In-Depth Evaluation of Camperdown Common Ground:
Permanent housing for vulnerable long-term homeless people
Final Report

Prepared for:
NSW Department of Family and Community Services

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<tr>
<td>AWG</td>
<td>Advisory Working Group</td>
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<tr>
<td>CALD</td>
<td>Culturally and linguistically diverse</td>
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<td>CBA</td>
<td>Cost benefit analysis</td>
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<td>CCG</td>
<td>Camperdown Common Ground</td>
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<td>CEA</td>
<td>Cost effectiveness analysis</td>
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<td>CSS</td>
<td>Camperdown Support Services</td>
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<td>CTO</td>
<td>Community Treatment Order</td>
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<td>DA</td>
<td>Development Application</td>
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<td>DSP</td>
<td>Disability Support Pension</td>
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<td>ED</td>
<td>Emergency Department</td>
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<td>NSW Department of Family &amp; Community Services</td>
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<td>Housing NSW</td>
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<td>ICC</td>
<td>Inner City Coalition</td>
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<td>ICIS</td>
<td>Inner City Integrated Services</td>
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<td>MAH</td>
<td>Mission Australia Housing</td>
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<td>MoCA</td>
<td>Montreal Cognitive Assessment</td>
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<td>MoU</td>
<td>Memorandum of Understanding</td>
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<td>NCAT</td>
<td>NSW Civil and Administrative Tribunal</td>
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<td>NDARC</td>
<td>National Drug and Alcohol Research Centre</td>
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<td>NPAH</td>
<td>National Partnership Agreement on Homelessness</td>
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<td>NRAS</td>
<td>National Rental Affordability Scheme</td>
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<td>SAAP</td>
<td>Supported Accommodation Assistance Program</td>
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<td>UNSW</td>
<td>The University of New South Wales</td>
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<td>VI</td>
<td>Vulnerability Index</td>
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<td>WHOQoL</td>
<td>World Health Organisation Quality of Life</td>
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1 Executive summary

This report presents the findings of an in-depth evaluation of Camperdown Common Ground (CCG). Common Ground is a model of permanent supported housing that offers congregate or apartment-style affordable housing together with a range of onsite services. The purpose of the evaluation was to assess CCG's effectiveness in facilitating sustainable housing for vulnerable, formerly long-term homeless people, many of whom have spent long periods sleeping rough. The evaluation aimed to inform future planning and contribute to evidence about housing this group.

To address these aims, the evaluation focused on the following three streams of enquiry:

- **Stream 1:** Resident outcomes - incorporating housing, physical and mental health, social and economic outcomes for formerly homeless tenants.
- **Stream 2:** Structure and process of service delivery - including the physical design of the building, the tenancy management and support provider partnerships; impact; and relationships with other stakeholders and service providers.
- **Stream 3:** Total costs and benefits of CCG compared to other responses to homelessness, and compared to other Common Ground projects across Australia; where possible, calibrating the cost effectiveness of the project/approach, and assessing the potential reduction or avoidance of costs incurred across NSW Government agencies, or other organisations as a result of entry into the project.

**The Campedown Common Ground model**

CCG houses a social mix of homeless and low-income people. It does not require people to engage in treatment programs or prove their housing readiness as a condition of tenancy. In Australia, Common Ground targets the most vulnerable homeless people. CCG opened on 4 November 2011 with tenants moving in gradually from this date. It is Australia's third project based on the Common Ground model.

The CCG project has 104 units: of these, 52 are provided for vulnerable people who have experienced chronic homelessness (hereafter referred to as formerly homeless), 10 are for priority social housing tenants and 42 are for affordable housing tenants in a secure, socially integrated housing complex. Case management services are provided along with the housing, and a number of support services are co-located in the building.

Housing NSW1 funded Start-up, Concierge services, Support Services and on-site co-ordination support costs from 2010/11 to 2012/13 as well as an additional grant for Support Services in 2013/14. NSW Health provided funds for the design and fit out of therapeutic and interview rooms and other health related...

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1 Housing NSW merged with the Department of Community Services, and the Department of Ageing, Disability and Home Care to become the Department of Family & Community Services in 2014.
items. The Department of Community Services\(^2\) provided input into strategic service design and development and facilitated support service coordination. Mission Australia Housing (MA Housing) is the contract holder and is responsible for the property and tenancy management and for contracting out the concierge, cleaning, social enterprise, and support functions. Case management support is provided to tenants by Camperdown Support Services (CSS), operated by the Inner City Coalition (ICC), which is a partnership between five organisations: Mission Australia (lead agency), the Haymarket Foundation, Wesley Mission, St Vincent de Paul and the Salvation Army. Ownership of the Common Ground property was vested to MA Housing in 2015.

**Methodology**

The evaluation used a longitudinal, mixed-methods approach over an 18-month period, with data being collected in 2013 and 2014. The evaluation team collected: quantitative data to explore resident outcomes, qualitative data to assess the processes employed at CCG, de-identified program data collected by MA Housing, as well as financial data to explore the costs of the CCG model.

The evaluation design has limitations similar to other studies of this type. Participants in focus groups and interviews were self-selecting and may not be representative of all stakeholders and tenants. It was not possible to undertake any form of randomisation in the study methods and there is no counterfactual, i.e. it is not possible to know what would have happened to the formerly homeless tenants if they had not participated in the program. The evaluation of CCG is an ecological study involving a single group analysis in which tenant outcomes were evaluated at baseline and compared to results 12 months post-baseline to determine changes. We also examined subgroups in the data to identify any factors associated with risk and resilience. It should be noted, however, that the population of homeless people housed through Common Ground NSW is relatively small and given this, the analysis undertaken is primarily descriptive. Hence, it is not possible to determine a causal relationship between the provision of housing and outcomes. Additionally, imperfect recall and/or knowledge of past events may affect the quality of the data and may bias the results. On the other hand, a strength of the research method is the use of standardized assessment tools with established psychometric properties that have been trialed with similar cohorts in previous studies.

**Structure and process of service delivery**

The implementation process was generally well executed and had occurred in a timely manner. Selection and contracting of the ICC as a service provider occurred late in the establishment process, but the Coalition moved quickly to establish services.

The building design and location are generally appropriate. Some areas in the building, such as where the support providers are located, could have been better planned to ensure worker safety. MA Housing proposes to undertake building work to rectify key safety issues. Tenants were less satisfied with interactions with neighbours in the building than they were with other aspects of the housing, although the responses were still generally positive on average. Tenants on the whole reported feeling safe in the building, particularly when comparing CCG to other homelessness services.

There was overwhelming agreement among stakeholders that the reporting structure at CCG is multi-layered and complex. The key areas of concern and disagreement about the structure were: the decision to make one housing organisation the key contract manager for the entirety of the model, the complexity around the selection of a consortium of organisations to provide support to formerly homeless tenants, and the infrequency of advisory group meetings.

Partnerships within the ICC and between ICC and MA Housing have improved as the project has progressed. There is an ongoing need to clarify roles and responsibilities between these two partners in order to

\(^2\) Housing NSW merged with the Department of Community Services, and the Department of Ageing, Disability and Home Care to become the Department of Family & Community Services in 2014.
coordinate and increase the effectiveness of their work while maintaining the separation of housing and support. Common Ground is taking steps to adopt a more planned approach to case management, and to move away from a focus on crisis management. Some onsite services are provided to the broader community and stakeholders reported that this was a positive element of the project which built local relationships, and which they aimed to increase in the future. No problems were reported with relations in the local community.

Outcomes

Camperdown Common Ground was successful in providing secure, permanent housing and support to vulnerable people who had been homeless for many years. Formerly homeless tenants had been homeless for an average of 12 years before entering Common Ground, but at March 2014 there had been a 63% retention rate among the formerly homeless tenants over 28 months. Data from the client survey of formerly homeless tenants found that the vast majority (84%) were satisfied or very satisfied with their housing and the majority reported that the services provided to them had been useful. The vast majority of participants also reported noticing changes in their lives since working with the CCG service at baseline (96%) and follow-up (87%).

During the period of operation of CCG, some tenants had built up high levels of rent arrears. Since the baseline report, MA Housing and CSS have introduced improved measures to detect arrears early and deal with them more strategically.

The qualitative data collected as part of the client survey indicated that services provided on-site were assisting tenants to make positive changes in their lives. Tenant participation in case management is voluntary, but program data indicated that 63 of 76 formerly homeless tenants had engaged in case management. The proportion of participants who knew they had a case plan in place increased from baseline to follow-up (39% to 61%). Over time, fewer participants at follow-up felt that they had to repeat the same information to different services, although fewer participants thought services were working together.

New themes that emerged from participants’ comments at follow-up were the need for greater communication between staff and services and the desire for greater financial independence, with participants often reporting the need for more employment assistance. The majority of participants (96%) were unemployed at follow-up, and the proportion of participants who considered themselves unable to start work in the week prior to the survey due to long-term illness or disability remained stable over time (62%).

Stakeholders emphasised the importance of allowing sufficient time to achieve change for people who have experienced long-term homelessness, and who have disabilities and illnesses. They stressed the achievement of maintaining permanent housing, particularly for those who had lived on the street for decades, and reported positive visible changes in some tenants. Having basic needs met has enabled many to improve their quality of life.

The survey results show that most scores measuring quality of life improved over time; however, they remained lower than those of a broader community sample. Survey results also found some improvements in health outcomes and health service utilisation, with changes between baseline and follow-up including:

- lower treatment rates for most physical and mental health conditions;
- lower symptoms of psychological distress across all nine primary symptom dimensions;
- a drop over time in the proportions of participants reporting use of alcohol and other drugs; however, there was an increase in frequency of use amongst some opioid and amphetamine users;
- mostly stable service utilisation rates of Emergency Department (ED) and overnight hospital admissions for physical and mental health reasons across time, although there was an increase in the proportion of participants who reported the reason for attendance as drug-related problems;
- a smaller proportion of the sample admitted to a hospital overnight for a mental health reason, with those...
who were admitted reporting shorter stays;
- a reduction in the proportion of participants who attended a drug and alcohol treatment facility and who had been treated by the ambulance service.

**Key issues, gaps and areas for improvement**

Governance of Common Ground is an area for ongoing monitoring, including relationships between MA housing and the ICC, between MA Housing and Mission Australia, between the consortium that comprises the ICC as well as the role and effectiveness of the Common Ground Advisory Committee.

Many of the stakeholders involved in the delivery of the project felt that the current resources provided for support are insufficient given the number of residents with complex needs. These stakeholders suggested that reducing the number of people with complex needs in the building would allow those who remain to be adequately supported. However, this view also challenges the original intentions of the CCG model; it was funded and intended to assist the most vulnerable homeless people. This is also the reason why other stakeholders, including most of those involved in oversight and establishment roles, expressed concerns about reducing the proportion of those with complex needs.

In 2014, stakeholders reported that while Common Ground was now more stable, there was still a high number of crises and incidents, including difficult behaviours, which were often associated with excessive drug and alcohol use.

There is a risk that congregating multiple people with complex needs in one location could create dependency and institutionalisation among tenants and may compound management problems (e.g. managing conflicts) and stigmatisation. Issues raised by tenants highlight the extent to which the decisions and attitudes of Common Ground staff impact on tenants’ lives and increase the risk of institutionalisation. Some of the elements of the model that need to be further clarified to avoid this risk include: the case management and property management approach, appropriate level of onsite services, and exit pathways for people who need to leave the service urgently. Case management and property management approaches require further development to more effectively address risk, support a recovery approach and avoid institutionalisation. Stakeholders report that this work is continuing.

There is an ongoing need for monitoring and improvement of coordination between tenancy management and support provision functions. There is a need for strong communication while maintaining separation of tenancy and support roles. Examples of areas where further work is occurring and will continue to be required are the management of rental arrears and cleaning and pest control in apartments.

Support providers had initially expected greater involvement of mainstream services for high need tenants at Common Ground. The issue of how appropriate services can be delivered to this group requires resolution. For some formerly homeless tenants, high unmet support needs related to cognitive impairments and other disabilities have made living at Common Ground difficult, and in some cases meant they cannot safely live there. While some of these people have moved to higher support facilities such as aged care, not all are eligible, particularly those who are young. This was identified as a service gap.

Most stakeholders from all groups thought that both scatter-site housing and Common Ground models were of value. Stakeholders thought that scatter site housing was preferable for most people and suggested criteria for who might be better suited to each model. Further work is suggested to clarify optimum target groups for scatter-site and Common Ground models.
Economic analysis

The economic analysis presents the first available figures for CCG, assessing total costs in the context of program benefits and in comparison with other responses to homelessness across Australia.

The economic analysis includes inherent study limitations due to the relatively small sample sizes, the complexity in client baseline characteristics, and variation in the various homelessness program models. These factors restrict the assessment of causal relationships in client outcomes, the corresponding estimated effectiveness and the direct comparability of CCG and comparative program models. For this reason, the figures are presented as indicative estimates based on the available cost and support service data.

Program cost and estimated average cost per tenant

The total program cost for the 2013-14 financial year was $2.81 million, comprising of relatively equal cost components of $1.4 million for building and tenant maintenance and $1.4 million for resident support services.

This represents an estimated average cost per tenant of $13,526 per annum for the affordable accommodation component and $21,994 per supported tenant per annum for support services. The majority of support services, an estimated 80 per cent, were provided to long-term homeless residents. Additionally, the estimated cost of capital invested in the CCG building is estimated at $25,384 per unit per annum, reflecting the relatively high cost of property in central Sydney.

Combining these components, the estimated total average cost per resident is $38,910 for affordable housing residents and $60,904 for long-term homeless residents, including support services and cost of capital.

These costs are partially offset by resident rental payments estimated at $8,968 per tenant, with initial high levels of rental arrears improving with proactive monitoring and management.

Additionally, there are potentially cost offsets resulting from changes in service usage, for example as a result of residents’ improved mental and physical health or reduced contact with criminal justice services. Previous research indicates potentially significant cost offsets associated with homelessness programs as a result of these types of service use changes; however, estimated individual costs are highly variable and given the small study group, these costs are not able to be specifically calculated for individual tenants residing in CCG. For this reason, while these types of cost offsets present additional plausible cost savings, consistent with the conservative approach of this evaluation, these potential cost offsets are not explicitly presented in the program cost effectiveness figures.

Program benefits

The primary outcome is transitioning long-term homeless clients to stable and sustainable long-term accommodation. The CCG tenancy retention rate is 63 per cent over the study period, with the effective success rate potentially higher as the figure includes both evictions as well as planned exits to more suitable accommodation, for example residential aged care.

The program benefits incorporate the range of positive resident outcomes as outlined above which are implicit in the program effectiveness and cost-effectiveness. These include improvements across physical and mental health conditions, symptoms of psychological distress as well as measures of quality of life.
Program cost effectiveness

The estimated average cost per long-term homeless tenant is in the order of $60,000 per annum, including building and tenant maintenance, building security, the cost of capital invested in the property as well as the range of support services. When including tenant rental payments, the estimated average cost per tenant is approximately $51,000 per annum.

The estimated CCG average cost per tenant is in the higher range of annual cost for alternative homeless programs in absolute terms, although direct comparisons reflect a range of factors including variation in service models and client needs, as well as the relatively high cost of property in central Sydney.

The overall program cost is comprised of an affordable accommodation component which is generally constant over time. Separately, the estimated average cost of support services of around $22,000 per year is considered a conservatively high estimate because it is assumed that tenants would continue to require high levels of support after the initial stabilisation phase. In this context, estimated support costs may reduce over time.

From the NSW government's perspective, a substantial proportion of CCG program funding is sourced through Commonwealth government grants, support benefits and rental assistance, while the benefits are provided directly to Sydney people who are homeless. This represents a proportionally low funding to outcome ratio, with potential additional cost offsets cumulatively extending into the longer term in the case that stable housing and resulting health benefits are achieved and sustained.
Camperdown Common Ground opened on 15 November 2011 and is Australia’s third project based on the Common Ground model. Common Ground is a model of permanent supported housing that offers congregate or apartment-style affordable housing together with a range of onsite services. The model houses a social mix of homeless and low-income people. It does not require people to engage in treatment programs or prove their housing readiness as a condition of tenancy. In Australia, Common Ground targets the most vulnerable homeless people.

Permanent housing models, and in particular ‘housing first’ models, aim to remove barriers to housing for the most vulnerable homeless people (Gulcur et al., 2003). ‘Housing First’ is an approach which rejects the assumptions of the transitional approach and assists homeless people by providing immediate access to long-term independent housing with tailored, flexible support services, but without requiring sobriety or treatment. A range of ‘Housing First’ approaches have been widely adopted in a number of Western countries as a policy response to chronic homelessness (Pleace and Bretherton, 2012).

Camperdown Common Ground accommodates formerly long-term homeless people and people on low to moderate incomes in a socially integrated housing complex in inner Sydney. According to the NSW Department of Family & Community Services (FACS)-HNSW, CCG was initiated as part of a coordinated government response to homelessness and the Australian Government’s 2008 commitment to reduce the number of people sleeping rough by 25% by the year 2013 (Australian Government, 2008). It aimed to respond to high levels of homelessness and rough sleeping in the inner city of Sydney and to promote a model of ‘Street to Home’ housing coupled with support services (Housing NSW, 2012).

FACS-HNSW commissioned a research team at UNSW (The University of New South Wales) to undertake an in-depth evaluation of the CCG project. The baseline report (Bullen, Whittaker, McDermott, & Burns, 2013): explains the methodology and sample, describes the demographics of the formerly homeless tenants accepted into the program as well as the selection process, provides a description and analysis of the service model and a description of baseline resident characteristics. This report analyses resident outcomes over time and draw comparisons between the outcomes experienced by CCG tenants and tenants in other comparable programs, where data is available.

2.1 Aims and objectives of Camperdown Common Ground

The project has been developed on land owned by FACS-HNSW at 31 Pyrmont Bridge Road, Camperdown. The site is between two public housing buildings, Johanna O’Dea Court on the East and the heritage listed Alexandra Terraces on the West. The CCG building is made up of 104 units, including:

- 88 studio apartments
- 12 one bedroom apartments
- 4 two bedroom apartments.

The model is also structured to provide:

- permanent housing rather than transitional or crisis accommodation;
- a sustainable social mix in the building – 52 units are provided for vulnerable people who have experienced chronic homelessness⁴, 10 are for priority social housing tenants and 42 are for affordable housing tenants;
- 24-hour concierge service to provide safety and security for tenants;
- onsite facilities and activities for tenants and the local community such as a computer room, multi-purpose room, social enterprise initiative, education and training;
- a range of services delivered onsite to assist tenants to sustain a tenancy and integrate with the community.

According to FACS-HNSW (2012), the key objectives of CCG are to:

- develop a project consistent with the principles of a Common Ground approach to supported housing;
- provide formerly homeless people with safe, stable, long-term accommodation and support services to enable them to sustain their tenancies;
- achieve a social mix in the building by accommodating formerly homeless people and people on low to moderate incomes;
- maximise opportunities for tenants to become reconnected with the mainstream community in order to build capacity and improve wellbeing;
- adopt a coordinated and integrated “whole-of-site” approach to tenancy and issues management to ensure consistent tenancy management for all tenants on the site; and
- build partnerships with Government agencies and the non-government and corporate sectors to achieve social inclusion for tenants.

2.2 Key agencies

MA Housing was selected as the preferred Community Housing Provider for CCG in 2009. From this time, MA Housing was involved in the development of the project and had input into the design of the building.

Following agreement between FACS-HNSW and FACS, MA Housing was appointed as lead agency for the whole project in May 2011, with responsibility for all services including property and tenancy management, concierge, the social enterprise project, and the management of support services. MA Housing has subcontracted Guardian Security to provide concierge services after hours. Following an open tender process that involved representatives from FACS-HNSW, FACS and the Australian Common Ground Alliance, the ICC was selected to provide support services to tenants. The ICC is a partnership between five specialist

⁴ A particular emphasis of this evaluation is to understand the impact of the program on residents who have a history of chronic homelessness. Throughout the report, this group of vulnerable people who have experienced chronic homelessness are referred to as formerly homeless tenants.
homelessness services: Mission Australia (lead agency), the Haymarket Foundation, Wesley Mission, St Vincent de Paul and the Salvation Army and it operates as Camperdown Support Services (CSS). MA Housing conducted a tender process for the social enterprise component in 2012. The tender did not result in any proposals and MA Housing is considering using a consultant to develop a social enterprise.

2.3 Onsite services

A wide range of services are also provided onsite. Almost all services are open to both tenants of Common Ground as well as tenants in the nearby FACS-HNSW buildings. All services except for the Food Bank are provided free of charge. The services are detailed in Table 2.1.

Table 2.1: Onsite services available at Camperdown Common Ground

<table>
<thead>
<tr>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekly art classes</td>
</tr>
<tr>
<td>Weekly cooking classes in onsite community kitchen</td>
</tr>
<tr>
<td>Weekly distribution of food parcels</td>
</tr>
<tr>
<td>Community lunch serving weekly hot meals</td>
</tr>
<tr>
<td>Personal fitness training in onsite gym</td>
</tr>
<tr>
<td>Gym induction program</td>
</tr>
<tr>
<td>CG Hosted 10-week Community Kitchen biyearly</td>
</tr>
<tr>
<td>Chiropractor available bimonthly</td>
</tr>
<tr>
<td>SMART Recovery meetings to beat addictions</td>
</tr>
<tr>
<td>Mental Health Clinic: weekly onsite mental health clinical nurse practitioner and psychiatrist</td>
</tr>
<tr>
<td>Computer advice drop-in run in computer HUB</td>
</tr>
<tr>
<td>Gardening club weekly meetings/practical hands-on in onsite community garden</td>
</tr>
<tr>
<td>Weekly transport to Broadway shops</td>
</tr>
<tr>
<td>Centrelink onsite weekly</td>
</tr>
<tr>
<td>Psychologist available weekly</td>
</tr>
<tr>
<td>Weekly GP clinic run by Glebe Medical Family Practice</td>
</tr>
<tr>
<td>Weekly Nurse clinic run alongside GP clinic</td>
</tr>
<tr>
<td>Weekly BBQ Breakfast onsite</td>
</tr>
<tr>
<td>Weekly walking group exploring the local neighbourhood</td>
</tr>
<tr>
<td>Weekly drives exploring the neighbourhood</td>
</tr>
<tr>
<td>Every 3rd Month RSPCA runs a vet clinic onsite</td>
</tr>
<tr>
<td>Monthly trip to Monica’s dog shelter to exercise the dogs</td>
</tr>
<tr>
<td>Fishing trips</td>
</tr>
<tr>
<td>Onsite movies</td>
</tr>
<tr>
<td>Alcoholics Anonymous</td>
</tr>
</tbody>
</table>
Yoga
• Worm farm/composting workshops
• Drawing classes
• Tenancy meetings
• Lambert Street Festival
• Card Playing club

2.4 Evaluation scope and focus

The purpose of the evaluation was to assess CCG’s effectiveness in facilitating sustainable housing for vulnerable, formerly long-term homeless people, many of whom have spent long periods sleeping rough. The evaluation aimed to inform future planning and contribute to the evidence of what works to house this group.

To address these aims the evaluation focused on the following three streams of enquiry:

• Stream 1: Resident outcomes - incorporating housing, physical and mental health, social and economic outcomes for formerly homeless tenants.

• Stream 2: Structure and process of service delivery - including the physical design of the building, the tenancy management and support provider partnerships; impact; and relationships with other stakeholders and service providers.

• Stream 3: Total costs and benefits of CCG compared to other responses to homelessness, and compared to other Common Ground projects across Australia; where possible, calibrating the cost effectiveness of the project/approach, and assessing the potential reduction or avoidance of costs incurred across NSW Government agencies, or other organisations as a result of entry into the project.

The main focus of the evaluation was on the formerly homeless tenants with histories of long-term or chronic homelessness, who are housed in 52 units in the building. This group is referred to as the formerly homeless tenants. The remaining 52 units comprise 10 units for priority social housing tenants (some of whom have histories of homelessness) and 42 units for affordable housing tenants.

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5 According to Illback et al. (1997), judgments of effectiveness are based on whether a program is operating as planned and whether it has met its program goals.

6 At CCG, there are 88 bedsits, 12 1-bedroom apartments and four 2-bedroom apartments so some units are occupied by more than one person.
3 Methodology

The evaluation aimed to evaluate the effectiveness of the CCG service model. To meet this aim, the evaluation utilised a longitudinal, mixed-methods approach. Over an 18-month period, the evaluation team collected: quantitative data to explore resident outcomes, qualitative data to assess the processes employed at CCG, de-identified program data collected by MA Housing, as well as financial data to explore the costs of the CCG model. The theoretical framework underpinning this approach, as well as an explanation of the specific methods employed in this report, is described in this section.

3.1 Evaluation framework

The evaluation methodology was based on a framework called program theory, which articulates the elements of a program and how these elements work together to meet an identified need or to solve a particular problem. It works by characterising the elements of a program, including its inputs, activities, outputs and outcomes, and shows how these elements work together to meet an identified need. In addition, program theory draws attention to how the program is influenced by the wider service system, the policy context and other external contextual factors (McLaughlin and Jordan, 1999).

The outcomes experienced by formerly homeless tenants of CCG were given context through the process evaluation, which aimed to develop an understanding of why outcomes occurred. Together, the process and outcomes were used to determine ‘for whom, in what circumstances and in what respects a family of programmes work’ (Pawson, 2006: 25).

A program logic has been developed for the CCG, which provided a framework for understanding the relationship between the service delivery model and outcomes for individual formerly homeless tenants.
**Methodology**

The evaluation was approved by the UNSW Human Research Ethics Committee (HREC) in February 2013 (HREC Reference Number 12625). Prior to participation in interviews, focus groups and surveys, all participants received an Information Statement and Consent Form outlining the rights of participants, including that participation was voluntary and that participants could withdraw from the study at any time by revoking their consent. The information and consent forms and survey instruments used for the evaluation are in Appendix B in this report.

The methods used to collect data on the processes and outcomes are described below.

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**Figure 3.1: Program logic model for Camperdown Common Ground**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Activities and Strategies</th>
<th>Outputs: Short &amp; Medium Term</th>
<th>Outcomes: Long Term</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing that is safe, affordable and promotes social integration.</td>
<td>Strategies to ensure safety in common areas; strategies and supports to promote safe housing &amp; social integration implemented.</td>
<td>Safe common areas; effective security systems; clear protocols to deal with problems.</td>
<td>Formerly homeless tenants satisfied with their accommodation (safe, comfortable, affordable). Increased social networks and participation. Reduced homelessness.</td>
</tr>
<tr>
<td>Establish target groups and implement client selection criteria in accordance with Common Ground principles.</td>
<td>Clear and efficient referral and assessment procedures; people within the target group are referred.</td>
<td>An appropriate social mix is selected.</td>
<td>Formerly homeless tenants maintain housing. Reduced costs of homelessness to community, government, participants.</td>
</tr>
<tr>
<td>Key stakeholders involved in design and implementation.</td>
<td>Partnership arrangements between key housing and support agencies e.g. MoUs, policies.</td>
<td>Partner agencies effectively co-ordinate and deliver services.</td>
<td>Efficient and effective integrated service delivery. Better individual outcomes for formerly homeless tenants: improved health, mental health and wellbeing; improved self-management skills; increased engagement with the labour force, education and training programs.</td>
</tr>
<tr>
<td>Resources/Funding</td>
<td>Tenancy management and support services funded.</td>
<td>Tenancy management and support services provided.</td>
<td>Resources used effectively. Cost per resident is no higher than other similar models. Reduced level of re-offending.</td>
</tr>
</tbody>
</table>
3.2 Qualitative data

Interviews and focus groups were conducted with key stakeholders and tenants of the CCG project at two points in time: March 2013 and March/April 2014.

Qualitative data was collected to provide information about the strengths and weaknesses of the program’s implementation, service delivery, tenancy management practices, how the community was functioning and perceptions of the quality of services provided. Qualitative data was also collected to understand formerly homeless tenants’ satisfaction with the housing and support provided by the project. All participants in qualitative data collection were provided with a Participant Information Statement and Consent Form, which they were asked to read and sign. If a participant was unable to read, all information and instructions were read aloud.

3.2.1 Focus groups with tenants

Focus groups were held with formerly homeless tenants in both 2013 and 2014 to explore their experiences and perceptions of the project’s operation. Topics covered in the focus groups included: perceptions of the building design, services and supports, relationships with staff, relationships with neighbours, community atmosphere, safety, maintenance, interaction with other formerly homeless tenants and suggested improvements to the program. Staff from CCG were responsible for recruiting participants to take part in the focus groups. This ‘arm’s length’ process, using a trusted person, was consistent with the ethics protocol as it aimed to avoid real or perceived coercion by the researchers. Formerly homeless tenants received a $20 gift voucher as reimbursement for their time participating in focus groups in 2013. In 2014, the reimbursement was increased to $40.

In 2013, nine formerly homeless tenants participated in focus groups. The evaluation team had hoped to attract up to 15 formerly homeless tenants to attend focus groups but this was not successful despite an additional group being held. In 2014, 10 formerly homeless tenants participated in focus groups.

In 2014, a focus group was held with 8 low to moderate income (affordable housing) residents. Topics covered in the focus group included participants’ views on their housing and, in particular, the experience of living in close proximity to formerly homeless people with complex needs and the extent to which the project had built a safe and strong community for all who lived there. The focus group also covered respondent accounts of how they came to take up their tenancy and the extent to which their decision to do so was based on a full understanding of living in a ‘mixed use’ building. The low to moderate income residents were recruited by letter and advertisements posted in common areas of the building. Low to moderate income residents received a $40 gift voucher as reimbursement for their time participating in the focus group.

Table 3.1: Overview of qualitative data collection with formerly homeless tenants and low income tenants

<table>
<thead>
<tr>
<th></th>
<th>Phase 2 (March 2013)</th>
<th>Phase 4 (March/April 2014)</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formally homeless residents (focus groups)</td>
<td>9</td>
<td>10</td>
<td>19</td>
</tr>
<tr>
<td>Low-moderate income residents (focus groups)</td>
<td>-</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>9</td>
<td>18</td>
<td>27</td>
</tr>
</tbody>
</table>
3.2.2 Interviews with key stakeholders

Forty-two semi-structured interviews were conducted with project staff and other stakeholders across the evaluation. Twenty-three interviews were conducted in 2013 and 19 interviews were conducted in 2014. Twelve people were interviewed on both occasions. Participants were chosen using a purposive sampling method, which is commonly used in qualitative research to target participants with experience and knowledge regarding the implementation and operation of the service model.

The purpose of collecting the qualitative data was to understand the barriers and facilitators related to achieving project objectives, and the effectiveness of contractual and partnership structures embedded in the project. In consultation with FACS-HNSW and the ICC, key stakeholders were targeted based on their level of involvement in and understanding of the service model. Representatives from the following agencies took part in interviews:

- Inner City Coalition: service managers as well as front line staff providing support services to project tenants
- MA Housing;
- other organisations who provide services to CCG tenants on site;
- key staff at FACS-HNSW with a commissioning and/or oversight role in relation to the project;
- other relevant government departments with whom the project’s formerly homeless tenants may be expected to have contact, including Mental Health Services, FACS and the local police;
- other government and non-government stakeholders who were involved in establishing or monitoring the project.

