Dying with Their Rights On: The myths and realities of ending homelessness in Australia

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Culture, Prosperity & Civil Society
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Executive Summary

Despite the average Australian equating homelessness with sleeping on the streets, only 7% of the people officially classified as homeless in Australia are rough sleepers. Though the numbers of people sleeping rough increased by approximately 2000 people nationally between 2011 and 2016, their proportion of the total homeless population has remained the same over this period. This is despite government spending on homelessness exceeding $817.4 million in 2016-17, an increase of 29% from $634.2 million in 2012-13.

Australian Bureau of Statistics (ABS) data indicate that the total number of homeless people has grown from 89,728 in 2006 to 116,427 in 2016 — an increase of 30% over the decade. These inflated figures are based on a questionable definition that includes people such as those living in overcrowded accommodation. Overcrowding has increased most in the cities where rates of net overseas migration have been the highest. For some groups, such as recent migrants, living in crowded dwellings is a rational economic decision, while for others it may reflect cultural preferences for shared living spaces.

By including the 'housed homeless' (such as those living in supported accommodation) and people who would never consider themselves to be homeless, the current official definition distorts resource allocation and dilutes out those most in need; chronic rough sleepers. It is in the interest of the 'homelessness industry' — the

academics, charities and NGOS that undertake research, conduct advocacy, and lobby government for more taxpayer-funded spending on the alleged problems and solutions — for the numbers of homeless to be artificially high.

The orthodox understanding of the causes of homelessness promoted by the industry overemphasises the role of economic and social structures (structuralism). Solutions based on structuralist explanations — such as increasing the supply of affordable social housing — are insufficient to reduce rough sleeping. Such approaches minimise the role of, and fail to address, the individual characteristics, choices, and behaviours; especially the high rates of mental illness and drug abuse that afflict rough sleepers.

Current public housing policy contributes to the problem. By encouraging unemployment and poverty through a number of perverse incentives, social housing maintains people on the margins of homelessness. Tenancy breakdowns are often related to the antisocial behaviours and criminal activities associated with drug use (especially methamphetamines). While tenancy support provides an opportunity for vulnerable individuals with complex needs to maintain housing, there is too much scope for such people to refuse support and to potentially face eviction.

Homelessness services have proved unable to reduce the numbers of rough sleepers because of an

unwillingness to implement the benign and enlightened paternalism necessary to help the most vulnerable exit the streets. 'Housing First' initiatives — which seek to provide unconditional access to housing, independent of treatment options and requirements — are successful in exiting some rough sleepers from the streets but do little to address the mental illness and drug abuse factors leading to homelessness.

To effectively reduce genuine homelessness and the wide range of health, social, and physical risks and harms that cause, and are caused by, rough sleeping, this research report therefore recommends:

- Underpinning assertive outreach programs for rough sleepers with a non-opt-out triage process to reduce non-participation and ensure those who suffer mental illness are referred to mental health services and treated assertively.

- Appointing public guardians to help make decisions on behalf of rough sleepers who lack decision-making capacity.

- Expanding mandatory drug treatment for individuals who are homeless or at high risk of homelessness, to improve the chances of maintaining stable accommodation.

- Requiring occupants of public housing referred to mental health services to accept mandatory psychosocial support as a condition of ongoing tenancy (consistent with the principle of mutual obligation).

- Re-establishing long term institutional care facilities for the proportion of chronically homeless people, particularly those with mental illness and complex needs, who would benefit from high levels of support.

Introduction

In 2017, the 'tent city' episode in Sydney's Martin Place reignited the debate about 'what should be done' about homelessness. The NSW government argued that the makeshift encampment posed an unacceptable impost on the public, while the city council — with the backing of assorted NGO's and academics — framed the issue in terms of homeless rights.[1] Was this public display of rough sleeping a lifestyle choice, or an example of government inaction failing the most vulnerable in society?

The cost of homelessness to the taxpayer continues to grow. Total state and territory recurrent expenditure on homelessness increased from $634.2 million in 2012-13 to $817.4 million in 2016-17.[2] Combined federal and state annual expenditure on housing and homelessness is about $10 billion per annum.[3]

Given these massive sums, it seems strange that the homelessness rate has increased sharply since the release of the Rudd Government's landmark 2008 white paper *The Road Home: A National Approach to Reducing Homelessness*, which aimed to "... *halve homelessness by 2020 and offer supported accommodation to all rough sleepers who need it.*"[4] Between 2006 and 2016, there has been no appreciable reduction in the numbers of rough sleepers; and according to the Australian Bureau of Statistics (ABS) the total number of homeless people has grown from 89,728 to 116,427 - a 30% increase.[5]* The rate of homelessness was 45.2 people per 10,000 in 2006 and currently sits at 50 people per every 10,000.[6] This places Australia as one of the worst performers in the OECD[7]. The lifetime aggregate cost of homelessness is estimated to range from $900,000 to $5.5 million per homeless person.[8]

If you were to ask the average Australian what they understand by the term 'homeless', the most common answer would be 'a person who sleeps rough, and usually on the streets'.[9] Despite this common perception, only 8200** of the 116,427 (7%) homeless people counted nationally on census night 2016 met this definition of homeless. This percentage is unchanged from 2011.[10]

There is clearly a mismatch between public understanding of homelessness and the official account of the problem. This paper will explore some of the reasons behind this incongruence and will examine two decades of homelessness in Australia, with a focus on NSW. It will explain how the orthodox approach to homelessness promoted by the 'homelessness industry' and outlined in *The Road Home* and other strategic plans is failing the most severe and chronically homeless people. A range of targeted and pragmatic policy responses will be proposed.

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* Interestingly, from 2001-2006 homelessness rates per 10,000 dropped from 50.8 to 45.2. The rise following this inter-census period was blamed on the GFC rather than the change of government.

** Probably an underestimate.

A growing problem or a misplaced definition?

Unsurprisingly, enumeration of homeless people is a complex task. Census data gives us a snapshot of an often mobile and transient demographic. Many people — for example those experiencing family crises — tend to be homeless for a short duration. The 2010 General Social Survey found that more than 50% of people who had experienced an episode of homelessness in the past decade had been homeless for less than 3 months.[11]

Along with New Zealand and the Czech Republic, Australia has one of the broadest definitions of homelessness in the OECD, and therefore one of the highest rates of homelessness as a percentage of the total population. Some countries like Japan and Latvia only include people who sleep rough in their definitions.[12] In Australia, the definition of homelessness has been expanded to encompass those who might have until recently been considered as either 'marginally homeless' or not homeless at all.

Prior to 2012, local researchers used a so-called 'cultural' definition of homelessness first outlined by Chamberlain and MacKenzie[13] that hinged on the notion of a 'minimum community standard' equivalent to a small rented flat with a bedroom, living room, kitchen and bathroom. It categorised the homeless population according to severity:

> Primary homelessness: people without conventional accommodation (living on the streets, in deserted buildings, improvised dwellings, under bridges, in parks, etc.).

> Secondary homelessness: people moving between various forms of temporary shelter, including friends, emergency accommodation, youth refuges and hostels.

> Tertiary homelessness: people living in single rooms in private boarding houses without their own bathroom, kitchen or security of tenure.[14]

This statistical definition was widely adopted by policy makers and was used in estimating rates of homelessness in 1996, 2001 and 2006.[†]

In 2011 however, the ABS had to revise down its 2006 count of 105,000 (the figure seized upon in *The Road Home* white paper) to 63,472 because it had mistakenly inferred homelessness in people who were not housed in the conventional sense at the time of the census.[15] These included young professionals travelling overseas, grey nomads, construction crews and people travelling for work. In 2012, after extensive consultation with stakeholders and lobbyists, the ABS jettisoned the cultural definition and *again* redefined homelessness. The 'ABS definition' this time also included people living in houses and flats that lack privacy, safety, or security of tenure of their dwelling.[16] According to the new criteria, when a person does not have suitable accommodation alternatives, they are considered homeless if their current living arrangement:

> Is in a dwelling that is inadequate; or

> Has no tenure, or if the initial tenure is short and not extendable; or

> Does not allow them to have control of, and access to space for social relations.[17]

This conceptual change was borne out of influential sociological research that sought to prioritise subjective perceptions of homelessness.[††] This definitional pivot by the ABS gave rise to a new population known as the 'housed homeless'. Bound by this novel definition, the ABS was compelled to upwardly revise their own 2011 and 2006 census data to include the new category of 'severely crowded dwellings' in their homeless operational criteria (see Box 1). They argued that people living in overcrowded dwellings were homeless by reason of an absence of access to personal space. Was this *volte-face* a convenient justification for the resurrecting of the 'magical' figure of 100,000 homeless? After all, according to Chamberlain and MacKenzie "Advocates are often attracted to higher figures because it is assumed that they put more pressure on those in power to take action."[18]

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† Whether some kinds of secondary and tertiary kinds of homelessness should be included in the definition at all is debatable. Johns has argued for example that staying in boarding houses or with friends may be pragmatic solutions and shouldn't be categorised alongside rough sleeping. (Gary Johns, Paved With Good Intentions: The Road Home and the Irreducible Minimum of Homelessness in Australia. Agenda: A Journal of Policy Analysis and Reform (2012) pp 41-59.)

