant Consent Form

Support requirements and accommodation options for people in the ACT with high and complex needs

Researcher team: Cameron Parsell, Chris Ambrey, Andrew Clarke, and Margarita Vorsina

- I understand what the project is about and agree that I have been given the chance to ask questions. I understand that I can continue to ask more questions through my participation in the project.
- I understand that participation in this research is voluntary and I can refuse to participate.
- I am aware that I can withdraw from the study whenever I like. I may decide to allow the researchers to continue using any data they have previously collected from me, but I retain the right to refuse if I wish.
- I understand that my name, address and other identifying information will not be disclosed in any report or publication produced from this project. Information pertaining to the identity of my organisation will also be removed.
- I am happy to participate in the research. I have made this decision freely and I am not obliged to answer any question I do not like.

	YES	NO
I am happy for the interview to be audio-recorded	☐	☐

I have read the points outlined in this Consent Form and I agree with them.

Signed by research participant ……

Please Print Name ……

Date ……

Service user information sheet

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Interview Participant Information Sheet

Support requirements and accommodation options for people in the ACT with high and complex needs

Researcher team: Cameron Parsell, Chris Ambrey, Andrew Clarke, and Margarita Vorsina

What is the research about?
The research is about people in the ACT who are homeless or 'at risk' of homelessness, with a particular focus on those who have high and complex service needs. It is particularly concerned with a) describing and segmenting this population based on types of service need; b) examining what support and accommodation options are currently available to, and used by, this population and what demand for these services might be like in the future; and c) assessing ways in which the provision of support and accommodation to this population can be improved.

Who is conducting the research?
This study is being conducted by researchers from the Institute for Social Science Research based at the University of Queensland.

How can you participate?
We wish to understand the perspectives and experiences of people who provide accommodation and/or support to people who are at risk or homeless and who have high and complex needs, as well as the perspective of advocacy/peak organisations. We therefore invite you to participate in an interview to share your views. The interview will be held at a time and location convenient to you. The interview will go for between 30 and 60 minutes. We would like to record the discussion (with your consent) to make sure we have correctly documented your views. You can also choose not to be audio recorded during the interview, in which case the interviewer will take written notes of the interview.

How will the information be used?
The information that you provide in the interview will inform the findings of the study, which will be written up in a report to be presented to the ACT Government at the end of June, 2018. The information may also be used in articles written by the research team for publication in academic journals. Any publication will be subject to ensuring privacy and confidentiality and maintained.

Voluntary participation
Your participation in an interview is completely voluntary. If you choose not to participate, this decision will not have any impact on your relationship with the ACT Government, the University of Queensland or any other people or organisations. You can also withdraw from the study at any time by contacting a member of the research team using the contact information provided. You will not be

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Confidentiality
Whatever you say will be kept confidential by the researcher team. All recordings of the interviews and notes about what was said in the interviews will be kept in a secure place during the course of the study, and only the researchers involved in the study will have access to them. No individual will be identified and your name will not be related to any comment. If you like, a written transcript of your interview can be provided to you after the interview has finished for you to review. You can request such a summary by e-mailing the research team (contact details below).

Ethics approval
This study has been cleared by the human ethics committees of the University of Queensland in accordance with the National Health and Medical Research Council's guidelines (Ethics Approval #2018000418). You are welcome to discuss your participation in this study with project staff (contactable on 07 3346 8742). If you would like to speak to an officer of the University not involved in the study, you may contact the Ethics Officer on 07 3365 3924.

Risks and benefits
Participation in the study will not expose you to any risks beyond those experienced in your everyday life. Individual participants will not benefit directly from their participation in the study. However, the findings of the study will be reported back to the ACT government for their consideration in future policy and planning decisions regarding accommodation and support services for people who are homeless or at risk of homelessness. Your involvement in this project will therefore contribute toward improving the accommodation and support services available to people in the ACT who are homeless or at risk of homelessness.

Thank you for your help with this important piece of research.

For more information please contact:

Andrew Clarke
a.clarke4@uq.edu.au
07 3346 8209

Service user consent form

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Interview Participant Consent Form

ACT Cohort Study

- I understand what the research is about and I have been given the chance to ask questions. I understand that I can continue to ask more questions if and when I like.
- I understand that participation in this research is voluntary and I do not have to participate if I don't want to.
- I am happy to participate in the research. I have made this decision freely.
- I understand that I do not have to answer any questions that I am not comfortable answering.
- I understand that if I find any aspect of the interview uncomfortable stressful I can skip these topics, take a break or end the interview.
- I am aware that I can pull out from the study whenever I like. I understand that if I pull out, any information collected from me by the researchers will be destroyed and not included in the study.
- I understand that my name and other identifying information will **not** be disclosed in any report or publication produced from this project.
- I understand that I will not directly benefit from participation in the study

	YES	NO
I have received my $30 voucher	☐	☐
I am happy for the interview to be audio-recorded	☐	☐

I have read this Consent Form and I agree with it.