Of the 23 stakeholders interviewed in 2013, 9 were from the ICC and MA Housing; 8 were from other organisations that provided services to or had contact with Common Ground tenants; and 6 were from government and non-government organisations with a commissioning and/or oversight role or an involvement in establishing the project. Of the 19 stakeholders interviewed in 2014, 10 were from the ICC and MA Housing; 5 were from other organisations that provided services to or had contact with Common Ground tenants; and 4 were from government and non-government organisations with a commissioning and/or oversight role or an involvement in establishing the project.

Table 3.2: Overview of stakeholder interviews

<table>
<thead>
<tr>
<th>Stakeholder group</th>
<th>N 2013</th>
<th>N 2014</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common Ground service providers (MA Housing, Inner City Coalition)</td>
<td>9</td>
<td>10 (6 repeats)</td>
<td>19</td>
</tr>
<tr>
<td>Other service providers (located on- or off-site)</td>
<td>8</td>
<td>5 (2 repeats)</td>
<td>13</td>
</tr>
<tr>
<td>Organisations involved in oversight and establishment roles</td>
<td>6</td>
<td>4 (4 repeats)</td>
<td>10</td>
</tr>
<tr>
<td>Total</td>
<td>23</td>
<td>19</td>
<td>42</td>
</tr>
</tbody>
</table>
3.2.3 Analysis

Thematic analysis was used to analyse the qualitative interviews and focus groups. Interviews were recorded, transcribed and coded in line with the evaluation streams.

To protect participants’ privacy, interviewees are not identified according to their organisational affiliation in this report. The qualitative data presented throughout this report is described in such a way as to give some indication of the prevalence of particular views that were expressed, as well as some indication of the types of stakeholders expressing these views.

3.3 Quantitative survey

The quantitative component of this evaluation comprised the Camperdown Common Ground Client Survey, which was adapted from a longitudinal survey tool developed through the National Drug and Alcohol Research Centre (NDARC) and previously employed in similar research projects, which also examined long-term housing for long-term homeless people, including the Way2Home (Whittaker, Schollar-Root, Zaretzky, et al., 2014) and Platform 70 (Whitaker, Schollar-Root and Burns, 2014) evaluations. This tool was modified to include questions pertaining specifically to tenants’ perceptions of housing quality, and took approximately 60 minutes to complete.

The CCG Client Survey was administered at each data collection time point (baseline and 12 months post-baseline). The 12-month follow-up survey focused on formerly homeless tenants’ experiences and outcomes over the previous 12 months. At both time points, the survey examined how tenants were faring in the areas of housing, labour market and income, health and social outcomes, which enabled an analysis of change in outcomes over a 12-month period. The survey also examined the factors of health service utilisation, contact with the justice system and experiences with case management, which allowed any changes in those areas over the 12 months to be identified.

3.3.1 Participants

In 2013, tenants who had experienced long-term homelessness were invited to participate in the CCG research by way of posters that were displayed throughout CCG. The staff at CCG were also asked to identify eligible formerly homeless tenants and to approach them to see if they were willing to participate. Formerly homeless tenants were eligible to participate if they: were at least 18 years of age at the time of completing the survey, were able to provide informed consent, were currently living at CCG, had experienced long-term homelessness, and had not previously completed the survey. Thirty-eight tenants agreed to participate, although three were not included in the study because they did not meet the eligibility criteria of being formerly homeless (n=2) or they appeared intoxicated during the interview (n=1), resulting in a final sample in 2013 of 35 participants. The sample predominantly comprised vulnerable people who had experienced chronic homelessness but it is possible that it also included a very small number of tenants who had entered CCG as priority social housing tenants and who had also experienced homelessness.

Ten eligible formerly homeless tenants had recently completed the client survey as part of the Way2Home evaluation (Whittaker, Schollar-Root, Zaretzky, et al., 2014), and as such were only required to complete additional questions regarding perceptions of CCG’s housing quality. All participants were reimbursed with Coles vouchers to cover costs involved in attending and participating in the interview; formerly homeless tenants who completed the CCG Client Survey were reimbursed a $40 Coles voucher, while formerly homeless tenants who only completed the perceptions of housing quality questions received a $10 Coles voucher. Participants were not denied payment if they began the interview but then did not meet the eligibility criteria or chose to withdraw.
All 35 formerly homeless tenants who completed the baseline survey were invited in 2014 to participate in the 12-month follow-up survey through a letter that was delivered to their apartments. The letter advised the baseline participants of the dates the interviewers would be onsite to complete the interviews, and that a booking form was available from the concierge if they would prefer to pre-book their interview time. The research team also reviewed the Locator Forms completed by participants at baseline, which provided additional contact information such as their phone number, or details of family, friends and service providers with whom they had contact. In instances where a participant was unable to be contacted through their apartment at CCG, any alternative contact avenues provided by the tenant at baseline were followed up. For example, baseline participants who had moved out of CCG since the baseline interview could only be followed up through the details provided on their Locator Forms.

Of the baseline sample, 26 tenants agreed to participate and completed the 12-month follow-up survey. Two of these participants were ex-tenants of CCG at the time of follow-up interview. Five of the 26 tenants who participated had recently completed the Client Survey as part of the Way2Home evaluation, and as such were only required to complete the questions pertaining to their perceptions of CCG’s housing quality. All participants were reimbursed in Coles vouchers to cover costs involved in attending and participating in the interview in the same way as in 2013.

### 3.3.2 Procedure

All formerly homeless tenants who were willing and eligible to participate were provided with a Participant Information Statement and Consent Form, which they were asked to read and sign. If a participant was unable to read, all information and instructions were read aloud. The surveys were administered by a trained interviewer who read the questions aloud to the participant and recorded their responses. Once the CCG Client Survey had been completed, the survey was sealed in an envelope before being returned to the research team. Data collection was completed from 7th March 2013 to 15th March 2013 and from 26th March 2014 to 2nd April 2014.

All interviewers had completed a three-hour training session on the Client Survey tool and had become familiar with this tool during the completion of the Way2Home and Platform 70 evaluation interviews (Whittaker, Schollar-Root and Burns, 2014; Whittaker, Schollar-Root, Zaretzky, et al., 2014). Further to this, all interviews were checked at the end of each day to ensure that all interviewers were adhering to high quality data collection standards.

In order to reduce attrition from the study, a systematic process for tracking participants was carried out. The core function of the tracking system was to collect information at the baseline interview which would be relevant for locating and communicating with participants regarding the 12-month follow-up survey.

Before completing the baseline survey participants signed a consent form which not only provided consent for the baseline survey, but also consent to locate them for the 12-month follow up survey. Interviewers assisted participants to fill out a locator form asking them for their primary contact information (e.g. phone number and/or mailing address) as well as the contact information (e.g. phone number and/or mailing address) for family, friends, and service providers with whom they had contact. The locator form also provided space for participants to note down any specific instructions for contacting them or any of their nominated contacts. This allowed participants to provide details of the easiest way to contact them and any sensitive issues that the researcher should consider. Participants were also asked to sign a Release of Information form, which gave consent for the researchers to contact and obtain contact details from Centrelink (a government agency responsible for welfare payments). The form provided space for participants to record their Centrelink client identification number to facilitate record access and matching. Signing the Release of Information form was voluntary and did not exclude participants from being involved in the client survey.
At the follow-up data collection time point, 26 of the original 35 baseline formerly homeless tenants completed the 12-month follow-up survey, which equated to a follow-up rate of 74%. Efforts to follow-up participants included sending letters to the participants' most recent address, assistance from the concierge who phoned participants' apartments and contacting participants using mobile phone numbers provided at baseline. Despite efforts from the service providers and research team, nine baseline participants did not complete the 12-month follow-up survey due to a number of reasons (see Figure 3.2). Six participants were unable to be contacted to take part in the 12-month follow-up survey; one participant refused to complete the follow-up survey; one participant agreed to participate but provided invalid responses and one participant had passed away during the time between the baseline and 12-month interviews.

Figure 3.2: Flowchart of follow-up process

Table 3.3 outlines basic demographic characteristics of participants at baseline and 12-month follow-up interviews. Throughout the report when baseline and 12-month follow-up data are compared to identify change over time, a 'matched sample' methodology has been adopted, whereby the group under analysis is restricted to those 26 individuals who were interviewed at both time points (i.e. excluding the nine dropouts).
Table 3.3: Characteristics of survey sample at baseline and 12-month follow-up

<table>
<thead>
<tr>
<th>Variable</th>
<th>Baseline data (N)</th>
<th>Follow-up data (N)</th>
<th>Attrition (n)</th>
<th>(%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sample size (N)</td>
<td>35</td>
<td>26</td>
<td>-9</td>
<td>-26%</td>
</tr>
<tr>
<td>Females</td>
<td>7</td>
<td>6</td>
<td>-1</td>
<td>-14%</td>
</tr>
<tr>
<td>Males</td>
<td>27</td>
<td>20</td>
<td>-7</td>
<td>-30%</td>
</tr>
<tr>
<td>Transgender</td>
<td>1</td>
<td>0</td>
<td>-1</td>
<td>-100%</td>
</tr>
<tr>
<td>Mean age in years (range)</td>
<td>44 (21-74)</td>
<td>45 (22-62)</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Aboriginal and/or Torres Strait Islander</td>
<td>5</td>
<td>3</td>
<td>-2</td>
<td>-40%</td>
</tr>
<tr>
<td>Born in Australia</td>
<td>26</td>
<td>19</td>
<td>-7</td>
<td>-27%</td>
</tr>
<tr>
<td>Usually speaks a language other than English with family</td>
<td>3</td>
<td>2</td>
<td>-1</td>
<td>-33%</td>
</tr>
<tr>
<td>Average complexity of need (1-4)(^6)</td>
<td>3.0</td>
<td>2.8</td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

**Potential bias**

Analyses were undertaken to compare the 26 formerly homeless tenants who completed both baseline and follow-up surveys against the nine formerly homeless tenants who only completed the baseline survey using Predictive Analytics Software (PASW) Statistics Version 18 (PASW, 2009). The purpose of these analyses was to determine whether there were any key characteristic differences between the groups that might suggest an attrition bias for those who failed to complete the follow-up survey.

The two samples were tested for differences in a number of baseline variables, including socio-demographic characteristics (gender, age, country of origin, Aboriginal status, language and education level); housing and homelessness variables; cognitive capacity and physical and mental health issues, including substance use disorder rates. There were no significant differences found across the socio-demographic characteristics. However, the formerly homeless tenants who completed both baseline and follow-up interviews were significantly more likely to have reported living in crisis accommodation \((p<0.01)\) and staying with relatives or friends \((p<0.05)\) at some point in their lifetimes than those participants who only completed the baseline interview. Participants who completed both interviews were also significantly more likely to report that they had a range of physical health problems, including asthma \((p<0.01)\), cancer \((p<0.05)\), cellulitis \((p<0.05)\) and vision problems \((p<0.001)\), as well as a significantly higher prevalence of particular mental health conditions, including psychotic disorder \((p<0.001)\) and impulse disorder \((p<0.05)\). No difference between the two groups in relation to substance use disorder prevalence was found.

Table 3.4 shows that the demographic characteristics of people who completed the survey were similar to all formerly homeless people at CCG.

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7 The complexity of needs amongst CCG formerly homeless tenants was examined across four areas: cognitive impairment; substance use disorder; physical health condition/s; and mental health condition/s. All participants reported at least one area of difficulty. Half of the tenants experienced issues in three different areas (51%) and an additional quarter co-managed difficulties across all four areas (23%). Only one participant (3%) reported difficulty in one area, suggesting that most tenants were dealing with a multitude of complex needs. Details are at Section 9.4.
Table 3.4: Characteristics of survey sample and all formerly homeless tenants at Camperdown Common Ground

<table>
<thead>
<tr>
<th>Variable</th>
<th>Program data 2014 (n=76)</th>
<th>Survey data 2014 (n=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>79% male; 18% female; 2% transgender</td>
<td>77% male; 23% female; 0% transgender</td>
</tr>
<tr>
<td>Mean Age</td>
<td>45 years</td>
<td>45 years</td>
</tr>
<tr>
<td>Aboriginal</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td>Born in Australia</td>
<td>75%</td>
<td>73%</td>
</tr>
<tr>
<td>Average length of time in CCG</td>
<td>482 days</td>
<td>493 days</td>
</tr>
</tbody>
</table>

3.4 Program data

Quantitative program data was collected in 2013 and 2014 from MA Housing and the ICC on resident characteristics, services provided, and baseline housing outcomes. A template for collecting the data was negotiated with MA Housing in the planning stage of the evaluation, and the data was returned to the researchers in a de-identified format for analysis.

Existing monitoring data was collected to understand the demographics of all formerly homeless tenants in the program, the support provided to formerly homeless tenants, details about people who had exited from the program, the number of people in rental arrears, and the number and type of incidents recorded in the building. Case workers were also asked to complete the LSP-16 which is designed to measure the life skills of people with schizophrenia and other major psychiatric disorders, including people’s self-care, anti-social behaviour, withdrawal and compliance (Alan Rosen et al., 2006). The LSP-16 is regularly collected by mental health clinicians across Australia, where a higher score on the LSP-16 indicates poorer functioning (A. Rosen et al., 2001). Potential scores on this measure range from 0 to 48.

The variable names and timeframes for which data were available are provided in Appendix B.

3.4.1 Analysis

Descriptive analysis was done to determine the characteristics of formerly homeless tenants accepted into the program, the frequency of exits, the number of tenants in rental arrears and the amount of money, the number and type of incidents at CCG as well as the case management and onsite services accessed.

3.5 Literature review

The research team conducted a brief literature review to identify and classify supportive interventions targeted at vulnerable people who have experienced chronic homelessness, including long-term housing and support models. The review focused on NSW programs and included other Australian and international programs where appropriate. The literature review involved searches of academic and ‘grey’ literature on housing/support interventions for rough sleepers, focusing especially on recent evaluations of distinct project models. It identified some established outcome measures that are useful to be included in the data collection tools, as well as potential comparative data. Appendix A contains the literature review for this project.

6 The domains in LSP-39 are labelled: self-care, non-turbulence, social contact, communication and responsibility.
3.6 Cost effectiveness

The developing research base examining the cost effectiveness of homelessness programs indicates potentially significant cost savings resulting from the stabilisation and transition of the long-term chronic homeless to stable long-term accommodation (Flatau 2008).

In this broad context, evaluation of specific homelessness program models naturally reflects the variation in accommodation and support service components. The related source of variation is the complexity and levels of individual needs and the mix of baseline characteristics, duration and history of homelessness circumstances. Combined, this variation in models and program populations will potentially influence individual outcomes, the relative timing of achieving outcomes and the corresponding cost to achieve them.

For this reason, the economic evaluation of human service programs such as CCG is characteristically complicated by relatively quantifiable upfront program development and then ongoing operational costs, against outcomes that are typically diffused across multiple dimensions, with cost offsets overlapping with multiple government agencies, and with lags across varying timeframes.

The economic component of the CCG evaluation incorporates stream 3 of the specification, to assess the total costs and benefits of CCG, and compares the model with other responses to homelessness and other common ground projects across Australia. The cost effectiveness component also includes assessment of the potential reduction or avoidance of costs incurred across other NSW government agencies as a result of the program.

Consistent with the evaluation overall, the primary focus is on the 52 formerly homeless residents with complex needs, but also includes the cost and benefits of the additional 52 social and affordable housing residents in the context of the common ground objective of achieving a social mix within the building and the wider benefits for individuals through social and community interaction.

3.6.1 Economic evaluation approach

Of the range of economic evaluation methods applied to program evaluations, the approach taken for CCG is a cost effectiveness analysis (CEA) as commonly and increasingly used in human service evaluations where the major benefits cannot generally be valued in money terms. For the CCG outcomes, costs are examined in terms of achieving the primary output of reducing homelessness through transitioning the long-term homeless into stable, long-term accommodation.

The application of CEA for human service programs is consistent with NSW Treasury Guidelines for Economic Appraisal, specifically as the approach is more readily applied to the bulk of social and community service programs, in particular where areas of physical and mental health outcomes, education, welfare and law and order are significant program components.9

In the case of human service benefits, the process of attempting to value health and welfare outcomes in monetary terms may require substantial resources and there are inherent difficulties in establishing consensus across specific valuations. This is reflected in the homelessness comparison programs examined in this evaluation with all but one of the five comparison programs taking a CEA approach, and one undertaking a cost benefit analysis (CBA).

9 NSW Government Guidelines for Economic Appraisal, NSW Treasury, July 2007
3.6.2 Economic evaluation objectives

The objectives of the CCG evaluation economic component include:

- Assess the total cost of establishing and delivering the CCG program, including:
  - The development and capital cost of the building
  - Property and tenancy management
  - Concierge and security
  - Support services
  - Net cost in terms of funding and income sources as well as estimated cost offsets
- Estimate the average cost per tenant
- Identify whole of government savings or cost offsets resulting from the program
- Examine the relative costs and benefits of CCG compared with other responses to homelessness

3.6.3 Homelessness program models

The economic analysis examines the total program costs and outcomes for CCG in comparison with other responses to homelessness across Australia.

Each homelessness program model provides particular elements across Housing First, support and outreach services, which historically have been the responses to crisis situations with varying short-term support of accommodation and services. Medium and longer term longitudinal follow-up is necessary to verify whether outcomes are sustained or whether individuals revert to unstable circumstances or return to homelessness.

This variation in homelessness models and the timeframe of respective outcomes provides an overarching perspective for the cost effectiveness comparison with alternative programs. The endpoint is long-term sustained stable accommodation, which in turn is necessary to realise long-term health and wellbeing benefits.

The comparability of programs need to be positioned not only in terms of baseline characteristics, model components and comparative time frames, but in terms of achieving the long-term objectives, implicit in the Commonwealth and State policy aimed to reduce homelessness. These objectives are reflected in the key targets of the NSW Homelessness action plan 2009 – 2014, which includes a target to reduce the overall level of homelessness in NSW by 7% as well as a target to reduce the number of people sleeping rough by 25%. CCG has been initiated as one of the response models to help achieve these targets.

3.6.4 Program costs

The program costs are based on final audited CCG financial reports, prepared by Mission Australia, providing aggregate annual costs. Figures are reported separately for building maintenance and tenant management as well as for support services. Capital costs of the property are also reported separately in line with periodic valuations.

The program financial reports include annual funding sources and other income, including rent contributions from tenants. The potential cost offsets to other agencies, in particular for healthcare and justice systems, are based on recent Australian published research.

With tenant surveys undertaken in March 2013 and March 2014, the evaluation timeframe aligns predominantly with the 2013-14 financial year, which is used as the primary complete annual cost basis.
The cost of capital invested in the CCG building reflects the relative cost of property across Australian capital cities and in this context is presented separately for reference, providing comparison across primary cost categories of building, support services, and cost of capital. This provides visibility of the cost of capital component for comparison of common ground or other homelessness models. For example, the cost of property at Common Ground Tasmania in Hobart is substantially lower than central Sydney where CCG is located, and correspondingly, the comparison of project costs are examined in the context of location.

The support service cost data reflects the aggregate, typically monthly, payments to service providers, and further details of tenant level cost or service usage data are not available.

### 3.6.5 Average cost per tenant

The cost components of CCG and other comparison programs incorporate a mix of affordable accommodation components, combined with a range of integrated support services. Additionally, for Common Ground models, building cost of capital invested is also a cost component.

Where possible, the figures articulate each cost element as a sub component of the average cost per tenant or program participant, to enable comparison of the relative provision of both the affordable accommodation component and, separately, the support services.

For CCG, the average cost estimates combine a flat allocation of costs for building and tenancy management across the 104 units, as well as estimated allocation ranges for support services across the tenant sub groups of long-term homeless and low income residents.

The estimated average cost per tenant is based on allocating all reported costs for the study period across the fully utilized building capacity of 104 units. This approach assumes full tenancy of all units in line with the sustained high tenancy developed during the establishment phase, with the moving in period for long-term homeless tenants extending over several months following CCG commencement in Nov 2011. Periods of vacancy of any units would naturally be reflected in slightly higher average costs per tenant given that property and maintenance costs are predominantly fixed.

### 3.6.6 Monthly reports

Monthly update reports are prepared by MA Housing, the CCG lead agency, and provided to FACS-HNSW. These monthly updates include separate report series for general KPI progress, contract management, meeting comments, issues, risks and achievements, as well as a separate monthly report for CSS. The support service content includes the number of clients in each sub group that received services that month, as well as the total number of delivered service hours and the number of hours provided by external service providers. This provides monthly aggregate hours by tenant subgroup as a supplementary source of the proportion of support services provided to each group.

As part of the cost analysis, these monthly reports were collated to establish the number of tenants in each subgroup that received support services, which was then used as the basis to derive the proportion of support recipients in each subgroup. The trend in proportional support service delivery was relatively stable across months with generally all long-term homeless tenants receiving the majority of support services, along with a number of social housing residents and a small number of affordable housing tenants. These proportions were established for context in estimating the average cost per tenant.

The hours of support in the MA Housing monthly reports are presented as indicative, with noted caveats for not fully capturing hours spent in group activity or time spent locating or attempting to engage clients.
3.6.7 Comparison with other responses to homelessness

A growing number of Australian and international research projects provide evidence of potentially significant cost offsets resulting from programs targeted toward long-term homelessness. The figures from previously published economic evaluation of homelessness studies are examined in context of potential additional cost savings, but are not calculated as actual client level service usage data and linkage are not within the scope of this study.

The primary cost offsets are associated with healthcare costs, which establish the disproportionally high health system service usage by long-term homeless individuals compared with the general population. The potential cost savings result from initial phases of diagnoses and stabilisation on a range of inadequately treated long-term conditions, as well as a gradual transition to the use of mainstream and preventative health services. This is in comparison to crisis and emergency response and often extended hospital based care once conditions have progressed. Additional cost offset figures estimate the use of criminal justice services by the long-term homeless and the corresponding changes following transition to suitable long-term housing.

There is significant variation in estimated cost offsets reflecting the uncertainty in longer term health outcomes and the related service usage. Cost offset estimates of several thousand dollars per year appear plausible based on longitudinal comparisons of long-term homeless service usage compared to general population averages. This may reflect a reduction in hospital or psychiatric admissions of several days per year, which depending on level of care may be in the order of $1,000 per night. Similar cost offset levels may result for some individuals due to reduced nights in custody. In this context, cost offsets in the order of $20,000 may potentially reflect an avoided 15 nights in hospital, combined with reduced drug and alcohol program usage, avoided emergency department attendance or psychologist consultations, with a further potential $10,000 from reduced nights in prison or remand facilities.

Given the small sample size and other limitations of this evaluation, as well as relatively small sample sizes in previous cost offset studies and the corresponding high uncertainty in actual outcomes, there is insufficient basis to confidently estimate actual cost offsets for CCG residents. Consistent with the conservative approach of this evaluation, these potential cost offsets are not explicitly presented in the program cost effectiveness figures.

A review was undertaken of alternative homelessness responses where economic evaluation content was available for comparison with CCG costs and high level outcomes. The comparison programs include:

- The Michael Project
- The MISHA Project - Michael Project extension
- Micah Projects – Breaking Social Isolation: A housing first approach to homelessness (includes reference to Brisbane Common Ground)
- Meeting the challenge J2SI (Sacred Heart Mission)
- The Rooming House Plus Project (RHPP)

Evaluations are in progress for both Common Ground Queensland and Common Ground Victoria. If made public, the results of these respective evaluations will provide further comparative figures. An evaluation of Common Ground Tasmania has been completed; however, this includes preliminary high level program cost figures with insufficient detail for cost effectiveness comparison.

3.6.8 Program outcomes

The primary endpoint for the CCG economic evaluation is the transition of long-term homeless individuals into stable, secure and appropriate long term accommodation. In line with the Common Ground model, as a ‘housing first’ approach, this incorporates the combined priorities of providing suitable affordable housing, as the foundation for wrap around support services.
The endpoint in broad context aims to improve the outcomes of this client group, which if achieved may result in significant and sustained benefits in health, wellbeing, social engagement, and the associated resource usage which may return to being more in line with the general population. The transition process for particularly complex cases may be extended over several months or years.

There is also the perspective that levels of support and service usage may increase over the short term, particularly in physical and mental healthcare services that may have been neglected for many years. This relative initial increase in support service usage, and the lagged timing of resulting offsets will naturally also impact estimated cost effectiveness of homelessness intervention programs.

### 3.6.9 Cost effectiveness model projections

To examine the timing perspective of the primarily upfront investment in supporting and stabilising long-term homeless individuals, compared to the lagged and potentially sustained cost offsets that may result, a projection has been developed over a 5-year horizon to reflect the proportional effect of a potentially reduced support service cost scenario and rental income for program cost effectiveness.

In broad terms, the program cost-effectiveness implicitly includes a wide range of consumer outcomes, positioned against the total program funding. The focus of the cost-effectiveness estimates is, however, based on the primary outcome of transitioning long-term homeless individuals to stable and sustainable accommodation.

It is emphasised that there are substantial program outcomes in terms of wellbeing and lifetime pathways that provide the overarching perspective of program effectiveness and overall cost-effectiveness.

### 3.7 Caveats and limitations

The evaluation design has limitations similar to other studies of this type. Participants in focus groups and interviews were self-selecting and may not be representative of all stakeholders and tenants. Given that the CCG initiative was to be rolled out to individuals deemed in need by caseworkers, it was not possible to undertake any form of randomisation in the study methods. There is no counterfactual in this study, i.e. it is not possible to know what would have happened to the clients of a homelessness programme such as Common Ground if they had not participated in the programme (Flatau and Zaretzky, 2008). The evaluation of CCG is therefore an ecological study involving a single group analysis in which tenant outcomes were evaluated at baseline and compared to results 12 months post-baseline to determine changes. We also examined subgroups in the data to identify any factors associated with risk and resilience. It should be noted, however, that the population of homeless people housed through Common Ground NSW is relatively small and given this, the analysis undertaken is primarily descriptive. Hence, it is not possible to determine a causal relationship between the provision of housing and outcomes. Additionally, imperfect recall and/or knowledge of past events may affect the quality of the data and may bias the results. On the other hand, a strength of the research method is the use of standardised assessment tools with established psychometric properties that have been trialed with similar cohorts in previous studies.

In addition to these aspects, the economic evaluation component is limited by the annual aggregation of reported cost figures and the potentially confounding detail that may be masked in estimated high level average figures. The economic figures are presented as indicative estimates based on the available cost and support service data. See Section 7 for more detail.
3.8 Summary of key points

The evaluation used a longitudinal, mixed-methods approach.

This final report provides data on the demographic characteristics of the formerly homeless tenants, the operation of the service model, and resident outcomes.

The key methods drawn on in this report are:

- qualitative interviews with 23 key stakeholders in 2013 and 19 key stakeholders in 2014;
- focus groups with nine formerly homeless tenants in 2013, 10 formerly homeless tenants in 2014 and 8 affordable housing tenants in 2014;
- a quantitative survey conducted with 35 formerly homeless tenants in 2013 and repeat surveys with 26 of these tenants in 2014;
- program data in 2013 and 2014 to provide details on resident characteristics, services provided and baseline housing outcomes;
- program cost data for 2013-14; and
- a literature review.
This section describes the demographics of the formerly homeless tenants accepted into Camperdown Common Ground, the referral pathways and the selection process. The section is based on program data provided by CCG, data collected through the CCG Client Survey and qualitative interviews conducted with stakeholders.

### 4.1 Demographics

Camperdown Common Ground opened on 15 November 2011. This analysis period extends until the end of March 2014 and therefore covers the first 28 months of the program’s operation. The Common Ground building is made up of 104 units: of these, 52 are provided for vulnerable people who have experienced chronic homelessness, 10 are for social housing tenants, and 42 are affordable housing placements. As at March 2014, 163 people have lived at CCG, 47% of whom are formerly homeless tenants ($n=76$;Table 4.1, an increase from 2013, Figure 4.1).

#### Table 4.1: All Camperdown Common Ground tenants by housing type ($n=163$) (Program data)

<table>
<thead>
<tr>
<th>Housing type</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formerly homeless</td>
<td>76</td>
<td>47</td>
</tr>
<tr>
<td>Affordable</td>
<td>72</td>
<td>44</td>
</tr>
<tr>
<td>Social</td>
<td>15</td>
<td>9</td>
</tr>
<tr>
<td>Total</td>
<td>163</td>
<td>100</td>
</tr>
</tbody>
</table>

Source: CCG program data, March 2014

#### Figure 4.1: Common Ground tenants by housing type, 2013-2014
As of March 2014, the mean age of all tenants, including people on affordable or social housing leases, was 41 years old (n=163), and ranged from 21-82. A little over 55% of all tenants were males, and 12% of all tenants were of Aboriginal descent.

The outcomes for the 76 formerly homeless people who resided at CCG were the focus of the evaluation, and the rest of this section will focus on this cohort. According to the program data, formerly homeless tenants were predominantly male (79%; n=60), with an average age of 45 (range 23-74). Of the 76 formerly homeless tenants, 12 identified as Aboriginal, and another 20 were from culturally and linguistically diverse communities (CALD), meaning that 42% of formerly homeless tenants identified as having an Aboriginal or CALD background.

The majority of formerly homeless tenants (75%, n=57) were born in Australia. The remaining formerly homeless tenants came from a range of countries including Aden-Yemen, Burma, Fiji, Indonesia, Ireland, Mexico, New Zealand, Poland, Portugal, Singapore, South Korea, and Vietnam.

According to the program data, formerly homeless tenants have been living at CCG for an average of 482 days (compared to 315 days at baseline), and an average of 493 days (370 at baseline) days for people in other types of tenancies.

The tenant survey included further detail on formerly homeless tenant demographic and personal characteristics. Comparisons between the program data and the survey revealed no substantial differences between the two cohorts, so the following section utilises descriptive information recorded in the sample to further understand the profile of formerly homeless residents residing at CCG.

### 4.1.1 Employment, education, and income

Figure 4.2 shows that almost two-thirds of the sample last worked in a full-time position over five years ago (63%), and an additional 23 per cent worked full time two to five years ago. Few people had never worked full time (6%).

**Figure 4.2: Last full-time employment position among client survey participants prior to Camperdown Common Ground (formerly homeless tenants) (N=35) (Client survey)**

![Chart showing employment history](chart.png)
In regards to income, the vast majority were in receipt of some form of government benefit at both time points (96%). The Disability Support Pension (DSP) was recorded as the most common source of income (58%), which is consistent with the previous finding of ‘own health and disability’ being a barrier to employment for many participants. Over the 12 months prior to follow-up, there appeared to be a reduction in the proportion receiving the DSP (69% to 58%), and a concurrent increase in the proportion receiving Newstart (23% to 35%) (Figure 4.3).

Figure 4.3: Sources of income currently received (N=26*) (Client survey)

4.1.2 History of housing and homelessness

According to the program data, the average resident was homeless for 11.6 years before entering CCG (range between 1-38 years’ experience of homelessness; Figure 3.6). This is very similar to the baseline report which showed an average duration of homelessness of 12 years (Bullen et al., 2013).

Figure 4.4: Formerly homeless tenants: years living in homelessness prior to Camperdown Common Ground (N=50) (Program data)
As we reported in the baseline report, the vast majority of formerly homeless tenants had previously slept rough, lived in crisis accommodation, and lived in hostel or boarding houses at some point in their lives. Of the formerly homeless tenants who had formerly slept rough, the majority had spent over five years in total living in this situation. This length of time spent sleeping rough is expected amongst CCG formerly homeless tenants, which comprises of predominately long-term rough sleepers.