†† Melbourne University's Shelley Mallett is a leading figure in this movement and played a major role in developing the ABS definition. The abstract from her influential paper "*Understanding home: a critical review of the literature*", The sociological review 52, no. 1 (2004) pp 62-89, contains this paragraph:

> This paper brings together and examines the dominant and recurring ideas about home represented in the relevant theoretical and empirical literature. It raises the question whether or not home is (a) place(s), (a) space(s), feeling(s), practices, and/or an active state of being in the world? Home is variously described in the literature as conflated with or related to house, family, haven, self, gender, and journeying.

The NSW Homelessness Strategy 2018-2023 even recognises the category of 'spiritual homelessness' for Indigenous people who, despite having housing, may have experienced separation from land, family, kinship networks or a crisis of cultural identity (NSW Homelessness Strategy 2018-2023 FACS NSW Government).

Source: ABS 2049.0 *Census of Population and Housing: Estimating Homelessness*, 2016.

To the frustration of the homelessness industry, the general public have been slow to 'catch on' to the contemporary conceptualisation of homelessness.[19] UK Academic Nicholas Pleace worries that: "In effect defining and responding to homelessness as if it is mainly or only rough sleeping experienced by 'different' people, has meant that the narratives around homelessness... are distorted."[20] Nevertheless, our governments have uncritically accepted the changed narrative, leading to some unintended consequences.

Firstly, this (re)revision worsened the apparent homelessness problem overnight.[21] Figure 1 demonstrates how changing definition of homelessness increased the extent of the problem. The graph shows changes in homelessness over time according to definition (the 'ABS' definition includes the category of severe overcrowding).

Secondly, by flattening the 'hierarchy' of severity, it is now possible for a person's circumstances to improve because of successful interventions (for example moving from the streets into a crowded dwelling) but for them to be still counted as homeless. Surely the 21,235 people sleeping in supported accommodation for the homeless are on average much better off than those sleeping in the open? [22]

Thirdly, the definition change distorts resource allocation. For example, funding under the National Affordable Housing Agreement (now the NHHA) is allocated to the state and territory governments based on their respective share of the homeless population.[23] Using the ABS definition, this would disproportionately allocate resources to the Northern Territory where the percentage of people living in severely overcrowded accommodation increases the percentage of the national homeless population from 3.6% to 14.7% based on the 2011 census.[24]

Finally, and perhaps most importantly, the inflated definition operates as a displacement activity for the homelessness industry. The new operational groups (especially severe overcrowding), provide an ever-growing 'homeless' population that justifies increased research, advocacy and calls for more funding and social housing.[25] Unfortunately, activity attached to the expanded definition generates 'noise' that drowns out the 'signal' of those most in need; chronic rough sleepers. The definitional inflation facilitates the cognitive dissonance attached to the implementation of the (necessary) benign and enlightened paternalism required to manage the most 'difficult' homeless population. The CEOs who volunteer to 'sleep out' each year as a fundraising and awareness exercise for the homeless industry are unwitting accessories to the misrepresentation of the rough sleeping problem: this annual spectacle both normalises and overstates the problem by promoting the notion that homelessness can, and does, happen to anyone.

Figure 1: Numbers of homeless depending on definitions
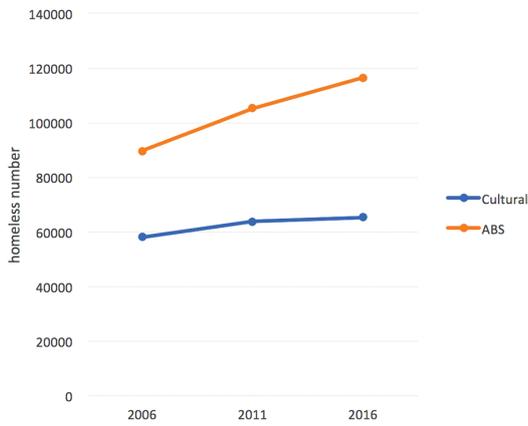
Source: ABS, 2016. *20490DO001_2016 Census of Population and Housing: Estimating Homelessness*, 2016 Table 1.1.

Figure 2: Percentage of homeless by operational criteria NSW
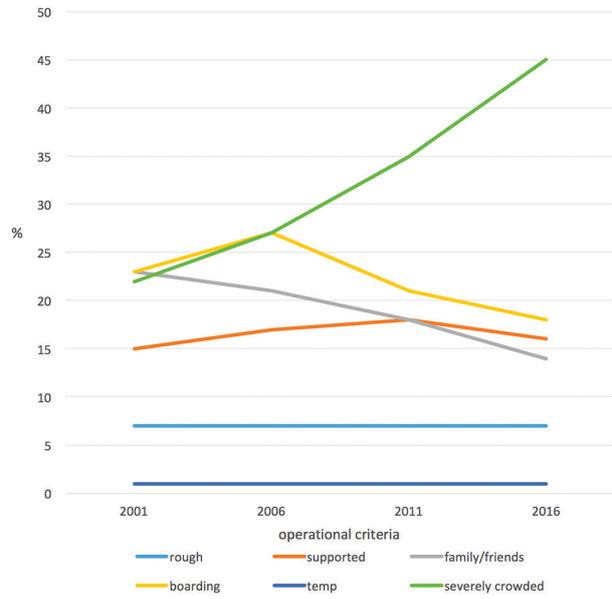
Source: ABS, 2016. *20490DO001_2016 Census of Population and Housing: Estimating Homelessness*, 2016 Table 1.4.

Figure 3: Change in overcrowding rate vs change in immigration rate 2006-2016
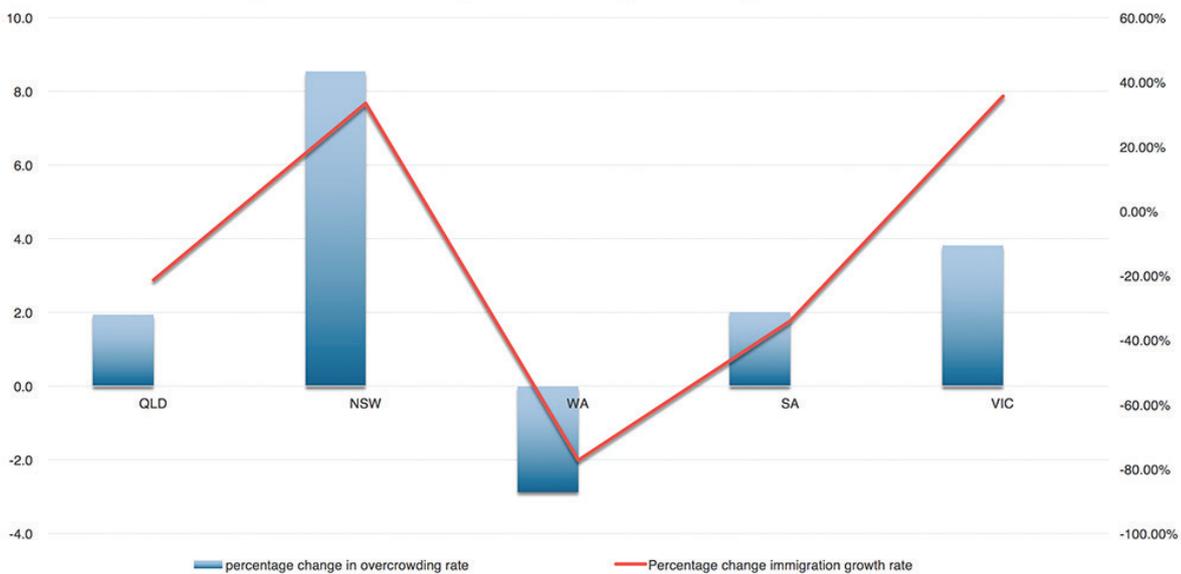
Source: ABS, 2016. *20490DO001_2016 Census of Population and Housing: Estimating Homelessness*, 2016 Table 1.3 *and* ABS 2017 3101.0 *Australian Demographic Statistics* p29.