Signed by research participant ……

Please Print Name ……

Date ……

APPENDIX 4: DEMAND AND UNMET DEMAND FOR SERVICES AND ACCOMMODATION IN THE ACT

Table 9: Average numbers of needs and needs met, 2011–12 to 2016–17

	Average numbers	11–12	12–13	13–14	14–15	15–16	16–17	Annual avg.
Homeless HCSNs	Needs	5.1	5.0	5.3	5.4	4.8	4.3	5.0
	Needs provided	3.2	2.9	2.7	2.7	2.5	2.5	2.8
	Needs referred only	1.2	1.0	1.3	1.3	0.3	0.4	0.9
	Needs unmet	0.8	1.1	1.3	1.3	1.9	1.4	1.3
Homeless non-HCSNs	Needs	4.9	4.8	4.9	4.9	4.9	4.2	4.8
	Needs provided	2.6	2.4	2.5	2.6	2.5	2.4	2.5
	Needs referred only	1.0	0.7	0.8	0.7	0.5	0.5	0.7
	Needs unmet	1.2	1.7	1.6	1.6	1.9	1.3	1.6
At-risk HCSNs	Needs	3.2	3.2	3.3	3.4	3.4	2.8	3.2
	Needs provided	2.1	2.3	2.3	2.5	2.4	2.1	2.3
	Needs referred only	0.5	0.3	0.3	0.3	0.2	0.1	0.3
	Needs unmet	0.5	0.5	0.7	0.7	0.8	0.6	0.6
At-risk non-HCSNs	Needs	3.2	3.1	3.1	3.0	2.9	2.9	2.8
	Needs provided	2.1	2.0	2.0	1.9	1.9	1.8	1.6
	Needs referred only	0.4	0.2	0.3	0.2	0.2	0.2	0.3
	Needs unmet	0.7	0.8	0.8	0.8	0.9	0.9	0.8

Source: SHS CURF data.

Note: Data is adjusted for non-response. Due to rounding, the average numbers of needs provided, referred and unmet may not always add to the average number of needs.

Table 10: Total numbers of needs for accommodation and housing assistance services and the percentages of those needs provided for, referred only and unmet

		Homeless		At-risk		All clients
		HCSN *n* = 1,199	Non-HCSN *n* = 13,307	HCSN *n* = 1,099	Non-HCSN *n* = 7, 623	*n* = 23, 227
N1: Short-term accommodation provision	Need identified	913	10,115	253	2,000	13, 281
	Need identified as % of clients	76%	76%	23%	26%	57%
	Provided as % of need identified	64%	45%	38%	18%	42%
	Referred only as % of need identified	6%	9%	7%	7%	9%
	Unmet as % of need identified	30%	46%	55%	76%	50%
N2: Medium-term accommodation provision	Need identified	807	9,484	184	1,815	12,291
	Need identified as % of clients	67%	71%	17%	24%	53%
	Provided as % of need identified	15%	19%	7%	7%	17%
	Referred only as % of need identified	31%	16%	12%	8%	16%
	Unmet as % of need identified	53%	65%	81%	85%	67%
N3: Long-term housing provision	Need identified	822	10,113	432	2,728	14,095
	Need identified as % of clients	69%	76%	39%	36%	61%
	Provided as % of need identified	10%	8%	45%	13%	10%
	Referred only as % of need	36%	29%	15%	21%	28%
	Unmet as % of need identified	53%	62%	40%	66%	62%
N4: Assistance to sustain housing tenure	Need identified	395	5,048	400	3,994	9,836
	Need identified as % of clients	33%	38%	36%	52%	42%
	Provided as % of need identified	72%	77%	89%	88%	81%
	Referred only as % of need identified	8%	7%	3%	3%	5%
	Unmet as % of need identified	20%	16%	7%	9%	13%

Source: SHS CURF data for 2011–12 to 2016–17

Note: Data is adjusted for non-response. Due to rounding, percentages for needs provided, referred only and unmet may not always add to 100%.

Table 11: Total numbers of needs for health services and the percentages of those needs provided for, referred only and unmet

		Homeless		At-risk		All clients
		HCSN *n* = 1,199	Non-HCSN *n* = 13,307	HCSN *n* = 1,099	Non-HCSN *n* = 7, 623	*n* = 23, 227
N5: Mental health services	Need identified	423	2,739	218	818	4,198
	Need identified as % of clients	35%	21%	20%	11%	18%
	Provided as % of need identified	39%	41%	59%	40%	41%
	Referred only as % of need identified	36%	33%	19%	32%	32%
	Unmet as % of need identified	25%	26%	22%	28%	26%
N7: Disability Services	Need identified	46	360	47	155	608
	Need identified as % of clients	4%	3%	4%	2%	3%
	Provided as % of need identified	43%	44%	51%	32%	41%
	Referred only as % of need identified	19%	28%	20%	14%	23%
	Unmet as % of need identified	38%	28%	29%	54%	35%
N8: Drug/alcohol services	Need identified	340	1,342	126	238	2,046
	Need identified as % of clients	28%	10%	11%	3%	9%
	Provided as % of need identified	66%	56%	51%	34%	55%
	Referred only as % of need identified	15%	19%	19%	32%	20%
	Unmet as % of need identified	20%	25%	30%	33%	25%
N12: Other specialist services	Need identified	575	4,198	477	1,719	6,968
	Need identified as % of clients	48%	32%	43%	23%	30%
	Provided as % of need identified	57%	62%	77%	73%	65%
	Referred only as % of need identified	32%	27%	14%	15%	24%
	Unmet as % of need identified	11%	11%	9%	12%	11%

Source: SHS CURF data for 2011–12 to 2016–17.

Note: Data is adjusted for non-response. Due to rounding, percentages for needs provided, referred only and unmet may not always add to 100%.

