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# Evaluation of the Complex Needs Coordination Project

## Final Report

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## Abbreviations

| | |
|---|---|
| ADHC | Ageing Disability and Home Care |
| CNCP | Complex Needs Coordination Project |
| CNMG | Complex Needs Management Group |
| CCG | Care Coordination Group |
| CCP | Coordinated Care Plan |
| HNSW | Housing NSW |
| NGO | Non-government organisation |
| NSW | New South Wales |
| SPRC | Social Policy Research Centre |

# 1 Executive summary

The Complex Needs Coordination Project (CNCP) was implemented in 2007 with the aim of assisting people with complex needs who are chronically homeless in the City of Sydney Local Government Area to access long term housing and support services. The Project was inspired by a housing first philosophy but, given that it was established without additional resources, CNCP focused on linking clients with local support services and establishing pathways into secure housing.

The SPRC was commissioned in June 2010 to conduct an evaluation of CNCP. This report draws on 28 interviews with stakeholders and clients, analysis of CNCP project data, and a review of CNCP documents to assess the extent to which the Project met its two key aims:

(i) to establish a framework for coordinating service delivery to chronically homeless people based on flexible and collaborative service responses, and

(ii) to facilitate exits from homelessness by linking clients in with appropriate housing and coordinated support.

## 1.1 Service coordination framework

CNCP established the Complex Needs Management Group (CNMG) and the Care Coordination Group (CCG) to coordinate services around chronically homeless people with complex needs in Sydney. Data from stakeholder interviews indicate that CNCP was able to improve partnerships among key agencies and services which did not exist prior to this initiative. The coordination framework contributed to a better understanding of different organisational priorities, improved flexibility to meet client needs, improved communication and networking, and instilled wider acceptance of a housing first approach amongst participating members. As a result of the coordination framework, as well as the commitment of lead agencies and advocacy of the Project Coordinator, CNCP was able to improve partnerships between key agencies and services in inner Sydney.

## 1.2 Assisting clients to exit from homelessness

Between September 2007 and October 2010, the Project received 64 referrals of which 41 were accepted into the Project. CNCP successfully accessed its target group. It assisted people who had more than one disabling condition: 95 per cent had a primary mental illness, three quarters had a physical illness, three quarters had substance abuse problem, and half had a cognitive impairment. Interviews with clients and stakeholders indicated that clients also had an array of other issues, including contact with the criminal justice system, a history of abusive relationships, hoarding and squalor, social isolation, challenging behaviours, and difficulty carrying out daily living skills. The Project was also successful in assisting people who had been continuously or episodically homeless for an extended period of time – CNCP clients experienced homelessness for an average of 10 years before joining the Project.

CNCP was able to achieve a level of coordinated services for all 41 CNCP clients. Achieving this required that the Project confront an array of service system barriers that were unique to each individual referred to the Project. This success of the Project in coordinating supports is due to the willingness of the Project Coordinator to act as a case manager when necessary, and the high level of commitment from the lead agencies, other participating organisations and individual workers to find positive solutions for clients. The coordination framework

implemented by the Project also assisted in linking clients with support because it provided opportunities for networking and knowledge sharing amongst participating agencies.

As a result of these support processes, the Project was successful in providing coordinated services for all clients and finding appropriate accommodation for 36 clients. Clients had to wait approximately nine months to receive a property because of difficulties with locating appropriate support, sourcing appropriate housing, negotiating existing debt with Housing NSW, and engaging clients. As a result of receiving housing and support services, clients reported that they felt less exposed to the elements and safer, that it was easier to access services they needed and felt like they had somewhere to turn to. While clients experienced ongoing challenges in their lives around access to children, drugs and alcohol, physical health issues, and social isolation, most of those interviewed seemed to feel that some positive change was happening in their lives. These changes cannot be solely attributed to the activities under the CNCP but, given the clients' long history of homelessness before becoming clients, it is unlikely that these changes would have occurred for many clients without the involvement in the Project.

## 1.3 Key lessons

CNCP is scheduled to complete operations on 4 November 2010. Although the Project will not continue in its current form after this date, a number of key lessons can be learnt from the experience of the Project.

### Service coordination

The primary activity of CNCP was to coordinate existing services around the needs of chronically homeless people in Sydney. The coordination framework implemented by the Project led to improved relationships between partner agencies, improved interagency communication, and more awareness of other services in the community. The activities of the Project, the commitment of partner agencies to achieving results for this target group, as well as partners' willingness to work outside of rigid operating guidelines and eligibility criteria, made it possible for 41 chronically homelessness clients to gain access to coordinated support.

The experience of the Project shows that coordination works well when:

- There is strong leadership from lead agencies and project partners;
- Multiple agencies with different expertise, knowledge and networks are represented on the steering group;
- Clear roles and responsibilities are identified for Project partners and groups;
- A strong commitment is made by individuals and key organisations and services to participating in CNCP to work flexibly and to prioritise client need over operating guidelines;
- Regular meetings are held and these meetings have clear objectives;
- There are good systems for communication and information sharing; and

- Resources are dedicated to facilitating coordination.

The experience of the Project also shows that coordination is hard work and takes time and resources to actualise. The service system is structured in such a way that ensures that coordination at a systems level will always be difficult. As a result, service coordination models like CNCP require dedicated resources and are difficult to sustain over time.

**Engaging and supporting chronically homeless people**

Interviews with stakeholders confirm that it is challenging to engage this target group because of their multiple diagnoses, lack of permanent address, and other lifestyle issues. Chronically homeless people are rarely serviced by one agency alone, and so engaging these clients required that people had to work outside of their normal operating guidelines to, for example, contact the client at suitable times and locations. While the Project was able to overcome these barriers for 41 clients, many support providers expressed frustration at the amount of effort required to engage this group, which indicates that relying on coordinating existing services to engage this group would not be sustainable over time without dedicated resources.

**Gaps in the broader service system**

The Project had to overcome a multiplicity of systemic barriers to link clients with housing and coordinated support. These systemic barriers include:

- The lack of flexibility in the service system and willingness of organisations to take ownership over clients with multiple needs and diagnoses;
- Difficulty accessing assessment, which can preclude people from receiving services, and treatment without a fixed address;
- Lack of proactive follow up when people transition out of institutional care (e.g. prison) or are discharged from hospital;
- Dearth of prevention and early intervention services to stop people from accruing debt when in HNSW properties;
- Shortages of support services with the skills and capacity to engage and work with this target group;
- Lack of appropriate, affordable housing for this target group. Private rental accommodation (i.e. headlease) is difficult to source for this group, and there are few alternative housing models to support people who have difficulty living independently.
- The lack of housing that also includes access to support packages.

The experience of the Project points to the necessity of broader service system reform to address the needs of this group.

# 2 Introduction

The Complex Needs Coordination Project (CNCP) was implemented in September 2007 with the aim of assisting people with complex needs who are chronically homeless in the City of Sydney Local Government Area to access long term housing and support services. The Social Policy Research Centre (SPRC) at the University of New South Wales was commissioned in June 2010 to conduct an evaluation of CNCP. This document intends to assess: whether the Project attracted its target group, the effectiveness of Project's coordination, support, and governance functions, as well as the impact of CNCP on clients. The report concludes with recommendations for the future of the Project.