Rise in official homelessness is due to population growth.

People living in severely overcrowded accommodation[‡] represent both the largest and the most rapidly growing proportion of the homeless.[26] (Figure 2) Homeless rates in the other categories have remained largely unchanged over the past decade. Analysis of the relationships between homeless operation criteria shows that severe overcrowding correlates poorly with other operational groups, suggesting it has different causal factors.[27] It may be that crowding is not a 'type' of homelessness per se, but rather a by-product of population growth and a reflection of the preferences of some Indigenous and migrant cultures.

According to the ABS, people living in severely overcrowded dwellings rose from 31,531 to 51,088 between census nights in 2006 and 2016 respectively.[28] Most of the increase over that period is in NSW where the jump has been from 27% to 45% of the state's total homeless population.[29] The highest overall rates of overcrowding are in the Northern Territory where there is higher ratio of Indigenous population.[‡‡] Indigenous Australians are five times more likely than non-Indigenous Australians to live in overcrowded spaces.[30]

Although the ballooning rates of overcrowding in Sydney and Melbourne relate in part to worsening private-sector housing affordability, our two main cities also belong to the states that have seen the most rapid population growth, driven primarily by increases in recent overseas migration.[31] Net Overseas Migration (NOM) nationally was recorded at 262,500 in 2016-2017, 27.3% more than in 2015-2016.[32] Figure 3 plots change in immigration rates against change in overcrowding rates across five states, showing a broadly positive correlation.

NSW and Victoria account for 68.6% of the total national increase in population over the past year and those two states absorbed 75.6% of national NOM.[33] People born overseas who migrated to Australia in the five years prior to the 2016 census accounted for 15% of all homeless people.[34] Homeless youth (aged 12-24 years) made up 32% of total homeless people living in severely crowded accommodation.[35]

A proportion of overcrowding in urban centres reflects differences in family size and cultural traditions, including intergenerational occupancy of housing. Some Pacific and Maori cultural norms value communal spaces over separate living areas for sleeping. According to Easthope and colleagues, it is not uncommon to have families with two adults and five children sharing a two-bedroom property.[36] Would these families consider themselves homeless?

A rapidly growing population will necessarily reduce housing availability if stock does not increase commensurately. This is as much a problem of increased demand as it is of insufficient supply. NOM in Australia climbed 30% between 2004 and 2015 while there was a 22% increase in housing stock in that period.[37] One of the goals of *The Road Home* was to 'turn off the tap' of people at risk of homelessness. A 'Big Australia' policy combined with an inflated definition of homelessness that includes severe overcrowding will make the homelessness problem appear much worse than it really is and will mis-allocate resources while 'diluting out' those who need the most assistance.

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‡   The ABS defines a severely overcrowded dwelling as one which requires four or more extra bedrooms to reasonably accommodate its occupants. This metric is borrowed from the CNOS (Canadian National Occupancy Standard).

‡‡   Once severely overcrowded accommodation is included in estimates, the proportion of Indigenous people who are considered homeless rises from 11.9% to 27.6% of the homeless population (Chamberlain 2014)

Inflated official statistics obscure the small subset of those most in need

Despite comprising a small percentage (7%) of officially homeless people, rough sleepers are among the most prolific users of specialist homelessness services (SHS) and have the poorest health outcomes.[38] They are the most vulnerable and visible homeless group.[§] Rough sleeping shortens life expectancy dramatically and exposes individuals to a wide range of social and physical harms. Health risks associated with rough sleeping include:

> Premature death; Bronchitis; Asthma; Gastroenteritis; Pneumonia; Scabies; Pediculosis (Head Lice); Dermatitis; Epilepsy; Hepatitis A (see recent outbreak in Victorian rough sleepers)[39]; Hepatitis B; Hepatitis C; HIV; Diabetes; Smoking related illness; Risk of assault by others; Traumatic brain injury; Malnutrition. [40] [41]

On Census night 2016, there were 8200 rough sleepers nationally, an increase of 20% from 6810 in 2011.[42] According to the Australian Institute of Health and Welfare (AIHW), 47% of SHS clients have a mental health issue and 34% a drug and/or alcohol issue.[43] Chronic rough sleepers are more likely to have complex needs comprising combinations of:

> Developmental disability; Traumatic brain injury; Serious physical health problems; History of abuse and/or trauma; Mental illness; Psychiatric disability; Addictions. [44] [45]

The AIHW identifies three broad cohorts of rough sleepers: persistent service users (13%), service cyclers (42%) and transitory service users (44%).[46] People in the first two categories show much higher rates of mental illness (up to 80% in persistent service users) and problematic substance misuse (63.3% in persistent service users). Persistent users are more likely to have multiple periods of Specialist Homelessness Services (SHS) support and remain homeless at the end of the support period.

In a recent local study of people attending psychiatric clinics in inner city homeless hostels, Nielssen and

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§   It is certainly the case that a highly visible homeless population stimulates public awareness (and guilt), making a compelling case of the need for more funding. Here is Waleed Aly in 2016 defending the practice of begging: "Maybe, the reason we are punishing the homeless for begging us to help isn't because we object to taking some coins out of our pocket. Maybe our real objection is the guilt we are forced to carry away with us when their poverty is rubbed in our face." (Waleed Aly on The Project, reported by Daniella Miletic, Sydney Morning Herald, 2016)

colleagues found that the chronically homeless were likelier to have a psychotic illness, receive the disability support pension, and sleep in the open.[47] Pathways to homelessness for the recently homeless tended to involve release from prison or psychiatric hospital, and 21% of attendees at the clinics had lost a public housing tenancy. In our major cities, demand for homeless hostel beds continually exceeds supply.[48]

Chronically homeless rough sleepers are more susceptible to adopting the culture of homelessness that involves marginalisation from mainstream society and some degree of 'social adaptation' to viewing the streets as 'home'.[49] These people are likely to remain homeless for longer than those who have had housing crises.[50] Some people prefer to sleep rough rather than to accept beds in boarding houses or hostels where drug use and antisocial activity are all too common.[51] Some rough sleepers may prefer to spend their pension money on drugs and alcohol rather than on homeless accommodation,[52] or are unwilling (or unable) to abide by the 'house rules' of boarding house operators.

The first systems barrier to the effective management of this group relates to inadequate information collection and sharing. State governments, local councils and charities have insufficient personal information about many individuals who sleep rough. While the AIHW has generated some good cohort data,[53] individually identifiable information is often missing, incomplete, and difficult for agencies to access. One of the key weaknesses of the system as a whole is the absence of database linkage.[54] [55]

Rough sleepers commonly have no means of identification on their person and are frequently unwilling to disclose personal details. Key questions should include: Is the person on the priority housing list? Do they have accommodation already? Is that accommodation being sub-let? Have they declined offers of accommodation because they prioritise spending on drugs or alcohol over rent? Do they have psychiatric support and are they compliant with it? Have they been evicted from accommodation because of antisocial behaviours, gambling and/or substance abuse? Do they have a legal guardian?

In some areas of central Sydney, a multi-agency organisation called the Homeless Assertive outreach Response Team (HART) attempts to collect individualised data for FACS through its annual registry week and

during other regular street patrols. The HART includes members from FACS, the police, charities and the local council. They also provide a case-management service for some rough sleepers.[56]

Despite their best efforts, outreach workers have a difficult job made even more challenging by systems issues:

- Many of the rough sleepers approached decline to provide information.

- Not all agencies within the HART use the same databases.

- External databases aren't linked (e.g., Housing and Centrelink).

- Once registered, homeless people can opt out of further engagement: "'Those who provide consent are signed up to the HART and are provided with information about how the group can support them, how they are prioritised for support, and how they can opt out if they change their mind."

- Inter-agency information sharing is made difficult because consent is required.[57]

As a consequence, outcomes have been modest. In the period 1 July-30 September 2016, the HART was able to:

- Monitor 254 clients with active consent for HART case coordination.

- Engage 237 people sleeping rough through assertive outreach HART Patrols.

Despite this, they were only able to:

- Support 10 people who were sleeping rough to access sustainable long-term housing.[58]

These results show that current assertive approaches can achieve only limited results when rough sleepers have the option of non-participation, despite the best efforts of those attempting to provide support. It is difficult to believe that only 10/254 (3.9%) of the most severely homeless people in this cohort were able to access long term accommodation. This raises the questions of whether there are voluntary participation remedies that *would* work and, if not, whether there is community support for stronger interventions.