Table 12: Total numbers of needs and the percentages of those needs provided for, referred only and unmet

		Homeless		At-risk		All clients
		HCSN *n* = 1,199	Non-HCSN *n* = 13,307	HCSN *n* = 1,099	Non-HCSN *n* = 7, 623	*n* = 23, 227
N6: Family Services	Need identified	115	2,054	126	819	3,114
	Need identified as % of clients	10%	15%	11%	11%	13%
	Provided as % of need identified	73%	67%	80%	68%	68%
	Referred only as % of need identified	19%	19%	7%	17%	18%
	Unmet as % of need identified	8%	14%	13%	15%	14%
N9: Legal/financial services	Need identified	144	1,504	88	1,089	2,825
	Need identified as % of clients	12%	11%	8%	14%	12%
	Provided as % of need identified	58%	57%	52%	80%	65%
	Referred only as % of need identified	23%	26%	19%	12%	20%
	Unmet as % of need identified	18%	17%	28%	9%	14%
N10: Immigration/cultural services	Need identified	89	1,200	39	337	1,665
	Need identified as % of clients	7%	9%	4%	4%	7%
	Provided as % of need identified	60%	72%	76%	80%	73%
	Referred only as % of need identified	30%	19%	11%	11%	18%
	Unmet as % of need identified	10%	9%	13%	9%	9%
N11: Domestic violence services	Need identified	164	2,569	83	871	3,688
	Need identified as % of clients	14%	19%	8%	11%	16%
	Provided as % of need identified	72%	76%	73%	69%	74%
	Referred only as % of need identified	15%	9%	2%	9%	9%
	Unmet as % of need identified	14%	16%	24%	22%	17%
N13: General services	Need identified	1,163	12,895	1,044	6,220	21,322
	Need identified as % of clients	97%	97%	95%	82%	92%
	Provided as % of need identified	99%	99%	99%	98%	99%
	Referred only as % of need identified	–	0%	0%	0%	0%
	Unmet as % of need identified	1%	1%	1%	1%	1%

Source: SHS CURF data for 2011–12 to 2016–17.

Note: Data is adjusted for non-response. Due to rounding, percentages for needs provided, referred only and unmet may not always add to 100%.

APPENDIX 5: UNDERSTANDING DEMAND AND UNMET DEMAND FOR SERVICES AND ACCOMMODATION IN THE ACT—REGRESSION ANALYSIS

For the regression analysis, we estimated three probit models.

The first probit model was estimated, using maximum likelihood estimation, to predict the probability of each need being identified for clients who were homeless or at risk of homelessness. An indicator of whether or not a need had been identified was used as a dependent variable, while being homeless HCSNs, being at-risk HCSNs and being homeless were used as independent variables. This model was used to explain needs for services identified by service providers.

The second probit model was estimated, using maximum likelihood estimation, to explain the provision of services for each need. Naturally, the provision of services for each need was contingent on that need being identified by the service provider. An indicator of whether or not the need had been provided was used as the dependent variable. Similarly to the first probit model, being homeless HCSNs, being at-risk HCSNs and being homeless were used as independent variables.

The third probit model was estimated to predict the probability of each need being referred for clients who were homeless or at risk of homelessness. An indicator of whether or not the need had been referred was used as the dependent variable.[29] Similarly to the other two probit models, being homeless HCSNs, being at-risk HCSNs and being homeless were used as independent variables.

Table 13 provides further detail and descriptive statistics for the variables used in the models.

Table 13: Variable definitions and descriptive statistics

Variable name	Definition	%
Dependent variables		
Need 1	Short-term accommodation provision—needed (0 – 1)	59%
Need 2	Medium-term accommodation provision—needed (0 – 1)	55%
Need 3	Long-term housing provision—needed (0 – 1)	63%
Need 4	Assistance to sustain housing tenure—needed (0 – 1)	44%
Need 5	Mental health services—needed (0 – 1)	18%
Need 6	Family services—needed (0 – 1)	14%
Need 7	Disability services—needed (0 – 1)	3%
Need 8	Drug/alcohol services—needed (0 – 1)	8%
Need 9	Legal/financial services—needed (0 – 1)	12%
Need 10	Immigration/cultural services—needed (0 – 1)	7%
Need 11	Domestic violence services—needed (0 – 1)	16%
Need 12	Other specialist services—needed (0 – 1)	29%
Need 13	General services—needed (0 – 1)	91%
Provided need 1	Short-term accommodation provision—provided (0 – 1)	39%
Provided need 2	Medium-term accommodation provision—provided (0 – 1)	14%
Provided need 3	Long-term housing provision—provided (0 – 1)	8%
Provided need 4	Assistance to sustain housing tenure—provided (0 – 1)	78%
Provided need 5	Mental health services—provided (0 – 1)	41%

[29] Need 13 (general services) was omitted from the analysis of the referred needs due to the small number of observations (only 60 clients were indicated as referred for Need 13 during the six-year period).