Detailed information on clients’ mental and physical health and well-being and substance use history is in Appendix A.

4.2 Referral process and the target group

As described in the baseline report (Bullen et al., 2013), referrals of formerly homeless tenants were initially drawn from the Vulnerability Register which was compiled during a week-long survey of people sleeping rough, conducted in November 2010 by the Mercy Foundation and NEAMI’s Way2Home program.10

Since the original one-off selection process, CSS has managed a waiting list for CCG, which was developed from the Vulnerability Register and also from recommendations from programs such as Inner City Integrated Services (ICIS), Way2Home and other services in the Specialist Homelessness Services program. The process of selecting new tenants to reside at CCG takes the Vulnerability Index (VI) into account, but also considers a range of other factors, including some input from the support provider, which is a change from the original process.

Most stakeholders did not comment on the changes in the selection process. Those who did comment in 2014 were of the view that ‘the essence of the client group is the same’ [ST_8 CG service provider] under the changed selection process. This was in contrast to several stakeholders who in 2013 were opposed to relying less on the VI. These stakeholders expressed concern that people with the strongest advocates would be likely to be housed rather than the people who had the most need for the service; however, these concerns were not repeated in the 2014 round of data collection.

Stakeholders overwhelmingly thought that the key strength of Common Ground was that vulnerable people who had been ‘shut out of other secure tenure’ [ST_7 CG service provider] and had been homeless for very long periods had been housed. Nevertheless, they held some differences of opinion about the optimal balance between formerly homeless tenants and other tenants in Common Ground. In both 2013 and 2014, a substantial number of Common Ground service providers expressed concern about the high level of complexity among formerly homeless tenants in the building, and felt that the mix of tenants should be changed to reduce the proportion of those with very complex needs. Other stakeholders, including most of those involved in oversight and establishment roles, expressed concerns about reducing the proportion of those with complex needs. These stakeholders pointed out that the model was funded and intended to assist the most vulnerable homeless people. On the other hand, one service provider was of the view that the proportion of formerly homeless and other tenants did not need to be changed, but instead that there was a group of people with serious health issues and a lack of living and self-care skills who were at risk in a unit by themselves and should not be at Common Ground. A small number of these clients had been moved from Common Ground into aged care facilities, but in some cases there did not appear to be any facility for which they were eligible and which was appropriate for their needs.

10 The Vulnerability Register is a list of homeless people developed using a Vulnerability Index (VI) to assess the needs of rough sleepers in order to prioritise them for housing and support. The VI was developed by Dr Jim O’Connell from Boston’s Healthcare for the Homeless, based on research that showed the presence of eight key health indicators that put a long-term homeless person at risk of dying (Common Ground, 2010).
Common Ground service providers also noted that the level of need among other tenants was higher than had been anticipated, so that the building was ‘not as mixed as anticipated’ [ST_1 CG service provider]. Some of the social housing tenants had also formerly been homeless, and some of the affordable housing tenants were at risk of homelessness. The affordable housing tenancies have a fixed rent that does not change with changes in income. Some affordable housing tenants had been employed at the beginning of their tenancy, but had since lost their employment, and some were in financial difficulty and rental arrears and required support. Some had been moved from affordable housing to social housing.

These issues are discussed in more detail in Section 5.5.1.

### 4.3 Summary of key points

- Referrals of vulnerable people who experienced chronic homelessness were initially drawn from the Vulnerability Register which had been completed in November 2010 and was held by the Mercy Foundation and NEAMI Way2Home. The use of the register was followed by a sector-wide email seeking eligible referrals, acknowledging that some people from the target group would not have already been on the register.

- The demographic information indicates that the formerly homeless tenants at the CCG project meet the intended target group of vulnerable people who have experienced chronic homelessness. This finding was echoed in the stakeholder interviews.

- Since the original selection process, Camperdown Support Services has managed a waiting list for the CCG project, which includes people who were originally assessed with the Vulnerability Index and people referred from programs such as ICIS, Way2Home and other Specialist Homelessness Services. This process takes the Vulnerability Index into account, but also considers a range of other factors. Data from stakeholder interviews suggests that some differences of opinion about the level of complexity among the target group and the optimal balance between factors may emerge in future.
This section of the report draws on interviews in 2013 and 2014 with stakeholders, focus groups with nine formerly homeless tenants, and data from the Camperdown Common Ground Client Survey in order to understand the key elements of the project’s implementation, partnerships, housing, support services, and emerging issues.

### 5.1 Implementation

The baseline report (Bullen et. al, 2013) details the background to the CCG project which is a jointly funded initiative of the NSW and Federal Governments, delivered in partnership with Grocon Consortium, the Common Ground Working Group and MA Housing. The Common Ground Working Group had advocated for the development of a Common Ground project in Sydney since 2008 and included representatives from the Mercy Foundation, the City of Sydney, the Philanthropic Foundation, KPMG and Baptist Community Services Lifecare. Figure 5.1 shows a flow chart of management for CCG.

Figure 5.1: Flow chart of management for Camperdown Common Ground
MA Housing met its objectives in contracting out the support services, cleaning and concierge functions; managing the construction and furnishing of the building; and successfully tenancing the building. Formerly homeless tenants were moved into the building slowly over a period of eight months. While stakeholders thought that HNSW had done a good job overall in implementing the project, some noted HNSW made the decision very late in the establishment process about funding for and selection of the support provider. The ICC was contracted as the support provider at CCG only two working days prior to the official opening on 15 November 2011, and after affordable housing tenants had started to move in. Following their selection as support provider, the ICC had worked quickly to establish the CSS and onsite support services. The establishment of support services within a very short time frame was a key achievement.

5.1.1 Implementation developments in the second year of operation

In late 2013/early 2014 several additional staff members were added to the team on either an ongoing or temporary basis, depending on ongoing funding. This followed a period of delay in funding during the second half of 2013 due to administrative issues within FACS-HNSW, which led to a slightly reduced level of service provision overall at Common Ground. One service provider said that the delay in receiving funding had made planning difficult.

The new staff members were a Clinical Practice Leader to oversee and support case management, a Triage support worker to respond to immediate support issues, a new clinical nurse to work with the visiting GP, and a central Manager position to work between the housing and support teams. This last position arose from work done at Common Ground by one of the Mission Australia Area Managers to improve the operational partnership between MA Housing and the CSS, and in particular the joint response to rent arrears at Common Ground. These positions are discussed in the relevant sections below on housing (Section 5.2), support services (Section 5.3) and partnerships (Section 5.4).

5.1.2 Perceptions of the reporting and governance structure

There was overwhelming agreement among stakeholders closely involved in the project that the reporting structure at CCG is complex. This view was expressed by almost all interviewees from Common Ground, most involved in oversight and establishment roles and by some other service providers. The key areas of concern and disagreement about the structure expressed in both 2013 and 2014 were: the decision to make one housing organisation the key contract manager for the entirety of the model, and its relationship to the support provider; the complexity around the selection of a consortium of organisations to provide support to tenants; and the lack of recent advisory group meetings.

First, there were inconsistent views about the impact of selecting a housing organisation to manage the building and oversee the other elements of the model, including the support functions. A small number of stakeholders not involved with the operation of the program believed this to be the optimal approach because it was seen as consistent with international practice. Others, however, both from Common Ground and from groups not involved with program operation felt that structuring the lease this way had the potential to blur the boundaries between the tenancy management and support functions provided in the project, and they were concerned that the support provision could potentially be subsumed to meet the needs of the housing provider. Issues relating to the separation of housing and support at operational level are discussed in Sections 5.3 and 5.4.

This situation is further complicated by the fact that the contract manager, MA Housing, is a company within the Mission Australia Group, which is also a member of the ICC. MA Housing therefore has a contract with the ICC which has its own parent company (Mission Australia) as the lead agency, which could be potentially problematic should it have to manage any breaches of the contract by a partnership led by its parent company. Legal advice (through MA Legal Services and other Coalition legal services) was sought prior to MA being identified as the lead agent in the Coalition, and the structure was agreed upon with MA Housing, who were represented by the law firm Freehills. Nevertheless, several stakeholders expressed strong
reservations about the arrangement. One stakeholder interviewed in 2014 advised that this situation had become even more complex because:

MA recently went through a restructure, and although MA Housing is still a separate entity, legally, they are actually operationally managed under MA again rather than having separate operational arm management systems. So I see that convoluting that arrangement of the support services and the tenancy services being separated. [ST_20 organisational/establishment role]

The partnership between MA Housing and the support provider and the issue of the separation of housing and support is discussed further in Sections 5.2.4 and 5.4.2.

It is expected that the new contract for providing support at Common Ground from mid-2014 will be directly between the government and a support provider, rather than between MA Housing and a support provider. This will mean one less contract for MA Housing to administer, and could be expected to change the dynamic between the housing and support providers. MA Housing is reliant on support being provided in order for the building to be viable.

The second concern that emerged in the data was the decision to select a consortium of organisations to provide support to tenants. This decision was initially made with the intention that each of the organisations would add value by bringing different types of resources and support to the model. In the 2013 data collection, most stakeholders, including most of the Common Ground service providers interviewed for the evaluation reported that, in practice, this decision added extra layers of complexity to decision-making and operations at all levels. Interviewees reported inconsistencies and difficulties related to supervision and reporting, differing skill and training levels, and approaches to case management.

For example, a case manager from each of the five organisations was placed at CCG, but each worker reported both to the CCG Support Services Manager and to their manager at the Coalition organisation, while also continuing to participate in supervision and meetings in their own organisation. In addition, the background, skill levels and training of case managers differed, as did the approach to case management that they had developed within their Coalition organisation. In the first year of operation, this led to a lack of consistency in the type of support provided to tenants, and a lack of coordination and cohesion among the team.

In 2014, however, there was a widespread view among Common Ground Service providers that these issues had been addressed at operational level (see Section 4.3 for more details) and there was widespread acceptance of the coalition. Nevertheless, one interviewee from the ICC commented that there were ‘way too many meetings’ although the information from these meetings was good [ST_7 CG service provider].

Governance of CCG includes a Health Steering Committee, which meets every two months, a monthly internal Coalition meeting, and a fortnightly Coalition/MA Housing meeting. Prior to the introduction of the current CSS-designed referral form in June 2012, an Allocation Panel was responsible for allocations. The MA Housing contract also includes the establishment of an Advisory Working Group (AWG) to monitor progress and resolve issues for the first 12 months of the CCG Project, and to be reviewed annually. At minimum, the AWG is to include representation from MA Housing, the support provider, FACS-HNSW and FACS. This group met regularly until October 2012, at which time it was cancelled on the basis that the Group was only considering progress reports from MA Housing rather than providing strategic advice. Working Group members believed the meeting to be of strategic importance and wanted the group to continue, and MA Housing reinstated the group on advice from FACS-HNSW. A meeting called in October 2012 had limited attendance and another meeting was held in May 2013, with MA Housing consulting with FACS-HNSW in the interim. In both 2013 and 2014, a number of stakeholders including most of those with oversight and establishment roles expressed concern about the lack of recent meetings and were of the view that, without a greater level of oversight, there was a lack of transparency and motivation for continual improvement.

In 2013, the direction of the AWG changed. The Group was divided into two: the AWG was to deal with more
operational issues; and a Contract Control Group with similar membership was established. The latter was a higher-level, more strategic group and did not meet regularly. AWG participants said that this new meeting format was much more useful, but noted that the AWG had met in November 2013 and February 2014 but not since.

5.2 Housing

There was broad agreement amongst stakeholders in both 2013 and 2014 that a key strength of the CCG project is that it provides secure, permanent housing to vulnerable people who had previously been homeless for many years. Most stakeholders believed that providing permanent housing would assist people to begin to address other issues in their lives and develop ongoing contacts with needed services. The following section examines perceptions of the building design and location, safety, community, and tenancy management of CCG.

5.2.1 Building design and location

The overwhelming majority of people interviewed for the evaluation were positive about the location of the CCG building. A few stakeholders from service provider organisations expressed concern in the 2013 interviews that the project was some distance from city suburbs where people had been sleeping rough, which meant that the formerly homeless tenants were some distance away from former services and social networks. However, tenants appreciated this distance because it provided the opportunity to break unhealthy social networks without being completely isolated from them. Some tenants were also appreciative that the building was not situated in an area in which large amounts of drug dealing occurred. On the other hand, one stakeholder thought that the building should have been located further away from the city.

Although the building’s residential areas were generally reported to be of high quality, stakeholders identified a few problematic features in 2013 which were still current in 2014. Because the support provider was contracted just before the building opened, there was a lack of consultation with CSS in the design of the building layout that contributed a number of operational challenges, especially in managing crisis issues. The support providers’ office is located at the rear of the lobby area, away from the reception desk, while the housing providers’ office is more visible and is located near the reception desk. Service providers reported that this had meant that housing staff were becoming involved with critical incidents and support issues. In addition, the support providers’ workspace is unsafe because it only has one exit, making escape difficult. Having access to an escape route is important as staff members have been threatened and assaulted in this area. The area is small, shared, and has glass doors, so it lacks privacy and limits the space in which workers can meet to discuss confidential matters with tenants. The risks associated with this space were identified when the building opened.

MA Housing has submitted a Development Application (DA) for building works that will enable the support worker area to be swapped with the housing provider area, which has a second exit, and funds have been identified to carry out the work. A support worker will sit at the reception desk together with the MA housing worker (see Section 5.3). There will also be some interim changes pending DA approval.

Some other issues of concern will not be addressed as part of the DA, including poorly designed interview rooms which are ‘tiny and claustrophobic, not appropriate for angry tenants ’ [ST_1 CG service provider]; and a number of key rooms (the two external rooms used as a kitchen and currently as a gym, and the activity room) which have only one door, therefore creating a risk. The kitchen and gym have external access only, creating additional issues.
Most external service providers including health providers reported that the health provider rooms are generally suitable, although the Centrelink provider has had ongoing problems with internet access in the building.

Some stakeholders from Common Ground and organisations involved in establishment/oversight reported that some areas of the building are not yet well utilised. MA Housing is, however, continuing to work on engaging service providers to develop the use of these areas. The two front rooms in the building were intended as a community kitchen and a social enterprise. The community kitchen was initially poorly utilised, but stakeholders report that it is now more frequently used. The other room is set up as a gym, available to external users as well as CCG tenants. Stakeholders from Common Ground reported in 2013 that it was not well used and this was still the case in 2014. This area may be leased to a community organisation for office space, thus generating additional income for Common Ground. As we noted in the baseline report (Bullen et al., 2013), the communal courtyard area, where people are allowed to smoke, lacks sunshine which means that it is not used by tenants, who prefer to congregate at the front of the building to smoke; and the roof garden is still not fully set up.

The overwhelming majority of stakeholders and formerly homeless tenants reported that the CCG building is generally well maintained, and that the housing units are of high quality. Tenants who gave feedback in 2013 particularly liked that the building was new, clean, and free of vermin, although in 2014 some tenants reported that there had been problems with cockroaches onsite and that the building was not always clean (see Section 5.2.4 for more details about tenancy management and Section 5.2.5 for more details about tenant perceptions of the building). Service providers also reported that some individual tenants had not kept their units clean and service providers had instituted a cleaning and fumigation program.

Most stakeholders from all stakeholder groups felt that a strength of the building is that it is structured in a similar way to a hotel or apartment block, and they did not believe that the building had an institutional feel. A small number of external stakeholders thought that the building design itself was somewhat institutional. A small number of off-site service provider stakeholders also felt that the notice board advertising the day’s activities, the fact that support staff were visible behind glass walls and the inclusion of rooms onsite for medical practitioners and other services could make the service feel too much like an institution or crisis centre rather than a residential development. This point relates to a broader debate in the stakeholder interviews about the appropriate level of onsite service provision and the overall structure of service provision, which is discussed in Section 5.3.

5.2.2 Safety and security

A key element of the model, and one which differentiates it from other community housing buildings, is that CCG is meant to provide a higher level of safety and security to protect vulnerable people. As a result, the building includes a 24-hour concierge service, which is staffed by MA Housing staff in the day, and security guards during the night and on weekends. Training has been provided by MA Housing and the support provider to the security guards who work as concierge staff. Nevertheless, some tenants and service providers stated that despite this training, the security guards did not respond consistently, and while they made a positive and appropriate contribution on some occasions, on other occasions they were:

… escalating rather than de-escalating het-up tenants a lot of whom have issues with authority figures, and [the security guards] …will shape up as they would if they were [working] as a bouncer up at Kings Cross. [ST_24 CG service provider]

Some other steps taken to ensure the safety of all tenants involved: the inclusion of CCTV in the building, swipe tags for all tenants and staff which only admit tenants to their own floor, and a requirement that visitors only enter when admitted by a tenant. Staff carry walkie talkies with a distress button and there is a distress button located under the table in most of the interview rooms and activity rooms.
Tenants on the whole reported feeling safe in the building, particularly when comparing this form of housing to other homelessness services (Section 4.2.5). Stakeholders from Common Ground and other closely involved service providers reported that there had been a number of violent incidents in the building, and some violent tenants had left. A discussion about the level of critical incidents is provided in Section 6.1.3.

5.2.3 Community

A sustainable social mix is another key element of the CCG model. Data from the tenant survey suggests that tenants were less satisfied at both baseline and follow-up with interactions with neighbours in the building than they were with other aspects of the housing, although the responses were still generally positive on average (Section 5.2.5). The focus groups in 2013 suggested that at that time, there was not yet a strong sense of community in the building, but that tenants felt that they had choice about the amount of interaction they had with their neighbours. The 2014 focus groups with both formerly homeless and affordable housing clients indicated that while some tenants still preferred to keep to themselves, there were increasing positive contacts and friendships between tenants, including between formerly homeless and affordable housing tenants. Some affordable housing tenants wished to participate in more group activities but did not do so because of work commitments or because they were not aware that the activity was being held.

Some tenants commented about the distress they had experienced when other tenants had died, and their perception that staff had not communicated sensitively with them. There had been memorial ceremonies in the building for some but not all of the tenants who died. There was an expressed need to have some closure or ceremony for each of these tenants.

Monthly community meetings for service providers, support staff and tenants to collectively participate in the community within Common Ground are intended to be empowering and address a wide range of issues that arise in the building. However, some tenants said in focus groups that they did not feel listened to by staff, that the meetings had not always been held, and that they felt their concerns and suggestions were not acted on. On the other hand, another formerly homeless tenant said that tenants' voices were now being heard and acted on.

Some onsite services are provided to the broader community, including residents of Johanna O’Dea public housing next door (see section 5.3.2), and stakeholders reported that this was a positive element of the project which built local relationships, and which they aimed to increase in the future. No problems were reported with relations in the local community.

5.2.4 Tenancy management

Since the baseline report, MA Housing and CSS have introduced improved measures to detect rent arrears early and deal with them more strategically. During the period of operation of CCG, some tenants had built up high levels of arrears (see Section 6.1) before action was taken. Further, high arrears among some formerly homeless tenants developed without the support team being made aware of the situation. Some affordable housing tenants also developed high arrears because they lost their employment and their rent did not change with their income.

Some tenants were taken to the NSW Civil and Administrative Tribunal (NCAT) (formerly the Consumer, Trading and Tenancy Tribunal), and some were evicted for arrears. Support workers attend the NCAT to ensure the tenant understands the process and their rights. It is also noted that support is not compulsory and it is necessary to balance tenants’ right to privacy with the benefits of offering support. Some other tenants have been placed under financial management to resolve the issues and ensure the tenancy. On the other hand, some tenants, in particular affordable housing tenants, stated that MA Housing had wrongly recorded their rental payments, leading to unfounded eviction notices.
Stakeholders said that communication about rent arrears between housing and support providers had greatly improved in recent months. New strategies for detecting and responding to arrears had been implemented. These are Tenants at Risk Meetings, a handover between housing and support staff every two days to identify who is in arrears, and production of a ledger of arrears each week.

The housing and support partners are also seeking to improve their response to what several stakeholders referred to as issues of ‘squalor’ [ST_5 CG service provider] in tenants’ apartments, in particular the formerly homeless tenants. At the time of the 2014 data collection, MA Housing had been conducting inspections of apartments every six months, and case managers were also not aware of the state of some apartments. MA Housing was looking at moving to a more formal process to inspect more often where needed. There has also been a major cleansing program and fumigation for cockroaches in the building. For some tenants, forensic cleaners are being organised every 2-3 months. Several stakeholders identified care for people who have high needs for this type of assistance as a significant issue, both for Common Ground and more widely:

It’s hard, isn’t it? ... So these are people that have no idea about how to clean their place and are needing major squalor cleans every couple of months, who need prompting to have a shower at least intermittently, who may get bed bugs and need to go through processes. And just dealing with them can be quite complicated. It’s not their issue, they’re not saying, “I really want someone to help me clean up my place.” They have no issue with it; it’s our problem, not theirs … I think that’s a bit of a service gap but also a systemic gap, too, because if those people aren’t really agreeing for it to happen, that’s a big challenge in terms of supports. [ST_25 other service provider]

Stakeholders noted that there were some tenants at Common Ground whose cognitive and other capacities did not enable them to recognise their behaviours or the need for cleaning. They were, however, not eligible for home help (see section 5.3). Some of these tenants were moved to aged care facilities, but suitable alternative care had not been sourced for all of those who needed it, and some remained at Common Ground. Unfortunately, those tenants did not participate in our focus groups so their own perspectives on this topic are not included here.

Several affordable housing tenants stated that they did not have adequate information about the nature of the building when they applied for accommodation, although others were well informed. Some said that the rules were heavy-handed and as independent tenants they found it difficult to accept the way they perceived themselves as being treated by staff. Others had experienced communication difficulties with tenancy staff and security guards, for example about rules regarding visitors and children in the building and advice about the delivery of parcels. Some were dissatisfied that the tenancy manager required only 2 days’ notice to access their unit, which sometimes made it difficult to arrange work commitments in order to attend.

The two organisations are continuing to work together to improve communication and tenancy management practices. The partnership between the housing and support providers is discussed at Section 5.4.2.

5.2.5 Tenant perceptions of housing quality

Participants rated how satisfied they were with various aspects of CCG. Figure 5.2 shows how satisfied they were with their housing in general, with the vast majority continuing to indicate at follow-up that they were ‘very satisfied’ (48%) or ‘satisfied’ (36%). One participant did report, however, being ‘very dissatisfied’ with their housing at follow-up. The scores provided by participants for their housing quality overall were mostly similar; 4.4 out of 5 at baseline and 4.2 out of 5 at follow-up.
Participants also rated their level of satisfaction, on a five point scale (1=very dissatisfied; 5= very satisfied) for a number of aspects of CCG (Figure 5.3). Overall, it appears that the ratings remained either the same or decreased slightly from baseline to follow-up. The exception to this pattern was ‘how complaints are managed’, which increased on average from 3.0 to 3.4. This item, however, retained the lowest overall satisfaction rating. Similarly to baseline results, participants reported the highest satisfaction ratings for the building’s proximity to public transport and the quality of the living space. The largest change in rating scale scores was privacy, which decreased from 3.9 at baseline to 3.5 at follow-up.

Paired samples t-tests were performed to determine whether the differences observed in participants ratings at the two points were significantly different. No significant differences between baseline and follow-up ratings were found for any of the variables.
Figure 5.3: Client survey participants (formerly homeless tenants) mean level of satisfaction across various aspects of housing (Client survey)

*Based on a matched sample
Satisfaction with safety and security at follow-up was analysed by gender. Most (16 of 19) men who completed the question on safety and security were satisfied or very satisfied; of the 6 women who completed the question two were satisfied and four were neither satisfied not dissatisfied.

Formerly homeless tenants who participated in focus groups stressed the importance of having permanent housing after long periods of homelessness, and in many cases, living on the street. They appreciated that apartments were self-contained and the building was secure. Both formerly homeless and affordable housing tenants appreciated that the building was new and clean, although some pointed out recent problems with cockroaches and that the building was usually but not consistently clean. It was also close to public transport, although tenants noted it was not very close to supermarkets. Some compared it very favourably to crisis accommodation that they had used, noting that places they had stayed were dirty, had curfews or lacked privacy. Tenants, including affordable housing tenants, generally thought the housing was safe, particularly in comparison with other places they had stayed in and with living on the street. Tenants also appreciated being able to keep pets, with some stating that this was very important to them. Only a few minor suggestions for improvement emerged from the focus groups: some tenants found the rooms at Common Ground too hot or cold, while another had noted a troubling sewage smell on the eastern side of the building.

5.3 Support services

Support services offered at the CCG project comprise case management provided by the ICC plus a range of health and other services through off site providers. This section describes the services provided, as well as the extent to which the services are used by current tenants.

5.3.1 Case management

As described in the baseline report (Bullen et al., 2013), the ICC supplies 5.6 full time case managers. Tenant participation in case management is voluntary, but program data indicates that staff members have successfully engaged 63 of the 76 formerly homeless tenants in some level of case management services from April 2013 until March 2014. Stakeholders from Common Ground reported that as a result of factors including long histories of homelessness (Section 4.1.2) and very high and complex needs of the formerly homeless tenants, crisis management had also continued to be a major task in support provision.

Stakeholders from Common Ground advised that some social and affordable housing tenants also have histories of homelessness and other issues, and the case managers have provided support to 15 (17%) of these tenants as well. This activity is not specifically funded under the model, and so case managers are providing this support in addition to their other core tasks. This approach is consistent with the overall aims of the programs, one of which is to maximise opportunities for tenants to become reconnected with the mainstream community in order to build capacity and improve wellbeing.

Figure 5.4 shows the proportion of tenants in each housing type who have received case management assistance, and the areas of assistance, while Figure 5.5: Proportion of tenants for whom a referral has been made in each area (%) (Program data) shows the proportion of tenants in each housing type for whom a referral has been made in each area. The data shows that more than half of all formerly homeless tenants have needed assistance with finances, health, mental health, alcohol and drugs, and relationship problems.
Figure 5.4: Proportion of tenants in each housing type who have received assistance in the following areas (%) (Program data)

- Other assistance
- Financial assistance
- Health assistance
- Mental Health assistance
- Alcohol & Drug
- Relationship assistance
- Legal assistance
- Disability assistance
- Education, Training and...

![Bar chart showing percentages of tenants who received assistance in different areas, with bars for formerly homeless (n=63) and other tenants (n=55).]

Figure 5.5: Proportion of tenants for whom a referral has been made in each area (%) (Program data)

- Health referral
- Financial referral
- Other referral
- Mental Health referral
- Alcohol & Drug referral
- Legal referral
- Disability referral
- Relationship referral
- Education, Training and...

![Bar chart showing percentages of tenants referred in different areas, with bars for formerly homeless (n=63) and other tenants (n=55).]
The ICC has established case management services at Common Ground despite challenges due to the short timeframe because of the late selection of support provider (see Section 5.1). The ICC initially selected a team of case managers with a broad range of skills and approaches to case management to work at CCG. The intention behind this was to build a team of people with the ability to provide individualised, tailored support to tenants to the greatest extent possible. The implementation of consistent case management principles, supervision arrangements and administrative approaches among such a diverse team was reported as a key challenge in 2013. Issues included the degree to which case managers used different strategies to approach the formerly homeless tenants. Although there was agreement that acceptance of case management is not compulsory, some case managers used an assertive approach, while others provided assistance only when people actively presented with a support need. Another issue was the extent to which Common Ground provided a support service designed specifically for people in permanent housing, rather than a crisis approach of the type provided by the Coalition partners to people who are still homeless.

By 2014, stakeholders generally agreed that most of these issues had been resolved. During the first year of operation, the ICC improved case review and supervision and conducted training for staff on assertive case management and managing challenging behaviour. The ICC has also worked to clarify procedures for case managers.

In 2014, stakeholders reported that, while Common Ground was now more stable, there was still a high number of crises and incidents (see Section 6.1.3). Difficult behaviours, often associated with excessive drug and alcohol use, were a problem in the building. Service providers reported that they had not been able to provide planned case management as hoped because of the frequency of crises. They reported that there had been threats against staff, and although at the time of the 2014 interviews the case worker team was stable, the level of staff turnover had been ‘quite difficult’ [ST_25 other service provider]. The staff changes included two staff on workers’ compensation after being threatened by a tenant. One case manager said that ‘everybody drowns’ when they come to work at Common Ground before they ‘learn to float a bit more’ [ST_28 CG service provider]. As a result of these pressures, at times there had been a lack of continuity in staffing with vacancies sometimes being filled with changing relief staff. Both stakeholders and formerly homeless tenants reported this. In a focus group with formerly homeless tenants, one tenant said that ‘I changed case workers within Common Ground quite frequently’, while another tenant said that staff changes caused difficulties:

Staff have changed and it takes a long time to adapt to a case worker, and then a new staff member comes along and you don’t want to repeat your information to them. [Tenant focus group]

Consistent with the comments above, in the tenant focus groups, participants also stated that case managers were crisis-focussed and were sometimes not responsive to ongoing case management. Some formerly homeless tenants in a focus group said they did not receive sufficient support with their issues because they ‘weren’t hard enough’, were ‘not helpless’ or did not exhibit ‘crisis behaviour’. Some formerly homeless tenants also had the perception that staff treated them ‘as one entity’ rather than as individuals. Some tenants also complained that there was a lack of confidentiality in some of their interactions with case managers. Other tenants stated they had received ‘good support’ and that they had a case worker who they liked.

Support providers found caseloads of clients with very complex needs to be high. This was exacerbated by the fact that Common Ground has not, as had been hoped, been able to access mainstream services such as home care and the mental health related Housing and Accommodation Support Initiative (HASI) for high need clients. Applications to HASI had been unsuccessful because Common Ground residents are viewed as already receiving services, although Common Ground staff described their case management role as more ‘coordinating services’ [ST_1 CG service provider] than undertaking all the direct provision. Similarly, it had not been possible to access ‘home care type services for people who aren’t aged’ [ST_1 CG service provider], even though these people had ‘chronic serious health problems and cognitive impairments’ [ST_1 CG service provider].
Some formerly homeless tenants thought that case workers were ‘not qualified enough’ or ‘did not have experience in homelessness’. Most stakeholders thought that caseworkers were more adequately trained and experienced than a year ago, but some thought improvement was still needed, with one stakeholder suggesting that case managers’ ‘style is a little passive’ [ST_16 other service provider]. However, stakeholders did acknowledge that the crisis focus had meant that ‘some clients missed out because there wasn’t time’ [ST_28 CG service provider]. In addition, case managers also supported some affordable housing and social housing tenants, with one social housing client receiving ‘15 hours per week [while] others miss out that are funded to have the support’ [ST_28 CG service provider]. Nevertheless, most stakeholders, including Common Ground service providers, were of the view that these additional clients should be eligible for support, and that the tenants’ needs were in general being met.