The 'right' to sleep rough

The second barrier to housing rough sleepers is task ambivalence. According to the SHS Assertive Outreach Good Practice Guidelines: "The primary goal of outreach when working with people who are sleeping rough is to assist people to improve their health and housing outcomes."[59] And then in the same paragraph: "However, in order to reach these goals, focus should initially be placed on the prevention of harms associated with rough sleeping *rather than focusing on the prevention of rough sleeping itself*".[60]

This apparent task confusion speaks to an ongoing debate within outreach teams as to whether the very principle of assertive outreach violates the 'social work ethos'.[61] This refers to the radical sociological notion promoted by the social work 'academy' since the 1970s that social problems such as homelessness are the result of structural socio-economic injustice. It follows that subjecting the 'victims' of social injustice to 'paternalistic' and 'judgemental' approaches that 'punish the poor' are rejected in social work circles, and are seen, in the case of homelessness, to violate the 'right' of rough sleepers to live on the streets.[62]

While some rough sleepers have had public guardians appointed by relevant state tribunals (such as NCAT in NSW), many have not. Legal guardians can consent on behalf of the person to medical treatments and can also manage his/her finances and accommodation. Homelessness NGO case managers do not ordinarily have these statutory powers. If a rough sleeper is fortunate to have a guardian appointed this is usually a result of happenstance (e.g. an application for guardianship is made during a hospital admission) rather than because of a formal comprehensive triage process. It seems strange that the role of public guardians is not more widespread, given the preponderance of lifelong cognitive impairments in many rough sleepers.

In practice, moral paralysis over appearing paternalistic pervades outreach guidelines on homelessness and filters upwards so that politicians and police are often not sure how to deal with groups of people who often drink, use drugs and engage in antisocial acts in public spaces.

Police are reluctant to enforce 'move-on' or anti-begging legislation. Staff on homeless outreach teams are advised to be person-centred; but none of this is of much benefit to rough sleepers if they remain on the streets for years. While this approach (understandably) attempts to avoid the risks of trauma through unwanted intervention, it potentially worsens the real trauma and physical risks of ongoing rough sleeping. The longer a person is on the streets, the more difficult it becomes for them to exit[63] because of adaptation to the rough sleeping 'culture'.[64]

This is also at odds with the principle of finding accommodation as quickly as possible. This is the core feature of the 'Housing First' interventions, which aim to provide housing independent of any treatment options or requirements that are otherwise the increasingly favoured policy approach recommended by the homelessness industry. This approach is dealt with in more detail in Box 2.

The orthodox account of the causes of homelessness

An extensive literature supports the notion that homelessness results from, and is an interplay between, structural factors (housing and labour markets) and an array of individual characteristics.[65] [66] [67] While this idea is uncontroversial, it is vital to assess whether conventional policy approaches understate the role of individual factors largely for ideological reasons.

Individual attributes associated with homelessness can range from those over which the person has no control — such as their gender, culture or age — to those more heavily influenced through personal choices, like smoking or drug-taking. Factors such as mental illness, domestic violence and incarceration can sit anywhere between the ends of the 'accountability spectrum'. Researchers view these individual factors as vulnerabilities that increase the likelihood of poor housing outcomes if acted upon by structural pressures and adverse life events.[68] In theory, the greater the range and extent of a person's vulnerabilities, the more susceptible they are to systemic forces that lie outside of their control.

Johnson and colleagues explored the degree to which structural factors such as housing and labour markets impact on homelessness. Their study drew a diverse sample of 1,682 people from the Journeys Home dataset of Centrelink income-support recipients identified as having either recent experience or high risk of homelessness. The authors uncovered a complex picture of dynamic interactions between individual and structural factors. They found that:

- Risky behaviour (drinking, smoking and drug use) raises the chances of entering homelessness.

- An average alcohol consumption of one extra drink per day on average results in a significantly elevated (0.2 percentage point) risk of homelessness. *The smoking of only one extra cigarette per day leads to the same increase.*

- A one percentage increase in the unemployment rate lifts homelessness by one percentage point. However, area level housing and labour markets *do not appear to significantly affect the propensity to exit homelessness* (emphasis added).

- If a person has risky behaviour or ill health, the chances of homelessness are high regardless of housing and labour market conditions.

- Addressing these (risky) behaviours is *the optimum approach of reducing the entry to homelessness*. [69]

Despite the role played by individual factors, the conventional structuralist orthodoxy that dominates the policy discourse commonly cites lack of affordable housing for low-moderate income earners as the major contributor to homelessness. One of the core promises of *The Road Home* was for government to 'invest'[§§] in 50,000 affordable rental homes for low- and moderate-income earners by 2012 at a cost of $623 million with a further 50,000 to be made if demand remains strong[70] However Wood and colleagues' analysis of the structural drivers of homelessness noted that:

> In Australia it has become accepted wisdom that a lack of affordable housing and poor job prospects causes as well as perpetuates homelessness. This assumption is embedded in state and federal homelessness policies... as well as the advocacy work of the homelessness sector. Yet the findings from both our descriptive analysis and modelling work in this report, as well as our previous work… paint a much more complex, if not puzzling, picture of the way that housing markets, labour markets, demographic factors, climate and income inequality might be related to aggregate rates of homelessness.[71]

The researchers found, *inter-alia*, that:

- Areas with higher homelessness tended to have a larger supply of affordable housing relative to demand from low-income households.

- The supply of affordable housing was unrelated to rates of homelessness.[72]

They explained these counter-intuitive findings by reference to dynamic interactions between labour and housing markets. For example, 'at risk' people are more likely to move to less affluent areas where there is also more abundant low-cost housing. Regardless, these findings should give pause to those who think that homelessness is *only* a problem of housing supply and affordability.

While improving (private) housing affordability will do little to directly help those who sleep rough, it may help people exit social housing. Increasing the volume of housing at any level of the market improves the availability and reduces costs of the properties at or below that stratum. Stephen Kirchner has argued that the supply side of housing provision could be enhanced (with net benefit to the taxpayer) by lowering tax and regulatory barriers to new dwelling supply.[73] Reducing or eliminating taxes on housing transactions and streamlining of zoning, planning and approval processes would remove barriers to property development.

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§§ It is unclear how social housing can be considered an investment when the taxpayer is liable for the initial construction costs and then indefinite expenditures thenceforth. At best it represents an opportunity for cost-offset.

Understanding the relative contributions of risk factors and the sequences of events that lead to homelessness are crucially important if intervention strategies are likely to be successful. Different paths are associated with different average durations of homelessness.[74] [75] For example, there may be little or no overlap in the causal factors that lead to a 19-year-old female migrant who 'couch surfs' and a 65-year-old man with chronic alcoholism who has slept rough for a decade. Yet despite the differences in severity and trajectory of these cases, both people are deemed *equally* homeless by the ABS.

The orthodox account of the supposed problems and solutions contained in The NSW Homelessness Strategy[76] and *The Road Home*[77] do acknowledge the impact of certain individual factors such as the role of family and domestic violence, mental illness, substance misuse and transitions from institutions (prisons and hospitals). However, the orthodox view also contextualises personal vulnerabilities as being *consequences* of underlying social structures. Australian academics from a range of universities recently stated their position thus:

> The individual vulnerabilities, support needs, and 'risk-taking' behaviours implicated in some people's homelessness are themselves often, although not always, rooted in the pressures associated with poverty and other forms of structural disadvantage.[78]

Box 2: Housing First

- Domestic policy responses to rough sleeping are shifting in emphasis from traditional charitable outreach (usually a temporary crisis response) to a relatively novel 'Housing First' approach based on international models including programs in the US, UK, Canada and Finland.[79] [80] In Australia, Common Ground, Street to Home and Way2Home are representative models.

- The philosophy underpinning Housing First is of an unconditional right to long term (supportive) housing regardless of current health or behavioural factors such as drug abuse. This contrasts with existing programs that make the provision of housing for clients with complex needs contingent upon psychosocial supports — the so-called 'linear model' (or treatment first) in which clients proceed through sequential care settings.

- Housing First rests on the notion that many homeless people are unable or unwilling to participate in treatment programs and so will remain homeless unless 'housing comes first'. The originators of the concept hoped that "Having a place of one's own may — in and of itself — serve as a motivator for consumers to refrain from drug and alcohol abuse."[81]

- Housing First was first outlined in the US in the 1990's by Tsemberis and colleagues who founded the Pathways to Housing program[82]. Its core features are:[83]

  – The absence of sobriety or treatment preconditions for housing;

  – An emphasis on rapid placement into permanent housing; and

  – The assurance of sufficient support services in the community. Access to support is voluntary and is driven by the client.