Variable name	Definition	%
Provided need 6	Family services—provided (0 – 1)	69%
Provided need 7	Disability services—provided (0 – 1)	47%
Provided need 8	Drug/alcohol services—provided (0 – 1)	53%
Provided need 9	Legal/financial services—provided (0 – 1)	63%
Provided need 10	Immigration/cultural services—provided (0 – 1)	72%
Provided need 11	Domestic violence services—provided (0 – 1)	74%
Provided need 12	Other specialist services—provided (0 – 1)	61%
Provided need 13	General services—provided (0 – 1)	99%
Referred need 1	Short-term accommodation provision—referred only (0 – 1)	9%
Referred need 2	Medium-term accommodation provision—referred only (0 – 1)	16%
Referred need 3	Long-term housing provision—referred only (0 – 1)	27%
Referred need 4	Assistance to sustain housing tenure—referred only (0 – 1)	6%
Referred need 5	Mental health services—referred only (0 – 1)	34%
Referred need 6	Family services—referred only (0 – 1)	17%
Referred need 7	Disability services—referred only (0 – 1)	21%
Referred need 8	Drug/alcohol services—referred only (0 – 1)	18%
Referred need 9	Legal/financial services—referred only (0 – 1)	22%
Referred need 10	Immigration/cultural services—referred only (0 – 1)	19%
Referred need 11	Domestic violence services—referred only (0 – 1)	9%
Referred need 12	Other specialist services—referred only (0 – 1)	27%
Independent variables		
Homeless HCSNs	A person is identified as homeless with HCSNs (0 – 1)	5%
At-risk HCSNs	A person is identified as at risk of homelessness and having HCSNs (0 – 1)	4%
Homeless	A person is identified as homeless (0 – 1)	63%

Source: SHS CURF data for 2011–12 to 2016–17.

Tables 14 to 16 report results for the probit models using needs 1 to 13 (columns 1 to 13 in Table 14), provided needs 1 to 13 (columns 1 to 13 in Table 15) and referred needs 1 to 12 (columns 1 to 12 in Table 16) as dependent variables. The results are reported as average marginal effects. The results should be interpreted in terms of the probability of the needs being identified (Table 14), the needs being provided (Table 15) or the needs being referred (Table 16). For example, column 2 in Table 14 can be explained as follows: a person identified as homeless *with* HCSNs has a 3.4% lower likelihood of having a need for medium-term housing identified compared to a homeless person *without* HCSNs (statistically significant at the 5% level); a person at risk of homelessness *with* HCSNs has a 7.8% lower likelihood of having a need for medium-term housing identified compared to a person at risk of homelessness *without* HCSNs (statistically significant at the 1% level).

The results in Table 14 show that compared to homeless non-HCSNs, homeless HCSNs were identified as having statistically significantly *higher* needs for mental health services (13.3% higher likelihood), drug and alcohol services (15.4% higher likelihood) and other specialist services (16.0% higher likelihood). Compared to homeless non-HCSNs, homeless HCSNs were identified as having statistically significantly *lower* needs for medium-term accommodation (3.4% lower likelihood) and long-term accommodation (7.4% lower likelihood), assistance to sustain housing (5.1% lower likelihood), family services (5.3% lower likelihood) and domestic violence services (4.9% lower likelihood).

The results in Table 14 also show that compared to at-risk non-HCSNs, at-risk HCSNs were identified as having statistically significantly *higher* needs for long-term accommodation (3.9%

higher likelihood), mental health services (11.9% higher likelihood), disability services (2.7% higher likelihood), drug and alcohol services (14.7% higher likelihood), other specialist services (22.9% higher likelihood) and general services (6.7% higher likelihood). Compared to at-risk non-HCSNs, at-risk HCSNs were identified as having statistically significantly *lower* needs for medium-term housing (7.8% lower likelihood), assistance to sustain housing (14.9% lower likelihood), legal/financial services (5.5% lower likelihood) and domestic violence services (4.8% lower likelihood).

Table 15 shows the likelihood of the provision of a given need for those who had been identified as having that need. The results show that, compared to homeless non-HCSNs, homeless HCSNs had a statistically significantly *lower* likelihood of service provision for an identified need for medium-term housing (4.1% lower likelihood) and immigration/cultural services (12.1% lower likelihood) and had *higher* likelihood of service provision for a need for short-term housing (20.4% higher likelihood) and drug and alcohol services (12.0% higher likelihood).

The results in Table 15 also show that, compared to at-risk non-HCSNs, at-risk HCSNs had *lower* likelihood of service provision for a need for legal services (30.7% lower likelihood) and had a *higher* likelihood of provision of a need for short-term housing (27.9% higher likelihood), long-term housing (22.4% higher likelihood) and family services (15.6% higher likelihood).

Table 16 provides results for the likelihood of a need being referred to another agency for those who had been identified as having a given need. The results indicate that, compared to homeless non-HCSNs, homeless HCSNs had a statistically significantly *lower* likelihood of a need being referred where the need was for short-term housing (4.2% lower likelihood) and had a *higher* likelihood of a need being referred where the need was for medium-term housing (17.0% higher likelihood), long-term housing (10.7% higher likelihood), immigration/cultural services (12.9% higher likelihood), domestic violence services (9.8% higher likelihood) or other specialist services (7.9% higher likelihood).

The results in Table 16 also show that, compared to at-risk non-HCSNs, at-risk HCSNs had a *lower* likelihood of a need being referred if the need was for mental health services (15.0% lower likelihood) or family services (13.1% lower likelihood).