Stakeholders noted, however, that there were a number of tenants who were frequently unhappy about aspects of Common Ground or decisions made by staff. While one stakeholder suggested this attitude was ‘part of their psychological profile and they’re the vocal minority’, the same stakeholder was of the view that the problem was exacerbated by inconsistencies and problems in service provision, or what they referred to as ‘the cracks in Common Ground’ [ST_25 other service provider]. Formerly homeless tenants perceived inconsistencies between what different case managers said or provided, including matters such as whether they gave out free bus tickets, as inequitable. The issue of consistency between case managers is discussed further in Section 5.4.1 and issues relating to the service as a whole are discussed further in Section 5.5.2. It was suggested that the case management team could do more to prevent this from occurring:

Those people shine a torch on the deficits of the agency, on the difficulties with communication and any inconsistencies because they’re the ones that are picking that up and being very vocal about it, sometimes unreasonably so but there are things that Common Ground, as a service, could do better that would probably manage those people with multiple and complex needs and never-ending complaints a bit better [ST_25 other service provider]

The ICC is aware of the focus on crisis and in January 2014 appointed a new Clinical Practice Leader and a Triage Support Worker. Prior to the appointment of the Triage Support Worker, tenants would knock on the glass door of the support office, and case managers had little option but to open the door, so it was very difficult to work in a planned way. The Triage Support Worker sits at the reception desk beside the receptionist from MA Housing, and deals with immediate issues while at the same time arranging appointment times for tenants to see case managers. The role of the Clinical Practice Leader is to direct and support all aspects of case management and to work in consultation with mental health and clinical services that are involved in people’s care. It is anticipated that these two roles will result in better case management and less of a focus on responding to crises. Some stakeholders were of the opinion that the change had already had an impact on case management approaches.

The interview data suggests that issues such as strategies for assertive case management, supporting formerly homeless people after they are housed, balancing crisis and planned support, supporting a recovery approach and preventing burnout are ongoing priorities for the support team at Common Ground.

5.3.2 Onsite services

A range of onsite services are provided to tenants and the broader community. These services include: a Centrelink officer who provides weekly outreach services on site; a local GP who is onsite one morning per week (some tenants attend offsite at the practice); a bulk billing psychiatrist who practices a half day per week; and a bulk billing psychologist who also attends onsite (Section 1). NSW Health provides a clinician to follow up 10-15 of CCG clients with highest mental health needs. The uptake of services in the initial period was slow due to the staggered approach to housing formerly homeless tenants. Figure 5.6 outlines all of the onsite services and shows the proportion of tenants in each group who access these services.
There have been some changes in services provided during the operation of CCG. Some services that were engaged after the project opened were not continued because of low tenant engagement, and as a result have ceased to operate onsite. For example, a podiatrist is still available, but is no longer located onsite. Some services currently operating have opened more recently; for example, the GP service opened in early 2013. Since that time, more tenants have also been consulting the GP at her nearby practice. In early 2014, nursing support was added to the GP service. Some stakeholders suggested that there was a need for a drug and alcohol worker onsite, but funds have not yet been identified for this role. Tenants attending focus groups expressed a variety of views about particular onsite services and service providers.

Although, as detailed in Section 5.3.1 above, some mainstream services declined applications from Common Ground tenants because the environment was regarded as already providing stable housing and support, stakeholders emphasised that some Common Ground tenants would require lifetime support and believed it was appropriate that mainstream services undertake this. They were actively working with mainstream service providers to encourage them to work with Common Ground tenants.
5.3.3 Resident perceptions of services

Camperdown Common Ground survey participants were asked a range of questions about the support services and case management they had received in the 12 months prior to each interview (baseline and follow-up) (see Table 5.1). These services could therefore include both services accessed at Common Ground and elsewhere.

The mean number of support services accessed remained mostly stable for accommodation and health services from baseline to follow-up. There was a reduction in the mean number of basic support services accessed by participants from an average of two at baseline to one at follow-up. While the majority of participants did not access a legal service in the 12 months prior to each interview, ten participants at both baseline and follow-up accessed one legal service, and a small number accessed two or more legal services.

Table 5.1: Mean number of support services accessed over the past 12 months (client survey)

<table>
<thead>
<tr>
<th>Support service</th>
<th>Baseline data (N=25)</th>
<th>Follow-up data (N=26)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accommodation</td>
<td>1 (range 0-5)</td>
<td>1 (range 0-8)</td>
</tr>
<tr>
<td>Health</td>
<td>2 (range 1-7)</td>
<td>2 (range 0-12)</td>
</tr>
<tr>
<td>Basic support e.g. food, clothing</td>
<td>2 (range 0-6)</td>
<td>1 (range 0-5)</td>
</tr>
<tr>
<td>Legal</td>
<td>0.6 (range 0-3)</td>
<td>0.5 (range 0-2)</td>
</tr>
</tbody>
</table>

As a measure of integration between services, participants were asked how often they had to give the same information to different services. CCG offers tenants a number of onsite services, including case management support. As shown in Figure 5.7, there was a notable shift in perceptions from baseline to follow-up, with a greater proportion of participants reporting that they ‘never’ (4% to 31%) or ‘rarely’ (0% to 15%) had to give the same information to different services. However, just over half of the participants continued to report at follow-up that they had to provide the same information to different services ‘sometimes’ (23%), ‘often’ (15%) or ‘always’ (15%). It is not known what range of services survey participants used, or the reason for not sharing information.
Participants were asked how often providers of different services worked together to coordinate their care. At follow-up, the tenants perceived that services were working together less often than at baseline, with the majority indicating that coordination between services occurred ‘never’ (16%), ‘rarely’ (24%) or ‘sometimes’ (44%). Interestingly, no participants at baseline or follow-up reported that different services ‘always’ worked together to coordinate their care (see Figure 5.6).

Despite participants’ common perception that services did not tend to work together to coordinate care, the majority of participants continued to report at follow-up that it was either ‘quite important’ (31%) or ‘very important’ (42%) for services to share information with each other about their care and needs (see Figure 5.9).
At follow-up, almost all participants (92%) reported that they had a case manager, with the majority indicating that they were currently engaged with one (64%) or two (27%) case managers (range 1-5). This is similar to baseline results, whereby all participants reported that they had a case manager, with the majority indicating that they were currently engaged with one (56%) or two (32%) case managers (range 1-5).

In relation to the level of importance participants placed on having a case manager, the majority of the sample continued to feel at follow-up that it was ‘quite important’ (25%) or ‘very important’ (38%) to have a case manager to help coordinate access to different services (see Figure 5.10). However, it appears that the level of importance for some participants may have reduced over the 12-month period; at baseline, a greater proportion of participants felt that having a case manager was ‘quite important’ (40%) or ‘very important’ (48%).

Figure 5.9: Level of importance that participants placed on different services sharing information with each other about their care and needs (Client survey)

Figure 5.10: Level of importance that participants placed on having a case manager to help coordinate access to different services (Client survey)
At baseline, two-fifths (39%) of the sample indicated that they had a case plan for their care, and this proportion increased to three-fifths (61%) at follow-up. At both waves of data collection, two tenants were unsure as to whether or not they currently had a case plan. While the majority of the sample indicated that they ‘often’ (32%) or ‘always’ (32%) had a say in what their case manager or services did for them, there seems to have been a slight shift over the 12-months post-baseline towards the lower ratings of ‘never’ and ‘rarely’ (see Figure 5.11).

Figure 5.11: Degree to which participants felt that they had a say in what their case manager/s or service/s did for them (Client survey)

![Figure 5.11](image)

*Based on a matched sample

Similarly to baseline results, as shown in Figure 5.12, the majority of participants reported that the services provided to them had been ‘quite a bit’ (36%) or ‘extremely’ (24%) useful. However, at follow-up there was a rise in the proportions reporting that the services were ‘not at all’ (8%) or ‘a little bit’ (20%) useful.

Figure 5.12: Extent to which participants felt that the services provided to them had been useful (Client survey)

![Figure 5.12](image)

*Based on a matched sample

Analysis of the qualitative data captured from the CCG Client Survey at follow-up revealed similar themes to those identified at baseline. Participants continued to report that greater access to support services, particularly employment, education and financial support, would be useful. Furthermore, increased access
to physical and mental health services remained an important issue for participants. A new theme to emerge was the need for greater communication between staff and services to allow for clearer explanation to tenants about treatment and/or case plans.

At baseline, the majority of participants (96%) reported changes in their lives since living at CCG and this continued to be reported by most people at follow-up (87%). Improvements in physical and mental health were commonly identified, particularly a reduction in drug and alcohol use. This was often linked to having stable access to health and support services as well as feelings of stability, security and safety in general. Participants continued to report mixed views about whether CCG had enhanced or decreased their independence and self-esteem.

In order to ensure on-going positive change, a need for increased and continued access to services for physical and mental health care remained consistent across time points. Increased involvement in social activities also continued to be important, with a particular emphasis on wanting to reconnect with family and children. A recurrent theme at follow-up was the desire for greater financial independence and participants often reported the need for more employment assistance to help with this.

5.4 Partnerships

The operation of CCG involves multiple service providers and partnerships. This section describes and assesses the ongoing development of the relationships between the key partners.

5.4.1 Relationships within the Inner City Coalition

As mentioned previously in this chapter, the ICC faced a number of challenges in establishing a coordinated approach to service provision in the early stages of the project.

Stakeholders from Common Ground emphasised that the organisations and staff involved had worked well together to overcome the challenges and deliver a more coordinated service in practice. The operation of the ICC is now managed with several meetings: the five contributing organisations meet monthly; managers from each Coalition organisation meet with the staff who work at CCG, and also meet with the Support Services Manager. Support workers report to the Support Services Manager on a day-to-day basis. The Support Services Manager reports to Mission Australia, prepares a monthly report for the Coalition Board of Management and does a report for MA Housing. As described above, the case managers have received additional training aimed in part at achieving a more coordinated approach to providing support.

Stakeholders generally reported that many of the problems in providing a coordinated approach to service provision had been addressed so that there is now much better cohesion among the CCG support team. The appointment of the clinical Practice Leader is expected to further assist this. However, it was reported that case managers still had different amounts of brokerage money available for clients, ‘which translates to inconsistency and perceived favouritism between the tenants’ [ST_25 other service provider].

5.4.2 Relationship between MA Housing and the Inner City Coalition

One of the key principles of CCG is the separation of tenancy management from the support function in the model: the tenancy manager is responsible for addressing tenancy breaches, while the support provider is responsible for assisting the tenant to resolve any issues that may impact on his or her ability to meet tenancy requirements. Although these two functions are separate, the tenancy manager and support provider also need to work together in order to make sure that the objectives of the project are met.

Stakeholders generally thought that MA Housing and the ICC worked together well, with some noting that there were still some areas where the respective responsibilities were being defined. The ICC and MA Housing meet fortnightly. The Support Services Manager and the Building Manager meet together weekly and, as reported above, the support team and the housing team meet monthly (this frequency has recently
been increased – see section 5.2). In addition there is a handover each morning and evening between the housing staff, the support staff and the concierge. The support team has also conducted some training with MA Housing staff to support the partnership. In addition, stakeholders who worked onsite reported that staff from the two teams had contact during the day.

A substantial number of stakeholders, including a majority of Common Ground interviewees reported that the process of working both separately and in a coordinated manner within the same building sometimes presented challenges for MA Housing and the ICC. In 2013, stakeholders reported that the MA Housing presence at the reception desk meant that MA Housing workers sometimes felt pressured to respond to support requests. There was also a reported lack of clarity about who should be responsible for monitoring the maintenance of tenants’ rooms, although this would normally be the role of the tenancy provider rather than the support team.

In the 2014 data collection, it became clear that there have been serious problems with squalor and rental arrears had developed at Common Ground, and that poor communication between the partners has enabled this. Section 5.2 describes measures that have now been taken by the two partners to address this by improving communication and coordination and by introducing more cleaning services. In addition, a new central Manager has been appointed, currently on a temporary basis, to work between the two teams and provide ‘a single point of leadership which is fairly strong’ [ST_30 CG service provider]. The aim of this is to address issues of the two teams working in isolation from each other. While the Common Ground model, as with other models where housing and support are separate, requires the two teams to work closely, it is not clear how the new approach will work and how the central manager position can operate within the context of separation of services. This is particularly the case now that MA Housing is operationally managed under MA (see Section 5.1.2). One stakeholder suggested that this change within MA:

… should make things more succinct, we’re all managed under one arm, we all meet together, [MA Housing Services Manager, MA Operations Manager, CEO MA]. I think it allows us to work together even better, I don’t see why there’s any complexity [ST_30 CG service provider].

A further issue raised by stakeholders was that the support providers are providing case management to some of the affordable housing tenants. MA Housing have contracted CSS to provide support services to the entire tenant population at Common Ground, with the understanding that this is part of the Common Ground model and that CSS are not to separate or stigmatise any tenants based on histories of homelessness. A small number of stakeholders in oversight/establishment roles noted that Community Housing Providers are already responsible for sustaining tenancies for this group as part of their normal operation, and were of the view that CSS support for affordable housing tenants constituted a diversion of the resources of the support providers targeted to the most vulnerable, to progress the ends of the housing provider.

5.4.3 Other partnerships

In addition to the key project partners, there are a variety of other organisations involved with CCG. MA housing contract a security firm to provide the concierge services, consisting of two security staff present on site from 5:00 pm to 9:00 am Monday to Friday, and for 24 hours per day on Saturday and Sunday. CSS have commissioned a number of health providers to operate their practices from the building. Local area police meet monthly with both building and support management, and discuss the calls to the Common Ground building as well as any AVOs, arrests, bail conditions (such as not consuming alcohol) or other relevant matters.

Some services are coordinated, for example most but not all of the health providers meet quarterly and communicate about clients on a day-to-day basis. However, some service providers reported little coordination, with one having decided to withdraw from providing services at Common Ground because their skills were not being appropriately used. Some other services are being provided by volunteers but residents reported that some of these were discontinued because of unavailability of volunteers.
Some ICC interviewees were of the view that more services should be provided on the ground floor of the building, with the aim of addressing any risk of Common Ground becoming too institutional as the centre would be open to all. However, Mission Australia advises that planning in this area is not finalised. These issues are discussed further in Section 5.5.2.

### 5.5 Emerging issues about the service model

A number of concerns and questions about the broader service model were raised during the qualitative interviews. These concerns centred on the mix of tenants with complex needs in the building, sustainability of support, and avoiding institutionalisation of formerly homeless tenants. Stakeholders also provided their assessment of how they thought the Common Ground model compared with other supported housing models for people who were homeless.

#### 5.5.1 Complexity and sustainability

The concerns around sustainability that emerged in the 2013 interviews were still current in the 2014 interviews. A substantial number of the service providers involved in delivering CCG felt that the resourcing for support services is currently inadequate for the number of tenants in the building whose needs are very high and complex. They suggested that high need tenants should comprise a smaller proportion of tenants in the building than the 2014 proportion of half of all tenants.

Most stakeholders who are not involved in service delivery held a conflicting view: they believed that while the government does want to address the needs of the most vulnerable, it is not in a position to fund an increased number of projects like CCG to enable each project to contain lower numbers of high need people. These stakeholders felt it is unrealistic to reduce the proportion of people with complex needs in the building. Indeed, one external service provider was of the opinion that “having this number of people with co-morbidities in close quarters to professional staff and clinical care allows us to manage those people really well, and engage with them onsite” [ST_16 other service provider].

The tension around the current levels of complexity and funding for support is further complicated by the fact that there is an expectation from the government that the intensity and type of support and therefore the level of funding needed will decrease and stabilise. Common Ground did take a conservative approach to spending in the second half of 2013 due to a delay in receiving funds, but started some new activities when funds arrived.

In addition, FACS-HNSW intends that the ICC should take on full responsibility for funding the case management support. Stakeholders involved in service provision felt strongly that the level of complexity cannot be sustained at the current level, let alone when responsibility for funding is transferred to the ICC. This may conflict with one of the original aims of the model, which was to target a specific group of the most vulnerable and high need long-term homeless people in the service system.

#### 5.5.2 Avoiding institutionalisation

The baseline report (Bullen et al., 2013) described the risks of institutionalisation associated with congregating a high number of people with complex needs in one location while also providing onsite support services. While these concerns are still current, progress has been made since 2013 in case coordination and developing processes for enabling and assisting tenants who need to move from the building urgently, for example due to safety concerns.

There was some concern voiced by a small number of stakeholders from offsite service providers and oversight/establishment organisations that the CCG building has an institutional feel to it, and that the number and range of onsite services does not encourage people to engage with the broader community. One stakeholder expressed concern that people at Common Ground were expected to use many homeless-specific services and identified themselves as part of the homeless population even though they were no
longer homeless. Some other tenants expressed concern that they were judged negatively by others as a result of living at Common Ground, and were ‘brushed off as loonies’ or that ‘the building gives off the perception we’re all crazy’. A few interviewees expressed the opinion that scatter-site housing might work better to avoid institutionalisation.

Formerly homeless tenants raised a number of specific instances where they were dissatisfied with decisions or attitudes of staff, including support workers, building/tenancy managers and security staff. The issues raised by formerly homeless tenants about service provision highlight the extent to which the decisions and attitudes of Common Ground staff impact on tenants’ lives and increase the risk of institutionalisation. Some of the issues are similar to those raised by affordable housing tenants (discussed in Section 5.2.4). Issues raised focussed on details of building management, and whether staff were perceived as being respectful, responsive and consistent. These included:

- Sometimes security don’t help you when you need it, or they act over the top when it isn’t necessary.
- I made an appointment with [staff member] and they didn’t turn up and avoided me and have made no effort to meet with me.
- Staff hurt your feelings and don’t comfort you when you come to them with a problem.
- They don’t advertise that someone comes in to the gym out the front to teach you how to use the equipment safely – staff need to let us know when someone is going to be there otherwise I won’t go in there.
- I didn’t think Common Ground was a good fit for me … if you want to transfer you have to stick with MA Housing and they all have security and no privacy. I want somewhere where friends don’t have to buzz to come in and people don’t see who is visiting. Since moving in here I am cranky, at times I would rather live in a tent …
- I was told kids can be here but now they can’t.

The evidence from stakeholders indicates that there are two key issues at CCG that require further reflection in order to avoid institutionalisation and to provide the most appropriate support for the target group. The first is the approach to onsite service provision, which is one of the most challenging aspects of the Common Ground model. It was recognised early in the implementation of the project that there was some inconsistency between workers about how to support people appropriately in a residential environment. While there has been some upskilling of existing staff, more needs to be done to ensure that the tensions around providing onsite support within a residential environment are continually challenged and interrogated. Further training and supervision will help to equip staff to respect consumer choice while enabling tenants to choose to participate and engage in support. Service providers have made a number of positive changes in this area, but stakeholders agree that this will continue to be an area requiring ongoing improvement.

Another key area of disagreement among stakeholders concerned what level and type of onsite service provision should be provided at CCG. A substantial number of stakeholders suggested that services should be increased, for example by extending the hours that the GP and mental health support staff are available, and that other additional services should be provided. On the other hand, a small number of stakeholders felt strongly that an extensive provision of services was inconsistent with the Common Ground model because it had the potential to make the project less like a residence and more like an institution or crisis centre.

In 2013, stakeholders expressed differing views about whether the tenants’ use of medical and psychiatric services outside of the building should be more assertively coordinated by their case managers or whether this decision should be left to the client. Interestingly, the client survey (see Section 5.3.2) suggested that participants perceived that different service providers often did not work together to coordinate their care, although the number who thought this decreased between 2013 and 2014.

In 2013, some stakeholders raised questions about the most appropriate exit processes and assistance in relocating tenants. In 2014, stakeholders reported that service providers had been assisting clients who wished to relocate to higher or lower support housing although, as described above, not all formerly homeless
tenants were happy with the opportunities available.

5.5.3 Common Ground and other models of supported housing

Qualitative data was collected about how stakeholders thought the Common Ground model compared with other supported housing models, in particular scatter-site models. Some stakeholders preferred Common Ground because the new building had provided additional housing stock and was more secure than private rental housing. They also preferred Common Ground because support was ongoing if needed, whereas some scatter-site models, including ICIS, passed support to mainstream services after approximately a year. These services may, however, not be appropriate or may not continue support. One stakeholder preferred Common Ground because it was easier to access tenants to deliver health services. Some stakeholders preferred scatter-site models because they did not congregate people with problems together in one building and did not carry risks of institutionalisation.

However, although stakeholders generally thought that scatter-site housing was preferable for most people, most also thought that both models were of value for different tenants. Indeed, stakeholders from the ICC, which also operates the Inner City Integrated Services (ICIS) project, reported that some clients had been transferred between the two projects in order to better meet their needs. It was considered good practice for people to be able to move to a different type of housing as appropriate. However, some stakeholders were beginning to develop criteria for who would be better suited to each model.

Scatter-site housing was identified as more suitable for those who:

- are more independent;
- struggle in close social proximity to others;
- quickly get agitated with others’ high needs or disruptive behaviour, or who get agitated and then their own behaviour gets disruptive very quickly;
- want to shift away from a homelessness identity and others with a homeless identity; and
- are trying to address their drug and alcohol issues and maintain abstinence, and may find a building where substance use is occurring to be risky or unhelpful.

Common Ground was identified as more suitable for those who:

- would feel isolated in scatter-site housing and need to be connected to a community; these people might otherwise abandon their housing and return to the street;
- are isolated and wish to engage but lack confidence, and who make friends at Common Ground and enjoy participating in activities;
- have serious health risks, such as serious alcohol related illness; while there is still a risk that these people could die at Common Ground, the risk is reduced because there is greater monitoring; and
- need security in the building because they find it difficult to keep predatory people out of their apartment.
5.6 Summary of key points

- MA Housing is the overall contract manager for the Project. The support services are provided by the ICC, which includes Mission Australia as the lead agency, the Salvation Army, the St Vincent de Paul Society, the Haymarket Foundation and Wesley Mission. MA Housing reports to the Community and Private Market Housing Directorate within FACS-HNSW, but Housing Services in Central Sydney monitors the delivery of the support services.
- Ownership of the Common Ground property was vested to MA Housing in 2015.
- Stakeholders agreed that the reporting structure at CCG is complex. Some concerns arose around the selection of one housing provider as the overall contract manager, and the organisational relationship between the housing and support providers.
- There was general agreement that having a consortium of five organisations deliver support services had added extra layers of complexity to decision making and operations although the organisations had worked well to overcome these challenges.
- MA Housing met its objectives in contracting out the support services, cleaning and concierge functions; managing the construction and furnishing of the building; and successfully tenanting the building.
- Since the baseline report, MA Housing and CSS have introduced improved measures to detect rent arrears early and deal with them more strategically. Some tenants had built up high levels of arrears before action was taken. Some affordable housing tenants also developed high arrears because they lost their employment and their rent did not change with their income.
- The housing and support partners are also seeking to improve their response to what several stakeholders referred to as issues of ‘squalor’ in tenants’ apartments, in particular the formerly homeless tenants.
- There was broad agreement that a key strength of CCG is that it provides secure, permanent housing to vulnerable people who had been homeless for many years.
- Data from the client survey found that the vast majority (84%) were satisfied or very satisfied with their housing. Tenants on the whole reported feeling safe in the building, particularly when comparing this form of housing to other homelessness services.
- The building design and location were generally viewed positively. Some areas of the building, such as where the support providers are located, could have been better planned to ensure worker safety. MA Housing proposes to undertake building work to rectify key safety issues.
- Tenants were less satisfied with interactions with neighbours in the building than they were with other aspects of the housing although the responses were still generally positive on average.
- Program data indicated that 63 of 76 formerly homeless tenants had engaged in case management. All survey participants had engaged in case management to some extent.
- The client survey showed a marked increase in the proportion of participants who knew they had a case plan in place from baseline to follow-up (39% to 61%).
- Common Ground is taking steps to adopt a more planned approach to case management, and to move away from a focus on crisis management.
- Partnerships within the ICC and between ICC and MA Housing have improved as the project has progressed. There is an ongoing need to clarify roles and responsibilities between these two partners in order to coordinate and increase the effectiveness of their work while maintaining the separation of housing and support.
- Two key issues continue to require discussion among stakeholders: the tenancy mix and sustainability of support; and further steps that can be taken to avoid institutionalisation.
- Most stakeholders thought that both scatter-site housing and Common Ground models were of value for different formerly homeless tenants, and some suggested criteria for who might be better suited to each model. Stakeholders thought that scatter site housing was preferable for most people.
6 Tenant outcomes

This section presents data on tenants’ housing, health, mental health, service use, and wellbeing gathered as part of the Camperdown Common Ground client survey. Some data on housing outcomes was also drawn from the Campedown Common Ground program data.

In addition to these sources, stakeholders commented on their perceptions of tenant outcomes. While stakeholders stressed that because of the long-term homelessness, disabilities and illnesses of tenants, change would be slow, they also reported visible changes in some tenants. Stakeholders stressed the achievement of maintaining permanent housing, particularly for those who had lived on the street for decades. Some formerly homeless tenants have also reduced alcohol consumption, are engaging in more meaningful relationships and are accessing the community independently. Some have been engaging in activities such as art classes; some have reconnected with families, and a small number have gained casual, temporary or part time work or work experience. In addition to being housed and fed, formerly homeless tenants are overall receiving more continuous physical and mental health treatment and follow-up. Some have received treatment for health problems that they were not aware of. Having these basic needs met has enabled many to improve their quality of life.

For some others, cognitive impairments and other disabilities have limited their capacity to engage further and in some cases to live safely at Common Ground. Stakeholders acknowledge that there are some within this group for whom there is a service gap. While some of these people have moved to higher support facilities such as aged care, not all are eligible, particularly those who are young.

Formerly homeless tenants who participated in focus groups stressed the importance of having permanent housing and the opportunity to receive support after long periods of homelessness, which in many cases meant living on the street.

6.1 Housing

6.1.1 Retention in housing

The average length of time all tenants have resided in the building is 493 days, though the formerly homeless tenants have been residing at CCG for less time than people in other types of tenancies. This is most likely because formerly homeless people were moved in more slowly to minimise disruption and allow tenants time to settle into the building. While the building opened on 15 November 2011, it was not fully tenanted until June 2012.
### Table 6.1: Mean number of days spent in Camperdown Common Ground by housing type (n=163) (Program data)

<table>
<thead>
<tr>
<th>Housing Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formerly homeless</td>
<td>76</td>
<td>482.2</td>
<td>254.9</td>
<td>29.2</td>
</tr>
<tr>
<td>Other housing type</td>
<td>87</td>
<td>502.8</td>
<td>301.8</td>
<td>32.5</td>
</tr>
</tbody>
</table>

Between November 2011 and March 2014, 163 tenants lived at CCG. As at March 2014, 100 people (61%) of all tenants remained there. Sixty-three people exited, which is a turnover rate of 39% (Figure 6.1).

**Figure 6.1: Proportion of exits by housing type (n=163) (Program data)**

Note: A number of units had multiple tenancies over the period, so these figures (current tenancies, less exits) do not total the units for different tenancy types.

Of the 28 formerly homeless people who exited (moved out, never moved in, or died) 25 were male, two were female and one was transgender female. Of the 3 social housing tenants who moved out, two were male and one was female. Of the 32 affordable housing tenants who moved out, 11 were male, 17 were female and the gender of four was unknown.

When isolating the formerly homeless tenants, 63% have remained tenanted at CCG since they moved in. However, those counted as not remaining at Common Ground include two formerly homeless people who did not move in.\(^{11}\)

In comparing retention at CCG with international literature on permanent supportive housing projects such as the Pathways to Housing model, which report retention rates of 75-85 per cent in the first year (Martinez and Burt, 2006; Rog, 2004; Shern et al., 2000; Stefancic and Tsemberis, 2007; Wong et al., 2006), some contextual information on the service models should be borne in mind. If residents of the Pathways to Housing program lose their housing, for example, the service does not stop supporting them and people may be rehoused up to four times (Nicholls & Atherton, 2011; Pleace, 2012). Therefore, the retention rate achieved by Pathways to Housing may represent retention in a number of apartments in one program rather than stability in the first apartment offered (Stefancic & Tsemberis, 2007; Tsemberis & Eisenberg, 2000). As Table 6.2 shows, of the formerly homeless people who moved out of CCG, six people relocated, including three to supported accommodation and aged care homes. Literature suggests there may be a range of other factors...

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\(^{11}\) The calculation above does not take into account the fact that formerly homeless tenants moved in gradually between November 2011 and July 2012. At March 2014, of those who moved in on or before July 2012, the date that the formerly homeless component was fully tenanted, 36 of 76 (47%) remained. The Baseline Report found that, at March 2013, 82% of formerly homeless residents had remained tenanted since they moved in.
outside of the project itself that could influence variations in supportive housing models in different countries and their tenancy outcomes (G Johnson et al., 2012).

Table 6.2 Reasons for exiting, formerly homeless

<table>
<thead>
<tr>
<th>Reason for exit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unknown</td>
<td>10</td>
</tr>
<tr>
<td>Relocated</td>
<td>6</td>
</tr>
<tr>
<td>Deceased</td>
<td>4</td>
</tr>
<tr>
<td>Abandoned</td>
<td>3</td>
</tr>
<tr>
<td>Never moved in</td>
<td>2</td>
</tr>
<tr>
<td>Evicted</td>
<td>2</td>
</tr>
<tr>
<td>Incarcerated</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>28</td>
</tr>
</tbody>
</table>

Of those people on affordable housing leases who left and for whom information was known, six relocated, and one was evicted. The person on a social housing lease who left for known reasons was evicted.

The quantitative survey also collected data on accommodation outcomes for 26 formerly homeless tenants who completed both the baseline and follow-up surveys. All participants at baseline reported their current living situation to be in ‘long-term community housing accommodation’, with half residing in CCG for the entire 12 months prior to the interview (50%). The remaining participants had either lived in one (42%) or two (8%) places prior to receiving residency at CCG in the last 12 months, including on the street (46%) or in crisis/short term Supported Accommodation Assistance Program (SAAP) accommodation (15%).

At follow-up, accommodation was more stable with the majority of the sample still residing at CCG (92%), while two participants (8%) had moved into public housing. Of these, one moved straight into long-term housing while the other transitioned between two other types of short-term accommodation. One Common Ground tenant also reported that although they had stable accommodation, they chose to sleep rough in inner Sydney for half of each week.

Most participants at baseline and follow-up (92%) were residing in their CCG apartment alone. The mean time spent in CCG over the last 12 months was 294 days (median 350 days, range 30-365) at baseline and this increased to a mean of 334 days at follow-up (median 365, range 4-365).

6.1.2 Rental arrears

Fifty formerly homeless tenants (96% of 52 tenants) and 17 people in affordable or social housing tenancies (33% of 52 tenancies) were in rent arrears in April 2014 (see Table 6.3). Arrears are discussed in more detail in Section 5.2.4.

Table 6.3: Arrears amount by housing type, March 2014 (Program data)

<table>
<thead>
<tr>
<th>Housing Group</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Formerly homeless</td>
<td>50</td>
<td>$1,494.26</td>
<td>$1,474.31</td>
<td>$210.62</td>
</tr>
<tr>
<td>Other housing type</td>
<td>17</td>
<td>$3,245.22</td>
<td>$4,380.58</td>
<td>$1,062.45</td>
</tr>
</tbody>
</table>
6.1.3 Incidents

Incident data collected from CCG gives some indication of the amount of urgent assistance required by tenants. Complete data is available from December 2012 until April 2014. In this period, there were 660 incidents recorded, and the majority of these incidents (72%) involved formerly homeless tenants (Figure 5.2).

Figure 6.2: Incidents recorded by housing type of the tenants involved, Dec 2012 to April 2014 (Program data)

Many different types of incidents were reported, but the most common across the cohort were verbal abuse (19%), physical illness or injury (13%) and noise complaints (12%) (see Figure 6.3). The miscellaneous category comprised diverse minor breaches and incidents (mostly non-medical); no one type of incident had more than 5 occurrences. Red bars indicate medical incidents, and blue bars indicate non-medical incidents.