## 2.1 Background

CNCP emerged from the recommendations of the 'Vulnerability, Complexity and Homelessness' forum held by the City of Sydney in conjunction with state and federal government and local non-government organisations in June 2006 (City of Sydney, 2007). In formulating the model for the Project, the City of Sydney carried out a review of other projects servicing people with complex needs in Australia and overseas. The review found several key elements common to those projects:

- **Service agreements**: Most projects operated with the assistance and framework of service agreements which elicit the formal commitment of relevant bodies to participate in the Projects according to agreed principles.

- **Advisory groups or steering committees**: All projects established an advisory group or steering committee to receive referrals, advise on support provided to clients, allocate resources, reduce service blockages, and formalise service collaboration.

- **Key workers**: Every project employed a key worker who was responsible for a range of tasks such as the development and implementation of care plans, brokering services, developing key relationships, and reporting back to advisory groups.

- **Dedicated funding**: All reviewed projects had dedicated funding and/or other resources that were used to employ staff, coordinate services, and to provide housing and support.

Unlike the models identified in the review, CNCP was established and implemented without dedicated funding or resources. Therefore, the CNCP model was developed to emulate other projects while harnessing resources in the existing service system.

The Project was inspired by the success of housing first approaches that have been implemented in the US. The housing first philosophy emphasises the provision of permanent, rather than transitional, housing for chronically homeless people along with comprehensive and multidisciplinary support services on site (Gordon, 2007; Gulcur, 2003; Stefancic and Tsemberis, 2007). One of the cornerstones of this philosophy is that people are provided with stable housing and support without prerequisites related to treatment and compliance because this enables people to address other aspects of their lives more effectively than if they are living on the street or provided with temporary accommodation.

While CNCP was inspired by the idea that the chronically homeless people do not need to be housing ready to access stable accommodation, it was never intended that the Project would be responsible for providing housing or support services. Rather, CNCP was set up with the aim of coordinating existing resources and services so that they would become accessible to people with complex needs who are chronically homeless. To this end, the Project focused on establishing pathways into secure housing by applying for priority housing through Housing NSW (HNSW) or other types of accommodation such as Community Housing. This process became more streamlined when Housing NSW introduced a Housing First initiative in 2008 as a pilot project under the NSW Housing and Human Services Accord which enabled the Project to secure in principle access to 30 public housing properties or private rental accommodation for this target group.

## 2.2 Service model

The two key objectives of the Project are to (i) establish a framework for coordinated service delivery to the chronically homeless, based on flexible and collaborative service responses and (ii) provide intensive assistance to link clients with long term housing with support. The Project targets people who are chronically homeless within the City of Sydney Local Government Area who have one or more disabling conditions and who have either been continuously homeless for a year or more, or have had at least four episodes of homelessness in the past three years (Complex Needs Coordination Project, 2009). People with a history of failed interventions are a particular focus of the Project.

Referrals to the Project are prepared and submitted by a key worker who is supporting the client at the time of referral. Referrers are asked to collect a range of information about the client, such as the number and type of disabling conditions, the history of interventions to date, and the other services who are involved with a client. This process aims to provide a comprehensive picture of issues facing the client and to enable an understanding of the type of interventions that had been tried, what had or had not worked and why. Referrals are assessed by the Care Coordination Group (CCG), which includes representatives who have relevant assessment skills and experience in areas such as adult mental health, alcohol and other drugs, corrective services, disability, guardianship and financial management. The CCG meets on a monthly basis and reports four times a year to the Complex Needs Management Group.

After reviewing the referral, the CCG provides advice to the key worker about the type and range of services that could be engaged to support the client. The key worker arranges a meeting with the client and all relevant services to develop a Coordinated Care Plan (CCP), which identifies clients' needs and goals and the specific actions needed to link clients in with housing and support. The CCG then provides advice about the content of the CCP and assists to address any barriers that may have been identified in accessing stable housing and support. Depending on the outcomes of these meetings, an application for long term housing is made either through the Housing First initiative under the NSW Housing and Human Services Accord or through another long term accommodation option if independent living was not identified as a suitable outcome (e.g. where nursing home care or congregate supported living was identified as the most suitable outcome). Once a housing application is approved and a tenancy is allocated, the support agency is required to sign a Service Lease Agreement with Housing NSW to ensure that the client receives ongoing support to maintain their tenancy.

The Project initially aimed to provide tenancies for a target of 30 chronically homeless people with complex needs. Since that time, the Project has accepted 41 clients, 36 of whom have been provided with stable housing. Three people are still waiting for an appropriate tenancy to be identified and the other three people are no longer in need of stable housing.[1]

### 2.3 Governance arrangements

The Project is overseen and monitored by the Complex Needs Management Group (CNMG) with the City of Sydney and Community Services as lead agencies. Other members include representatives from government organisations including HNSW, Sydney South West Area Health Service, South Eastern and Illawarra Sydney Area Health Service, NSW Police, St Vincent's Hospital, Corrective Services, Ageing, Disability and Home Care (ADHC), and the NSW Trustee and Guardian. It also includes representatives from non-government organisations and peak bodies such as Homelessness NSW and Mission Australia.

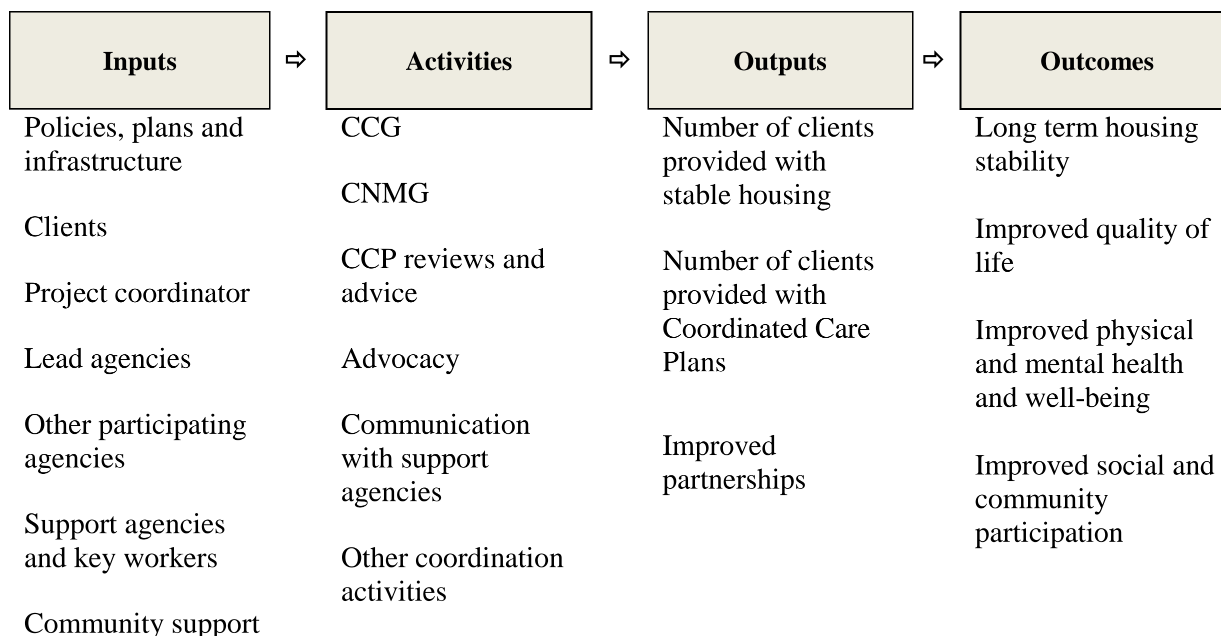
The Complex Needs Project Coordinator is responsible for the day to day operation of the Project. The Coordinator is funded by the City of Sydney and HNSW and employed by the City of Sydney Council. The Coordinator works across all areas of the Project and provides the interface between support agencies and the Project.