- The existence of different models of supportive housing makes comparisons and generalisability difficult. Variations exist in the 'fidelity' of programs studied, including the degree and nature of support as well as in the types of housing provided (e.g. single building versus scattered-site).

- Analyses of interventions and outcomes have been hampered by (non-random) attrition, selection and response bias, imprecise definitions and implementation of housing programs, and lack of appropriate controls.[84] Many studies depend of self-reporting rather than on administrative data. Researchers often use convenience — samples of those who give their consent and who can answer surveys at baseline and follow-up. Subjects who drop out of supported housing trials are typically more 'complex'; this phenomenon can distort the accuracy of outcome measurement and reduces statistical power. Most studies are of limited duration (12-24 months) and regression to the mean in both treatment and control groups appears to occur in studies that record outcomes at 24 months or later.[85] [86]

- Although housing retention rates are unequivocally superior to those achieved through other 'standard' programs (Sydney's Way2Home program successfully assisted 90% of participants achieve sustained housing)[87] the results of Housing First across other domains have been mixed.

- Housing First achieves modest improvements in employment and social inclusion and the clinical benefits are equivocal.[88]

- Engagement with drug and alcohol services remains voluntary in this model of care.

- Generally speaking substance misuse does not improve in those provided housing;[89] [90] [91] in one local study rates of amphetamine and cannabis use actually increased.[92]

- This is hardly surprising. After all, people with severe dependence do not usually seek help unless there are strong incentives for them to do so.

- A recent Australian study[93] used administrative data to look at outcomes for a cohort (N=41) of long term homeless people before and after Housing First tenancies. Researchers found improvements in mental health service usage and court appearances but no statistical differences in days in hospital, emergency department presentations or ambulance use.

- Kertesz and Johnson (2017)[94] have urged caution in interpreting and generalising the positive cost outcomes of Housing First. They examined a number of programs in North America and Australia and found that the cost benefits were often smaller than claimed. For all but the most 'expensive' homeless people, the costs of Housing First *exceeds* the savings attached to reduced service use[95].

- The Canadian Chez-Soi trial reported that for high need clients, savings of $9.32 were achieved for every $10 spent, but this diminished to $3.42 in savings for moderate need participants.

- An Australian trial of just under 100 participants reported that for every $1 invested there was a $0.32 return to the community[96].

- Housing First operates as a downstream intervention and does little to modify the factors that lead to homelessness in the first place. Like other orthodox approaches it rests on voluntary engagement; an attribute that becomes scarcer as the effects of mental illness and substance misuse become more severe.

- It may be that Housing First is a suitable intervention for a percentage of 'moderately severe' rough sleepers who are impacted less by mental illness and substance misuse, and that the more chronically disabled will require some form of long term institutional care with high levels of nursing and medical support.

- The transient, elusive and resistive nature of some rough sleepers may preclude them engaging with outreach teams; a necessary condition of the Housing First approach.

- An Australian RCT examining 48-month social and economic outcomes of a supportive housing initiative stated that "…policy makers will need to explicitly acknowledge that a small minority of homeless people require ongoing and indefinite support."[97]

So, for example, the criminal behaviour that leads to incarceration (and subsequent homelessness) is conceptualised as being a result of intergenerational poverty, inequality or poor economic conditions rather than of bad personal choices. QUT academic Dr Cameron Parsell opined in 2017 during the Martin Place controversy: "People are sleeping rough...because of decisions we make and sanction about the inequitable distribution of resources."[98]

If the search for structuralist answers is unhelpful, so are the explanations for disadvantage that are sometimes sought in more abstract social phenomena such as historical racism, stigma and discrimination.[99] For example, homelessness in Indigenous people might be attributed to racism and discrimination rather than to the person living remotely where chances of employment are reduced. Tenancy breakdown in public housing due to demanding behaviour is blamed on 'intolerance of difference' including lifestyle factors, cultural differences and prejudice rather than anti-social behaviour linked to mental health and drug and alcohol abuse.[100] These chains of causation ensure that individual factors and behaviours are transmogrified into either the direct products or emergent phenomena of economic and social structures.[101]

When homelessness is viewed through this prism, solutions will necessarily require substantial intervention by government into broader economic and social structures and will often be technocratic. Writing recently on homelessness in the UK, Professor Nicholas Pleace of the University of York proposes that the conventional and desirable policy responses should be to reverse the "deep cuts in social housing, mental health services, to welfare reform, to labour market and housing market failures, and to the cutting of homelessness services."[102]

Invoking these kinds of meta-interventions avoids difficult judgements about lifestyle or cultural choices as per the non-judgemental social worker ethos. Hence, proponents of structural interventions also prefer this response because they assume that individual lifestyle or cultural choices are the result of structural factors. Structural solutions also make easily digestible media soundbites, and are perennially valid regardless of prevailing economic or political conditions.

Yet there are good reasons to doubt this seemingly intuitive narrative. Specifically, it should be questioned whether structural solutions are good methods of reducing homelessness, even where its causes are primarily structural (such as immigration or culturally-driven overcrowding), let alone whether structural solutions are effective when applied to the challenges of chronic and severe ('literal') homelessness (rough sleeping) which is driven (and sustained) predominantly by individual factors.

Flaws in existing structural solutions

There are a number of reasons why the structural solutions posed by those following the orthodox account of homelessness have been ineffective. A specific issue is that they do little to address behavioural factors, because of the belief that the causes of homelessness are primarily structural. In some cases this oversight — particularly with respect to public housing policy — causes these structural solutions to exacerbate the problems they are designed to solve.

Social housing is oversubscribed and inefficiently used

Social housing provides a low-cost alternative for people who cannot afford comparable rentals in the private sector. 80% of the 812, 900 Australians who live in social housing live in public housing that is funded and run by state governments.[103] The remainder live either in community housing (NGO operated) or indigenous housing. Taxpayer-funded accommodation is difficult to access because of high consumer demand and low rates of voluntary exit by existing tenants. Social housing maintains people for many years — and sometimes intergenerationally — on the cusp of homelessness. While housing support has been traditionally aimed at low-income families, it now preferentially services those in 'greatest need', including those at high risk of homelessness.[104]

Social housing merits critical investigation because it is one of the most expensive structural 'solutions' to homelessness. Combined state government expenditure on social housing reached $5.6 billion in 2016-17.[105] Governments are unanimous in their pledges to increasing social housing supply to match the demand (this was one of the key policies outlined in *The Road Home*). The relationship between supply and demand in social housing is not straightforwardly unidirectional. It is conceivable that generating supply might actually *stimulate* greater demand, motivating people who would otherwise live with family or in private rentals to apply for social housing, requiring even more stock to be built.[106]

The social housing sector in general is fraught with substandard accommodation and inefficiencies.[107] On aggregate it is simultaneously under-utilised and overcrowded.[108] As at 30 June 2017, there were 142,500 applicants awaiting public housing application nationally.[109] People with certain chronic medical conditions (mental illness, physical disabilities and so-forth) can join a smaller priority list if there is persuasive medical evidence relating to the functional impact of their condition, or if their level of need is deemed high for other compelling reasons.

In efforts to achieve priority status, some patients who would ordinarily fall short of the eligibility threshold apply for the Disability Support Pension (DSP) as a way

of demonstrating 'greater need' to the Department of Housing, further straining the welfare budget. This is one of several perverse incentives associated with the provision of social housing. Other examples are explored below.

A small and shrinking proportion of social housing occupants move into private rental accommodation, and 17% of these people end up returning to social housing.[110] Annually, vacancies caused by voluntary tenant-initiated exits represent approximately 5% of all housing stock.[111] The reduced turnover for housing means there will be a longer waiting list for housing, while at the same time prolonging the duration of dependency (and intergenerational dependency) for those already publicly housed.

In the early days of social housing, there was a greater proportion of 2- and 3-bedroom flats suited to poor families. The demographic shift towards single occupancy of public housing that has accompanied changes to traditional family structure means there are currently a substantial number of dwellings (15% NSW and 28.2% for Indigenous housing in 2016) with surplus bedrooms.[112] Despite objections from various advocacy groups and legal agencies,[113] the NSW government introduced a vacant bedroom charge in 2013 to encourage people living in under-used housing to 'downsize'.[114] The charge, in reality a reduction in the subsidy provided by government, is applied to occupants of under-occupied accommodation, who can choose between either downsizing or paying extra rent for unused rooms. It is too early to know how effective this initiative has been and how rigorously it has been enforced, but there is merit to the idea of optimising existing resources before new projects are undertaken.