Figure 6.3: Incidents by type (n=660) (Program data)
The most common actions when incidents occurred were for the staff to intervene (40%), police attendance (14%) or for an ambulance to attend (12%). Staff intervention generally involved calming the tenant down, directing them to return to their apartment or leave the building, assessing risk, and redirecting tenants’ behaviour (see Figure 6.4).

Figure 6.4: Actions taken when incidents occur (n=660) (Program data)

The number of incidents decreased markedly between the early months of the project (December 2012 to May 2013), and the period from June to December 2013. However, the number of incidents increased again in the period January-March 2014, before falling again in April 2014 (Figure 5.5). Qualitative data suggests that the decrease in incidents resulted from an overall increase in the stability of individual tenants and the project itself. Stakeholders reported that factors that may have contributed to the increase in incidents in the early months of 2014 were: the actions of one particular tenant who threatened staff; a change in support staff, which could perhaps have led to increased reporting of incidents that had otherwise been normalised by long standing staff; and the introduction of security guards as concierge on the front desk and increased incidents due to anti-authority attitudes of many tenants and job expectations of some security guards (see Section 5.2.2 and Section 5.3).
6.2 Physical health

Participants were advised of a number of physical health conditions at baseline and asked whether a doctor or nurse had ever told them that they had this condition. If participants reported that they had been diagnosed with a condition, they were subsequently asked whether they had received treatment for it in the past 12 months. Figure 6.6 below shows the treatment rates received for the various physical conditions at baseline and follow-up.

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12 Complete data is not available for January and February 2013
It is clear that at the two time points, treatment rates varied across physical health conditions. At baseline, the highest treatment rates for participants occurred for those diagnosed with cancer, high blood pressure and/or chronic pain (100%, 80% and 73% respectively). At follow-up, the conditions with the highest treatment rates were chronic pain, epilepsy/seizure and respiratory disease (67%, 67% and 57% respectively). It is likely that the reduction in reported treatment rates for conditions at follow-up, particularly cancer, high blood pressure, chronic infection, diabetes and dental problems, were a result of the condition being addressed and better managed than at baseline.
6.3 Mental health

Similarly to the physical health section, participants were asked whether they had been diagnosed with specific mental health conditions at baseline, and if so, whether they had received treatment in the past 12 months. Of those who had been diagnosed, the majority of participants continued to receive treatment in the 12 months prior to follow-up for anxiety disorders, psychotic disorders and mood disorders (82%, 80% and 71%). Interestingly, there were marked reductions in the proportions of participants with a substance use disorder and/or personality disorder who had received treatment for these conditions in the 12 months prior to follow-up compared to baseline treatment rates, though this may have been due to treatment ameliorating the symptoms they experienced at baseline (see Figure 6.7).

Figure 6.7: Percent of participants with diagnosed mental health conditions who received treatment (Client survey)

*Based on a matched sample
6.4 Psychological distress

The Brief Symptom Inventory was used to provide an overview of the psychological symptom patterns which contributed to distress over the past seven days. Nine primary symptom dimensions were rated on a 5 point scale of distress (0-4), ranging from ‘not at all’ to ‘extremely’ distressed. A score of 50 represents an average level of distress, meaning that scores above this percentile demonstrate high, or above-average, distress levels.

Results suggest that at baseline, all nine primary symptom dimensions received distress ratings that were well above average (above the 50th percentile), with somatisation, phobic anxiety, paranoid ideation and obsessive compulsive rated as having contributed the most notable distress among participants (see Figure 6.8). However at follow-up, distress ratings across the nine primary symptom dimensions were all lower than baseline rates. The most notable reductions from baseline to follow-up were for the symptoms of obsessive compulsive, interpersonal sensitivity and hostility, all of which recorded ratings below the 50th percentile.

Figure 6.8: BSI T-Scores for primary symptom dimensions (N=24) (Client survey)
6.5 Health service use

6.5.1 Emergency service use: physical health

A similar proportion of the sample attended the Emergency Department (ED) for a physical health problem in the 12 months prior to baseline (42%) and follow-up (39%). At both time points, these participants attended the ED on a median number of 2 visits in the past 12 months (baseline: mean 18, range 1-104; follow-up: mean 6, range 1-20). The reasons for attending the ED are shown in Figure 35, with epilepsy/seizure (12%) being reported as the most common reason for ED attendance at follow-up.

Figure 6.9: The primary physical health problem/s that participants attended the Emergency Department for on their most recent admission at baseline and follow-up (n=11) (Client survey)

At both baseline and follow-up, a similar proportion of the sample had been admitted overnight to hospital for a physical health problem in the past 12 months (30% and 28% respectively). Of those who reported a stay in the hospital overnight, the median number of admissions remained low and stable (baseline: median 2, mean 24, range 1-123; follow-up: median 1, mean 5, range 1-20). However, there was a noticeable difference in the median duration of each admission, with participants at follow-up reporting a noticeably longer hospital stay for physical health problems (baseline: median 3, mean 54, range 1-208; follow-up: median 14, mean 24, range 1-90). The most common reason for admissions overnight were epilepsy/seizure at both time points (see Figure 6.10).
6.5.2 Emergency service use: mental health

Similarly to physical health, under one-third of the sample at both time points (baseline 30%; follow-up 28%) had attended the ED for a mental health problem in the past 12 months. These participants had a low median number of visits at both time points (baseline: median 2, mean 4, range 1-8; follow-up: median 1, mean 2, range 1-5). The most common reason for attending the ED at baseline was for psychosis (86%), and of these six participants, only one continued to report this at follow-up (14%). The most common reason for ED admission at follow-up was for drug related problems (57%), which increased slightly from baseline (43%) (see Figure 6.11).
Compared to the ED figures for physical health, a slightly lower proportion of participants at baseline (26%) and follow-up (20%) had been admitted overnight to any hospital for a mental health problem in the past 12 months. At follow-up, these participants reported less frequent admissions on average (baseline: median 2, mean 3, range 1-8; follow-up: median 1, mean 1, range 1-2) and also had shorter stays in hospital than baseline rates (baseline: median 17 nights, mean 15 nights, range 2-30; follow-up: median 3 nights, mean 3 nights, range 1-8). The most common reasons for admissions overnight at both time points were psychosis, drug related problems and depression (see Figure 6.12).

Figure 6.12: The primary mental health problem/s that participants were admitted overnight for on their most recent admission (Client survey)

Note: Participants could select multiple responses.
6.5.3 Drug and alcohol treatment facility

At baseline, 22% of the sample had stayed overnight in a residential or inpatient drug and alcohol treatment facility in the past 12 months for a median of two occasions (mean 4, range 1-12). The total length of these admissions for participants averaged a median duration of 21 days (mean 27, range 8-57).

In contrast, 8% of the sample at follow-up had stayed overnight in a residential or inpatient drug and alcohol treatment facility in the past 12 months for a median of three times (mean 3, range 1-4). On average, participants reported a total length for all admissions as a median duration of 29 days (mean 29, range 7-50).

6.5.4 Ambulance service

Just over half the sample at baseline (52%) were treated by the ambulance service in the past 12 months. On average, these participants were treated on a median of four occasions (mean 9, range 1-52). At follow-up, a slightly smaller proportion of participants (42%) were treated by the ambulance service in the past 12 months. On average, these participants were treated on a median of two occasions (mean 4, range 1-20). Similarly to baseline results, on the last occasion participants were treated by the ambulance service, this was most commonly for a physical health condition (73%) (see Figure 6.13).

Figure 6.13: The primary health condition participants treated by the ambulance service for on the last occasion (Client survey)

![Graph showing % of sample who received ambulance treatment in the past year.](image)

6.5.5 General practitioners

All participants at baseline (100%) reported at least one consultation with their General Practitioner (GP) in the last year, with a median number of six consultations during this period (mean 14, range 1-48). Approximately half (54%) reported that at least one of these visits had been for mental health reasons.

At follow-up, the majority of participants (88%) reported at least one consultation with their GP in the last 12 months, with a median number of six consultations during this period (mean 12, range 1-30). Two-fifths (41%) reported that at least one of these visits had been for mental health reasons.

As shown in Figure 6.14, the majority of participants at baseline had one GP (70%) who they visited at the one general practice clinic (74%) in the past year. Consistent with these self-reported figures, it was found that 74% of participants reported that all of their GPs worked at the same clinic. A similar pattern was found at follow-up: the majority of participants had one GP (68%) and 82% of participants reported that they consulted their GP/s at one GP clinic. Furthermore, 82% reported that their GP worked in the same clinic (see Figure 6.15).
6.5.6 Other health services

In the 12 months prior to interview, two-thirds of the baseline sample (65%) had consulted a health professional who provided specialist mental health services, such as social workers, occupational therapists or counsellors. On average, participants had a median of five consultations with specialist mental health services during this time (mean 23, range 1-116). At follow-up, a similar proportion had continued to consult mental health professionals (60%) for a median of five consultations (mean 17, range 1-100).

At baseline, two participants reported having been on a Community Treatment Order (CTO) in the past 12 months and this was for a median of five months (mean 5, range 3-6). At follow-up, one participant reported being on a CTO and on average this was for a median of four months.

At baseline, three participants had been appointed a Guardian through the Guardianship Tribunal in the past 12 months, which on average was for a median of three months (mean 5, range 1-12). At follow-up, two participants reported that they had had an active Guardian for the entirety of the past 12 months.
6.6 Contact with the Justice System

Overall, participants demonstrated increased rates of contact with the justice system at the time of follow-up compared to baseline. As shown in Figure 6.16, half of the sample (52%) had been stopped by police on the street at baseline on a median of six times in the prior year (mean 21, range 2-100). This increased to two-thirds of the sample at follow-up (64%), and occurred on a median of six times (mean 26, range 2-150).

Figure 6.16: Participants’ engagement with different forms of the Justice System over their lifetime and in the last 12 months (Client survey)

- Stopped by police on the street: Baseline (N=23*) 52, Follow-up (N=25) 64
- Attended court for a criminal matter: Baseline 30, Follow-up 36
- Held overnight by the police: Baseline 13, Follow-up 20
- Contact with Parole or other Justice Officer: Baseline 4, Follow-up 4
- Spent time in adult prison: Baseline 0, Follow-up 4

*Based on a matched sample

Less than one-third of the sample reported attending court for a criminal matter in the past 12 months at baseline (30%), occurring on a median of one time (mean 1, range 1-2). The proportion of participants who attended court at follow-up increased slightly, with over one-third attending court in the past 12 months (36%) on a median of two occasions (mean 2, range 1-5).

At baseline, approximately one-in-ten participants (13%) reported being held overnight by police in the last 12 months and this was for a median of one night (mean 1, range 1-2). This proportion increased at follow-up to one-in-five participants (20%), who reported being held overnight for a median of two nights (mean 6, range 1-21).

Contact with a Parole or Justice Officer in the past year was reported by one baseline participant, who had 10 visits and missed one visit. Similarly at follow-up, one participant reported contact with a Parole or Justice Officer in the past year, and this was for three visits. Again, this participant missed one scheduled visit during this time period.

At baseline, no participant reported spending time in an adult prison in the prior 12 months. However at follow-up, one participant reported that they had recently spent 60 nights in an adult prison.
6.7 Self-care, hygiene and nutrition

A number of self-care questions were administered to participants to assess hygiene and nutrition in the week prior to the interview. Firstly, participants were asked to report how many days in the past week they had cleaned their teeth (see Figure 6.17).

At follow-up, the largest proportion (31%) of participants reported that they had cleaned their teeth every day over the past week. Although 19% of the sample reported not brushing their teeth in the week prior to the follow-up interview, this was a notable improvement to baseline rates where 29% reported not brushing their teeth in the last week. Similarly, all participants (100%) at follow-up reported that having access to a toothbrush and water was ‘never’ an issue, which again was an improvement from the baseline rate (92%). It was anecdotally noted at both time points that some participants did not have teeth and therefore reported that they had not cleaned their teeth in the last week.

There was a noticeable reduction in the proportion of participants who needed to go to the dentist at some point in the 12 months prior to interview but did not go from baseline (60%) to follow-up (42%). Conversely, as illustrated in Figure 6.18, a larger proportion of participants attended a dentist over the past year.

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**Figure 6.17: Number of days in the week prior to the interview that participants had cleaned their teeth (Client survey)**

![Bar chart showing number of days participants cleaned their teeth (Client survey)](chart1.png)

*Based on a matched sample

**Figure 6.18: Time since participants had last consulted a dentist (Client survey)**

![Bar chart showing time since participants last consulted a dentist (Client survey)](chart2.png)

*Based on a matched sample
Participants were also asked to report how many days in the last week they had changed their socks. The majority of the sample at follow-up (68%) reported that they had changed their socks every day (see Figure 6.19). Overall at follow-up, participants were reporting that they changed their socks more frequently than they reported at baseline. The vast majority of participants (92%) reported that having access to a spare pair of socks was ‘never’ an issue at follow-up, which is a higher proportion than baseline results (80%).

Figure 6.19: Number of days in the week prior to the interview that participants had changed their socks (Client survey)

The proportion of the sample that indicated they had a problem with their feet at baseline was markedly reduced at follow-up (58% to 35%). Various problems reported by participants included ingrown toenails, swollen or cracked skin, and musculoskeletal pain. Despite this, very few participants reported consulting a podiatrist in the 12 months from baseline to follow-up (see Figure 6.19).

Figure 6.20: Time since last consultation with a podiatrist for those participants who had consulted a podiatrist in their lifetime (Client survey)

In terms of personal hygiene, most participants at both baseline and follow-up (84% and 88% respectively) reported that in the past week, they were always able to wash their hands after going to the toilet (see Figure 6.21).
To obtain an understanding of the nutrition and frequency of meals being consumed, participants were asked to recall how many days in the last week they had eaten fruit, vegetables, breakfast, lunch and dinner. While the frequency of fruit and vegetable consumption was similar on average at baseline, there was a reduction between baseline and follow-up in the frequency of fruit consumption (3.1 days to 1.9 days) and a concurrent increase in the frequency of vegetable consumption (2.9 days to 3.6 days) (see Figure 6.22).

Of the three traditional meals of the day, breakfast continued to appear to be the least commonly eaten amongst participants at follow-up, which was consumed on average 2.5 days in the last week. Although lunch and dinner were consumed more frequently throughout the week, it is notable that on average, participants are not eating regular meals every day. On a positive note, participants appeared to be eating meals more frequently overall on average than reported at baseline.
6.8 Quality of life

Quality of life refers to an individual’s overall wellbeing and satisfaction. It was measured using the World Health Organisation Quality of Life (WHOQoL-BREF) instrument which comprises four domains: physical, psychological, social relationships and environment. The results for the whole baseline sample are detailed in the Baseline Report (Bullen et al., 2013).

Figure 6.23 shows the mean scores for each of these domains for the CCG formerly homeless tenants matched sample and a comparative Victorian community sample. Overall, the formerly homeless participants scored lower (had poorer quality of life) on all four domains (Hawthorne et al., 2000) than the Victorian community sample. On all domains except for environment, participants perceived their quality of life to be better at follow-up than baseline, with the most noticeable increase observed for the physical health domain.

Figure 6.23: Mean domain scores for the WHOQoL instrument among Camperdown Common Ground respondents compared with mean scores for the 2000 Victorian Validation Study community sample (Client survey)

*Based on a matched sample

6.9 Relative deprivation

Survey participants were asked to indicate from a list of material items those that they did not have, and whether the lack of a material item was because they could not afford it. This list was adapted from one used in a recent Australian study of deprivation and social exclusion (Saunders et al., 2007).

Figure 6.24 shows the proportion of participants who had each necessary item at the time of the baseline interview. A majority (78%) of participants reported that they did not have $500 saved for emergencies or a one-week holiday from home each year because they could not afford it. Most respondents also did not own a car and did not have a hobby available for their children. However, this was mostly due to reasons other than affordability. On a positive note, the vast majority of participants at baseline reported having a number of material possessions, including medical treatment when needed (100%), a TV (100%), a decent and secure home of their own (100%), warm clothes and bedding (94%) and a phone (94%).

At follow-up, a higher proportion of participants reported that they had $500 saved for emergencies (39%), owned a car (4%) and had a hobby for their children (33%) compared to baseline. Another notable increase from baseline to follow-up was the proportion with a substantial meal each day (78% to 89%) (Figure 6.25).

These results are mixed in comparison with the broader Australian community, where 92 per cent have a decent and secure home; 92 per cent have a car, and 76 per cent have up to $500 in savings for an emergency (Saunders et al., 2007).
Figure 6.24: In possession of items of necessity at baseline (N=18*) (Client survey)

- $500 for emergencies: Yes, have it (22%), No, don't have it (other reason) (59%), No, don't have it (can't afford it) (22%)
- Car: Yes, have it (59%), No, don't have it (other reason) (28%), No, don't have it (can't afford it) (17%)
- One week's holiday a year: Yes, have it (78%), No, don't have it (other reason) (22%), No, don't have it (can't afford it) (17%)
- Dental treatment: Yes, have it (56%), No, don't have it (other reason) (28%), No, don't have it (can't afford it) (17%)
- A substantial meal daily: Yes, have it (78%), No, don't have it (other reason) (22%), No, don't have it (can't afford it) (17%)
- Hobby for children (n=12): Yes, have it (69%), No, don't have it (other reason) (22%), No, don't have it (can't afford it) (17%)
- Buy prescribed medicines: Yes, have it (89%), No, don't have it (other reason) (6%), No, don't have it (can't afford it) (6%)
- Social contact with others: Yes, have it (94%), No, don't have it (other reason) (6%)
- Phone: Yes, have it (100%), No, don't have it (other reason) (0%)
- Decent and secure home: Yes, have it (100%), No, don't have it (other reason) (0%)
- Warm clothes and bedding: Yes, have it (94%), No, don't have it (other reason) (6%)
- TV: Yes, have it (100%), No, don't have it (other reason) (0%)
- Medical treatment: Yes, have it (100%), No, don't have it (other reason) (0%)

*Based on a matched sample

Figure 6.25: In possession of items of necessity at follow-up (N=26) (Client survey)

- $500 for emergencies: Yes, have it (39%), No, don't have it (other reason) (16%), No, don't have it (can't afford it) (45%)
- Car: Yes, have it (62%), No, don't have it (other reason) (35%), No, don't have it (can't afford it) (0%)
- One week's holiday a year: Yes, have it (45%), No, don't have it (other reason) (39%), No, don't have it (can't afford it) (15%)
- Dental treatment: Yes, have it (46%), No, don't have it (other reason) (15%), No, don't have it (can't afford it) (39%)
- A substantial meal daily: Yes, have it (89%), No, don't have it (other reason) (11%), No, don't have it (can't afford it) (0%)
- Hobby for children: Yes, have it (67%), No, don't have it (other reason) (33%), No, don't have it (can't afford it) (0%)
- Buy prescribed medicines: Yes, have it (89%), No, don't have it (other reason) (12%), No, don't have it (can't afford it) (0%)
- Social contact with others: Yes, have it (81%), No, don't have it (other reason) (19%), No, don't have it (can't afford it) (0%)
- Phone: Yes, have it (89%), No, don't have it (other reason) (12%), No, don't have it (can't afford it) (0%)
- Decent and secure home: Yes, have it (89%), No, don't have it (other reason) (11%), No, don't have it (can't afford it) (0%)
- Warm clothes and bedding: Yes, have it (96%), No, don't have it (other reason) (4%), No, don't have it (can't afford it) (0%)
- TV: Yes, have it (92%), No, don't have it (other reason) (8%), No, don't have it (can't afford it) (0%)
- Medical treatment: Yes, have it (96%), No, don't have it (other reason) (4%), No, don't have it (can't afford it) (4%)
6.10 Social relationships

The nature of social relationships relies on context. Participants were asked to indicate the degree to which four different relationship styles resembled their own style on a scale of 1 to 7, where 1 was ‘not at all like me’ and 7 was ‘very much like me’ (see Figure 6.26 and Figure 6.27). Overall, there were some noticeable shifts in relationship styles between baseline and follow-up.

At baseline, half the sample (52%) reported that the statement, ‘It is relatively easy for me to become emotionally close to others’, did not resemble them at all. However at follow-up, the majority of participants (63%) reported that this statement now resembled their relationship style to some degree. From baseline to follow-up, there was also strong shift in the proportion who indicated that they preferred not to depend on others or have others depend on them (78% and 92% respectively).

There was a noticeable increase from baseline to follow-up in the proportion of participants who disagreed with the statement ‘I often find that others are reluctant to get as close as I would like’ (39% and 50% respectively). At baseline, the majority of participants agreed with the statement ‘I want emotionally close relationships, but I find it difficult to trust others completely’. However at follow-up, there was a noticeable shift towards participants disagreeing with this statement.

Figure 6.26: Distribution of participants’ scores for different relationship styles at baseline (N=23*) (Client survey)

Figure 6.27: Distribution of participants’ scores for different relationship styles at follow-up (N=24) (Client survey)
As shown in Figure 6.28, at both baseline and follow-up, the majority of participants indicated they were treated with respect by others (89% and 85% respectively) and were accepted by others for who they were (83% and 81% respectively). These results are similar to those of the community sample from the Saunders et al. (2007) study, in which 93 per cent of respondents reported that they were treated with respect, and 92 per cent said they were accepted by others for who they were. Interestingly, the results for the CCG participants compare favourably with the sample of clients of Australian community service organisations, such as Mission Australia and Anglicare Sydney, who reported lower levels of being treated with respect (77%) and being accepted by others for who they were (72%) (Saunders et al. 2007).

Figure 6.28: Proportion of participants who reported having various types of social contact (Client survey)

Further to this, participants were asked to report the number of close friends and relatives that they had, that is, people they felt at ease with and could talk to about what was on their mind. Participants reported having close contact with a median of two people at both baseline (mean 4, range 0-15) and follow-up (mean 11, range 0-150).

6.11 Social exclusion

Participants were asked a series of questions that aimed to document their experience of isolation from society in respect to a lack of resources or support, or else resulting from the behaviour of others towards them.

The prevalence of social isolation among the baseline sample is shown in Figure 6.29. Overall, it appears that participants are experiencing less social isolation at follow-up than at baseline. The most common contributors of social isolation at baseline involved: a) lacking the means to participate, such as a lack of money (61%) and lack of paid work (44%); and b) lacking a support system of family and friends, including absence of supportive family members (61%) and family-related problems (56%). A notable portion of participants at baseline also indicated that mental (56%) and physical (44%) health problems contributed to their experiences of social isolation.

At follow-up, it appears that lacking a support system of family and friends continued to impact upon approximately half of the sample, with 62% reporting an absence of supportive family members and 50% reporting family-related problems. There was a noticeable decrease in the proportion reporting that a lack of money (46%) and problems due to mental health (39%) were contributing to social isolation. Although there was a marked reduction in the proportion who reported social isolation due to disability discrimination between the two time points (39% to 19%), there was a concurrent increase in the proportion reporting that they were experiencing social isolation due to problems from a disability (28% to 39%).
Figure 6.29: Sources of social isolation among participants in the last year (Client survey)

- Lack of money: 61% (Baseline), 62% (Follow-up)
- Lack of family members: 61% (Baseline), 62% (Follow-up)
- Family-related problems: 56% (Baseline), 56% (Follow-up)
- Problems due to mental health: 39% (Baseline), 56% (Follow-up)
- Lack of community involvement: 50% (Baseline), 50% (Follow-up)
- Lack of friends: 44% (Baseline), 44% (Follow-up)
- Lack of paid work: 44% (Baseline), 44% (Follow-up)
- Problems due to physical health: 39% (Baseline), 39% (Follow-up)
- Lack of transport: 27% (Baseline), 28% (Follow-up)
- Disability discrimination: 39% (Baseline), 39% (Follow-up)
- Lack of access to children: 27% (Baseline), 39% (Follow-up)
- Irregular/expensive transport: 28% (Baseline), 19% (Follow-up)
- Problems due to disability: 39% (Baseline), 39% (Follow-up)
- Problems due to homophobia: 15% (Baseline), 22% (Follow-up)
- Problems due to sexism: 17% (Baseline), 8% (Follow-up)
- Problems due to racism: 17% (Baseline), 8% (Follow-up)
- Other caring responsibilities: 6% (Baseline), 8% (Follow-up)
- Bullying: 4% (Baseline), 0% (Follow-up)
- Other: 8% (Baseline), 8% (Follow-up)

*Based on a matched sample.
*At follow-up, other reasons included distance from friends and labels/judgement from living in Common Ground.
6.12 Employment, education and income

The majority of participants continued to describe their current overall employment situation at follow-up as ‘unable to work due to own ill-health, injury or disability’ (62% at both baseline and follow-up), followed by ‘not actively looking for a job but want to work’ (15%). Two participants reported that they were currently studying (8%), and one participant reported that they were ‘voluntarily out of the workforce’ (4%) (see Figure 6.30).

Figure 6.30: Participants’ self-reported current overall employment situation (N=26*)

As shown in Figure 6.31, although only 8% of the baseline sample looked for work in the last four weeks, 27% indicated that they could have started work last week if they had found a job. Similarly, 15% of the follow-up sample reported looking for work, while 39% stated that they could have worked in the past week.

Figure 6.31: Proportion of participants who actively looked for work in the past month and were available to work in the past week (N=26*)

In regards to income, the vast majority were in receipt of some form of government benefit at both time points (96%). The Disability Support Pension (DSP) was recorded as the most common source of income (58%), which is consistent with the previous finding of ‘own health and disability’ being a barrier to employment for many participants. Over the 12 months prior to follow-up, there appeared to be a reduction in the proportion receiving the DSP (69% to 58%), and a concurrent increase in the proportion receiving Newstart (23% to 35%) (see Figure 6.32).
6.13 Problems and coping

6.13.1 Problems

Participants were asked about serious problems they may have experienced over the 12 months prior to follow-up. Overall, the majority of participants at follow-up reported that they had some degree of problem with ‘being bored’, ‘feeling depressed, anxious, or stressed’, ‘repeating the same mistake’ and ‘being lonely’. Of the proportions of participants who reported serious problems, ‘getting on with my family’ had the highest percentage across all of the variables (Figure 6.33).
Participants were also asked to rate the degree to which they had experienced these same problems in the past month at both baseline and follow-up. This data is shown in Figure 6.34. The greatest reductions in the proportions that had problems from baseline to follow-up were for ‘losing my temper’, ‘repeating the same mistake’ and ‘managing money/debt’. Problems that recorded the greatest increases from baseline to follow-up included ‘dealing with authorities’, ‘being bored’ and ‘getting into trouble with the police’.
Figure 6.34: Past month prevalence of various problems among participants at baseline (N=18) and follow-up (N=26) (Client survey)
6.13.2 Self-efficacy

Related to the above measures on the severity of problems experienced by participants, self-efficacy – or the belief in one’s ability to succeed in specific situations – was assessed. Participants completed the General Self-Efficacy (GSE) Scale (Schwarzer and Jerusalem, 1995). General self-efficacy is defined as a ‘stable sense of personal competence to deal effectively with a variety of stressful situations’ (Schwarzer, 1994). This scale consists of 10 items, with responses made on a 4-point scale (Not at all true; Hardly true; Moderately true; Exactly true). Figure 6.35 shows the proportion of participants who answered ‘moderately true’ or ‘exactly true’ to the item responses at baseline and follow-up.

Figure 6.35: Degree to which participants rated items on the Global Self Efficacy Scale as ‘moderately true’ or ‘exactly true’ at baseline and follow-up (Client survey)

The items at baseline that participants felt were least true were ‘if someone opposes me, I can find the means and ways to get what I want’, ‘I can remain calm when facing difficulties because I can rely on my coping abilities’ and ‘it is easy for me to stick to my aims and accomplish my goals’, indicating that these aspects of self-efficacy are the weakest among the respondents at baseline. It appears, however, that at the time of follow-up, self-efficacy ratings overall had improved amongst the participants, with notable increases in the originally lower scored statements of ‘I can remain calm when facing difficulties because I can rely on my coping abilities’ and ‘I can solve most problems if I invest the necessary effort’. The strongest aspect of self-efficacy, which remained...
consistent across both time points, relates to problem solving ability; ‘I can always manage to solve difficult problems’, ‘I can usually handle whatever comes my way’ and ‘if I am in trouble, I can usually think of a solution’.

Overall GSE scores were calculated by summing the participant’s responses across the 10-item scale to yield a composite score (ranging from 10 to 40). The mean GSE score of baseline (mean 31, range 18-40) and follow-up (mean 30, range 17-40) participants was high and stable across both time points. Cross-cultural studies using the General Self Efficacy Scale has yielded the mean score for English speaking countries (e.g. Great Britain and the United States) as 30 (Scholz et al., 2002). A small proportion of the baseline (11%) and follow-up (4%) sample had a score of 20 or less, and 44% of respondents at baseline and follow-up scored 33 or higher.

### 6.14 Summary of key points

- Stakeholders emphasised the importance of allowing sufficient time to achieve change for people who have experienced long-term homelessness, and who have disabilities and illnesses.
- For some formerly homeless tenants, high unmet support needs related to cognitive impairments and other disabilities have made living at Common Ground difficult, and in some cases meant that they cannot live there safely. While some have moved to higher support facilities such as aged care, there are service gaps for younger people with these support needs.
- Housing:
  - There has been a 63% retention rate among formerly homeless tenants over 28 months.
  - There were 50 formerly homeless people and 17 people in affordable or social housing tenancies in arrears at March 2014.
  - There were 660 critical incidents in the building in December 2012 and April 2013, 72% of which were attributed to formerly homeless tenants. Many different types of incidents were reported, but the most common were (verbal abuse (19%), physical illness or injury (13%) and noise complaints (12%).
  - At survey follow-up, the majority of the matched sample was still residing at CCG (92%), while two participants (8%) had moved into public housing.
  - The frequency of accommodation changes in the 12 months prior to follow-up was noticeably more stable compared to baseline results.
  - Overall, participants remained satisfied with their CCG housing at follow-up (baseline 4.4/5.0; follow-up 4.2/5.0).
  - The ratings provided by the participants for individual housing quality aspects remained mostly stable from baseline to follow-up. The exception to this was, ‘how complaints are managed’; although this was the only aspect to receive a higher satisfaction rating score at follow-up than baseline, overall it continued to have the lowest satisfaction rating.
Support services and case management:
- Fewer participants at follow-up felt that they had to repeat the same information to different services. However, the participants perceived that services were working together less often at follow-up than at baseline.
- At both time points, the majority of participants appeared to place notable importance on having someone to coordinate their access to different services. However, there was a slight decrease in perceived importance of service coordination at follow-up among some participants, which may be due to a reduced reliance on case management.
- There was a marked increase in the proportion of participants who knew they had a case plan in place from baseline to follow-up (39% to 61%).
- Similar to baseline results, the majority of participants reported that the services provided to them had been useful.
- The vast majority of participants reported noticing changes in their lives since working with the CCG service at both baseline (96%) and follow-up (87%).
- New themes that emerged from participants’ comments at follow-up were the need for greater communication between staff and services and the desire for greater financial independence, with participants often reporting the need for more employment assistance to help with this.

Employment and income:
- The majority of participants (96%) remained unemployed at follow-up, and the proportion of participants who considered themselves unable to start work in the week prior to the survey due to long-term illness or disability remained stable between baseline and follow-up (62% respectively).
- Almost all participants were in receipt of some form of government benefit at baseline and follow-up (96% respectively). The proportion on Disability Support Pension reduced from baseline to follow-up (69% to 58%); however, the proportion on Newstart increased across the two time points (23% to 35%).