### 2.4 Evaluation methodology

This evaluation used program theory as its conceptual basis, in order to identify distinct but closely linked phases in the process of human service delivery: inputs, processes, outputs and outcomes (Bickman, 1996). The particular value of this approach is that it assists us to understand the complex interactions between these elements over time; it draws attention to the way in which policy is implemented and services are delivered, and how the consequences of these actions are eventually expressed in terms of outcomes for homeless people and the service system. Program theory assists in identifying the **inputs** – resources allocated to the Project; **activities** – how the Project was implemented; **outputs** –types of supports and services provided to clients; and **outcomes** – for clients and the service system. This goes beyond just the question of what works, to include consideration of why it works, under what circumstances and for whom (Pawson and Tilley, 1997). The evaluation framework is also underpinned by social justice principles, which emphasises the importance of participatory and collaborative research.

[1] One client moved interstate, another passed away and a third is in gaol.

**Figure 2.1: Program logic model for CNCP**




## Methods

This report draws on 28 qualitative interviews with clients and stakeholders, de-identified information from CNCP program data and a review of Project documentation. The research received ethics approval from the UNSW Human Research Ethics Committee in 2010.

*Qualitative interviews*

The primary source of data for this evaluation was qualitative interviews with clients and stakeholders. Interviews provided an important source of information about the effectiveness of the service coordination activities, as well as the impact of the Project on clients, including client satisfaction with the housing, support provided by the Project, and perceptions of changes in other aspects of clients' lives. A total of 28 interviews were conducted, including 21 stakeholders and seven clients.

Stakeholders were approached to participate in the research by an email which explained the aims of evaluation and their rights as research participants. Participants were drawn from a diversity of organisations including stakeholders from City of Sydney, Community Services, Housing NSW, members of the CNMG and CCG, and others involved in the referral process and service provision.

**Table 2.1. Stakeholder interviews by stakeholder group**

| Stakeholder group | Number of interviews | Per cent |
|---|---|---|
| Referring or support agencies | 10 | 48 |
| Current members of CCG | 5 | 24 |
| Current or former members of CNMG | 6 | 28 |
| Total | 21 | 100 |

Stakeholders interviewed for the Project included people from local government (n= 2 or 10 per cent), state government organisations (n= 9 or 43 per cent) as well as non-government organisations (n= 10 or 48 per cent). Feedback on the findings of the evaluation was sought at a stakeholder workshop and again at a CNMG meeting, and comments were incorporated into the final report.

An important element of this evaluation was interviews with CNCP clients. The researchers invited clients to participate in interviews to explore their satisfaction with housing and support received and any changes experienced in their lives since their involvement with CNCP.

Due to the complexity of this client group, the researchers took care to ensure that clients did not feel coerced to participate in the research. To accomplish this, clients were invited via a trusted person to participate in the evaluation and, after the person gave initial consent to the trusted person, contact details were passed to the researchers to arrange the fieldwork and to gain full consent to participate. The multiplicity of issues facing this group meant that clients were, at first, difficult to recruit. After sustained effort by the Project Coordinator and the researchers, a total of seven clients were interviewed. Of the eighteen clients who support agencies deemed it was appropriate to contact, nine declined, two were not contactable and seven agreed to an interview (Table 2.2). It was not always appropriate to record interviews with clients, in which case the researchers took handwritten notes. As a result, this report includes both direct quotes from clients and client summaries where appropriate.

**Table 2.2. Interviews with clients**

| | Number | Per cent |
|---|---|---|
| Not appropriate | 15 | 45 |
| Declined | 9 | 27 |
| Agreed and participated | 7 | 21 |
| Not contactable | 2 | 6 |
| Total clients invited to participate in an interview | 33 | 100 |

### Project data

Data collected by the Project was used to analyse the characteristics of clients. This included information on demographics, income, guardianship, tenancy stability, mental health, disability, physical health, substance use, legal issues, and support networks. Although it was intended that data would also be used to analyse changes experienced by clients over time, the database did not include sufficient detail to include this in the evaluation.

**Document review**

A review of Project documents was undertaken to understand the governance structure, Project model and processes. Such documents include the Project Operating Agreement, Coordinated Care Plans, Care Coordination Group outcomes and CNMG reports. This information is analysed in relation to interviews conducted with stakeholders and incorporated throughout the report.

## 2.5 Conclusion

This evaluation intends to assess whether the Project has met its aims to (i) establish a framework for coordinated service delivery to the chronically homeless, based on flexible and collaborative service responses and (ii) provide intensive assistance clients to enable exits from homelessness into long term housing with support. The evaluation did this through a mixed methods approach which involved interviews with 21 stakeholders and seven clients and an analysis of CNCP project data, project documents, and costs.

# 3 Client profile

CNCP aims to provide coordinated and sustainable support and housing to chronically homeless people with complex needs in the Inner city of Sydney. To be eligible for the Project, people had to have more than one disabling condition and to have been continuously homeless for a year or more or had at least four episodes of homelessness in the past three years (Complex Needs Coordination Project, 2009: 3). This section describes the characteristics of clients accepted into the Project and discusses the extent to which the Project attracted its intended target group.

## 3.1 Referrals

Between September 2007 and October 2010, the Project received 64 referrals. Referrals to CNCP predominantly came from organisations specialising in the provision of homelessness services (n=24; 59 per cent) and mental health services (n=10; 24 per cent). Over two thirds of referrals (n=29) were made by non-government organisations (NGOs), which highlights to the important role of NGOs in identifying and working with this target group.

**Table 3.1: Client referrals by agency type (n=41)**

| Type of agency | n | Per cent |
|---|---|---|
| Homelessness[1] | 24 | 59 |
| Mental health | 10 | 24 |
| Other[2] | 4 | 10 |
| Drug and alcohol | 2 | 5 |
| HIV | 1 | 2 |
| Total | 41 | 100 |

Source: CNCP client data
Notes: 1. NGOs whose focus is on assisting homeless people
2. Includes two referrals from ADHC, one from the NSW Trustee and Guardian, and one referral from out of state

Sixteen referrals were not accepted. The primary reason that people were not accepted into the Project was that they did not meet the eligibility criteria, meaning that they did not have one or more disabling conditions or did not require both housing and service coordination. A minority of referrals were not accepted because the person refused to accept services or because the referral was incomplete. Of the 48 clients who were accepted into the Project, an additional seven did not participate for the following reasons: three people were found not to require coordinated services after acceptance; two were housed immediately from applications to Housing NSW made outside of the Project; one client refused to participate; and one person died. In summary, CNCP has served a total of 41 clients. The following demographic characteristics are based on these clients.