Table 14: Probit regression: dependent variable—need identified

	(1) Need 1	(2) Need 2	(3) Need 3	(4) Need 4	(5) Need 5	(6) Need 6	(7) Need 7	(8) Need 8	(9) Need 9	(10) Need 10	(11) Need 11	(12) Need 12	(13) Need 13
Homeless HCSNs	0.002	**–0.034**[b]	**–0.074**[a]	**–0.051**[a]	**0.133**[a]	**–0.053**[a]	0.011[c]	**0.154**[a]	0.007	–0.014[c]	**–0.049**[a]	**0.160**[a]	0.003
	(0.018)	(0.016)	(0.018)	(0.018)	(0.016)	(0.010)	(0.006)	(0.015)	(0.012)	(0.008)	(0.011)	(0.018)	(0.012)
At-risk HCSNs	–0.032[c]	**–0.078**[a]	**0.039**[b]	**–0.149**[a]	**0.119**[a]	0.010	**0.027**[a]	**0.147**[a]	**–0.055**[a]	–0.013	**–0.048**[a]	**0.229**[a]	**0.067**[a]
	(0.017)	(0.018)	(0.016)	(0.016)	(0.018)	(0.013)	(0.009)	(0.020)	(0.009)	(0.011)	(0.013)	(0.020)	(0.004)
Homeless	**0.497**[a]	**0.471**[a]	**0.400**[a]	**–0.143**[a]	**0.102**[a]	**0.046**[a]	**0.007**[a]	**0.078**[a]	**–0.030**[a]	**0.045**[a]	**0.077**[a]	**0.091**[a]	**0.147**[a]
	(0.007)	**(0.007)**	**(0.008)**	**(0.008)**	**(0.006)**	**(0.005)**	**(0.003)**	**(0.004)**	**(0.005)**	**(0.004)**	**(0.006)**	**(0.007)**	**(0.005)**
Year dummies	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wald statistic Wald $\chi^2(8)$ =	4,040.83	3,900.13	2,671.53	473.18	439.57	111.79	28.65	589.34	86.19	162.76	235.44	416.44	1,133.16
Prob > χ^2	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000	0.000
Pseudo R^2	0.183	0.172	0.123	0.020	0.029	0.008	0.006	0.066	0.006	0.017	0.016	0.021	0.114
Observations	20,148	20,148	20,148	20,148	20,148	20,148	20,148	20,148	20,148	20,148	20,148	20,148	20,148

a $P < 0.01$.

b $P < 0.05$.

c $P < 0.1$.

Note: Unconditional standard errors in parentheses. Average marginal effects are reported, and the interpretation of those effects is in terms of the probability of reporting the outcome given a discrete change in a binary variable. For instance, the average marginal effect for homeless HCSNs in Column 2 is interpreted as a 3.4% lower likelihood of having a Need 2 if a person was identified as homeless HCSNs compared to a person identified as homeless non-HCSNs.

Source: SHS CURF data for 2011–12 to 2016–17.

Table 15: Probit regression: dependent variable—need provided

	(1) Provided need 1	(2) Provided need 2[d]	(3) Provided need 3	(4) Provided need 4	(5) Provided need 5	(6) Provided need 6	(7) Provided need 7	(8) Provided need 8	(9) Provided need 9	(10) Provided need 10	(11) Provided need 11	(12) Provided need 12	(13) Provided need 13
Homeless HCSNs	**0.204[a]**	**–0.041[b]**	0.000	–0.006	–0.022	–0.052	–0.077	**0.120[a]**	0.017	**–0.122[c]**	–0.083	–0.067[c]	0.004
	(0.023)	**(0.018)**	(0.017)	(0.031)	(0.035)	(0.063)	(0.105)	**(0.037)**	(0.057)	**(0.074)**	(0.056)	(0.035)	(0.004)
At-risk HCSNs	**0.279[a]**		**0.224[a]**	0.022	0.144[c]	**0.156[b]**	–0.052	–0.002	**–0.307[a]**	–0.287	0.102	–0.044	–0.003
	(0.087)		**(0.058)**	(0.054)	(0.080)	**(0.067)**	(0.156)	(0.163)	**(0.104)**	(0.277)	(0.080)	(0.067)	(0.008)
Homeless	**0.279[a]**	**0.112[a]**	**–0.033[a]**	**–0.112[a]**	**–0.098[a]**	**–0.080[a]**	–0.122	**0.199[a]**	**–0.255[a]**	**–0.196[a]**	0.046	**–0.122[a]**	0.006[c]
	(0.018)	**(0.012)**	**(0.012)**	**(0.013)**	**(0.037)**	**(0.028)**	(0.094)	**(0.077)**	**(0.026)**	**(0.039)**	(0.035)	**(0.027)**	(0.003)
Year dummies	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wald statistic Wald $\chi^2(8)$ =	238.82	117.75	69.15	84.50	52.10	28.40	8.32	145.73	82.90	30.79	28.05	50.31	78.81
Prob > χ^2	0.000	0.000	0.000	0.000	0.000	0.000	0.403	0.000	0.000	0.000	0.000	0.000	0.000
Pseudo R^2	0.030	0.026	0.013	0.018	0.018	0.013	0.021	0.111	0.047	0.033	0.014	0.012	0.064
Observations	8,474	8,054	8,864	4,999	2,302	1,893	296	1,087	1,464	901	2,055	3,455	11,648

a $P < 0.01$.

b $P < 0.05$.

c $P < 0.1$.

d At-risk HCSNs variable is omitted due to perfect prediction of the dependent variable.