Physical and mental health:
- Treatment rates were lower for most physical and mental health conditions at follow-up compared to baseline.
- Symptoms of psychological distress were lower at follow-up than baseline across all nine primary symptom dimensions. The most notable reductions over this time were for the symptoms associated with obsessive compulsive, interpersonal sensitivity and hostility.

In general, the drop over time in the proportions of participants reporting use of alcohol and other drugs; however, there was an increase in frequency of use amongst some opioid and amphetamine users.
**Tenant outcomes**

<table>
<thead>
<tr>
<th>Health service utilisation:</th>
<th></th>
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<tbody>
<tr>
<td>- Service utilisation rates of ED and overnight hospital admissions for physical health reasons remained mostly stable across time. The exception to this was that participants reported longer durations of overnight hospital stays at follow-up than baseline.</td>
<td></td>
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<tr>
<td>- The proportions who attended the ED for mental health conditions remained stable across time, but there was a notably higher proportion of participants who reported the reason for attendance as drug-related problems.</td>
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<tr>
<td>- At follow-up, a smaller proportion of the sample had been admitted to a hospital overnight for a mental health reason, and for those who were admitted, they reported shorter stays than the baseline sample.</td>
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<tr>
<td>- There were reductions at follow-up in the proportion of participants who attended a drug and alcohol treatment facility and who had been treated by the ambulance service.</td>
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<tr>
<td>- The majority of participants reported that they had consulted their GP in the past year at both time points, and the frequency of GP consultations remained stable over the two time points.</td>
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<table>
<thead>
<tr>
<th>Contact with the Justice System:</th>
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<tbody>
<tr>
<td>- Participants reported higher contact rates across most justice system channels examined at the time of follow-up compared to baseline.</td>
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<thead>
<tr>
<th>Quality of life:</th>
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<tbody>
<tr>
<td>- The mean scores measuring quality of life improved across all domains except for environment from baseline to follow-up; however, they remained lower on all four domains compared to a comparative community sample.</td>
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<thead>
<tr>
<th>Relative deprivation:</th>
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<tbody>
<tr>
<td>- At follow-up, a higher proportion of participants reported that they had $500 saved for emergencies, a car and a hobby for their children compared to baseline. There was also a notable increase in the proportion that had consumed a substantial meal each day. However, the proportion of participants who had dental treatment when required declined from baseline to follow-up.</td>
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<tr>
<th>Social environment:</th>
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<tr>
<td>- There were notable shifts from baseline to follow-up in relation to how participants perceived their personal relationship styles.</td>
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<tr>
<td>- The majority of participants continued to report at follow-up that they are treated with respect by other people or accepted by others. In comparison, the participants’ scores were higher than scores provided by a sample of clients of Australian community service organisations.</td>
<td></td>
</tr>
<tr>
<td>- Overall, participants appeared to be experiencing less social isolation at follow-up. However, there was an increase in the proportion reporting social isolation due to problems from a disability.</td>
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<table>
<thead>
<tr>
<th>Problems and coping:</th>
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<tbody>
<tr>
<td>- From baseline to follow-up, there were notable reductions in the proportion of participants reporting the following problems: losing my temper, repeating the same mistake and managing money/debt. Problems that recorded the greatest increases from baseline to follow-up included: dealing with authorities, being bored and getting into trouble with the police.</td>
<td></td>
</tr>
<tr>
<td>- At the time of follow-up, self-efficacy ratings overall had improved amongst the participants, suggesting that they had a greater belief in their ability to succeed in specific situations.</td>
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7 Economic analysis

As presented in previous sections of this report, the Common Ground model offers permanent housing together with a range of onsite support services specifically targeting the most vulnerable homeless people. Camperdown Common Ground was initiated in response to the Australian Government’s national commitment to reduce the high levels of homelessness and rough sleeping in the inner city of Sydney and to promote a model of ‘Street to Home’ housing integrated with individually tailored and case managed optional support.

In this broad context, this section examines CCG from an economic perspective under stream 3 of the evaluation to assess the total costs and benefits of CCG and compare the model with alternative homelessness programs in Australia.

The methodology section presents a range of inherent study limitations due to the relatively small sample sizes, the complexity in client baseline characteristics and variation in the various homelessness program models. Collectively these factors limit the isolation of specific causal relationships between the CCG housing and support service model intervention and individual outcomes. These limitations include:

- Due to overarching design limitations, similar to other homelessness studies, any form or randomisation is prevented.
- Due to the lack of a counterfactual, it is not possible to know what would have happened to the formerly homeless tenants if they had not participated in the CCG program.
- The population of homeless people housed through CCG is relatively small and given this, the outcome and cost data do not provide sufficient power to support statistically significant analyses or confidence intervals. For this reason, the program effectiveness and cost effectiveness undertaken is primarily descriptive.
- The economic evaluation component is also limited by the annual aggregation of reported cost figures and the potentially confounding detail that may be masked in estimated high level average figures.

In this context and given the limitations, the economic analysis is presented as indicative estimates based on the available cost and support service data.

Additionally, these limiting factors restrict the ability to infer potentially positive changes in other government funded programs and the associated cost offsets. A number of studies have identified significant cost offsets resulting from homelessness programs. These cost offsets are due to, for example, reduced service usage across healthcare and criminal justice. While these cost savings are highly plausible to some extent, the scale, timing and longer term sustainability of these types of improvements are characterised by high variation in individual outcomes. For this reason, cost offsets have been examined as ‘potential’ savings, reflecting the particularly high level of uncertainty in previously published estimates, and the extent to which
offsets may result for individual CCG residents.

The evaluation program logic incorporates resource use, the sources of tenancy management and support service funding, property management, maintenance and support services provided, and whether the program resources have been used effectively. Aggregate annual program cost is then aligned with the program outcomes, and the cost per resident estimated in context of other alternative homelessness models.

It is important to note that this comparison is complex due to variation in residents’ baseline characteristics, the respective homelessness program models and the range of potential confounding dimensions that limit the identification of causal program effects versus other factors that may be influencing outcomes. In this context, the figures are presented as the first available program cost figures for CCG as the basis for initial estimated costs per resident. Similarly, high level comparisons with alternative programs are also indicative.

The Common Ground program is a comprehensive model providing immediate ‘housing first’ secure accommodation as a platform for wrap around case management and support services. Importantly, the model is targeted at the highest need chronic homeless group through the Vulnerability Register of homeless people developed using a Vulnerability Index (VI) to assess the needs of rough sleepers and prioritise their need for housing and support.

The alternative models reviewed present a range of service models and position the role of the common ground approach as a high level support in Commonwealth and NSW government policy to meet targets to reduce chronic homelessness. This targeting of the most complex cases provides additional support while alternative shorter term programs might otherwise risk participants dropping out.

International studies provide examples of similar models, outcomes and high level program costs. As the international cases include additional variations in service model, target populations and baseline characteristics, combined with the unusually high variation in the Australian dollar exchange rate in recent years, the focus here is on the more directly comparable Australian program models.

The Australian responses are nonetheless still characterised by complexity of variation in study dropout rates for follow-up which may introduce additional bias into analyses, particularly in studies of smaller sample sizes or where higher numbers of clients were not included in longer term follow up waves.

Many homelessness studies have limited economic evaluation components and variation in model, target groups as well as baseline characteristics, which also limit direct comparability.

### 7.1 Program funding and costs

As presented in Section 3.6, the CCG program costs are based on audited final financial reports prepared by Mission Australia, providing aggregate annual costs. Reflecting the separation in building and tenant management, and support services provided through CSS, figures are separately reported under each entity, including separate funding and income sources and respective expenditures.

Program funding and costs have been collated from each data source, as summarised in Figure 7.1, to provide total program income and expenditure, as well as retain cost components from each program area for context of overall average cost per tenant estimates. The building and tenant maintenance reporting includes building capital cost from the 2014-15 financial year, when the property was vested to MA Housing. Separate figures are also reported for concierge and security expenses. The 2013-14 financial year provides the primary complete annual cost basis, predominantly aligned with the evaluation period.

The support service cost data reflects MA Housing staffing and operating costs as well as the aggregate (block) payments to service providers for contract support delivery. All cost figures are aggregate annual totals as tenant level cost or individual service usage data are not available. As the basis for estimating the relative proportion of tenants accessing support services, the separate monthly update report figures were collated to establish the number of tenants in each subgroup that received services. The trend in proportional support service delivery was relatively stable across months. All long term homeless received the majority
of support services, as did a number of social housing tenants and a small number of affordable housing tenants. These proportions were used for context in estimating the average cost per tenant.

Figure 7.1: Camperdown Common Ground funding and cost data sources

Program Funding

Building Maintenance and Tenant Management

- Funding
  - Grants
  - Rental Income
- Expenditure

- Concierge
  - 24 hour security

Camperdown Support Services (CSS)

- Funding
  - Grants
- Expenditure

Program Costs

- Building capital cost
- Monthly Reports

Source: MA Housing and Camperdown Support Service annual financial statements, monthly performance reports.

Preliminary investigations into detailed financial records indicated that monthly figures may not accurately reflect actual service delivery in each month due to lump sum periodic payments to service providers. For this reason, the monthly report totals were assessed to provide indicative service usage proportions for long-term homeless, social and low income housing.

Program funding and costs for each component are presented in the following sections.

7.1.1 Building maintenance and tenant management costs and income

The primary funding source for building maintenance and tenant management costs is rental income as presented in Table 7.1. For the evaluation period 2013-14 financial year, income through tenant rental agreements totalled $932,652, representing 66 percent of total income. Rental figures are grouped between Homeless and Social Housing, and separately for Affordable Housing tenants. The figures reflect the slightly higher rents received from the affordable housing group, with this 40 percent of tenants accounting for 54 percent of total rental income.

As the majority of residents receive government support payments, they also receive Commonwealth Rent Assistance (CRA), which is a supplementary non-taxable contribution to eligible people who rent in the private or community housing rental markets. The rental income figures are based on reported individual rental agreements and include both sources of Commonwealth payments.
Table 7.1: Building and tenant management income and expenditure 2013-14

<table>
<thead>
<tr>
<th></th>
<th>Dollars</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
</tr>
<tr>
<td>Rental Income</td>
<td></td>
</tr>
<tr>
<td>Homeless (n=52)</td>
<td>429,819</td>
</tr>
<tr>
<td>Social Housing (n=10)</td>
<td></td>
</tr>
<tr>
<td>Affordable Housing</td>
<td>502,833</td>
</tr>
<tr>
<td>Total Rental Income</td>
<td>932,652</td>
</tr>
<tr>
<td>NRAS Contributions</td>
<td>376,031</td>
</tr>
<tr>
<td>NPAH Funding - Support Services</td>
<td>111,026</td>
</tr>
<tr>
<td>Other Income</td>
<td>4,062</td>
</tr>
<tr>
<td>Total Income</td>
<td>1,423,770</td>
</tr>
</tbody>
</table>

|                      |         |
| **EXPENDITURE**      |         |
| Property Expenses    |         |
| Council & Water Rates, Repairs & Maintenance | - 313,327 |
| Repairs & Maintenance set aside [Sinking Fund] | - 96,857 |
| Employee Related Expenses | - 260,263 |
| Admin & Working Expenses | - 142,438 |
| Total Expenditure    | - 1,254,994 |

|                      |         |
| **EBITDA**           | 168,776 |
| Depreciation         | - 9,005 |
| EBIT                 | 159,771 |
| Surplus / (Deficit)  | 168,776 |

Source: Mission Australia Housing Annual Financial Statements

NRAS = National Rental Affordability Scheme; NPAH = National Partnership Agreement on Homelessness

MA Housing advise that average rentals are approximately $240 per week for affordable housing tenants and $150 per week for social and homeless tenants. The affordable rents are maintained below 75% of market rent in order to ensure affordability for people earning National Rental Affordability Scheme (NRAS) eligible levels of income that qualify for the NRAS grant income entitlement. This results in CCG rents being set between 60-70% of market rental levels.

Initial phases of the CCG program reported high levels of rental arrears which have since been improving with proactive monitoring and tenant management.

Program funding is also received through NRAS which provides Commonwealth funding to State governments to invest in affordable rental housing. This accounted for $376,031 in 2013-14, i.e. 26 percent of total income. The scheme aims to assist with the shortage of affordable rental housing to low and moderate income households at a rate that is at least 20 per cent below the market value rent. The scheme is also intended to encourage larger scale investment and innovative delivery of affordable housing such as CCG.
Additional funding is received through the National Partnership Agreement on Homelessness (NPAH), a joint funding initiative between the Commonwealth and State governments aimed at breaking the cycle of homelessness and improving and expanding homelessness service responses.

The Common Ground building was vested to Mission Australia Housing in 2015 for $33 million providing recent valuation as the basis for the estimated cost of capital.

The building and tenant management recurrent expenditure includes Council and water rates, repairs and maintenance, employee, administration and working expenses.

The cost of concierge and 24 hour security services were funded separately by FACS in initial years but as of October 2014, MA Housing are responsible for paying the costs of this service. The recurrent cost is reported to be a set allocation each year of $320,000 in 2012-13 and $329,280 in 2013-14, when adjusted for inflation.13

7.1.2 Tenant support services

A wide range of support services are provided onsite with most services open to both tenants of Common Ground as well as tenants in the nearby FACS-HNSW buildings. All services except for the Food Bank are provided free of charge to tenants. The full range of services is detailed in section 2.3.

Support services are predominantly funded through a NSW housing and accommodation state grant representing $1.14 million in 2013-14, 81 percent of total funding, and 98 percent if the rolled over income recognition entry of $256,491 is excluded, Table 7.2.

Grant funding includes a one-off allocation from the NSW Ministry of Health in support of health related services provided at CCG (n.a., 2011). HNSW worked with NSW Health in the CCG planning phase to develop the onsite as well as offsite health services, which guided the design and incorporation of a number of dedicated rooms within CCG to provide therapeutic services and for interviewing clients. NSW Health provided recommendations regarding the provision of these health services, including the design, fit-out and equipping of the therapeutic and interview rooms, the concierge space, security systems, fire retardant bedding and the management of sharps and clinical waste.

In addition, to assist with funding the costs of addressing these recommendations, NSW Health awarded two grants to HNSW of $100,000 in March 2011, and $500,000 in May 2011, totalling $600,000. The funds were allocated to go towards meeting the recommendations made by NSW Health, including:

- redesign and fit-out of the therapeutic and interview rooms to enable the provision of a range of health and allied health services;
- ensuring acoustic treatment for the therapeutic and interviews rooms meets the recommended levels;
- provision of duress alarms and CCTV cameras to provide adequate security coverage;
- provision of fire retardant and health care mattresses and pillows for the homeless residents;
- provision for storage and disposal of sharps and clinical waste;
- provision of medical equipment and IT requirements;
- provision for other equipment as required to support the health and wellbeing of tenants.

The majority of this grant was to meet non-recurrent start-up costs, including fit-outs, medical and other equipment, and was either expensed in prior years, or included in the building asset valuation. Remaining unspent grant funds of $96,943 were allocated in October 2013 to reconfigure the reception area and some consultation rooms to address staff safety issues and provide better service to the more vulnerable clients.

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Table 7.2: Camperdown Common Ground support service costs 2013-14

<table>
<thead>
<tr>
<th>Income</th>
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<tbody>
<tr>
<td>State Grant - Housing &amp; Accommodation</td>
<td>1,139,847</td>
</tr>
<tr>
<td>State Grant - Justice</td>
<td>10,325</td>
</tr>
<tr>
<td>Local Grant - Council</td>
<td>500</td>
</tr>
<tr>
<td>Rolled Over Income Recognition</td>
<td>256,491</td>
</tr>
<tr>
<td>Other Fees</td>
<td>7,370</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>1,414,532</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Expenditure</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Services Subcontractor Fees</td>
<td>401,734</td>
</tr>
<tr>
<td>Wage / Salary</td>
<td>297,189</td>
</tr>
<tr>
<td>Running Costs</td>
<td>267,459</td>
</tr>
<tr>
<td>Client Clothing, Food &amp; Other Expenses</td>
<td>440,280</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>1,406,662</strong></td>
</tr>
</tbody>
</table>

Source: Mission Australia Housing Annual Financial Statements

7.1.3 Average cost per tenant

The cost components of CCG and other comparison programs combine a mix of affordable accommodation, and a range of integrated support services. Additionally, for common ground models, building cost of capital invested is also a cost element. Where data is available the approach estimates each cost element of the average cost per tenant or program participant, for comparison with relative model components.

As described in the methodology in section 3.6, the average cost estimates combine flat allocation of costs for building and tenancy management across the 104 units, as well as estimated allocation ranges for support services provided to each tenant subgroup of long-term homeless, social and affordable housing residents.

The estimated average cost per tenant is based on allocating all reported building and tenancy maintenance costs for the study period across the fully utilized building capacity of 104 units. This approach assumes full tenancy of all units during 2013-14 in line with the sustained high tenancy developed during the establishment phase. It is noted that the process of moving in for long-term homeless tenants extended over several months following CCG commencement in Nov 2011. Periods of vacancy of any units would naturally be reflected in slightly higher average costs per tenant given that property and maintenance costs are predominantly fixed.

The average cost of support services is presented as an indicative estimate due to the high level aggregate cost and support service data. The aggregate figures may mask the levels of variation across each support service type and for each tenant group. The monthly reports confirm that all long-term clients receive support services, as do most social housing tenants, while very few of the affordable housing group access any support.14 A summary of average cost figures is provided in Table 7.3.

The upper limiting estimate is derived from the total service costs across the average 64.1 residents that received support during 2013-14: an estimated average cost of $21,994. It is highly likely that this figure overstates the support component average cost per tenant, given that some onsite services are also provided to neighbours in the broader community, including residents of Johanna O’Dea public housing next door, as

14 The 51.6 figure for long-term housing is an annual average of tenants receiving services in each month with gaps assumed to result from exits and new tenant entries.
shown in Figure 5.4. However, the relatively high number of neighbours accessing a small number of services suggests the majority of contacts are minor and for this reason, it is not possible to isolate the non-resident cost proportion. Given the data limitations, the estimated average cost of support service figure is presented as an upper limit. A reduced support service scenario of 25 percent lower per annum is provided for reference in the estimated cost effectiveness, to represent the plausible (but unverified) case where service levels will reduce following initial support intensive stabilisation phases.

### Table 7.3: Camperdown Common Ground average cost per client 2013-14

<table>
<thead>
<tr>
<th></th>
<th>Building and tenant management</th>
<th>Support services (CSS)</th>
<th>Total CCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program grant income</td>
<td>491,118</td>
<td>1,414,532</td>
<td>1,905,650</td>
</tr>
<tr>
<td>Rental income</td>
<td>932,652</td>
<td>0</td>
<td>932,652</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td><strong>1,423,770</strong></td>
<td><strong>1,414,532</strong></td>
<td><strong>2,838,302</strong></td>
</tr>
<tr>
<td>Expenditure</td>
<td>1,406,704</td>
<td>1,406,662</td>
<td>2,813,366</td>
</tr>
</tbody>
</table>

#### Tenants

<table>
<thead>
<tr>
<th></th>
<th>52</th>
<th>51.6</th>
<th>52</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term Homeless</td>
<td>52</td>
<td>51.6</td>
<td>52</td>
</tr>
<tr>
<td>Social Housing</td>
<td>10</td>
<td>8.7</td>
<td>10</td>
</tr>
<tr>
<td>Affordable Housing</td>
<td>42</td>
<td>3.8</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total clients</strong></td>
<td><strong>104</strong></td>
<td><strong>64.1</strong></td>
<td><strong>104</strong></td>
</tr>
</tbody>
</table>

| **Average cost per tenant** | 13,526 | 21,994 |

Source: Mission Australia Housing Annual Financial Statements and monthly performance reports

Notes:

Support service hours shown to 1 decimal place as a calculated average over 12 months.

Building and tenant management expenditure includes $3,166 per tenant concierge and 24-hour security cost ($329,280 / 104 units).

The estimated average cost per tenant also implicitly includes the average cost of capital of $25,384 per person, based on the 2013-14 building valuation of $33 million and a discount rate of 8 percent. This component is also incorporated into the cost-effectiveness estimates in section 7.3.

#### 7.1.4 Whole of government savings

Australian and international research into the cost-effectiveness of homelessness programs provides evidence of potentially significant cost offsets resulting from models targeted toward long-term homelessness. The primary cost offsets are associated with healthcare costs, which establish the disproportionally high health system service usage by long-term homeless individuals compared with the general population. The cost saving results from initial phases of diagnoses and stabilisation on a range of inadequately treated long-term conditions, as well as a gradual transition to the use of mainstream and preventative health services, compared to crisis and emergency response and often extended hospital based care once conditions have progressed.

As outlined in the methodology section, there is significant variation in estimated cost offsets reflecting the uncertainty in longer term health outcomes and the corresponding levels of service usage. Cost
offset estimates of several thousand dollars per year may result from a reduction in hospital or psychiatric admissions of several days per year which depending on level of care may be in the order of $1,000 per night. Similar cost offset levels may result for some individuals due to reduced nights in custody.

In this context, cost offsets in the order of $20,000 may potentially reflect, for example, an avoided 15 nights in hospital, combined with reduced drug and alcohol program usage, avoided emergency department attendance or psychologist consultations, with further potential cost savings, plausibly as high as $10,000 in the case of, again by way of example, 20 nights in prison or remand facilities are reduced.

However, given the small sample size and other limitations of this evaluation, as well as relatively small sample sizes in previous cost offset studies, and the corresponding high uncertainty in actual outcomes, there is insufficient basis to confidently estimate actual cost offsets for CCG residents. Consistent with the conservative approach of this evaluation, these potential cost offsets are not explicitly presented in the program cost-effectiveness figures.

Confirming the potential for this type of cost offset, examples are reported in estimates from the MISHA Project (Conroy et al., 2014), provided in program comparisons in section 7.3, which indicates a characteristically low healthcare offset of $1,178 in the first year as health conditions are stabilised, followed by increased estimated savings of $6,567 in the second and ongoing years where stable housing is maintained.

### 7.2 Cost effectiveness

The estimated program cost-effectiveness in broad terms reflects the number of formerly long-term homeless that have transitioned to stable long term accommodation, aligned with the establishment and recurring costs of achieving this outcome.

This estimate is sensitive to a range of factors given the dependence on aggregate cost and service use data, the relatively small sample size, as well as the treatment of program establishment costs and initial program development.

Additional factors that may influence the cost-effectiveness include:

- the short time frame between announcing successful service providers and the establishment of support services;
- the relative importance of CCG model components, differentiating it from other community housing buildings, for example the provision of higher levels of safety and security to protect vulnerable tenants. The comparison of these types of additional costs are in context of the contribution to outcomes, and the degree to which particularly vulnerable tenants may not be able to transition without these supplementary support elements, as under alternative program models; and
- the extent to which broader objectives, such as a sustainable social mix, are achieved. This objective is another key element of CCG that not only has implications for tenant wellbeing, but potential contributions to model success in reducing the risk of an institutional environment and building an integrated community environment.

In context of these factors, program implementation and timing, as well as variation in tenant baseline characteristics, the estimated average cost per client figures are presented as indicative ranges for high level comparison with alternative homelessness responses.

The estimated average cost per long-term homeless tenant is in the order of $60,000 per annum, including building and tenant maintenance, building security, the cost of capital invested in the property as well as the range of support services. When including tenant rental payments, the estimated average cost per tenant is approximately $51,000 per annum.

The estimated average cost per tenant is in the higher range of annual cost for alternative homeless programs in
absolute terms, although direct comparisons reflect a range of factors including variation in client needs, service models, and the relatively high cost of property in central Sydney.

The overall program cost is comprised of an affordable accommodation component which is generally constant over time. Separately, the estimated average cost of support services of around $22,000 per year is considered a conservatively high estimate because it is assumed that tenants would continue to require high levels of support beyond the initial stabilisation phase. In this context estimated support costs may reduce over time.

From the NSW government’s perspective, a substantial proportion of CCG program funding is sourced through Commonwealth government grants, support benefits and rental assistance, while the benefits are provided directly to Sydney people who are homeless. This represents a proportionally low funding to outcome ratio, with potential additional cost offsets cumulatively extending into the longer term in the case that stable housing and resulting health benefits are achieved and sustained.

7.3 Comparison with other programs

To compare the economic costs and benefits of CCG, we reviewed evaluations of similar programs that included an economic evaluation component. These evaluations had varying levels of economic content. The following summary presents the key components as a basis of positioning the CCG model in context of alternative models, the relative target groups, and aligned with the estimated program costs, outcomes and cost offsets, where available, of each program.

The included program evaluations are outlined in this section and summarised below in Table 7.4. All information on the programs comes from the following published evaluation reports:

- The Michael Project (Mission Australia, 2012)
- The MISHA Project - Michael Project extension (Conroy et al., 2014)
- Micah Projects – Breaking Social Isolation: A housing first approach to homelessness (includes reference to Brisbane Common Ground) (Mason and Grimbeek, 2013)
- Meeting the challenge J2SI (Sacred Heart Mission) (Guy Johnson et al., 2012)
- The Rooming House Plus Project (RHPP) (Elgood et al., 2009)

Comparisons of estimated costs and effectiveness between programs are presented as indicative first available figures for CCG and best available for comparative programs. This is for the following reasons:

- the lack of statistically significant quantitative results;
- the related lack of estimated confidence intervals;
- the inherent uncertainty in comparability given variation in sub-population baseline characteristics, including socio-demographic factors, length of time homeless, mental health diagnoses, and fit with various support models.

The Michael Project

The project commenced in 2007 and has informed and merged into a follow-on stage of the project, MISHA. The Michael Project was a three-year Mission Australia initiative that aimed to help homeless men in Sydney to improve their lives. The service model is significantly different from Common Ground as is the client group being men only. The findings from the evaluation are nevertheless relevant because they illustrate the life histories and circumstances of people experiencing long-term homelessness and the potential benefits of permanent housing and intensive support.

The Michael model is based on three elements: temporary accommodation (typically up to three months) or outreach support, case management and access to a range of specialist support services. It is delivered from within the existing accommodation support system through community collaboration. The project aims to assist
better utilization of available accommodation, separate from programs that incorporate increased housing capacity.

The evaluation indicates that the men achieved a number of positive outcomes across housing, employment, income and social engagement. The study establishes evidence of reduced service usage across physical and mental health systems, estimated at $8,222 per client over one year, which includes a shift from crisis type services to more mainstream community based care.

The study indicates that the cost savings to government in health and justice programs alone are sufficient to cover the cost of service delivery.

A high proportion (57%) of clients indicated longstanding physical health conditions including musculoskeletal, vision and neurological problems, as well as high proportions of mental health conditions including mood, anxiety and substance use disorders.

Findings are consistent with other studies indicating a high rate of health issues at 12-month follow-up, partly due to the chronic nature of many conditions identified on entry, as well as recent prevalence comparison against lifetime prevalence on entry. A similarly consistent finding is that the chronic homeless cohort uses a significantly higher level of health and justice services than the general public. In this context, programs that assist in reducing these levels of access to general population levels generate a significant cost offset to government agencies, with the potential to offset costs of running homelessness support programs several times over where stabilized health and justice outcomes are sustained in the longer term.

Of relevance to the CCG program, the Michael Project indicates that the relative proportion of health and justice offsets are higher for those receiving short- and medium-term accommodation services, with offsets estimated to be higher than the cost of the program. For clients receiving based outreach and emergency accommodation, there was a reduction in health and justice services, but at a lower level and did not entirely offset program costs. This suggests the important role of stable accommodation in achieving health and justice outcomes, which is of relevance to the CCG chronic homeless clients and supports the potential cost offsets for this group at CCG.

The study is also consistent with a stabilizing phase of health services with an initial increase in the first 12 months in usage of GP, specialist and allied health consultations as well as accessing mainstream and preventative health services. During the same period, there was a decrease in emergency and acute services, including ambulance, nights in hospital and mental health facilities, and a substantial reduction in the number of nights in drug and alcohol rehabilitation. These results were achieved with a maximum accommodation support of 3 months.

The Michael Project evaluation underlines the objective of targeting the individuals who are most likely to achieve positive outcomes while acknowledging, as with any complex program intervention, that the program worked better for some individuals than others. With this in mind, the model indicates strong outcomes for the target group of men who were in short- and medium-term accommodation. However, outcomes were less strong for cases where accommodation was not part of the model, which included those who were sleeping rough or in crisis accommodation. Again, this supports the importance of stable appropriate accommodation as a foundation for engagement and effective utilization of support services, with a transition in lifestyle that may have been entrenched for many years. The additional cost of inclusion of an affordable accommodation component is in this context offset by a larger component of service use savings.

This identified importance of including accommodation in program support for chronic homeless men has helped shape the following phase of the Michael project, the MISHA program, as described in the following section.

The economic evaluation found that the total average cost per client per year was $8,664. The Michael Project is not included in Table 7.4 because of the limited comparability with CCG.

**MISHA (Michael’s Intensive Supported Housing Accord)**
The MISHA program is a housing first scattered site model leased via social housing providers and MISHA support and linked to community programs in the Parramatta area of Sydney. This intensive program is targeted at men aged 25 or older who are eligible for social housing in New South Wales, have an income, or are eligible for income support, are willing to pay rent on time, and are willing to meet MISHA staff on a regular basis. The service model is different from CCG and the client group was also different: the target group for MISHA was men who had been continuously homeless for at least 12 months, and around one-third of the follow-up participants were sleeping rough immediately prior to entry to MISHA. In contrast, all Common Ground clients were sleeping rough prior to entry to the program. The evaluation findings are presented here to illustrate the potential effects of accommodation and support on health and other outcomes for people who have experienced long-term homelessness.

The main aim of the research project was to evaluate client outcomes and the direct economic benefits of the program to government and wider society, to contribute to the evidence base informing policy across housing and homelessness programs. A particular aim was to assess the program’s effectiveness of sustaining tenancies, and the related estimated cost-effectiveness of the model.

The evaluation used a mixed methods approach, including quantitative and qualitative components. This included analysis of a longitudinal client survey at five time points over two years. The baseline sample included 75 clients on entry, with the final follow-up of 59 clients after 24 months. The economic component examined the cost to government of services used by MISHA participants and the change in associated costs over time. It also examined cost offsets through decreases in the cost of mainstream services used by participants.

Key findings:

- The majority of participants sustained tenancies for the entire two-year study period with retention rates around 90%.
- Mental health of participants was poor at entry to the program and below population general estimates and these levels did not improve significantly during the program.
- Results were mixed for social participation. There was an improvement in physical environment and satisfaction with social relationships, although self-assessed quality of life did not improve over the time period.
- Incomes and employment of the follow-up group improved over the two years, with a reduction in the number of unemployed, and an increase of those employed from 10% to 15% after 24 months.
- The recurrent cost of MISHA support is estimated at $27,914 per client, for an average support period of 2.04 years, which equates to approximately $14,000 per year.
- The net cost is $9,260 per client per year, including the cost of health, justice and welfare offsets.
- Overall, the cost of mainstream health, justice and welfare services reduced from $32,254 per client in the baseline period, to $24,251 at the end of 24 months. This is reported as a saving to the state of $8,002 per participant per year.
- A range of additional potential cost offsets include reduced evictions and use of crisis and emergency accommodation services following transition to stable housing. Sensitivity analysis showed that if these cost offsets are sustained over five years, including from tenancy failures avoided ($2,400 per client) and reduced use of crisis and emergency accommodation ($6,427 per client), the net recurrent costs of support would be reduced to $9,865 per client, that is $4,836 per client per year, and the program would be cost neutral just under three years after support commences.
- The evaluation found that if a similar program were to be implemented by the government, the cost of support, when cost offsets have been included against mainstream services, would be comparatively low. In the short- and medium-term, it is likely that the program will be at least cost neutral, and if cost offsets are sustained create significant long-term whole of government savings.
A housing First approach to homelessness in Brisbane (MICAH Projects)

The MICAH projects program in Brisbane is a housing first approach, underlining the provision of housing as a core priority, as opposed to temporary support through a range of transitional short-term accommodation, consistent with the CCG approach. The report presents a preliminary comparison of a group of rough sleepers in scattered site housing, with the newly established single site Brisbane Common Ground model over an 18-month period. The initial study is based on a small sample of 12 formerly homeless individuals, reduced to 7 in the follow-up group.