## 3.2 Demographic and other characteristics

Just over half of CNCP clients were male (51 per cent, n=21) and the average age of clients was 40 years old. Approximately nine per cent of clients (n=3) were of Aboriginal or Torres Strait Islander descent.[2] Fourteen clients had children, and all had had limited or no access to

[2] Data missing on seven clients

their children. About half of all clients (48 per cent, n=19) had some form of social network through family, friends or a partner. According to the Project data, most clients' friends and partners were also homelessness.

CNCP data indicates that clients have high levels of complex needs. In addition to being homeless, all CNCP clients have multiple diagnoses. Close to all clients (95 per cent, n=35) had a mental illness: the most common diagnoses were schizophrenia (43 per cent, n=16) and depression (24 per cent, n=9). The rates of schizophrenia and alcohol and drug use among clients was higher than that of clients of the Integrated Services Project, a program which was developed by ADHC specifically to assist people with some of the most complex needs and challenging behaviours in the service system (McDermott et al., 2010).[3]

**Table 3.2: Mental illness (n=38)**

| | N | Per cent |
|---|---|---|
| Schizophrenia | 16 | 43 |
| Depression | 9 | 24 |
| Bipolar | 3 | 8 |
| None | 2 | 5 |
| Other[1] | 7 | 19 |
| Total | 37 | 100 |

Source: CNCP client data
Notes: Three clients had not had a psychiatric assessment
1. Includes schizo-affective disorder, psychosis, attention deficit disorder, Asperger's syndrome, Tourette's syndrome, personality disorder, panic attacks

Approximately three quarters of clients had a physical illness (73 per cent; n=27), three quarters had a drug and alcohol problem (74; n=29), and half (n=19) had a cognitive impairment.[4] All clients except for one were on some type of government benefit, 93 per cent (n=38) of whom receive the Disability Support Pension. Fifty six per cent (n=21) had either a guardian or financial manager.[5]

Interviews with clients and stakeholders reinforced that most clients face an array of other issues, including contact with the criminal justice system, a history of abusive relationships, hoarding and squalor, social isolation, challenging behaviours, and difficulty carrying out daily living skills such as property care and budgeting, as demonstrated from the following quotes from support providers:

> His general presentation was sort of [a concern]. He's a chronic alcoholic, so that's a restriction in itself, because you know, the level of intoxication, you won't find any agencies willing to actually work with him. (Case study 8, support worker interview)

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[3] This may be because complex needs are defined differently by the two programs. ISP targeted people with challenging behaviour, disability and disputed diagnoses, whereas CNCP targeted those who are chronically homeless and may therefore be more likely to have mental illness than ISP clients.

[4] These figures are taken from project data and are not necessarily based on a clinical assessment.

[5] Data is missing on four clients. Some guardians and financial managers were assigned over the course of the project so this data does not reflect how many clients had guardians at baseline.

> She was living in a boarding house which wasn't good for her at all because she had a multiplicity of problems – a lifetime of issues. She had been in and out of places – one of the main issues is hoarding. In her last place she had created over $10,000 worth of damage because of hoarding. (Case study 9, support worker interview)

In summary, as was the intention of the Project, the people assisted by the CNCP were those who had a multiplicity of needs.

### 3.3 Homelessness and housing

Most clients had a long history of homelessness before entering the Project.[6] Clients were homeless for between 1-26 years before joining the Project: they were on average homeless for 10 years (with the median number of years being seven). Clients first became homeless between the ages of 13 and 59 years. Clients reflected on the long period of time that they were homeless, and spoke particularly unfavorably about the exposure to harsh weather conditions experienced while living on the street in winter. For example, a male client who had been sleeping rough for nearly 10 years described his experience in the following way:

> [Q: What was life like before you got your house?] Just trying to survive – facing death every day. There was a cold spell there – I had to fight for my life every day and every night – night in and night out. I don't know if it was the cold or the cold related to going cold turkey from the marijuana – could have been that making me freeze....I slept under the stairs, under the awning, in the doorways. I got some sleep – sometimes I would be interrupted. (Male client, CL01)

Another client felt that it was the physical conditions (of rain, cold weather and mosquitoes) that made her experience living on the street so difficult, as well as fears for her safety and feeling disrespected by passersby while she was sleeping:

> People don't realise being homeless is very painful. You get 100 mosquito bites – all biting at once, one or two stings is painful but if you can imagine a thousand bites at once stinging. It's painful – you've got the cold, chilly air on top of the stinging and you have the rain coming down. It's painful and it's scary. It's nice knowing I won't have bites and people spiting on me walking past cause I'm sleeping on the church steps or something. (Female client CL02)

CNCP clients experienced different types of homelessness before entering the Project. The definition of this data item was drawn from Chamberlain and MacKenzie (1992) in which: primary homelessness refers to people who live in temporary shelter, sleep rough or do not have access to shelter; secondary homelessness describes people living in temporary accommodation such in hostels or with family or friends; and tertiary homelessness refers to people who live in rooming houses or boarding houses where they do not have their own bathroom and kitchen facilities and tenure is not secured by a lease. Ninety eight per cent of CNCP clients (n=38) were living in primary and secondary homelessness before entering the

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[6] Though CNCP worked closely with the referring agency to find out as much information about client history as possible, clients' itinerant history made it difficult for the project to capture accurate data on some measures.

Project (Table 3.4).[7] Almost two thirds of clients came directly into the Project from a situation of secondary homelessness, which had its own set of challenges particularly where that client was staying with friends or family (aka ‘couch surfing’):

> One client mentioned she was staying with friends but that she was sleeping on the floor. She indicated she was saving up to buy an air mattress so she would be more comfortable at her friend’s place. (Female client, CL03)

> You have friends but you can’t overstay your welcome. You can’t over stay you’re welcome. I was pretty lucky I wasn’t on the streets that long – but it’s not your place and you feel very – you know. (Female client CL02)

**Table 3.3: Type of homelessness (n=39)**

| | n | Per cent |
|---|---|---|
| Primary homelessness | 15 | 38 |
| Secondary homelessness | 23 | 60 |
| Tertiary homelessness | 1 | 2 |
| Total | 39 | 100 |

Source: CNCP client data
Notes: Data missing on 2 clients

### 3.4 Conclusion

Over a three year period, the Project received 64 referrals of which 41 were accepted into the Project. CNCP successfully accessed its target group. It assisted people who had more than one disabling condition: 95 per cent had a primary mental illness, three quarters had a physical illness, three quarters had a drug and alcohol problem, and half had a cognitive impairment. Interviews with clients and stakeholders indicated that clients also had an array of other issues, including contact with the criminal justice system, a history of abusive relationships, hoarding and squalor, social isolation, challenging behaviours, and difficulty carrying out daily living skills. The Project was also successful in assisting people who had been continuously or episodically homeless for an extended period of time – CNCP clients experienced homelessness for an average of 10 years before joining the Project. The reasons for this are explored in Section 5 of this report.