A welfare trap

Demand for public housing has grown not just because of problems with private sector affordability, but also because of migration, breakdown of the nuclear family, and de-institutionalisation.[115]

The minimum rental for public housing is only $5, and the maximum is the 'market rate' for that property as calculated by FACS. Most households are eligible for a rental subsidy, paying a 'rebated rent' of 25-30% their income, regardless of the value of the property. The gap between this amount and the market rate of the property is covered by the government.

A 2014 analysis of 30 years of Australian public housing found that:

- The proportion of households requiring rent subsidies has risen from 60% to almost 90% during that time.

- Labour force participation rates of social housing tenants have plummeted. In 1981, 48% of public housing tenants were supported primarily by the government. In 2009, this percentage was nearly 90%.[116]

Encouragingly, in one study, 71% of unemployed tenants in public housing expressed a desire to work.[117] However there are disincentives in the system that work against the desire to find a job.

For those seeking to leave welfare and enter the workforce, the tapering of welfare payments, together with the interaction of the income tax systems, mean a significant amount of additional income received from work is lost to government (the problem of high Effective Marginal Taxation Rates).

The problem is made worse for many public housing tenants due to the fixed percentage of income paid for public housing. For these tenants, a quarter of any surplus earned will be deducted and applied to the person's rent. The question of 'why work?' reflects the unemployment trap inherent in the current system.

The complex interaction of welfare and tax creates poverty traps that deter public housing renters from working more hours — or indeed working at all. Public housing becomes a barrier to the one escape from poverty available to the poor: employment. Some researchers have argued that facilitating employment should be offered as early as possible as an under-utilised practice for preventing and ending homelessness.[118]

Upgrading to private rentals is associated with risk for unemployed public housing tenants, including the loss of guaranteed tenure, and a switch from subsidised rent to a less generous Commonwealth Rent Assistance (CRA) which is approximately only $132.20 a fortnight (maximum) for an individual.

In an attempt to mitigate these risks, the NSW government has instituted the Start Work Bonus — introduced to encourage FACS tenants to move into paying jobs. Under the scheme, the household is eligible for a grace period of up to 26 weeks within a financial year before FACS adjusts their rent subsidy to take account of the change in income when the tenant or any member of the household starts a paying job.

Mutual obligation and anti-social behaviour

The welfare system in Australia has, since the 1980's, attempted in varying degrees to balance the provision of governmental support with the obligations of its recipients (conditionality). Examples include participation requirements (activity tests) for unemployment benefits and conduct tests to be met before Indigenous parents in some jurisdictions were able to receive parenting payments. Overall, mutual obligation has improved workforce participation and has discouraged dependency.[119]

Some academics claim that mutual obligation is a consequence of 'neo-liberal governmentality'.[120] [121] This view is shared by many charities and NGOs who deem the principle 'paternalistic', 'oppressive' and an affront to human dignity.[122] Advocates for welfare justice object to the notion that welfare recipients who are deemed responsible for their hardship should be less 'deserving' of assistance.

Despite fears that such measures might deny people's right to financial support,[123] mutual obligation penalties are often more honoured in the breach than in the observance. For example, while it might be argued that the modest requirements of Work for the Dole are 'draconian', the conditions attached to continued receipt of payments are generally not applied with a great degree of stringency and are open to numerous exemption loopholes.[124]

While supporters of mutual obligation believe it fosters self-reliance, social participation, and the benefits attached to the dignity of work, it has not noticeably reduced the size of the welfare state. The welfare system has continued its inexorable expansion since its inception, growing from 1% of GDP at the turn of last century to 23% in 2014-15.[125]

There are additional elements of mutual obligation that apply in relation to housing and homelessness, though the effectiveness and scope of these obligations is not clear, and they are less prominent in public awareness and media discourse than those associated with unemployment benefits or disability pensions.

One consequence of de-institutionalisation (see below) has been the linking of accommodation to the provision of support, especially for those with mental illness. Hence, *The Road Home* identified a need to "improve economic and social participation" to prevent homelessness.[126] However, the degree of mutual obligation in social housing depends upon both the 'type' of social housing for which the person has applied and their willingness to seek support. Some applicants to community housing must show that they have access to, and are willing to engage with, appropriate support services. If there are concerns about a client's ability to live independently, the housing provider can request permission from the applicant to obtain:

- A living skills assessment from an external support agency; or

- An independent living skills report from their support worker.

Specialist Homelessness Services do play an important role in preparing recently homeless people to obtain and maintain stable tenancies in public housing, and without their interventions there would no doubt be more homelessness.[127] Crucially though, it usually falls to the tenant to seek appropriate SHS assistance.

In general, public housing tenants are obliged to do very little to maintain their housing (other than to remain poor). According to FACS they need only to:

- Pay their rent;

- Look after their property;

- Not cause or allow antisocial behaviour;

- Live independently without support or with appropriate support in place; and

- Live in the property on an ongoing basis.[128]

According to the NSW Auditor General's 2108 report, antisocial behaviour is a significant problem in public housing.[129] Among the most common forms of behaviour are:

- Noise and nuisance.

- Threats and abuse.

- Hoarding and squalor.

- Drug use.

- Unauthorised occupants.

Many of these problems can be attributed to increased substance misuse and the growing proportion of public housing residents with mental illness and disabilities. The auditor general reported that: "Of the factors that limit a tenant's ability to comply with the tenancy agreement, drugs and alcohol was listed as the second most common factor after mental health problems. Staff at 16 out of 27 housing offices we visited specifically identified the drug 'ice' as a problem for tenancy management. According to FACS data on substantiated antisocial behaviour incidents, drug trafficking and supply almost doubled between 2016 and 2017." The housing estates themselves are often focal points for people who deal drugs or consume alcohol in public; creating so-called 'negative communities'.[130]

In 2016-17, 9% (2,107) of (predominantly public) housing tenancies in NSW were terminated[†††] due to a breach of tenancy agreement; and 30% of these were Indigenous tenancies.[131] Such is the impact of antisocial behaviour that the NSW government has recently instituted a 'three strikes' policy for public housing tenants. It is unclear as to how effective this policy has been, due to systems issues relating to the processing and recording of complaints. During the period of audit, from Feb 2016 to Dec 2017, FACS recorded 6,755 incidents of antisocial behaviour.[132] From these, 1,500 warnings, 200 first strikes, 58 second strike and 11 third strike evictions were ordered.[133] 4,000 incidents were recorded as 'no outcome'.

Unlike supported accommodation for the homeless or supported community housing, there are no frameworks or guidelines for managing tenants with mental illness or behavioural issues in public housing. FACS has a partner arrangement with NSW Health for the provision of psychosocial support but tenant attendance is voluntary, and services are often at capacity. This client-centred approach suits people who are motivated to engage but allows more vulnerable and complex people to avoid receiving the assistance they need — and thus places them at risk of losing tenancies and ending up living on the streets.

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††† An undisclosed number of renters also illegally sub-let their accommodation without the knowledge of the Department of Housing.

Individual factors are an important cause of homelessness

Far from being subordinate to structural issues, individual factors are an important cause of homelessness in their own right. The failure to address these issues is a significant reason why the rates of those sleeping rough have not declined despite the increased public investment in homelessness. There are two specific issues that are relevant: the impact of deinstitutionalisation on the seriously mentally ill; and the effect of substance abuse.

Deinstitutionalisation

The vignette below is from the NSW Auditor General's report for FACS:

> Mitch is a public housing tenant living in regional NSW. Reports on his tenancy indicate a history of mental ill-health, evidence of cognitive impairments due to injury, and alcohol dependency. Mitch and his partner have limited ability to care for their property. Neighbours have made complaints to FACS about the smell of the property, increasing rubbish around the property, and barking dogs. Mitch has multiple pets and hoarding behaviours. FACS housing staff have issued a warning and two moderate antisocial behaviour strikes against Mitch's tenancy.
>
> Housing staff have informed Mitch and his partner that their tenancy is at risk. Housing staff have periodically assisted the couple, by attending at the property and helping to clean the house and teach the couple housekeeping skills. Over the years, Mitch has been cleaning parts of the house by hosing the floors, and as a result, the floors are rotten.
>
> Housing staff have made multiple referrals to local mental health services and other services to assist Mitch to maintain his tenancy. Mitch is suspicious of strangers and refuses assistance, including assistance from cleaning services. The limited number of support services in the area are not willing to engage with Mitch and his partner due to their problematic, and at times, threatening behaviours. Maintenance contractors have refused to enter the property on Work Health and Safety grounds.
>
> FACS housing staff are aware that the 'strikes' approach will not assist in changing Mitch's problematic behaviour. He is not responsive to warnings and strike notices and does not fully understand the consequences of his behaviours. Housing staff see that the only solution is to start eviction proceedings, but this will likely make Mitch and his partner homeless.[134]

It should be immediately clear from the vignette that Mitch and his partner are wholly unsuited to living in public housing. Mitch was probably a victim of de-institutionalisation and has complex neuropsychiatric and behavioural difficulties which make living in social housing untenable, unsafe for himself and those around him, and unsustainable. His unmet needs include mental health, physical health, substance dependence and recurrent antisocial behaviours.