Note: Unconditional standard errors in parentheses. Average marginal effects are reported, and the interpretation of those effects is in terms of the probability of reporting the outcome given a discrete change in a binary variable. For instance, the average marginal effect for at-risk HCSNs in Column 1 is interpreted as a 27.9% lower likelihood of being provided a Need 1 if a person was identified as at-risk HCSNs, compared to a person identified as homeless non-HCSNs.

Source: SHS CURF data for 2011–12 to 2016–17.

Table 16: Probit regression: dependent variable—need referred only

	(1) Referred need 1	(2) Referred need 2[d]	(3) Referred need 3	(4) Referred need 4	(5) Referred need 5	(6) Referred need 6	(7) Referred need 7	(8) Referred need 8	(9) Referred need 9	(10) Referred need 10[d]	(11) Referred need 11	(12) Referred need 12
Homeless HCSNs	**–0.042[a]**	**0.170[a]**	**0.107[a]**	0.023	0.020	0.095[c]	–0.013	–0.032	–0.025	**0.129[b]**	**0.098[b]**	**0.079[b]**
	(0.010)	**(0.024)**	**(0.025)**	(0.020)	(0.034)	(0.057)	(0.088)	(0.030)	(0.045)	**(0.065)**	**(0.045)**	**(0.032)**
At-risk HCSNs	0.003		0.012	0.010	**–0.150[b]**	**–0.131[a]**	0.337	–0.086	0.089		0.007	–0.024
	(0.058)		(0.061)	(0.045)	**(0.066)**	**(0.044)**	(0.208)	(0.071)	(0.124)		(0.083)	(0.064)
Homeless	0.037[a]	0.070[a]	0.072[a]	0.040[a]	0.060[c]	0.082[a]	0.254[a]	–0.084	0.146[a]	0.164[a]	0.031[c]	0.120[a]
	(0.009)	(0.013)	(0.016)	(0.007)	(0.035)	(0.021)	(0.048)	(0.064)	(0.022)	(0.029)	(0.018)	(0.023)
Year dummies	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Wald statistic Wald $\chi^2(8)$ =	54.39	215.02	139.89	97.60	85.87	40.34	17.55	72.62	49.63	34.16	59.43	89.00
Prob > χ^2	0.000	0.000	0.000	0.000	0.000	0.000	0.025	0.000	0.000	0.000	0.000	0.000
Pseudo R^2	0.015	0.041	0.017	0.050	0.033	0.027	0.077	0.086	0.034	0.048	0.062	0.027
Observations	8,474	8,054	8,864	4,999	2,302	1,893	296	1,087	1,464	897	2,055	3,455

a $P < 0.01$.

b $P < 0.05$.

c $P < 0.1$.

d At-risk HCSNs variable is omitted due to perfect prediction of the dependent variable.

Note: Unconditional standard errors in parentheses. Average marginal effects are reported, and the interpretation of those effects is in terms of the probability of reporting the outcome given a discrete change in a binary variable. For instance, the average marginal effect for homeless HCSNs in Column 1 is interpreted as a 4.2% lower likelihood of being referred for a Need 1 if a person was identified as homeless HCSNs, compared to a person identified as homeless non-HCSNs.

Source: SHS CURF data for 2011–12 to 2016–17.

APPENDIX 6: COMORBIDITY—REGRESSION ANALYSIS

For our analysis of whether the experience of comorbid mental health and drug and alcohol service needs affected a person's ability to access support, we produced two probit models, estimated using maximum likelihood estimation.

The first probit model examined the provision of mental health services where that need had been identified. An indicator of whether or not those services had been provided was used as the dependent variable. An indicator for the drug/alcohol services need was used as an independent variable. Because the analytical population for the first probit model was restricted to people who had a need for mental health services, the independent variable captured people who had both a drug/alcohol services need and a mental health services need.

The second probit model examined the provision of drug/alcohol services where that need had been identified. An indicator of whether or those services had been provided was used as the dependent variable. An indicator for the mental health services need was used as an independent variable. Because the analytical population for the second probit model was restricted to people who had a need for drug/alcohol services, the independent variable captured people who had both a mental health services need and a drug/alcohol services need.

The results (Table 17) demonstrate that people with a combination of needs for drug/alcohol services and mental health services had a 15.4% lower likelihood of the mental health services need being provided for, compared to people without a need for drug/alcohol services but with a need for mental health services (Column 1). This result was statistically significant at the 1% level. The results also indicate that there was no statistically significant difference in the provision of the drug/alcohol services need for people with a combination of needs for drug/alcohol services and mental health services compared to people without a need for mental health services but with a need for drug/alcohol services (Table 17, Column 2).

Table 17: Probit regression: dependent variables—mental health services provided and drug/alcohol services provided

	(1) Mental health services—provided	(2) Drug/alcohol services—provided
Drug/alcohol services—needed	**–0.154**[a]	
	(0.018)	
Mental health services—needed		0.013
		(0.028)
Year dummies	Yes	Yes
Wald statistic Wald $\chi^2(6)$ =	107.64	95.81
Prob > χ^2	0.000	0.000
Pseudo R^2	0.024	0.050
Observations	3,593	1,695

a $P < 0.01$.

Note: Unconditional standard errors in parentheses. Average marginal effects are reported, and the interpretation of those effects is in terms of the probability of reporting the outcome given a discrete change in a binary variable.