### 3.5 Summary

- 64 people were referred to CNCP between September 2007 and December 2009.
- 48 people were accepted into the Project, and 41 clients received ongoing support and housing.
- Just over half of CNCP clients were male and the average age of clients was 40 years old.
- Approximately nine per cent of clients were of Aboriginal or Torres Strait Islander descent.

[7] Data missing on two clients

- All clients had multiple diagnoses: 95 per cent of all clients had a primary mental illness, three quarters had a physical illness, three quarters had a drug and alcohol problem, and half had a cognitive impairment.

- Client and stakeholder interviews also indicated that clients had an array of other issues, including contact with the criminal justice system, a history of abusive relationships, hoarding and squalor, social isolation, challenging behaviours, and difficulty carrying out daily living skills such as property care and budgeting.

- Clients were homeless on average for 10 years before joining the Project.

# 4 Framework to coordinate existing services

The CNCP aims to provide a framework to coordinate existing services to make them accessible to and more effective in assisting chronically homeless people in inner Sydney to exit from homelessness. Drawing on interviews from 21 stakeholders and analysis of Project documents, this section examines the framework implemented by the Project to coordinate services across government and non-government organisations. The framework impacted on working relationships between services and on the extent to which support for clients is coordinated. This section focuses on the partnerships formed as a result of the CNCP framework, and the impact on clients is discussed in the next section (Section 5).

## 4.1 Processes to support service coordination

The coordination framework implemented by CNCP consists of two groups: the Complex Needs Management Group (CNMG) and the Care Coordination Group (CCG). Both groups aim to facilitate service coordination and develop partnerships, but they also fulfill different functions in the Project. This section explores the effectiveness of the processes of both groups in relation to facilitating coordination amongst member organisations.

### Complex Needs Management Group (CNMG)

The primary role of the CNMG is to oversee and monitor the Project, facilitate coordination between key organisations that encounter chronically homeless people, and to assist key workers and support agencies to overcome systemic barriers faced by this target group. It is responsible for reviewing quarterly reports prepared by the Project Coordinator on Project outcomes, addressing systemic barriers that have been encountered by the Project, managing the Project's dispute resolution process, and overseeing the Project's information and data collection requirements (Complex Needs Coordination Project, 2009: 6). The City of Sydney and Community Services are the key Project partners and are represented on the CNMG as lead agencies. Other members include representatives from HNSW, Sydney South West Area Health Service, South Eastern and Illawarra Sydney Area Health Service, NSW Police, St Vincent's Hospital, Corrective Services, ADHC, and the NSW Trustee and Guardian. It also includes representatives from non-government organisations and peak bodies such as Homelessness NSW and Mission Australia.

According to CNMG members interviewed for the evaluation, one of the key achievements of the CNMG was that the Project was developed and implemented with minimal additional resources. Its success in this venture was attributed to the leadership shown by the City of Sydney and Community Services, which ensured that a wide variety of stakeholders from both government and the non-government sectors were involved, committed to the aims of the Project together and willing to devote time to the Project in addition to their usual workload. The management group also provided leadership and guidance to agencies concerning how to work effectively with people with complex needs. Stakeholders reported that the CNMG worked well to respond to issues which prevented individuals receiving the services they needed on a case by case basis. For example, if a support agency was having difficulty accessing mental health services for their client, the issue could be raised at the CNMG and the representative from the local mental health service would escalate and resolve this issue within their organisation.

While the CNMG was a driving force in the Project's development and implementation, as the Project matured, some CNMG members were concerned that the relevance of the CNMG became less clear and suggested that the Project may have benefited from reassessing the role and purpose of the CNMG as the Project became more established. Changes in the representation of key members on the CNMG was also perceived to have an unfavourable impact on how the CNMG functioned because knowledge and Project experience was lost when key representatives were replaced by new members with less experience of the Project and knowledge of its origins.

**Coordinated Care Group (CCG)**

The CCG is responsible for assessing referrals to the Project, advising support agencies in the development of care plans for each client, and providing ongoing follow up of care plans. CCG membership includes representatives who have relevant assessment skills based on their professional experience in adult mental health, alcohol and other drugs, corrective services, disability, guardianship and financial management. The Project Coordinator chaired this group, and also received and summarised referrals, presented the referrals at CCG meetings, prepared CCG reports, communicated feedback to referring agencies, and liaised with agencies through the care plan development phase.

The CCG provides a formal mechanism through which the needs of people referred to the Project could be comprehensively assessed and services could be coordinated. One of the primary benefits of this group in terms of developing partnerships between participating organisations was that it created an informal network among service providers already working with complex clients in the inner city. In this way, the CCG provided a forum in which committed individuals and organisations could work more cooperatively together to address the needs of the target group. The forum also assisted in sharing information between agencies and finding new solutions to old problems, which contributed towards building capacity and expertise in the sector.

As with the CNMG, one of the primary challenges facing the CCG was the natural attrition of staff within participating organisations; when people left their jobs and new representatives joined the group there was a need to redefine and clarify the roles and responsibilities of CCG members. The other improvement suggested by some current and former CCG members was that the procedural aspects of the group could be tightened, such as prioritising agenda items, to reduce the amount of time spent in CCG meetings. Finally, while some support providers expressed frustration around the amount of time they were expected to devote to the referral, assessment and care planning processes (see next section for further analysis of these processes) few interviewees felt that the development of partnerships was inhibited as a result.

Apart from those few challenges, almost all stakeholders interviewed as part of the evaluation (including support providers, as well as current and former members of the CCG and CNMG) believed that the CCG played an important role in strengthening partnerships between existing services in the sector. This group also played a key role in coordinating services for clients. The processes and outputs of the service coordination function of the CCG are discussed in Section 5 of this report.

**Project Coordinator**

When the Project was first established, staff from the two lead agencies were responsible for administering CNCP in addition to their full-time workload. In 2008, the Project secured funding from the City of Sydney and HNSW to create a full-time Project Coordinator position, which was responsible for the implementation and daily operation of the Project. All stakeholders interviewed for the evaluation felt that the operation of the Project improved following the introduction of this position. It streamlined processes around the CNMG and CCG because issues could be more proactively followed up outside of meetings, which reduced the time commitment required of both groups. This, in turn, helped agencies remain committed to participating in these groups over time. The Project Coordinator also played an important role in coordinating services for clients, which is discussed in greater detail in Section 5.

## 4.2 Impact of the coordination framework on partnerships

The CNCP established a framework that was generally successful in strengthening partnerships between participating organisations. Members of the CNMG and CCP were overwhelmingly positive about the partnerships that had formed between organisations as a result of this framework. A particularly beneficial aspect of the CNMG and CCG meetings was that they facilitated cross agency communication between organisations. This led to a greater understanding of the agencies and services that exist across Sydney and also contributed to the development of informal professional networks which improved stakeholders' ability to navigate through the service system in the inner city.