It is now more than 35 years since *The NSW inquiry into Health Services for the Psychiatrically Ill and Developmentally Disabled* recommended the process of de-commissioning long-stay institutions and moving towards the model of care in the community.[135]

The document "Living Well" A Strategic Plan for Mental Health in NSW 2014-24 of the NSW Mental Health Commission (p14) identifies complete de-institutionalisation as a core aspect of its vision.[136]

At time of writing, there are still a handful of so-called 'Schedule 5' hospitals in NSW. These are stand-alone, long stay facilities for people with combinations of psychiatric illness, intellectual disabilities, and alcohol and drug abuse. After the process of emptying the hospitals accelerated during the early 1990s, it became clear that some Individuals with complex needs and vulnerabilities (like Mitch) could not manage the difficult transition to community living. There is a broad consensus[137] that the process of de-institutionalisation was undertaken hastily with inadequate planning and investment in community alternatives. The questions remain: has the process of de-institutionalisation been economically advantageous? Are patients better off in terms of their health and well-being?

The economic benefits of a move to community care are equivocal. A systematic review of the costs of European de-institutionalisation found that "The evidence base on the economics of deinstitutionalisation is modest" and furthermore that "...there were a number of long stay patients with very challenging needs who were more costly to accommodate in community settings."[138]

While we don't have similar analyses for Australia, we do know that the costs of supported accommodation for people with complex needs is very high if that care is equivalent to care provided in an institutional setting. Organisations like HASI (Housing and Support Initiative) in NSW provide excellent supported accommodation for people with mental illness, but at a substantial cost.[139]

While it is true that many people with intellectual and/or physical disabilities have benefited from moving out of large-scale institutions and into smaller group homes, a significant cohort of people with severe mental illness have not fared so well. These people usually suffer from combinations of severe mental illness (often personality disorders), drug and alcohol abuse, and intellectual disabilities. This population is prone to 'trans-institutionalisation' characterised by frequent and expensive psychiatric hospitalisations, disproportionately high use of emergency services, and contacts with the criminal justice system — including incarceration. Many rough sleepers and residents of boarding houses and hostels fall into this category.[140]

The Living Well report paints institutions as dehumanising dens of horror.[141] There is no doubting there was much in the history of institutional psychiatry that we would consider inhumane by today's standards. Some hospitals witnessed systemic abuses of authority and unethical treatments. Many patients were hospitalised under flimsy pretexts.

However, it must be acknowledged that institutions helped alleviate suffering of the most vulnerable in our society by providing asylum from the everyday cares of existence. Institutions cannot be un-moored from their historical context; we have only had effective pharmacological treatments for schizophrenia since the second half of the 20th century. Many long-stay patients had no family supports. The more functional institutions operated as self-contained cities, with shops, dentists, hairdressers, workshops, and so forth. Patients had structure, support and routine 24 hours a day. The commission states that institutions were places "of great suffering for people with mental illness" but also that "Staff may be displaced, and we can't afford to lose their expertise."[142]

A good deal of ambivalence persists about the merits of closing the asylums. In outlining their aspirations for a move to the community, the commission promises that "A minority (of patients) will require long-stay care in a safe, supported environment, outside an institutional setting."[143] It is not clear how this can be safely achieved. Many patients staying in current Schedule 5 sites have significant forensic histories. It is naïve and disingenuous to believe that institutions can just be shut without some patients coming to harm, becoming homeless, or causing harm to others.

Mental illness and substance abuse

The relationship between mental illness, drug and alcohol abuse and homelessness is dynamic and complex. People with these morbidities are disproportionately represented in the homeless population. FACS estimates that people living in social housing are 2.4 times more likely to have a mental illness than those who are not, and methamphetamine abuse is featuring more prominently in antisocial behaviours.[144] Substance dependence has economic consequences for the individual beyond the opportunity costs of unemployment.‡‡‡

Among clients requiring assistance from SHS in 2016-2017, 37% identified a need for drug and alcohol counselling.[145] People becoming homeless through mental illness and substance misuse are usually homeless for longer periods and require more periods of support.[146] The number of clients with a current mental

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‡‡‡ Some patients in my care spend $1000 per week on heroin, for example.

health issue accessing SHS increased from 22,543 in 2012-13 to 27,295 in 2016-17[147].

In a local study exploring the relationship between homelessness and employment, Steen et al 2012 found that homelessness and housing instability are not barriers to workforce participation *per se*.[148] However, individual factors such as substance misuse contribute substantially to diminished workforce participation. In their 2002 study of 397 individuals, Zlotnick and colleagues found that recent drug users were only 5% as likely as other homeless individuals to be in the labour market.[149] Antonetti and Horn (2001) identified gambling (another addiction) as a causal risk factor for homelessness, particularly in Indigenous populations.[150] Australia has more poker machines per person than any country in the world.[151]

With the dissolution of psychiatric institutions there was a simultaneous and reactive expansion of in-patient psychiatric facilities within general hospitals; a process known as 'mainstreaming' (this has now plateaued in scope). In 2015-2016[152] there were 7,058 public specialised mental health care beds, a modest increase from 6556 in 2008-2009[153] given population increase of well over 1 million people in that period. Acute mental health services are stretched to breaking point; Australia ranks 26 out of 34 in the OECD for hospital beds per 10,000 people.[154] Naturally, patient 'turnover' for these acute beds is rapid, with a mean length of stay of 13 days.[155] This is due in part to demand on acute psychiatric beds from emergency departments which must meet stringent length-of-stay KPIs. Many patients with severe mental illnesses are discharged while still unwell, increasing their chances of relapse and readmission, or of disappearing 'off the radar' into the streets. A high proportion of the homeless population come directly from psychiatric wards. Once a patient is discharged, it falls to community mental health teams to attempt to provide treatment to the patient in their own accommodation; an undertaking that is often difficult and sometimes dangerous.

While it is still possible to mandate psychiatric treatment in the community through Community Treatment Orders (CTO's), or to admit patients involuntarily for psychiatric treatment to psychiatric wards under the Mental Health Act, it is very difficult to compel a person to participate in drug and alcohol treatments against their will. In NSW there are some pathways (coercive treatment) to involuntary drug treatment which a person can voluntarily undertake as an alternative to a more unpleasant alternative, such as incarceration or fines. Treatment can be mandated through drug courts, or as a condition attached to probation and parole.

However, in 2012 the NSW state government introduced a limited program called IDAT (Involuntary Drug and Alcohol Treatment) as a means of providing long-term residential mandatory drug/alcohol (civil commitment) treatment. The following strict inclusion criteria apply to patients with severe substance dependence:

- They have a tolerance to a substance and show withdrawal symptoms when they stop or reduce levels of its use;

- They do not have the capacity to make decisions about their substance use and personal welfare, primarily because of their dependence on the substance;

- The care, treatment or control of the person is necessary to protect the person from serious harm;

- The person is likely to benefit from treatment for his or her substance dependence but has refused treatment; and

- No other appropriate and less restrictive means for dealing with the person are reasonably available.[156]

Applications for treatment are subject to numerous bureaucratic hurdles and an order must be made with the blessing of a judicial tribunal. The program rests on the notion that sometimes it is necessary to "deny autonomy in order to create it."[157] There are fewer than 20 beds in NSW, and unmet demand from clinicians and patients' families is understandably very high. At present the beds are allocated to patients who are physically *in-extremis.*

Preliminary outcomes of the program look positive: 6-month outcomes were remarkably good in the 40 patients with alcohol dependence admitted for involuntary treatment.[158] Given the impact of drug and alcohol dependence in homeless people, there is an argument for commencing involuntary treatment earlier before brain damage and related psychosocial disabilities become permanent.

The cost of tobacco disproportionately disadvantages the homeless

Rates of cigarette smoking are 71% in the housed homeless population, and almost universal in rough sleepers (93%).[159] Homeless people, and especially those with mental illnesses, are disproportionately affected financially and physically through use of tobacco.[160] There are many barriers to smoking cessation in this population reflected in lower rates of quitting. Rough sleepers are more likely to engage in risky smoking behaviour; they often smoke discarded cigarette butts or smoke cheap, low-quality tobacco.