Source: SHS CURF data for 2011–12 to 2016–17.

APPENDIX 7: SPECIALIST HOMELESSNESS SERVICES IN THE ACT, 2017–18

Service provider	Service description	Target group	Accommodation (short-term, crisis, supported or transitional)	Support services (non-accommodation)	Accommodation type (congregate or standalone)	Accommodation places (congregate or standalone)
Toora Women	Coming Home program	Women (with or without accompanying children) exiting corrections and at risk of or experiencing homelessness and recidivism	✓	✓	Standalone	5
Toora Women	Toora Domestic Violence and Homelessness Service (National Affordable Housing Agreement)	Women (with or without accompanying children) at risk of or experiencing homelessness	✓	✓	Congregate and standalone	23
Karinya House and Home for Mothers and Babies	Karinya House	Women (with or without accompanying children) at risk of or experiencing homelessness	✓	✓	Congregate and standalone	6
Toora Women	Women and Children's Program	Women (with or without accompanying children) at risk of or experiencing homelessness	✓	✓	Congregate and standalone	11
Beryl Women	Women's Refuge	Women (with or without accompanying children) escaping domestic and family violence and in need of immediate safety	✓	✓	Congregate and standalone	9
Doris Women's Refuge	Women's Refuge	Women (with or without accompanying children) escaping domestic and family violence and in need of immediate safety	✓	✓	Congregate and standalone	7
YWCA	Housing Support Unit	Women (with or without children) at risk of or experiencing homelessness	✓		Standalone	13
Northside Community Service	Women's Program	Women (with or without accompanying children) at risk of or experiencing homelessness	✓	✓	Standalone	10

Service provider	Service description	Target group	Accommodation (short-term, crisis, supported or transitional)	Support services (non-accommodation)	Accommodation type (congregate or standalone)	Accommodation places (congregate or standalone)
EveryMan Australia	Early Intervention Program	Men at risk of or experiencing homelessness	✓	✓	Standalone (properties acquired when required)	20
EveryMan Australia	Managed Accommodation Program	Men at risk of or experiencing homelessness	✓	✓	Standalone (properties acquired as required)	15
St Vincent de Paul	Samaritan House	Men at risk of or experiencing homelessness	✓		Congregate	12
Domestic Violence Crisis Service	Room for Change	Families, in all their diversity, at risk of or experiencing homelessness due to domestic or family violence	✓	✓	Congregate and standalone	6
St Vincent de Paul	Blue Door	People at risk of or experiencing homelessness	—	✓	No accommodation	0
CatholicCare Canberra and Goulburn	MINOSA: Accommodation ASSIST: support with case management	Men at risk of or experiencing homelessness	✓	✓	Congregate	6
Toora Women	Family Program	Families, in all their diversity, at risk of or experiencing homelessness	✓	✓	Congregate and standalone	13
St Vincent de Paul	Family Service	Families, in all their diversity, at risk of or experiencing homelessness	✓	✓	Standalone	17
Communities @ Work	Reach Home Program	Families, in all their diversity, at risk of or experiencing homelessness	✓	✓	Standalone	7
Barnardos Australia	Youth Identified Accommodation and Support Program	Young people at risk of or experiencing homelessness	—	✓	No accommodation	0
Barnardos Australia	Friendly Landlord Service	Young people at risk of or experiencing homelessness	✓	✓	Shared (2 per property)	60

Service provider	Service description	Target group	Accommodation (short-term, crisis, supported or transitional)	Support services (non-accommodation)	Accommodation type (congregate or standalone)	Accommodation places (congregate or standalone)
Barnardos Australia	Our Place	Young people engaged in education and training and who are at risk of or experiencing homelessness	✓	✓	Shared (2 per property)	24
Salvation Army	Youth Emergency Accommodation network	Young people at risk of or experiencing homelessness	✓	✓	Congregate in cluster housing model	24
St Vincent de Paul	Young Parent Accommodation Support Program	Young people (with or without accompanying children) at risk of or experiencing homelessness	✓	✓	Standalone	4
Ted Noffs Foundation	Take Hold Program	Young people at risk of or experiencing homelessness	—	✓	No accommodation	0
CatholicCare Canberra and Goulburn	Youth Housing Support Service	Young people at risk of or experiencing homelessness	—	✓	No accommodation	0
Conflict Resolution Service	Family Tree House	Young people and families, in all their diversity, at risk of or experiencing homelessness	—	✓	No accommodation	0
Gugan Gulwan Youth Aboriginal Corporation	Youth Support Program	Young Aboriginal and Torres Strait Islander people at risk of or experiencing homelessness	—	✓	No accommodation	0
Toora Women / Everyman Australia	Indigenous Boarding House Network	Aboriginal and Torres Strait Islander families	✓		Congregate and standalone	6
Toora Women	Indigenous Program	Indigenous families, in all their diversity, at risk of or experiencing homelessness	✓	✓	Congregate and standalone	6
Winnunga Nimmityjah	Housing Liaison	Aboriginal and Torres Strait Islander individuals or families at risk of or experiencing homelessness	—	✓	No accommodation	0
Winnunga Nimmityjah	Home Maintenance Program	Aboriginal and Torres Strait Islander individuals or families at risk of or experiencing homelessness	—	✓	No accommodation	0