The coordination framework, along with the leadership of the lead agencies, CNMG and the Project Coordinator, also contributed to an increased awareness about the inability of the service system in its typical configuration to appropriately support people who are chronically homeless and who have complex needs. Indeed, all stakeholders had struggled to support clients with complex needs within a service system that has evolved to address one aspect of a person's life (e.g. physical health, mental health, or housing) at a time, sometimes to the exclusion of all else. CNCP was able to inject some flexibility into the service system, one client at a time, due to the commitment of participating agencies and the Project Coordinator to support this target group. As will be discussed in the next section, this meant that CNCP was successful in accessing housing and coordinating services around people who had been excluded from the service system or who had not achieved enduring outcomes within that system for many years.

CNCP also was successful in leveraging resources to support this target group. Participating organisations contributed staff time to participate in CNMG and CCG meetings. Following the creation of CNCP, HNSW introduced a Housing First initiative in 2008 as a pilot project under the NSW Housing and Human Services Accord which enabled the Project to secure in principle access to 30 public housing properties or private rental accommodation for clients. The City of Sydney and HNSW also contributed funding for the Project Coordinator position. ADAHC contributed funding towards the preparation of this Evaluation. Finally, NGOs contributed staff time to participate in the care coordination process and committed to supporting these complex clients. As we will see in the next section, the resources were critical to the success of the Project in linking clients with housing and coordinating supports.

Finally, through the leadership of lead agencies, the housing first principles which inspired the CNCP gained further credence amongst organisations that participated in the Project, which meant that people working in the sector who were initially skeptical about whether people with complex needs could be housed without pre-conditions began to accept that a housing first approach and independent supported living was possible for many within this complex client group.

### 4.3 Conclusion

Through the coordination framework, commitment of lead agencies and advocacy of the Project Coordinator, the CNCP was able to improve partnerships between key agencies and services in inner Sydney. The framework contributed to a better understanding of different organisational priorities, improved communication and networks amongst members, and improved the capacity of the service system to address the needs of individual clients with complex needs. As will be demonstrated in the next section, this coordination framework, along with the support of the Project Coordinator, was also instrumental in linking clients in with housing and coordinated support.

## 4.4 Summary

- The coordination framework implemented by CNCP consists of the Complex Needs Management Group (CNMG) and the Care Coordination Group (CCG).
- The role of the CNMG is to oversee and monitor the Project and to facilitate coordination between key organisations that encounter homelessness.
- One of the key achievements of the CNMG is that it developed and implemented the Project without any additional resources.
- As the Project matured, the relevance of the CNMG became less clear. Some CNMG members suggested that the Project may have benefited from reassessing the role and purpose of the CNMG as the Project became more established.
- The CCG provides a formal mechanism through which the needs of vulnerable people who were referred to the Project could be assessed and coordinated.
- One of the primary benefits of the CCG was that it created an informal network among service providers and agencies already working with complex clients in the inner city.
- CNMG and CCG member representatives showed a high degree of commitment to work together and to devote time to the Project in addition to their usual workload.
- Like the CNMG, the CCG faced challenges regarding the natural attrition of members. Some stakeholders also felt that the procedural aspects of the CCG could be strengthened by prioritising agenda items.
- The CNCP established a framework that was generally successful in strengthening partnerships between participating organisations.
- The coordination framework contributed to a better understanding of different organisational priorities, improved flexibility to meet client needs, improved communication and networking, and wider acceptance of a housing first approach amongst participating members.
- The coordination framework led to an increased understanding about the context in which existing organisations operate which. This, along with the commitment of members to support this target group and the leadership of lead agencies and the Project Coordinator, meant that CNCP was able to inject some flexibility into the service system one client at a time.
- CNCP also was successful in leveraging resources to successfully support this target group.

# 5 Assisting clients to exit from homelessness

CNCP aims to facilitate access to long term housing and coordinated support services for chronically homeless people with complex needs in Sydney. This section analyses the processes for supporting clients implemented by the Project, including referral, assessment and the development of care plans, and discusses the extent to which these processes facilitated coordinated support and access to housing. The impact of receiving housing and support services on clients is also discussed.

## 5.1 Processes for supporting clients

### Referral and assessment

The Project broadly targets people with complex needs who are chronically homeless in inner Sydney. The process of referring and assessing people in this target group to the Project involved the following steps:

1. Referrals to the Project are prepared and submitted by a key worker who is supporting the client at the time of referral.

2. The referral is assessed by the CCG, which considers eligibility, key risk factors, accommodation status, client support needs, past history of interventions, and the need for multi-agency coordination.

3. Eligibility is determined. If a person is determined not to be eligible the referring agency is provided with other options to consider for their clients. If the person is deemed eligible the key support worker is invited to a CCG meeting to discuss the referral information, client circumstances, the type of agencies and services that the client has been involved with, the interventions that have worked, those that have not, and future goals of the client.

One of the key elements of the referral process is that the referrer is asked to conduct a comprehensive assessment of the client's history and current situation, which includes gathering information on the number and type of disabling conditions, the history of interventions to date, and other services who are involved with the client. This process aims to provide a comprehensive picture of issues facing the client to enable an understanding of the type of interventions that have been tried, what has or has not worked and why.

Most CCG members and support organisations interviewed for the evaluation felt that the comprehensive assessment was important to determine the most effective way forward for these clients. For many clients, it was the first time a thorough assessment had been conducted and, given their long history of homelessness and their high level of complex needs, information was sometimes difficult to access. As a result, some referring agencies struggled with the amount of time they were expected to devote to the application and referral process, and a few support agencies felt that the process created another level of bureaucracy that did not necessarily help clients. However, the majority of support agencies interviewed felt that, while time consuming, the comprehensive assessment process was necessary to coordinate services around client needs. To address some of the feedback about the lengthiness of the referral process, the Project Coordinator created a one page assessment that could be used to quickly assess clients' eligibility for the Project, and referring agencies were

asked to complete the comprehensive application only after a person was deemed eligible for CNCP services.

The involvement of the CCG in assessing referrals and advising support agencies was believed to be positive by most stakeholders. Support agencies particularly appreciated that members of the group have a range of expertise and could therefore provide different kinds of knowledge and information about local services relevant to each client's situation in a comprehensive manner. For example, the CCG facilitated sharing knowledge across agencies by encouraging service providers to seek consent from their clients to share information, which is an important element of successful service coordination (Park and Turnbull, 2003). The involvement of key support services in CCG meetings also contributed to building capacity among the local services sector by providing guidance about how to respond more effectively to client needs as well as offering suggestions about new ways of navigating the service system and accessing resources. While most support providers found the CCG to be a useful resource when assessing clients, some found it intimidating to discuss clients' situations at the CCG meetings and suggested that the meetings could have been less formal while still retaining their comprehensiveness.

Support agencies felt that the referral and assessment process had become more streamlined over the course of the Project, and that the Project Coordinator played an important role in reducing the amount of time it took for clients to be assessed.