The preliminary outcomes are consistent with service system average costs increasing in initial stabilising phases and then declining in subsequent years, potentially on a sustained longer term basis. The evaluation considers the cost-effectiveness of the housing first approach as a long-term response to homelessness and presents initial indications that housing people, including the costs of support services, may be lower than a person remaining homeless. There are insufficient cost details in this preliminary evaluation to establish estimated average cost estimates.

Journey to Social Inclusion (J2SI)

The J2SI report underlines the context that Australia’s homelessness programs have previously tended to focus on crisis and relatively short-term interventions. The study is a Randomised Control Trial (RCT), comparing the J2SI support model with a randomized control group supported under existing services.

The model provides long-term support services for up to 3 years, including a focus on rapid housing of participants into safe, affordable long-term housing. Support services include an emphasis on mental health, as well as developing skills supporting self-esteem and other interpersonal, practical, tenancy management and vocational skills. The evaluation is being reported in a series of annual updates with the endpoint objective to identify longitudinal trajectories for clients. Virtually all tenants had chronic mental and physical health problems as well as problematic alcohol and other drug use. The program at 24 months reports positive outcomes for improved housing as well as reduced levels of service usage, and a high proportion had achieved sustained housing (86%).

The economic evaluation approach is a cost benefit analysis (CBA) which relies on complex assumptions to estimate all program outcomes in monetary terms. All other comparison projects have used a cost-effectiveness analysis (CEA) which has implications for comparison.

The program reports reduced numbers of presentation to emergency departments as well as reduced lengths of stay for hospital and psychiatric unit admissions. There are increased numbers of clients actively looking for employment, although from a small initial sample who were in the work force. The project underlines the process of reconnecting and being accepted in the community as a core element of the transition from homelessness, which is often an extended process. The transition from chronic homelessness is noted to be possible with suitable support services, in context of realistic expectations of the timeframe and challenges this may present.

The CBA reports positive benefit-cost ratios indicating positive program outcomes. It also demonstrates that the higher levels of investment required to establish the program and stabilise clients provide a significant return in longer term benefits. The time horizon suggests that costs remain above the levels of estimated benefits in the initial two years, but turn to potentially significantly positive outcomes in the order of a saving of 2 dollars for every dollar invested over an estimated 10-year timeframe. Sensitivity analyses indicate that scenarios of high attrition would potentially reduce the level of return, but that the program is highly likely to remain positive in the longer term, in the range of $1.50 per dollar invested.

The report underlines caveats to estimating costs for homelessness programs and related offsets in terms of hospital, psychiatric and justice services, particularly when based on intensive initial support, combined with annualising assumptions that may not hold where accommodation is not sustained. These caveats relate to potential limitations in comparative homelessness program figures including non-housing first models, variation of approaches in economic evaluations and the lack of RCT designs.
The Rooming House Plus Project (RHPP)

The program commenced in Melbourne in 2009 and provides residents with both tenancy and onsite support services with the aim of giving the 64 tenants a supportive home-like environment. Similar to CCG, tenancy management and support services are split between two separate lead agencies.

The evaluation includes financial information from the building and tenancy management as well as support services. The key findings include long-term tenancies being sustained and improved ongoing health outcomes for tenants. The study indicates preliminary evidence of viability of the model, but recommends further economic analysis to validate results, given the data limitations and scope of resident scenarios in the initial project. The estimated average cost per resident in 2008-09 is $10,900 for building and tenant management, and $9,375 for support services.

Additional preliminary evaluations

The review of alternative programs also included evaluations where preliminary economic content was insufficient to establish comparative cost-effectiveness estimates.

Common Ground Tasmania (CGT)

The report from the evaluation of Common Ground Tasmania (Verdouw et al., 2014) presents findings of the development and operation of CGT, including service establishment and evolving service arrangements. It analyses service provision, focusing primarily on supported tenants and includes service levels, client demographics, client presenting circumstances, services provided, and indicative costs of the service.

The report outlines establishment funding, similar to CCG, through Commonwealth and Tasmanian State sources. The Common Ground Tasmania (CGT) program was established in 2008 and incorporates the management of two accommodation sites with supporting services of tenancy management, security/concierge and support services to tenants.

It is noted that as for other Common Ground organisations, the establishment of the service was made possible through collaboration between State, Federal, and Local governments, and the private and philanthropic sectors. This included State and Federal funding for all CGT building capital expenditure, including cash reserves of $474,969 during 2011-12, to assist with initial operation. The State government also assisted in meeting the costs of the first year of operation.

Funding for the design and construction of the two buildings was through the Commonwealth Government homelessness and economic stimulus programs, including Barrack Street ($9.4 million, 47 units) and Campbell Street ($17.5 million, 50 units). There were also implementation funding sources including one-off operational costs and support for 2011-12 of $250,000, and Vacancy Compensation Funding for 12 months post commencement of $200,000. The ongoing support services are indicated to receive indexed operational block funding of $500,000 per annum to supported tenants at both sites. CGT also receives revenue through tenancy rents and income from car-park leases.

Tenants were still being assessed and moving into the sites at the time of the Tasmanian evaluation and there were still vacancies reported. For this reason, the preliminary costs are not based on full capacity or an initial period of support levels and correspondingly, it is not possible to assess individual service usage for a full year, or estimate associated average costs per client of support or accommodation. Nevertheless, based on the indicative recurrent service funding of $500,000 for the combined total 97 units at both sites, this suggests potential average support costs in the order of $5,000 per client.
Economic evaluation of the Homeless to Home Healthcare After-Hours Service

This study (Connelly, 2013) presents an economic evaluation of the Homeless to Home Healthcare After-Hours Service, a nurse-led outreach and healthcare support service integrated within a broader housing first model in the Brisbane metropolitan area.

The report underlines established Australian and international research into the high proportion of health services used by homeless and vulnerably housed people, and the effectiveness of support programs for this group. The service provided support to 110 individuals of a wider 227 people who have made the transition from homelessness to being housed, and examines the service usage and quality of life of this subgroup. The analysis estimates cost savings in terms of reduced hospital admissions and emergency department presentations as well as health related quality of life improvements.

As an outreach service, the aspects of accommodation and wider support services are not a part of the model. The program is, however, consistent with positive health sector service usage reductions resulting from support of the long-term homeless.

Table 7.4: Camperdown Common Ground comparison with other programs

<table>
<thead>
<tr>
<th></th>
<th>Camperdown Common Ground (CCG)</th>
<th>Rooming House Plus Project (RHPP)</th>
<th>MISHA Project</th>
<th>Journey to Social Inclusion (J2SI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program model</td>
<td>Housing first Common Ground</td>
<td>Housing first Scattered site</td>
<td>Support services to housing first model</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td>Sydney Camperdown</td>
<td>Melbourne</td>
<td>Sydney Parramatta</td>
<td>Melbourne</td>
</tr>
<tr>
<td>Year commenced</td>
<td>2011</td>
<td>2005</td>
<td>2010</td>
<td>2009</td>
</tr>
<tr>
<td>Long-term homeless (sample at follow-up)</td>
<td>52 (n=75)</td>
<td>29 (supported) (n=59)</td>
<td>n=40</td>
<td></td>
</tr>
<tr>
<td>Economic evaluation method</td>
<td>CEA</td>
<td>CEA</td>
<td>CEA</td>
<td>CBA</td>
</tr>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age range</td>
<td>21-74</td>
<td>Generally 24 to 64</td>
<td>&gt;25</td>
<td>N/A</td>
</tr>
<tr>
<td>Percent male</td>
<td>79%</td>
<td>75%</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Estimated average annual cost per tenant</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Development and capital cost of building</td>
<td>$33,000,000 (104 units)</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td>Annual cost of capital</td>
<td>$25,384</td>
<td>N/A</td>
<td>$16,524</td>
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<td>Property and tenancy maintenance</td>
<td>$10,360</td>
<td>$12,012</td>
<td>$9,048</td>
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<tr>
<td>Concierge &amp; security</td>
<td>$3,166</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Average cost of support services per tenant</td>
<td>$21,994</td>
<td>$10,331</td>
<td>$14,420</td>
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</tr>
<tr>
<td>Total average cost per client per year</td>
<td>$60,904</td>
<td>$22,343</td>
<td>$39,992</td>
<td>$54,165</td>
</tr>
</tbody>
</table>


Based on the estimated average costs per tenant the CCG base case is presented in Figure 7.2. The affordable accommodation component is shown as the combined bars including the estimated average building and tenant management cost (medium blue) and the estimated cost of capital (light blue). The cost of capital naturally reflects the relatively high cost of property in central Sydney. These costs are considered generally constant over time with an annual increase reflected through indexing at an assumed 5 per cent per annum.

The support services are presented separately (dark blue bar) to illustrate the broad estimated average cost per tenant per year. The average cost of CCG support services of around $22,000 per year is considered a conservatively high estimate, as presented in section 7.1. In addition to this figure potentially being overestimated in the base year, it is also plausible that this level of support would reduce following stabilisation and transition to stable tenancy. In the case that tenants do not continue to require initial high levels of support as during the initial stabilisation phase, support costs will reduce over time, reflected by the scenario of a 25 percent reduction year on year (dotted line).
Figure 7.2: Camperdown Common Ground cost effectiveness scenarios

Source: Mission Australia Housing Annual Financial Statements

Rental income is also considered to be relatively constant over time with similar annual indexing, and assuming that rental arrears are well managed.
7.4 Summary of key points

- The economic analysis presents the first available figures for CCG assessing total costs in context of program benefits and in comparison with other responses to homelessness across Australia.

- In line with the overarching evaluation design, the economic analysis includes inherent study limitations due to the relatively small sample sizes, the complexity in client baseline characteristics and variation in the various homelessness program models. For this reason the figures are presented as indicative estimates based on the available cost and support service data.

Program cost and estimated average cost per tenant

- The total program cost for the 2013-14 financial year was $2.81 million, which comprised of relatively equal cost components of $1.4 million for building and tenant maintenance and $1.4 million for resident support services.

- This represents an estimated average cost per tenant of $13,526 per annum for the affordable accommodation component, and $21,994 per supported tenant per annum for support services. The majority of support services, an estimated 80 per cent, were provided to long-term homeless residents.

- Additionally, the estimated cost of capital invested in the CCG building is estimated at $25,384 per unit per annum, reflecting the relatively high cost of property in central Sydney.

- Combining these components the estimated total average cost per resident is $38,910 for affordable housing residents, and $60,904 for long term homeless residents including support services and cost of capital.

- These costs are partially offset by resident rental payments estimated at $8,968 per tenant, with initial high levels of rental arrears which later improved with proactive monitoring and management.

- Additionally there are potentially cost offsets resulting from changes in service usage, for example as a result of residents’ improved mental and physical health or reduced contact with criminal justice services. Previous research indicates potentially significant cost offsets associated with homelessness programs as a result of these types of service use changes. However, estimated individual costs are highly variable and given the small study group, these costs are not able to be specifically calculated for individual tenants residing in CCG. For this reason, while these types of cost offsets present additional plausible cost savings, consistent with the conservative approach of this evaluation, these potential cost offsets are not explicitly presented in the program cost-effectiveness figures.

Program benefits

- The primary outcome focuses on transitioning long-term homeless clients to stable and sustainable long-term accommodation in line with Commonwealth and NSW government homelessness strategy frameworks. In broad terms, this is reflected in the CCG tenancy retention rate of 63 per cent over the study period, with the effective success rate potentially higher as the figure includes both evictions, of which there were 2 reported cases, as well as planned exits to more suitable accommodation, for example residential aged care.

- The program benefits incorporate the range of positive resident outcomes as outlined above, which are implicit in the program effectiveness and cost-effectiveness. These include improvements across physical and mental health conditions, symptoms of psychological distress as well as measures of quality of life.
The CCG program targets a highly complex client group of long-term homeless, many with mental and physical health as well as drug and alcohol related conditions.

The estimated average cost per long-term homeless tenant is in the order of $60,000 per annum, including building and tenant maintenance, building security, the cost of capital invested in the property, as well as the range of support services.

When including tenant rental payments the estimated average cost per tenant is approximately $51,000 per annum.

The estimated CCG average cost per tenant is in the higher range of annual cost for alternative homeless programs in absolute terms, although direct comparisons reflect a range of factors including variation in respective client complexity, characteristics of each comparative homelessness program model as well as the relatively high cost of property in central Sydney.

The overall program cost is comprised of an affordable accommodation component which is generally constant over time. Separately, the estimated average cost of support services of around $22,000 per year is considered a conservatively high estimate because it is assumed that tenants would continue to require the same high levels of support as during the initial stabilisation phase. In this context, estimated support costs may reduce over time.

From the NSW government’s perspective, a substantial proportion of CCG program funding is sourced through Commonwealth government grants, support benefits and rental assistance, while the benefits are provided directly to the homeless in Sydney. This represents a proportionally low funding to outcome ratio, with potential additional cost offsets cumulatively extending into the longer term in the case that stable housing and resulting health benefits are achieved and sustained in the longer term.
This report presents the findings from the evaluation of Camperdown Common Ground. The evaluation found that Common Ground provided secure housing to its target group and that there had been some positive changes in other areas of formerly homeless tenants’ lives. However, the evaluation also identifies a number of challenges that will require further work and ongoing monitoring.

The findings rely on two rounds of data collection, undertaken after approximately 16 and 28 months of operation. These findings focus on the outcomes for formerly homeless tenants, the structure and process of service delivery, and the costs and benefits of the project.

### 8.1 Structure and process of service delivery

Most stakeholders interviewed for the evaluation felt that MA Housing had met its objectives during the implementation of the Project, and that it had been implemented in a timely way. Selection and contracting of the ICC as service provider occurred late in the establishment process, but the Coalition moved quickly to establish services.

There was agreement among stakeholders that the reporting structure at CCG is multi-layered and complex. The key areas of concern and disagreement about the structure were: the decision to make one housing organisation the key contract manager for the entirety of the model, the complexity around the selection of a consortium of organisations to provide support to tenants, and the infrequency of advisory group meetings.

Steps have been taken to improve partnerships between ICC and MA Housing, particularly regarding tenancy issues. There is an ongoing need to clarify roles and responsibilities between these two partners in order to coordinate and increase the effectiveness of their work while maintaining the separation of housing and support.

Case management services have improved since the Project’s implementation to become more consistent and to focus support on planned case management rather than responding to crises. Participation in case management is voluntary. Between April 2014 and March 2014, 63 of the 76 formerly homeless tenants have participated in some level of case management. Although case management is not specifically funded for social and affordable housing clients, CSS has provided support to some of these tenants who have histories of homelessness and other issues.

The building location and design include many positive features; however, some negatives were identified, in particular the design and location of the support provider offices. At the time of the 2014 stakeholder interviews, planning was underway to rectify this.
8.2 Outcomes for formerly homeless tenants

Common Ground was successful in providing secure, permanent housing to its target group of vulnerable people who had experienced chronic homelessness. At March 2014, there had been a 63% retention rate among the formerly homeless tenants over 28 months. The vast majority (84%) of those who completed the client survey reported being satisfied or very satisfied with their housing. Many tenants had, however, built up high levels of rent arrears before action was taken.

Stakeholders stressed that because of the long-term homelessness, disadvantage, disabilities and health problems of the formerly homeless tenant group, change and improvement in other life areas would be slow. However, the vast majority of participants reported noticing changes in their lives since working with CCG at both baseline (96%) and follow-up (87%).

Similar to baseline results, the majority of survey participants reported that the services provided to them had been useful. Program data indicates that 63 of 76 (83%) of formerly homeless tenants engaged in case management while 100% of survey participants engaged in case management. There was a marked increase in the proportion of participants who knew they had a case plan in place from baseline to follow-up (39% to 61%).

Treatment rates were lower for most physical and mental health conditions at follow-up compared to baseline. Symptoms of psychological distress were lower at follow-up than baseline across all nine primary symptom dimensions. Service utilisation rates of ED and overnight hospital admissions for physical health reasons remained mostly stable across time. At follow-up, a smaller proportion of the sample had been admitted to a hospital overnight for a mental health reason, and for those who were admitted, they reported shorter stays than the baseline sample. There were reductions at follow-up in the proportion of participants who attended a drug and alcohol treatment facility and who had been treated by the ambulance service. The majority of participants reported that they had consulted their GP in the past year at both time points, and the frequency of GP consultations remained stable over the two time points. In general, the proportion of participants reporting use of opioids and amphetamines reduced at follow-up; however, the frequency at which substances were being used was mixed.

The majority of participants (96%) remained unemployed at follow-up, and the proportion of participants who considered themselves unable to start work in the week prior to the survey due to long-term illness or disability remained stable between baseline and follow-up (62% respectively). Almost all participants were in receipt of some form of government benefit at baseline and follow-up (96% respectively). The proportion on Disability Support Pension reduced from baseline to follow-up (69% to 58%); however, the proportion on Newstart increased across the two time points (23% to 35%).

The mean scores measuring quality of life improved across all domains except for environment from baseline and follow-up; however, they remained lower on all four domains compared to a comparative community sample. At follow-up, a higher proportion of participants reported that they had $500 saved for emergencies, a car and a hobby for their children compared to baseline. There was also a notable increase in the proportion who had consumed a substantial meal each day. However, the proportion of participants who had dental treatment when required declined from baseline to follow-up. Overall, participants appeared to be experiencing less social isolation at follow-up.
8.3 Costs and benefits

The economic analysis presents the first available figures for CCG assessing total costs in context of program benefits and in comparison with other responses to homelessness across Australia. Consistent with the overarching evaluation design, the economic analysis includes inherent study limitations due to the relatively small sample sizes, the complexity in client baseline characteristics and variation in the various homelessness program models. For this reason, the figures are presented as indicative estimates based on the available cost and support service data.

The total program cost for the 2013-14 financial year was $2.81 million, which comprised of relatively equal cost components of $1.4 million for building and tenant maintenance costs and $1.4 million for support services. This represents an estimated average cost per tenant of $13,526 per annum for the affordable accommodation component, and $21,994 per tenant per annum for support services. The support service estimated average cost is considered a conservatively high estimate which is expected to decline from high levels of initial support during the transition and stabilisation phase. In this context, estimated support costs are expected to reduce over time, potentially significantly.

Additionally, the estimated cost of capital invested in the CCG building is estimated at $25,384 per unit per annum, which reflects the relatively high cost of property in central Sydney. Combining these components, the estimated total average cost per resident is $38,910 for affordable housing residents and $60,904 for long-term homeless residents, including support services and cost of capital.

These total average costs are partially offset by resident rental payments estimated at $8,968 per tenant, with initial high levels of rental arrears reported to be improving with proactive monitoring and management.

There are also additional potential cost offsets to other NSW government departments resulting from changes in service usage, for example as a result of residents’ improved mental and physical health or reduced contact with criminal justice services. Previous research indicates homelessness programs may result in potentially significant cost offsets as a result of these types of service use changes. These types of cost savings are plausible in the case of CCG considering the program targets a highly complex client group of long-term homeless, many with mental and physical health as well as drug and alcohol related conditions. However, these types of service usage pathways are characterised by highly variable estimated individual costs and, given the small study group, these figures are not able to be specifically calculated for individual tenants residing in CCG.

For this reason, consistent with the conservative approach of this evaluation, these potential cost offsets are not explicitly presented in the program cost-effectiveness figures.

In addition to rental offsets and further potential cost offsets to NSW government agencies, the evaluation has identified a range of CCG tenant outcomes that are implicit in the program effectiveness and cost-effectiveness. These include improvements in physical and mental health conditions, symptoms of psychological distress and measures of quality of life as well as further potentially significant components outside the evaluation specification such as return to education, training and employment.

The estimated CCG average cost per tenant is in the higher range of annual cost for alternative homelessness programs in absolute terms, although direct comparisons reflect a range of factors including variation in respective client complexity, characteristics of each comparative homelessness program model as well as the relatively high cost of property in central Sydney.

The overall program cost is comprised of an affordable accommodation component which is relatively stable over time. Separately, the estimated average cost of support services of around $22,000 per year is considered a conservatively high estimate as it assumes that tenants would continue to require similar high levels of support after the initial stabilisation phase. In this context, estimated support costs may reduce over time.
From the NSW government’s perspective, a substantial proportion of CCG program funding is sourced through Commonwealth government grants, support benefits and rental assistance, while the benefits are provided directly to the homeless in Sydney. This represents a proportionally low funding to outcome ratio, with potential further cost offsets cumulatively extending into the longer term in the case that stable housing and resulting health benefits are achieved and sustained.

8.4 Key issues or gaps

Tenancy issues: rental arrears and property care

During the period of Common Ground’s operation up to April 2014, many formerly homeless tenants and some social and affordable housing tenants had built up high levels of rental arrears before action was taken by tenancy managers and support workers. Stakeholders said that steps had been taken in 2014 to improve coordination between these two providers with the aim of better detecting and responding to arrears as well as other tenancy issues such as cleaning and pest control in apartments.

Mix of tenants and financial sustainability of the model

Stakeholders held different opinions about the optimal balance between formerly homeless tenants and other tenants in Common Ground. A substantial number of Common Ground service providers expressed concern about the high level of complexity among formerly homeless tenants in the building, and suggested that the mix of tenants should be changed to reduce the proportion of those with very complex needs. These stakeholders felt that the resourcing for support services is currently inadequate for the number of tenants in the building whose needs are very high and complex.

Other stakeholders, including most of those involved in oversight and establishment roles, expressed concerns about reducing the proportion of those with complex needs. These stakeholders pointed out that the CCG model was funded and intended to assist the most vulnerable homeless people. These stakeholders believed that, while the government does want to address the needs of the most vulnerable, it is not in a position to fund an increased number of projects like CCG to enable each to contain lower numbers of high need people, and were of the view that it is not realistic, or in some cases, preferable to reduce the proportion of people with complex needs in the building.

The tension around the current levels of complexity and funding for support is further complicated by the fact that there is an expectation from the government that the intensity and type of support, and therefore the level of funding needed, will decrease and stabilise. In addition, FACS-HNSW intends the ICC to take on full responsibility for funding the case management support. Stakeholders involved in service provision felt strongly that the level of complexity cannot be sustained at the current level, let alone when responsibility for funding is transferred to the ICC. This may conflict with one of the original aims of the model, which was to target a specific group of the most vulnerable and high need long-term homeless people in the service system.

Managing risk when congregating tenants with multiple, complex needs

In 2014, stakeholders reported that while Common Ground was now more stable, there was still a high number of crises and incidents, including difficult behaviours, often associated with excessive drug and alcohol use. Service providers reported that they had not been able to provide planned case management as hoped because of the frequency of crises. Service providers, other stakeholders and tenants reported that at times, there had been a lack of continuity in staffing with vacancies sometimes being filled with changing relief staff.
Preventing institutionalisation

Some stakeholders have expressed concern about the risks of institutionalisation associated with congregating a high number of people with complex needs together in one location while providing onsite services.

Concerns included that the model may compound management problems and stigmatisation, a perception by some that the CCG building felt institutional, that the number and range of onsite services may not encourage people to engage with the broader community, and that people at Common Ground were expected to use many homeless-specific services and identified themselves as part of the homeless population, even though they were no longer homeless. Some formerly homeless tenants expressed concern that they were judged negatively by others as a result of living at Common Ground. A few interviewees expressed the opinion that scatter-site housing might work better to avoid institutionalisation.

Both formerly homeless and affordable housing tenants were of the view that rules or their implementation were sometimes heavy-handed or inappropriate. Issues raised focussed on details of building management and service provision, and whether staff were perceived as being respectful, responsive and consistent. The issues raised by tenants about service provision highlight the extent to which the decisions and attitudes of Common Ground staff impact on tenants’ lives and increase the risk of institutionalisation.

Access to mainstream services and higher support facilities

Support providers had initially expected greater involvement of mainstream services such as home care and the mental health Housing and Accommodation Support Initiative (HASI) to be available for high need tenants at Common Ground, but this has not been successful. The issue of how appropriate services can be delivered to this group at Common Ground requires resolution. For some formerly homeless tenants, high unmet support needs related to cognitive impairments and other disabilities have made living at Common Ground difficult, and in some cases meant they cannot safely live there. While some of these people have moved to higher support facilities such as aged care, not all are eligible, particularly those who are young. This was identified as a service gap.

8.5 Key areas for ongoing improvement

Clarifying optimum target groups for Common Ground and other models of supported housing

Stakeholders involved with CCG generally thought that scatter-site housing was preferable to the Common Ground model for most people. However, most also thought that both models were of value for different tenants, depending on several factors including whether they would find close social proximity of other tenants to be a positive or negative experience, whether they have serious health risks that require monitoring, and whether they require security because they find it difficult to keep predatory people out of their apartment. Further work is suggested to clarify optimum target groups for scatter-site and Common Ground models.

Governance

Differing views among stakeholders about the complex governance relationships within Common Ground signal that the governance of Common Ground is an area for ongoing monitoring. These relationships include those between MA housing and the ICC, between MA Housing and Mission Australia, and between the consortium that comprises the ICC. The role and effectiveness of the Common Ground Advisory Committee has also been the subject of concern and requires ongoing monitoring.
Overall support and tenancy management approaches that promote a recovery approach and avoid institutionalisation

Steps have already been taken that aim to improve the approach to case management. However, ongoing work is needed to ensure that strategies for: assertive case management, supporting formerly homeless people after they are housed; balancing crisis and planned support, ensuring greater consistency between case managers, supporting a recovery approach and preventing burnout are ongoing priorities for the support team at Common Ground.

The evidence indicates that there are two key issues at CCG that require further reflection in order to avoid institutionalisation and to provide the most appropriate support for the target group. The first is the approach to tenancy management and onsite service provision, which is one of the most challenging aspects of the Common Ground model. It was recognised early in the implementation of the project that there was some inconsistency between workers about how to support people appropriately in a residential environment. While there has been some upskilling of existing staff, more needs to be done to ensure that the tensions around providing onsite support within a residential environment are continually challenged and interrogated. Further training and supervision will help to equip staff to respect consumer choice while balancing tenancy management issues and enabling tenants to choose to participate and engage in support. Service providers have made a number of positive changes in this area, but stakeholders agree that this will continue to be an area requiring ongoing improvement.

Another key area of disagreement among stakeholders concerned what level and type of onsite service provision should be provided at CCG. A substantial number of stakeholders suggested that more services should be provided, such as extending the hours that the GP and mental health support are available, and that other services should be added. On the other hand, a small number of stakeholders felt strongly that the extensive provision of services was not consistent with the Common Ground model because the provision of onsite services had the potential to make the project less like a residence and more like an institution or crisis centre.

Better defined roles and responsibilities between tenancy management and support provision roles

There is an ongoing need for monitoring and improvement of coordination between tenancy management and support provision functions, involving strong communication while maintaining separation of tenancy and support roles. Examples of areas where further work is occurring and will continue to be required are the management of rental arrears and cleaning and pest control in apartments.

8.6 Critical success factors

Evaluation findings indicate that the following factors are essential to achieving good outcomes at Common Ground:

- Effective and clear governance;
- Resolving issues of complexity of target group and financial sustainability;
- Further work to clarify the optimum target groups for scatter-site and Common Ground models;
- Good coordination between housing and support providers;
- Case management and property management approaches that address risk, support a recovery approach and avoid institutionalisation;
Resolution of the issue of access by Common Ground tenants to mainstream services and access to higher support facilities for those from the Common Ground target group whose support needs cannot be met through the Common Ground service model.
9 Appendix A: Client health and substance use history (baseline survey)

9.1 Cognitive impairment

During the baseline survey, participants (formerly homeless tenants) were asked to complete the Montreal Cognitive Assessment (MoCA), which is a validated and reliable tool used for initial screenings of cognitive impairments. The MoCA assesses different cognitive domains: attention and concentration, executive functions, memory, language, visuoconstructional skills, conceptual thinking, calculations and orientation.

Scores on the MoCA range from 0 to 30, with a score of 26 and higher generally considered normal. Scores between 22 and 25 are indicative of a Mild Cognitive Impairment (MCI), while scores of 21 or less point towards cognitive capacity in line with Alzheimer’s dementia.

Of the 30 participants who agreed to participate and completed the assessment, 80% were found to have a cognitive impairment to some extent (see Figure 9.1). MCI was identified in just under half of the sample (47%), and one-third (33%) may have cognitive functioning in line with Alzheimer’s dementia. However, it is cautioned that the MoCA is a brief screening tool and further cognitive testing would be required to confirm these findings.

Figure 9.1: Breakdown of cognitive functioning level amongst client survey participants (formerly homeless tenants) who completed the Montreal Cognitive Assessment (MoCA; N=30)
9.2 Physical health

Baseline survey participants were read a number of physical health conditions and asked whether a doctor or nurse had ever told them that they had this condition. Of the 30 participants who answered questions on their physical health, 97% reported being told that they had at least one physical health condition. On average, participants reported experiencing a median of four physical health conditions in their lifetime (mean 4.6, range 0-12). Sixty-two per cent of the sample had been told that they had a dental problem. Just under half had been told that they had chronic pain (43%), a chronic infection such as a blood borne virus (43%) or epilepsy (40%). Other relatively common physical health conditions reported by participants included asthma (37%), skin problems (33%) and respiratory diseases (33%) (see Figure 9.2).

Figure 9.2: Proportion of client survey participants who were diagnosed with various physical health conditions, received treatment, and continued to experience the condition (formerly homeless tenants) (N=30)
9.3 Mental health

Similarly to the physical health section, formerly homeless survey participants were asked whether they had been diagnosed with various mental health conditions. Eighty-seven per cent of the sample had been diagnosed with at least one mental health condition, with participants reporting a median of 2 mental health diagnoses in their lifetime (mean 2.1, range 0-7). Almost three-quarters (73%) had been told that they had a mood disorder, such as depression or bipolar. Over half the sample had also been told that they had an anxiety disorder (67%), such as post-traumatic stress disorder. About one-third had been diagnosed with a substance use disorder (38%) or a psychotic disorder (37%) (see Figure 9.3).

Figure 9.3: Proportion of client survey participants (formerly homeless tenants) who were diagnosed with various mental health conditions, received treatment, and continued to experience the condition (N=29)

Of those who had been diagnosed, the vast majority of survey participants (formerly homeless tenants) received treatment in the 12 months prior to interview for anxiety disorders, substance use disorders and psychotic disorders. The least commonly treated conditions amongst the sample were impulse disorders and eating disorders.