At time of writing, the purchase price of one cigarette is approximately one dollar. For someone smoking a packet a day, the cost of this habit can exceed $300 a fortnight; more than one third of their income. For those at risk of homelessness, this can be enough to precipitate housing stress. In a sample of attendees at a homeless hostel clinic, some reported that they would prefer to sleep rough than give up tobacco.[161] Conventional smoking cessation interventions for rough sleepers are minimally effective.[162]

Research is currently being undertaken in the UK and the US to look at the introduction of nicotine containing e-cigarettes for homeless people as a means of harm reduction.[163] Nicotine containing e-cigarettes are currently illegal in all Australian jurisdictions.

It is simplistic and misleading to claim that homelessness is *just* about lack of housing — public or private — as the orthodoxy maintains. The homeless industry has argued for at least a decade that structural factors — economic and social — are at the root of the problem. Advocates have pointed policy makers in the wrong direction by misidentifying both causes and solutions. Remedies to the problem are predictable calls for more housing. The key issue is how to most effectively modify the behaviours and/or mental illnesses that lead to homelessness in the first instance, and then to focus on the population most at risk: chronic rough sleepers. Formulating solutions that focus on the real problem starts with reverting to a more literal definition of homelessness (or at the very least abandoning the operational group of severely crowded accommodation) that would help to clarify the optimal allocation of resources. Pressure from the homelessness industry to further expand the definition of homelessness should be avoided.[164]

Nevertheless, as Johns has suggested,[165] there is probably an irreducible minimum of homelessness, just as there is an irreducible minimum of unemployment.[166] Once we accept this reality, we can then proceed to discover which factors are modifiable, and at what cost. But most crucially, we must ask to what degree the irresistible quest to help more people, and the measures taken to achieve this, actually create more people who need help? Ineffective policy has the potential to create unintended harms.

Improve the quality and efficient use of social housing to turn off the tap

There could be a focus on optimising the use of extant housing rather than building new premises. The vacant bedroom tax could be rolled out nationally and applied consistently if it proves effective in NSW, and could be extended to Indigenous housing. Instituting automatic rent deductions from Centrelink payments for all tenants on welfare incomes (and preventing the option of tenants cancelling their rent deduction scheme) could prevent defaults on payments and evictions. Introducing cashless debit cards for all social housing tenants who are on disability pensions or unemployment benefits would improve responsible use of welfare (e.g. food and rent vs gambling and drugs). This should in theory help to reduce eviction rates.

There needs to be a greater flow through social housing into the private rental sector. Exit from social housing could be incentivised via several mechanisms aimed at reducing poverty and unemployment traps. High EMTRs dissuade tenants from working. Hulse and Randolph outlined 19 strategies for reducing the disincentives associated with social housing through modifying the interaction between income support, housing assistance and tax systems to remove penalties for work.[167] These include:

- Disregarding some or all earned income when assessing rents.

- Depositing into a savings account the rent increases that would have been charged due to increased earnings.

- Moving away from rents based on incomes to rents based on property values/locations. This would mean that earning extra through work would not increase rents.[168]

To reduce entries into rough sleeping, occupants of public housing referred to mental health services should be mandated to accept psychosocial support as a condition of ongoing tenancy (in keeping with the principle of mutual obligation). Specialist Homelessness Services already offer various effective programs to help people maintain their tenancies. At-risk clients of SHS could be taught how to prioritise short term goals over long term outcomes. Specific areas of intervention might include honest dialogues about anger management, better partner choice, staying in relationships if it is safe to do so, budgeting and financial literacy, family planning within financial means, taking medications for mental and physical illnesses, and not accumulating or breaching AVOs. These topics could be introduced into high-school curricula as a homelessness prevention strategy.

Improve substance misuse and mental health treatment and outcomes

There should be greater focus on modifiable individual factors such as risk-taking behaviours that will increase the risk of homelessness regardless of economic conditions and market forces. Policies should be aimed at support and treatment rather than 'victim-blaming'. These could include:

- Expanding the scope of IDAT for homeless people or those at high risk by increasing the number of detox and rehabilitation beds, reducing the barriers to entry of the program and lowering the clinical threshold for involuntary treatment.

- Commissioning the building of smaller, stand-alone and humane long-stay facilities to suit the needs of people unable to manage community living.

- Increasing the number of acute psychiatric beds and providing scope for longer in-patient episodes of care to help reduce eviction rates for people with severe mental illness.

- Maintaining efforts at making public housing premises safe for tenants and accessible for community support teams to be able to assist their clients.

- Commencing trials of e-cigarettes containing nicotine for rough sleepers and/or other homeless people as a safer and cheaper alternative to cigarettes. This would require a change in state government legislation and should be considered a harm-reduction measure like methadone for opiate dependence. Specific aspects relating to charging of devices, the production and pricing of the nicotine product and accurate monitoring or outcomes would be necessary.

Adopt benign and enlightened paternalism

The primary aim should be to facilitate rough sleepers exiting from the streets and into a healthier environment as soon as possible. This will require additional, fit-for-purpose public infrastructure by increasing the numbers of homeless hostel beds and providing better models of supported accommodation. But it will principally require a fundamental change of approach from a rights-based paradigm to the following benign and enlightened strategies:

- All rough sleepers should have a compulsory medical review, an assessment of mental capacity and a mental health evaluation.

- Increase the number of homeless hostel beds where medication can be supervised and provide better models of supported accommodation.

- Introduce a centralised rough sleeper online database — accessible to all agencies — that includes comprehensive and personally identifying housing and welfare information.

- Encourage public participation in alerting authorities to the presence of rough sleepers via a homeless hotline or via an app that records locations of rough sleepers in real time. Corporations and businesses should do likewise if a homeless person is sleeping rough on or near their premises. This is true corporate social responsibility — as opposed to virtue-signalling CEO sleep-outs.

- Raise public health awareness by discouraging the giving of money to those engaged in begging as this often contributes to substance abuse and maintains homelessness and harmful addictions.

- Appoint public guardians for all rough sleepers who lack decision-making capacity, to assist with or make proxy decisions about finances, accommodation and medical care.

Conclusion

We should not be surprised that genuine homelessness remains stubbornly resistant to government interventions. Over the past two decades, policy-makers have blurred the boundaries of the problem by continually shifting the definitional goal-posts. The flurry of activity around the 'non-problem' of the 'housed homeless' obscures the needs of the vulnerable, and the appropriate responses to those needs. Policy is failing because it cannot see the trees for the woods and applies predictable structural solutions where a focus on modifiable individual factors and appropriately targeted and tailored strategies would yield more benefit.

The provision of social housing in its current form disincentivises progression into private accommodation, reduces the chances of employment, and provides a steady stream of homeless people by dealing insufficiently assertively with antisocial behaviours and mental illness. The principle of mutual obligation inherent in our welfare system needs more rigorous and consistent application, especially in public housing. The problem has been compounded by the failures of de-institutionalisation and the inadequacy of mainstream psychiatric services to cope with demand. Housing First programs seem to be effective at exiting people from the streets, but do little to modify the factors leading to homelessness and address substance misuse and mental illness.

There are service and legislative gaps into which many rough sleepers fall. Current approaches to the most vulnerable cohort of homeless are hamstrung by a combination of systems inefficiencies and task ambivalence. There should be an expansion of long-term compulsory drug and alcohol rehabilitation (rather than the extreme positions of either permissiveness or victim-blaming) and a limited re-imagining of institutional mental health care for those people who, even with high levels of support, are unable to manage supported community living. E-cigarettes should be legalised and the use of the cashless debit cards increased, especially for those who preferentially spend their pensions or benefits on alcohol and tobacco.

It is often stated that homelessness is not a choice[169]. This is a glib oversimplification. Poor choices (even small ones) act cumulatively to either directly worsen a person's prospects, or to hamper their capacity to manage external adversity and misfortune. A compassionate and civilised community should be even less willing to abide, and fail to intervene to stop, poor choices linked to the cognitive impairments such as the mental illness and substance abuse problems that disproportionately afflict rough sleepers.

An inverse moral panic — a fear of being perceived to support 'moralistic' policies — has paralysed our treatment of the most severely homeless. The accompanying ideological shift, away from paternalism towards a human rights focus that preferentially preserves autonomy, has been achieved at a high cost to those individuals whose needs have gone unmet. The genuinely homeless Australians who sleep rough on our streets are 'dying with their rights on'.[170]

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