**Process of coordinating services around clients**

Once a person is accepted into the Project, the key worker is responsible for developing a care plan with the nominated support agency and other relevant services. The purpose of these documents is to provide a plan that is simple enough to be 'owned by the client but specific enough for services to respond to their needs' (Complex Needs Coordination Project, 2009: 7). The care plan is then reviewed by the CCG to identify additional services/service responses that the key worker may have not considered in relation to the particular client's circumstance. Once the CCP is endorsed, an application for long term housing is made either through the Housing First initiative under the NSW Housing and Human Services Accord or through another long term accommodation option.

As with the assessment process, most support staff interviewed for the evaluation felt that the multidisciplinary expertise and collaborative approach utilised by the CCG in the development of care plans worked well. Stakeholders liked that care plans were based on an individualised, comprehensive and flexible approach to service provision and, because the care plans included detailed roles, task and timeframes, it worked to formalise goodwill among the respective agencies. As well as offering advice about the care plan, the CCG and the Project Coordinator also played a support function for NGOs, which was particularly valued because of the difficulties associated with providing support to this complex client group.

While the process of developing care plans was perceived by most stakeholders to be an effective way to identify appropriate support services for this client group, suggestions for improvement were also made. Some support staff felt that the CCG inhibited the process of accessing housing because it sometimes took months to finalise care plans due to infrequency of meetings (the CCG met monthly) and due to the lack of appropriate supports and housing in the broader service system. Because this delay was sometimes attributed to the Project

rather than to gaps in the mainstream service system, a minority of stakeholders indicated that they would not refer clients to CNCP in the future, but instead would apply for housing and coordinate services independently of the Project.

In addition to the expertise and advice provided by the CCG, the CNCP Project Coordinator played a crucial role in ensuring that services were coordinated around client needs. When clients were referred to the Project without a key support worker, the coordinator worked to identify an appropriate service to support the client. He also mediated disputes between organisations, and followed up with organisations regarding the status of care plan development. If any confusion arose regarding the roles and responsibilities of services and agencies that had committed to support clients, stakeholders felt reassured that they could take their issue to the Project Coordinator who could function as an independent arbitrator to resolve disputes. This dispute resolution mechanism was a process which was particularly appreciated by HNSW because it gave them the confidence that any issues with clients' tenancies could be resolved.

## 5.2 Outputs

### The provision of coordinated support

According to interviews with NGO support workers and CCG and CNMG members, CNCP was able to achieve a level of coordinated services for all 41 CNCP clients. To do this required that the Project confront an array of service system barriers that were unique to each client. Two case studies are presented in this section to demonstrate the considerable effort required to facilitate access to stable housing and support, as well as the common systemic barriers faced by the Project.[8]

**Case Study 1**

A local emergency department rings CNCP about Sharon, a 50 year old woman with physical disability, alcohol dependence, and personality disorder. Sharon has a history of presenting at various emergency departments across Sydney: when sober she agrees to a plan, complies for a short time, then begins drinking and becomes uncooperative. Sharon leaves hospital before a referral to CNCP is made, but the social worker agrees to complete the referral when Sharon returns. The Project Coordinator secures agreement from an NGO to engage with her and to make a referral to CNCP, and also contacts various emergency departments and psychiatric hospitals across Sydney to seek more information. This process confirms that Sharon has no current case manager, that almost every emergency department knows her and has dealt with her in the last 12 months.

When Sharon returns to the emergency department, the social worker actively compiles a referral to CNCP. Plans are made to place her in transitional accommodation but the client leaves the hospital after two days and ends up in emergency accommodation. The Project Coordinator and NGO support begin searching for a support agency with requisite skills to support the client when she is placed in housing. Emergency departments and psychiatric hospitals in Sydney are asked to contact the NGO support when the client presents.

[8] All identifying details have been changed.

Meanwhile, CNCP works with HNSW to understand the client's housing history, which clarifies the housing and support options suitable for the client once she is engaged.

Three months after the initial referral, the NGO support provider compiled enough information to submit an application to CNCP. The client is accepted and housed in emergency accommodation until long term housing can be located. The NGO offers to become the in-home support for the client even though this is out-of-guidelines because there is no other agency that can provide the support. The NGO then works with another support agency to develop the Coordinated Care Plan, which is endorsed by the CCG three months after the client is accepted into the Project. One day later, the Project Coordinator delivers Housing First application to Housing NSW.

Due to service changes, the NGO informs CNCP that they can no longer provide support to the client and so CNCP searches for alternate support while HNSW searches for an appropriate tenancy. Six months after Sharon is accepted into CNCP she is offered a tenancy, which she rejects as unsuitable. Housing NSW continues to search for a property appropriate to her needs and in her desired location.

CNCP arranges alternative NGO support nine months after Sharon is accepted into the Project and HNSW locates a suitable property 19 months after she was accepted into CNCP.

Sharon's case highlights a number of systemic issues that are commonly confronted by CNCP clients and others with complex needs. Immediately apparent is the lack of proactive support following discharge from hospital, which results in the inability of hospital staff to stop people like Sharon from regularly cycling through emergency departments. Her situation demonstrates that there is a lack of support services available in the community with the capacity to provide outreach and in-home support, and that even the most well intentioned support agencies are constrained in their ability to provide long term support due to uncertainty around future funding. Finally, because Sharon has particular accessibility needs she was difficult to accommodate within the existing housing stock which delayed her entry into long term housing.

**Case Study 2**

Michael is a 30 year old man with mental illness, borderline intellectual disability, Tourettes Syndrome and a history of drug abuse. Michael spent 18 months rough sleeping at time of referral and has lived an itinerant lifestyle since he was 15 years of age.

Michael has a long history of contact with mainstream support services. He has been provided with multiple tenancies by HNSW but has been unable to maintain these tenancies due his complex needs and erratic behaviour (he is often noisy and sometime violent). He was unable to maintain his most recent tenancy due to his behaviours even though HNSW installed noise insulation and a high fence so that he could avoid contact with neighbours. He also owes HNSW a substantial amount of money due to damaged caused to the property. Michael is not eligible for residential disability services because his intellectual disability was not diagnosed before he turned 18. He has received other types of ADHC support but these have unable to continue providing services due to his complex needs.

Michael was referred to CNCP by a temporary accommodation service. Because he was not connected with a support agency or with mental health services at the time of the referral, the Project Coordinator provided case management for four months until a suitable support agency could be found. Over this period, the coordinator drafted the coordinated care plan, organised service collaboration meetings, made referrals and worked with the CCG to locate an appropriate support agency. There is difficulty finding an NGO that has the resources and is willing to support the client while he has no address. In addition, mental health refuses to issue a community treatment order until a person has an address. CNCP is also informed that the client is not eligible for housing due to his tenancy history

Meanwhile, the client moves from a psychiatric facility into emergency accommodation, where he is evicted due to violence, disengages from NGO support and is again placed in a psychiatric facility. He is released, spends two weeks in a boarding house, then is evicted due to violence and transferred back into a psychiatric facility.

Fifteen months after the client was accepted by CNCP, a state government organisation accepts the client to receive intensive housing and support services and the client is housed one month later. The support agency reports that Michael has ongoing issues interacting with neighbours and with his family but remains housed with supports. CNCP plays an ongoing role to locate more appropriate long term housing for the client.