Service provider	Service description	Target group	Accommodation (short-term, crisis, supported or transitional)	Support services (non-accommodation)	Accommodation type (congregate or standalone)	Accommodation places (congregate or standalone)
Australian Red Cross	Road House	People at risk of or experiencing homelessness	—	✓	No accommodation	0
Stanislawa Dabrowski	Soup kitchen	People at risk of or experiencing homelessness	—	✓	No accommodation	0
Hare Krishna Food for Life	Food services	People at risk of or experiencing homelessness	—	✓	No accommodation	0
Woden Community Service	OneLink	People at risk of or experiencing homelessness	—	✓	No accommodation	0
Woden Community Service	Sustaining Tenancy Service	People (with or without accompanying children) at risk of or experiencing homelessness	—	✓	No accommodation	0
Toora Women. / Everyman Australia	Tenant Assistance Program	People at risk of or experiencing homelessness	✓	✓	Standalone	8
			✓	✓	Standalone	5
St Vincent de Paul	Street to Home	People at risk of or experiencing homelessness	✓	✓	Standalone	6
UnitingCare Canberra	Early Morning Centre	People at risk of or experiencing homelessness	—	✓	No accommodation	0
Northside Community Service and Argyle Housing Ltd.	Common Ground tenant support	Common Ground tenants	✓ (PSH)	✓	Congregate	20 (PSH units for people previously homeless)
Domestic Violence Crisis Service	Domestic Violence Christmas Initiative	People (with or without accompanying children) who have been subjected to domestic violence	✓	✓	Motel accommodation	0
Woden Community Service	The Big Issue	People at risk of or experiencing homelessness	—	✓	No accommodation	0
Canberra Rape Crisis Centre	Crisis intervention, counselling and education	People who have experienced, been affected by or are at risk of sexual violence and/or their family members and supporters	—	✓	No accommodation	0

Service provider	Service description	Target group	Accommodation (short-term, crisis, supported or transitional)	Support services (non-accommodation)	Accommodation type (congregate or standalone)	Accommodation places (congregate or standalone)
Domestic Violence Crisis Service	Court Advocacy Program	People (with or without accompanying children) who have been subjected to domestic violence	—	✓	No accommodation	0
Council on the Ageing ACT (COTA ACT)	Housing information, advice and support	Older people in the ACT	—	✓	No accommodation	0
Care Inc	Financial counselling service	Low-income earners and vulnerable consumers	—	✓	No accommodation	0
					Total accommodation places	*321*

Source: Housing ACT.

APPENDIX 8: A NEEDS ASSESSMENT TOOL—DATA AVAILABLE FOR INTEGRATION

Nationwide administrative datasets include:

- SHS Collection (identifiable episode-level data) held by AIHW
- Supported Accommodation Assistance Program client collection held by AIHW
  - indicators of homelessness cohorts
  - detailed information on associated SHSs
- Data Over Multiple Individual Occurrences dataset held by the Department of Social Services (DSS)
  - indicators of demographic characteristics and payment types
- Enterprise Data Warehouse held by the Department of Human Services
  - indicator of homelessness
  - detailed information on urgent payments, crisis payments, Centrepay, advance payments and debt agreements, among other things
- Data Exchange dataset held by DSS
  - indicator of homelessness
  - detailed information on financial wellbeing and capability activities and DSS-funded support services
- Research Evaluation Database held by the Department of Jobs and Small Business
  - indicators of homelessness and 'at-risk' of homelessness
  - detailed information on job search activities, participation failures, program referral/participation and short courses taken
- Vocational education and training data held by the National Centre for Vocational Education Research
  - detailed information on vocational education and training studies
- Income and income type data held by the Australian Taxation Office
  - detailed information on income and source of income
- National Non-admitted Patient Emergency Department Care Database, national hospitals data collection collated by AIHW
  - detailed information on emergency department presentations (alcohol/drug-related)
- National Non-admitted Patient (episode-level) Database, national hospitals data collection collated by AIHW
  - detailed information on individual session occasions of non-admitted patient care (alcohol/drug-related)
- National Public Hospital Establishments Database, national hospitals data collection collated by AIHW
  - detailed information on emergency occasions of service (alcohol/drug-related)
- National Hospital Morbidity Database, national hospitals data collection collated by AIHW
  - detailed information on hospital separations by drug-related principal diagnosis

- Disability Services National Minimum Data Set collated by AIHW
- Medicare Benefits Schedule data collection collated by AIHW
- Pharmaceutical Benefits Scheme data collection collated by AIHW
- Juvenile Justice National Minimum Data Set collated by AIHW
- Child Protection National Minimum Data Set collated by AIHW
  - detailed information on notifications, investigations, substantiations, orders and out-of-home care placements
- National Perinatal Data Collection collated by AIHW
  - detailed information on mothers smoking during pregnancy, gestational age, birthweight, Apgar score (at 5 minutes), admission to specialist units and perinatal deaths
- National Death Index collated by AIHW.

ACT-wide administrative datasets include:

- Register of Births, Deaths and Marriages
- OneLink administrative data
- housing register
- rental agreement records
- housing support service records (such as bond loans, rental grants, public housing, supportive housing)
- private rental vacancy rates (CoreLogic)
- private rental prices (CoreLogic)
- ACT Policing
- Justice and Community Safety Directorate
- ACT Corrective Services
- Sobering Up Shelter (Ainslie Village).

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