As shown in Figure 9.4, almost one-third (29%) of the sample had been on a CTO for mental health reasons at some point during their lifetime. In the past year, a small minority of participants had been placed on a CTO, which averaged 4.5 months in duration (range 3-6).

Figure 9.4: Proportion of client survey participants (formerly homeless tenants) who had been placed on a Community Treatment Order for mental health reasons during their lifetime and in the last 12 months (N=28)
9.3.1 Substance use

Substance use was highly prevalent among the survey participants (formerly homeless tenants) (see Figure 9.5). All participants had consumed alcohol in their lifetime. Almost all participants had smoked tobacco (93%) and tried cannabis (93%), and over half had tried other illicit drugs in their lifetime such as amphetamines (86%), hallucinogens (72%), cocaine (69%) and opioids (59%).

Over half the sample had used tobacco (83%), alcohol (72%) and cannabis (65%) in the past three months. On average, participants used tobacco and cannabis daily, whereas the largest portion of participants who had recently consumed alcohol had done so once or twice in the past three months. With the exception of tobacco, the prevalence rates of substance use in the past three months were notably lower than the lifetime prevalence rates.

Figure 9.5: Lifetime and past three month prevalence of substance use among survey participants (formerly homeless tenants) (N=29)

Survey participants were asked about the presence of a number of symptoms indicative of substance dependence. Participants were asked how often they had a strong desire to use various substances (see Figure 9.6). On average, participants most frequently desired tobacco and cannabis on a daily basis, while alcohol and amphetamines were typically desired weekly.
Figure 9.6: Frequency of client survey participants’ desire to use various substances in the past three months (formerly homeless tenants) (N=29)

Note: Hallucinogens and inhalants were excluded from this analysis due to no participants reporting their use in the past three months.

Rates of injecting among CCG participants are shown in Figure 9.7 and Figure 9.8. Sixty-three per cent of participants had previously injected a drug, with 37% of the sample having injected in the past three months. Participants who had recently injected typically engaged in this behaviour ‘once weekly or less’ (55%) or ‘3 or more days in a row’ (27%).

Figure 9.7: Breakdown of survey participants (formerly homeless tenants) who have ever used a drug by injection (N=30)
9.4 Complexity of needs

The complexity of needs amongst CCG formerly homeless tenants was examined to attain a better understanding of the proportion of tenants managing multiple needs. Participants’ survey results were examined across four areas: cognitive impairment, substance use disorder, physical health condition/s and mental health condition/s. As shown in Figure 9.9, all participants reported at least one area of difficulty. Half of the tenants experienced issues in three different areas (51%) and an additional quarter co-managed difficulties across all four areas (23%). Interestingly, only one participant (3%) reported difficulty in one area, suggesting that most tenants were dealing with a multitude of complex needs.

Figure 9.9: Breakdown of the number of areas Camperdown Common Ground client survey participants are experiencing issues in (cognitive impairment, substance use, physical health and mental health condition/s) (formerly homeless tenants) (N=30)
9.5 Substance use

Substance use remained highly prevalent among the participants at both time points. As outlined in the Baseline Report (Bullen et al., 2013), almost all participants reported that in their lifetimes they had smoked tobacco (93%) and tried cannabis (93%), and over half had tried other illicit drugs such as amphetamines (86%), hallucinogens (72%), cocaine (69%) and opioids (59%).

Three-month prevalence rates

Participants were asked to report on their levels of substance use in the three months prior to the baseline and follow-up survey (for lifetime use, refer to the Baseline Report). The proportion of participants who used various substances in the three months prior to the baseline and follow-up interviews is displayed in Figure 9.10. The majority of the sample reported use of tobacco, alcohol and cannabis at baseline (83%, 71%, 71% respectively). This pattern remained at follow-up (88%, 62%, 60% respectively). However, there was an overall reduction in the proportion of consumers reporting recent use of most substances across the two time points, with the exception of tobacco and opioids, which increased over this time period. The greatest changes observed over the 12-month period were reductions observed for cannabis (71% to 60%), amphetamines (50% to 40%) and alcohol (71% to 62%).

Figure 9.10: Past three month prevalence rates of self-reported substance use (Client survey)

*Based on a matched sample.
Note: Hallucinogens and inhalants were excluded from all substance use analyses as no participants reported use in the past three months.
Frequency of recent use

Although the proportions of participants reporting use of most substances reduced between baseline and follow-up, the self-reported frequency at which they were being used at the two time points varied considerably. Figure 9.11 and Figure 9.12 show that at both baseline and follow-up, the majority of participants who reported smoking tobacco in the past three months were doing so daily (85% to 96%). The proportion of participants who consumed alcohol daily remained stable across the two time points (24% to 25%), and there was a slight reduction in the proportion who consumed alcohol weekly at follow-up (24% to 19%). Frequency of cannabis use remained stable across the two time points, with just over half the sample at both baseline and follow-up (53% respectively) reporting daily cannabis use.

The number of reported amphetamine users decreased from twelve participants to ten between baseline and follow-up (46% to 38%). Although there was a decrease in the proportion reporting daily use (17% to 10%), there was a concurrent increase in the proportion using amphetamines weekly (33% to 50%).

Low numbers for recent use of sedatives, opioids and cocaine at follow-up meant that these were too small to allow for comment.

Figure 9.11: Frequency of participants’ use of various substances in the past three months at baseline (N=23*) (Client survey)

*Based on a matched sample.
9.6 Symptoms of substance dependence

Participants’ desire or urge to use substances

Participants were asked about the presence of a number of symptoms indicative of substance dependence and how often they had a strong desire to use various substances (see Figure 9.13 and Figure 9.14). For the more frequently used substances, levels of desire remained mostly consistent across baseline and follow-up. On average, tobacco was most frequently desired on a daily basis (85% at baseline, 86% at follow-up). At baseline, the majority of alcohol users typically desired alcohol at least weekly (daily 41%; weekly 18%), and these figures were somewhat lower at follow-up (daily 27%; weekly 13%). The proportion of participants who had the urge to consume cannabis daily remained mostly stable between baseline and follow-up (59% to 60%).

The frequency of participants’ urge to use amphetamines decreased from baseline to follow-up, particularly the more frequent timeframes of daily (33% to 20%) and weekly (42% to 40%). Approximately one-fifth (17%) of opioid users had the urge to use daily at baseline, which fell to 0% at follow-up. In terms of sedatives and cocaine, caution is warranted due to small numbers reporting.
Figure 9.13: Frequency of participants’ desire to use various substances in the past three months at baseline (N=23*) (Client survey)

*Based on a matched sample.

Figure 9.14: Frequency of participants’ desire to use various substances in the past three months at follow-up (N=25) (Client survey)

Note: one participants did not answer for alcohol, cannabis, opioids and sedatives.
Problems experienced due to substance use

Participants were asked how often particular substances had contributed to health, social, legal and/or financial problems in their lives over the past three months (see Figure 9.15 and Figure 9.16). Overall, the majority of participants who were using these substances at follow-up had experienced a decrease in the frequency of reported problems. Just over half of participants (53%) reported problems associated with tobacco at baseline, and this decreased to one-third (36%) at follow-up, with fewer individuals also reporting a daily or weekly frequency of problems. A similar pattern was observed for those who used alcohol; just under half (44%) had experienced some problems in the three months prior to baseline, which fell to one-third (33%) at follow-up. In regards to problems due to cannabis, at baseline, the majority of cannabis users (56%) had experienced some form of problem in the prior three months; however, at follow-up, a minority of cannabis users (47%) reported a recent problem due to their use.

A noticeable reduction in the proportion experiencing problems due to amphetamine use was found at follow-up compared to baseline; 64% of participants at baseline reported a problem due to amphetamine use compared to 20% at follow-up. At both time points, the majority of opioid users reported that they had not experienced a problem due to their use (67% respectively). The small proportions reporting sedative or cocaine use reported at follow-up that they rarely experienced problems due to their use.

Figure 9.15: Frequency of health, social, legal or financial problems associated with substance use in the past three months at baseline (N=23*) (Client survey)

*Based on a matched sample.
Note: One participant did not answer for tobacco, alcohol, cocaine and amphetamines.
Frequency that participants failed to meet normal expectations due to substance use

Participants were asked to indicate how often they had failed to do what was normally expected of them in the three months prior to the interview due to their substance use (Figure 9.17 and Figure 9.18). At baseline, the substances most likely to result in failure to meet expectations to some extent were amphetamines (73%), sedatives (60%) and alcohol (44%). Those who used amphetamines mostly reported that this occurred weekly (36%), whereas those who had recently used sedatives or alcohol reported that this occurred only once or twice in the three months prior to baseline (60% and 25% respectively).

At follow-up, the impact of amphetamines on participants’ ability to do what was normally expected was markedly reduced (20%), while there was also a reduction for alcohol (27%). There was a slight increase in the number of participants reporting opioid-associated problems at follow-up (33%), particularly on a daily or weekly basis. In contrast, there was a reduction overall in the proportion reporting that cannabis was contributing to difficulties meeting expectations (31% to 20%).
Figure 9.17: Frequency that the use of substances contributed to participants failing to do what was normally expected of them in the past three months at baseline (N=23*) (Client survey)

*Based on a matched sample.
Note: One participant did not answer for tobacco, alcohol, cannabis, cocaine and amphetamines.

Figure 9.18: Frequency that the use of substances contributed to participants failing to do what was normally expected of them in the past three months at follow-up (N=25) (Client survey)

Note: One participant did not answer for alcohol, opioids and sedatives.
**Expressed concern about use of substances**

Participants reported on whether friends or relatives had ever expressed concern about their use of various substances in the three months prior to baseline and follow-up interviews (Figure 9.19). Overall, it appears that concerns were expressed for participants’ substance use more frequently at follow-up than at baseline. The proportions who reported that they had concerns expressed to them about their tobacco or amphetamine use almost doubled from baseline to follow-up (14% to 27% and 25% to 46% respectively). There were also slight increases in the proportions who had concerns recently expressed to them about their alcohol, cannabis and opioid use across the two time points.

Figure 9.19: Breakdown of whether or not participants’ friends or relatives had ever expressed concern about the use of substances at baseline and follow-up (Client survey)

*Based on a matched sample

Note: baseline and follow-up n’s for individual substances are as follows: tobacco (n=22, n=22); alcohol (n=24, n=13); cannabis (n=22, n=16); amphetamines (n=20, n=13); opioids (n=10, n=8); sedatives (n=10, n=4).
Tried and failed to cut down on substance use

As illustrated in Figure 9.20, participants were asked to report on whether they had tried and failed to control, cut down or stop using substances three months prior to baseline and follow-up interviews. One-third (32%) of the baseline sample reported trying and failing to control, cut down or stop using tobacco in the past three months, which reduced to one-quarter (23%) of tobacco users at follow-up. Similarly, there was a reduction from baseline to follow-up in the proportion of participants who reported unsuccessfully reducing alcohol use (29% to 13%). The proportion who attempted to cut down on cannabis use remained stable across the two time points. No participant attempted to stop their amphetamine or opioid use in the three months prior to follow-up.

Figure 9.20: Breakdown of participants who had ever tried and failed to control, cut down or stop using various substances at baseline and follow-up (Client survey)

*Based on a matched sample

Note: baseline and follow-up n’s for individual substances are as follows: tobacco (n=22, n=22); alcohol (n=24, n=15); cannabis (n=22, n=16); amphetamines (n=20, n=13); opioids (n=10, n=8); sedatives (n=10, n=4).
9.7 Injection of substances

Rates of injecting among participants are shown in Figure 9.21 and Figure 9.22. As illustrated in Figure 9.21, a total of ten participants reported illicit injecting behaviour in the three months prior to baseline and follow-up (42% respectively).

Figure 9.21: Breakdown of participants who self-reported injection of an illicit substance in the past three months (Client survey)

As shown in Figure 9.22, there was a notable difference between time points in relation to the frequency of these participants’ injecting behaviour; at baseline, the largest proportion of participants injected typically ‘once weekly or less’ (50%) whereas at follow-up, the majority of participants were injecting ‘3 or more days in a row’ (60%).

Figure 9.22: Frequency of injection of recent intravenous drug users (n=10) (Client survey)
## Appendix B: Program data fields and timeframes available for analysis

### Table 10.1: Demographic variables available in the Camperdown Common Ground Program data

<table>
<thead>
<tr>
<th>Variable name</th>
<th>Resident group</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Evaluation ID</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Date of birth</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Housing allocation type</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Country of birth</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Aboriginal</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>CALD</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Referring agency</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Case manager</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Date lease signed</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Date tenancy ended</strong></td>
<td>All tenants</td>
<td>Exit</td>
</tr>
<tr>
<td><strong>Exit reason</strong></td>
<td>Formerly homeless tenants</td>
<td>Exit</td>
</tr>
<tr>
<td><strong>Exit location</strong></td>
<td>Formerly homeless tenants</td>
<td>Exit</td>
</tr>
<tr>
<td><strong>Tenure in days</strong></td>
<td>All tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Amount arrears Apr 13</strong></td>
<td>All tenants</td>
<td>Apr 13</td>
</tr>
<tr>
<td><strong>Amount arrears Apr 14</strong></td>
<td>All tenants</td>
<td>Apr 14</td>
</tr>
<tr>
<td><strong>Years homeless</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Income per week</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Financial guardianship</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Assistance with living skills</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Has GP</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Social connections</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>External agency engagement</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
<tr>
<td><strong>Life Skills Profile (LSP-16)</strong></td>
<td>Formerly homeless tenants</td>
<td>Mar 14</td>
</tr>
</tbody>
</table>
### Table 10.2: Incident variables available in the Camperdown Common Ground Program data

<table>
<thead>
<tr>
<th>Incident data</th>
<th>All tenants</th>
<th>Unit record data available in March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incident date</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Details of incident</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Action</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Ambulance attendance</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Police attendance</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Fire brigade attendance</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Hospital attendance</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>MH Crisis team attendance</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>First aid applied</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Risk to staff</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Risk to tenants</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Threatened or actual self harm</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Building environment</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Non-violent anti-social behaviour</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Noise complaint</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Fire hazard (no fire brigade)</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Theft</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Complaint made</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
<tr>
<td>Complainant</td>
<td>All tenants</td>
<td>Unit record data available in March 2014</td>
</tr>
</tbody>
</table>
### Table 10.3: Case management data available in the Camperdown Common Ground Program data

<table>
<thead>
<tr>
<th>Case management and on-site service data</th>
<th>All tenants</th>
<th>Whether each resident had ever accessed the service between April 2013 and March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial assistance provided</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Financial referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and drug assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and drug referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and employment assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education and employment referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MH referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General health assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General health referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relationship referral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability referral</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 10.4: Onsite service variables available in the Camperdown Common Ground Program data

<table>
<thead>
<tr>
<th>Onsite service use</th>
<th>All tenants</th>
<th>Whether each resident had ever accessed the service between April 2013 and March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Art – Saturday</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Art – Wednesday</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>TURF Project</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Yoga</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Podiatry</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Private psychiatrist clinic</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Private psychological clinic</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Cooking</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Food Bank</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>AA meeting</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>SMART recovery</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Gym class</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>One off events (BBQ’s footy)</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Computer drop in</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Movie</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Breakfast club</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Transport to shops</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Card playing</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Employment support</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
</tbody>
</table>
### Onsite service use

<table>
<thead>
<tr>
<th>Service</th>
<th>Target Group</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/recreational outings</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Fishing</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Volunteering – breakfast club</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Volunteering – food box packing</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>GP</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Centrelink</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>Public psychiatrist</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
<tr>
<td>MH case management</td>
<td>All tenants</td>
<td>Whether each resident had ever accessed the service between April 2013 and March 2014</td>
</tr>
</tbody>
</table>
Appendix C: Literature review

It is widely agreed that adults experiencing persistent or chronic homelessness form a small but significant subgroup of the homeless population (Caton et al., 2007). The Australian Government’s White Paper on homelessness (Australian Government, 2008) describes this group in the following terms:

For ... a small minority, homelessness is part of a chaotic and uncertain life of poverty and disadvantage. These people tend to cycle in and out of homelessness and when they do find housing, it tends to be short term.

Chronic or persistent homelessness is linked to rough sleeping. The 2006 Census found that approximately 13 per cent of homeless people were sleeping rough on any given night. However, the experience of sleeping rough becomes more common the longer people are homeless (Chamberlain, 2007) and disadvantage, exclusion and homelessness have compounding negative effects over time (Johnson and Chamberlain, 2008b; Johnson et al., 2008; Robinson, 2003, 2010; Senate Select Committee on Mental Health, 2006). Nevertheless, people who have experienced prolonged homelessness can return to conventional accommodation if long term support is provided (Johnson and Chamberlain, 2008a), and housing interventions benefit homeless people with severe mental illness.

Housing and support models used by people who are homeless and vulnerable/sleeping rough

People who become homeless are assisted by human service systems generally, as well as by specialist homelessness services. Many industrialised welfare states including Australia have recently implemented policies to achieve targeted reductions in homelessness by seeking to move away from ‘managing homelessness’ and towards interventions that aim to permanently end homelessness.

Recently, there has been an increased priority given to services targeted specifically to people who are chronically homeless or sleeping rough. Existing service models are outreach, discharge planning and housing with support, including both transitional and permanent models. These interventions include ‘housing first’ responses, targeted to chronically homeless people, which provide housing with security of tenure immediately or as soon as possible and offer case management and/or other support, but do not require sobriety or psychiatric treatment as a condition of accessing housing (G Johnson et al., 2012; Pleace and Bretherton, 2012). Research suggests that Housing First programs can be effective and cost-effective in providing ongoing housing to people considered to be difficult to house (Culhane et al., 2011).
Human service system responses

People who become homeless interact with multiple human service systems, including health, justice, income support and emergency services (Commonwealth of Australia, 2008). Many people who become homeless have experienced multiple disadvantages in addition to problems with housing and homelessness and are likely to be in contact with more than one service system (Commonwealth of Australia, 2008). In addition, many people come to specialist homelessness services after discharge from other human service systems and institutions, including health services (particularly mental health), child protection, intellectual disability, drug and alcohol and correctional facilities (Baldry et al., 2002; Bostock et al., 2004; Cashmore et al., 1996).

Chronically homeless people both in Australia and internationally are high users of community services, health and mental health systems, policing and corrections, often moving between the streets, jails, hospitals and mental health facilities and shelters, but without finding permanent accommodation (2007; Commonwealth of Australia, 2008; Culhane et al., 2001; HomeGround Services, 2008; Victorian Government, 2006). In recent years, there has been an increasing understanding of the need for service integration to effectively assist people who become homeless, in particular those with complex needs (Flatau et al., 2010; O’Brien et al., 2002).

Specialist homelessness services

The primary approach in Western countries to providing housing and support to people who become homeless has, until recently, relied upon a ‘transitional’ approach which involves progressing people through a series of residential services (Johnsen and Teixeira, 2010). This approach views homeless people’s personal and clinical characteristics as obstacles to their being housed and its aim is that, as a result of progressing through this sequence of programs, people will develop a capacity to live independently or become ‘housing ready’ and can then become eligible to be placed into ‘normal’ housing (Johnsen and Teixeira, 2010). A growing number of projects internationally offer an alternative approach which places homeless people, in particular the most vulnerable, chronically homeless people, directly into permanent housing, in some cases without requiring stability, sobriety or treatment (Caton et al., 2007; Johnsen and Teixeira, 2010).

Most of Australia’s specialist homelessness service system is based on a ‘transitional’ approach, with many services established under the Supported Accommodation Assistance Program (SAAP), a transitional housing program which operated from 1985 to 2008 (Bullen, 2010). From January 2009 the SAAP agreement between the Australian Government and the states and territories was replaced by the National Affordable Housing Agreement (NAHA) and a new National Partnership Agreement on Homelessness. While some new service models are being developed under the NAHA, most former SAAP services are still transitional services (Bullen, 2010).

In 2010-11, the joint funding from the Commonwealth and state and territory governments to specialist homelessness services totalled $494.5 million and was provided to 1,547 agencies offering specialist homelessness services in Australia (AIHW, 2011a). These agencies assisted 142,500 adult clients and 88,000 accompanying children in 2010-11 (AIHW, 2011b). Specialist homelessness services are unable to meet the demand for assistance by homeless people generally and in 2010-11 turned away 59 per cent of all people who sought immediate accommodation (AIHW, 2011c). The transitional approach to service provision relies upon the availability of suitable permanent housing as an exit point (Erebus Consulting Partners, 2004).

There is no single measure available of how many people using specialist homelessness services are chronically homeless with complex needs. In 2010-11, 28.8 per cent of people using specialist homelessness services nationally had not been living in a conventional house or flat immediately before commencing support. Homeless people are likely to move between different living situations, and even some of those who are homeless for shorter periods sleep rough at times (Chamberlain et al., 2007). Thus, it would be expected that some, but not necessarily all, of this group would be chronically homeless, while on the other hand, some of those who had been living in conventional accommodation, including transitional housing, would have lengthy histories of recurrent homelessness and housing problems.
Models for people who are vulnerable, sleeping rough and/or chronically homeless

Reducing the number of people who are vulnerable and who experience persistent homelessness or are sleeping rough has recently become a greater policy priority in the US, UK and Australia, and a number of models of housing and support targeted to this group have been developed, in particular in the US, and in some cases implemented overseas (Caton et al., 2007; Commonwealth of Australia, 2008; Johnsen and Teixeira, 2010; G Johnson et al., 2012; Pleace and Bretherton, 2012).

Outreach

Outreach services have traditionally been a key response to people who are homeless in public places, and include the provision of food and drink, blankets and clothes; accommodation support and assessment; assistance in finding housing; legal and welfare advice; hygiene and medical support, including drug and alcohol; counselling; transport and relationship building (Phillips et al., 2011). Assertive outreach approaches have more recently been promoted in response to rough sleeping, and differ from transitional outreach in that they are part of broader integrated policy responses explicitly aimed at ending homelessness (Phillips et al., 2011). Examples of assertive outreach services include the ‘Street to Home’ program implemented by Common Ground from 2003, which was modelled on the earlier British Rough Sleeping Initiative (Parsell et al., 2013). Another example is Way2Home in Sydney, which aims to assist people sleeping rough in the inner city transition to appropriate long-term accommodation and support; to improve health outcomes for chronically homeless people; and to reduce presentations by this group to hospitals and other health facilities (NSW Government, 2009).

Discharge planning

Discharge planning is aimed at ensuring that people are not discharged into homelessness from services and institutions such as hospitals, statutory care, juvenile justice, prisons and treatment facilities (Australian Government, 2008; Caton et al., 2007). The NSW National Partnership Agreement on Homelessness: NSW Implementation Plan 2009–2013 (NSW Government, 2009) includes a series of measures to assist people leaving child protection services, correctional and health facilities to access and maintain stable, affordable housing. These measures include a focus on people experiencing chronic homelessness exiting from health facilities, through a new position in an inner city hospital to liaise with homeless people attending emergency departments and/or Psychiatric Emergency Care Centres to ensure responsive discharge planning.

Housing with support

Internationally, a number of models of housing with support exist for people who have been chronically homeless or have complex needs, and a combination of housing and support is viewed as best practice for ending chronic homelessness (Caton et al., 2007; Rog, 2004). These models include both transitional and permanent models of housing and support, as well as variations within these models.

Australian transitional models (described above) are often referred to as ‘supported accommodation’. Permanent housing models, and in particular ‘housing first’ models, aim to remove barriers to housing for the most vulnerable homeless people (Gulcur et al., 2003). Housing First’ is an approach which rejects the assumptions of the transitional approach and assists homeless people by providing immediate access to long term independent housing with tailored, flexible support services, but without requiring sobriety or treatment. The ‘Housing First’ approach has been widely adopted in a number of Western countries as a policy response to chronic homelessness.
Some examples of permanent housing models are:

Pathways to Housing in New York City has used the ‘Housing First’ approach since the early 1990s targeting the most vulnerable, chronically homeless people, in particular those with psychiatric disabilities and substance abuse problems. The Pathways to Housing program provides those consumers who wish, with an apartment without prerequisites for housing readiness, psychiatric treatment or sobriety, as well as treatment and other assistance by the program’s Assertive Community Treatment Program. The accommodation is in ‘normal’ privately rented scatter-site dwellings to promote community integration.

The Common Ground organisation has operated a permanent ‘supportive housing’ program in New York since the early 1990s, providing chronically homeless people with permanent, self-contained, high density housing, often in former hotels, with 24-hour onsite staffing, based on ‘housing first’ principles (Carter, 2008; Carter et al., 2008; Haggerty, 2007; Johnsen and Teixeira, 2010). The Common Ground model differs from some other forms of homelessness provision in that it involves centralised accommodation and in that Common Ground developments include social and/or affordable housing as well as housing with support designated for former homeless people. Common Ground projects use a ‘Street to Home’ outreach approach which identifies and prioritises the most vulnerable people among those sleeping rough and experiencing long term homelessness in order to assist them to access permanent housing and support (Johnsen and Teixeira, 2010; Parsell et al., 2013). The Common Ground model is one of a number of service models being implemented in Australia that aim to reduce homelessness among people experiencing long-term or chronic homelessness. The White Paper foreshadowed eight new Common Ground facilities across Australia (Australian Government, 2009), including the Common Ground project in Sydney. All states and territories are also to implement Street to Home initiatives for chronic rough sleepers to work with the chronically homeless on the streets and facilitate their move to long-term accommodation with support (Australian Government, 2009).

**Key strengths and weaknesses**

The suggests that best practices to end chronic homelessness are: outreach, discharge planning, case management, assertive community treatment, permanent supportive housing and low demand models (Burt et al., 2004; Caton et al., 2007).

A combination of housing and support is viewed as best practice for ending chronic homelessness (Caton et al., 2007; Rog, 2004). There is increasing evidence that permanent housing with support provides better outcomes than other approaches that do not involve housing (Martha Burt and Anderson, 2005; Rosenheck et al., 2003). However, for Housing First approaches to succeed, service providers need to change traditional provider-consumer relationships to reconsider assumptions about the capabilities of homeless persons and to relinquish authority to prioritise consumer housing needs and goals and place less emphasis on mental health and substance use (Stefancic and Tsemberis, 2007).

**Outreach case management**

Research suggests that while outreach may be an initial step in engaging those homeless people who have not been involved with services for a long time, these approaches will not end homelessness unless they are linked to housing and support (Caton et al., 2007; Gronda, 2009; Shern et al., 2000). Recent research suggests that resource problems including delays in accessing housing and lack of follow-up support may limit the success of some Australian outreach programs (Parsell et al., 2013).

**Discharge planning**

Discharge planning provides an opportunity to engage and assist chronically homeless people because of their frequent contact with such institutions. However, there is currently no evidence that it can prevent long term homelessness (Caton et al., 2007). The availability of housing and support in the community are equally or more important factors than discharge planning in determining whether people avoid or leave homelessness (Moran et al., 2005).
Service user outcomes: transitional housing

Transitional approaches can assist homeless people, and can be successful in removing chronically homeless people from the streets. However, the evidence base regarding the efficacy of transitional models for chronically homeless people is weak, and very little is known about how many chronically homeless people move from transitional housing to stable permanent housing, or about the characteristics of those who are successful compared with those who are not (Caton, Wilkins et al. 2007).

Data from Australian specialist homelessness services indicates that transitional specialist services do remove many homeless people from the streets, at least in the short term, with the percentage of people in improvised dwellings or sleeping rough decreasing from 8.2 per cent immediately before receiving assistance to 2.4 per cent immediately after receiving assistance (AIHW, 2011a). Evidence shows, however, that once people become chronically homeless these moves are frequently steps in a pattern of ‘iterative’ homelessness rather than a pathway out of homelessness (Robinson 2003; Johnson, Gronda et al. 2008).

Transitional homelessness services may not be able to adequately meet the needs of homeless people with complex needs (Reynolds and Inglis 2001). Australian research shows that, the longer that people are homeless, the more difficult it becomes to resolve the situation, and long-term support is required to return to conventional accommodation (Johnson and Chamberlain 2008). This implies that the short-term support generally provided by transitional specialist homelessness services is not sufficient to enable chronically homeless people to rebuild their lives, and that ongoing support is needed to help people remain in stable housing (Johnson and Chamberlain 2008).

Service user outcomes: permanent housing

In recent years, a number of research studies have found permanent models, in particular the Pathways to Housing model to be effective in increasing housing stability, with retention rates of 75-85 per cent in the first year, even for people who were chronically homeless and with substance abuse and mental health problems (Martinez and Burt, 2006; Rog, 2004; Shern et al., 2000; Stefancic and Tsemberis, 2007; Wong et al., 2006). One longitudinal randomized trial supported the Housing First low demand approach over a high demand model. This study found that participants receiving a Housing First program without treatment prerequisites obtained housing earlier, remained stably housed, and reported higher perceived choice than a control group who were randomly assigned to receive housing contingent on treatment and sobriety. While the control group had higher utilization of substance abuse treatment, no differences were found in substance use or psychiatric symptoms.

The Common Ground model has not as yet been subjected to independent evaluation and the literature suggests there is a need for a rigorous assessment of the model’s housing and other outcomes, including the extent to which the model reduces stigma, encourages community integration and avoids institutionalisation and whether the model meets a need for some homeless people with complex needs for whom independent housing may not be a realistic or desirable goal (Johnsen and Teixeira, 2010). However, Common Ground in New York states that homelessness in Times Square declined by 87 per cent since the ‘Street to Home’ program commenced. After Common Ground’s model and strategy were officially adopted to tackle homelessness throughout New York City, street homelessness declined by 47 per cent (Common Ground 2010). The average stay in US Common Ground projects is almost five years, with an eviction rate of under one per cent. (Common Ground, 2010).
Costs and benefits

The evidence base regarding interventions for chronically homeless, vulnerable people is limited. Empirical research on responses to chronic homelessness has not kept pace with the development and implementation of innovative services and much of the research that has been conducted both in the US and elsewhere does not meet the standard of evidence associated with large, randomised clinical trials (Caton et al., 2007; Chamberlain et al., 2007; G Johnson et al., 2012). In addition, the complexity of homelessness, and of the costs and benefits involved in homelessness services make it difficult to analyse all of the factors involved. Nevertheless, while care is needed that offsets are calculated in a way that does not overstate offsets, there is evidence that there may be cost offsets in areas such as reduced institutional care, emergency services and specialist homelessness service use associated with the Housing First approach (Flatau et al., 2008; Gulcur et al., 2003; G Johnson et al., 2012; Pleace and Bretherton, 2012).

Yes, in a registered marriage _______________________________________________________ 3

Yes, in a de facto marriage (i.e. live with someone as though you are married) _____ 4

1 How many children have you given birth to or fathered?

Number of biological children: ____________________________________________________

2 How many dependent children currently live with you all or most of the time? That is, children who are aged less than 16 and are financially dependent on you, or children aged 16 – 22 who are a full time student and are financially dependent on you.

Number of dependent children: __________________________________________________

3 What is the highest level of education you have completed? (Please answer using SHOWCARD B)

No education_____________________________________________________________0

Primary education ____________________________________________________________ 1

Specify highest primary level: _________________________________________________

Secondary education ___________________________________________________________ 2

Specify highest secondary level: ______________________________________________

Certificate ______________________________________________________________________ 3

Advanced diploma or diploma ___________________________________________________ 4

Bachelor degree_________________________________________________________________ 5

Graduate diploma or graduate certificate___________________________________________ 6

Postgraduate degree____________________________________________________________ 7

4 How old were you when you first left school? _________________________________________


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