Michael's case highlights some systemic issues similar to those discussed in relation to Sharon – particularly that there was no follow up after he was discharged from psychiatric facilities and there are few NGOs with the capacity to provide the type and amount of support he needs. But his situation also raises different systemic issues, such as the lack of accommodation suitable for people with behavioural problems, the difficulty accessing services for people who have disputed diagnoses, the lack of support providers willing to work with a person without a fixed address, and the lack of other accommodation options for people who are excluded from the public housing system for some reason or another. His situation also shows that accruing debt with HNSW threatens future housing options. Finally, his situation shows that when people with complex needs are placed in housing without the corresponding support, they are essentially being set up to fail, and this has long term consequences for the client's future.

These two cases demonstrate the immense amount of effort and advocacy provided by the Project to accommodate this target group within the existing service system. This success of the Project in coordinating supports is due to a number of reasons, including the willingness of the Project Coordinator to act as a case manager when necessary, and the high level of commitment from the lead agencies, other participating organisations and individual workers to find positive solutions for clients. Another factor that contributed to linking clients in with coordinated support was the coordination framework implemented by the Project through the CNMG and CCG which provided opportunities for networking and knowledge sharing amongst participating agencies.

**Linking clients with secure housing**

One of the core functions of the Project was to link clients in with housing by partnering with Housing NSW, which provided 30 properties for CNCP clients through the Housing First initiative. Even though clients were accepted into the Project, however, this did not guarantee

access to a housing first tenancy because Housing NSW followed their internal processes and procedures to determine whether the person was eligible for a public housing tenancy.

The Project successfully sourced housing or contributed to building housing pathways for 36 of the 41 clients (Table 5.2).[9] Housing for seven clients was not directly sourced by CNCP, but the coordination function of the Project did assist in building pathways for these clients. Several stakeholders felt that the Project was so successful in developing pathways into housing because of the commitment of Housing NSW and individual housing staff who were involved in the Housing First initiative to source properties appropriate to this needs of this complex target group.

**Table 5.1: Type of tenancies (n=33)**

| | n | Per cent |
|---|---|---|
| Housing first lease | 24 | 73 |
| Other | 7 | 21 |
| Other Housing NSW property | 1 | 3 |
| Aged care facility | 1 | 3 |
| Total | 33 | 100 |

Source: CNCP client data
Notes: Eight clients who have not been housed are not included in this table

Eight clients had not been housed by September 2010 because of ongoing difficulties in resolving debt to Housing NSW that clients had previously accrued (n=4), engaging the client to accept services (n=2), finding appropriate support services (n=1) and identifying appropriate housing (n=1). However, the delay in housing these clients points to gaps in the service system rather than to a particular failing of CNCP processes.

Stakeholders were fairly pleased overall with the type of housing made available to clients, and most felt that clients had been placed in appropriate housing in locations of their choice. For example, one client was housed in shared accommodation which was well suited to her needs:

> Her tenancy in community housing property [sharing with another person] is more sustainable for her rather than her own place in public housing. Having a stable house in community gives her a certain amount of freedom within bounds. I think it suits her to be living in a shared place. The other thing is it's not so lonely for her. A lot of clients – even though they may sometimes fight with each other – they like it because they are not so lonely. (Case study 10, support worker interview)

A number of difficulties with placing CNCP clients in appropriate housing were noted by stakeholders, particularly the length of time it took to access housing. CNCP data shows that clients waited an average of 269 days, or approximately nine months, from the time a person was accepted as a CNCP until the time they moved into accommodation. The delays in arranging housing were caused by a number of reasons, including difficulties finding support services that were configured to providing comprehensive support to high needs clients in a

[9] Of the six clients who are not housed: three are still waiting for an appropriate tenancy, one left the state, one is in gaol and the remaining client passed away.

tenancy, locating appropriate housing, negotiating debt clients had accumulated as previous tenants of Housing NSW, and engaging clients, some of whom lived itinerant lifestyles and were difficult to contact (Table 5.3).

**Table 5.2: Reasons for tenancy delay (n=39)**

| | n | Per cent |
|---|---|---|
| Difficulty finding appropriate support | 10 | 26 |
| Difficulty finding appropriate housing | 7 | 18 |
| Outstanding debt to housing | 6 | 15 |
| Difficulty engaging client | 6 | 15 |
| Delays with application | 4 | 10 |
| Client in prison | 4 | 10 |
| Delays developing care plan | 1 | 3 |
| Stabilise mental health | 1 | 3 |
| Total | 39 | 100 |

Source: CNCP client data
Notes: This table is out of the people for whom housing has been found; two clients had no delay in finding housing and are not included in this table

Even though the delay in accessing housing was seen by some stakeholders as contrary to a housing first approach, it was an unavoidable aspect of the Project given the lack of dedicated resources and housing stock. Other stakeholders felt that one of the upsides to the delay was that it provided an opportunity for key support workers and other services to develop rapport with clients before they were housed. Despite receiving support, five clients (15 per cent) have had difficulties with their tenancy due to hoarding (n=2), problems with neighbours (n=2) and uninvited guests (n=1). These issues have since been resolved and to date all 36 clients remain in a tenancy and have been housed for an average of 16 months.

The process of housing clients through service coordination activities revealed some gaps in the broader service system. The lack of housing stock was perhaps the most commonly noted frustration expressed by stakeholders but, as this section has shown, the availability of appropriate housing that is in close proximity to organisations with the capacity to provide the right support to clients is more important than more housing stock. In the case of CNCP, which had in principle access to 30 tenancies through Housing NSW, delays were caused by the shortage of other housing models which could be used for clients who cannot or do not want to be accommodated in social housing or live independently, as well lack of appropriate high needs support services in some locations.

## 5.3 Impact on clients

CNCP was successful in attracting its intended target group and linking most clients to secure housing and support services. Interviews with clients identified that, since receiving housing and support services, they have experienced a number of other changes in their lives. These changes cannot be directly attributed to the activities of CNCP, but they are worthwhile discussing as potential secondary impacts of the Project's activities.

### Life before the Project

As discussed earlier, all of the clients had experienced chronic homelessness before they were accepted into the Project. Stakeholders and clients described this period as erratic and

unstable, making it difficult to generate changes in other aspects of their lives. One stakeholder recounted the chaotic life of a client who accessed his service before participating in CNCP:

> …he'd disappear and be down at the train station begging for money and drinking whatever was the cheapest. I'd find him and he hadn't showered or bathed in a week. He'd miss his depo injection – he'd go off the rails. I'd have to bring him back to see the psych nurse – it was very erratic. His lifestyle before this was very erratic and huge binges and he'd take whatever drugs were offered … played some nasty games on his mental health and I'm surprised he's still alive. (Case study 10, support worker interview)

Almost all clients interviewed for the evaluation mentioned that they felt unsafe while they were living on the street, and this was confirmed by stakeholders who noted that living in public spaces, combined with mental illness and drug and alcohol problems made clients particularly vulnerable and at risk of assault:

> He was previously a high at risk client and due to his level of alcoholism, he was quite often a victim of assaults and you know, robberies. (Case study 8, support worker interview)

In addition to the violence, access to drugs, and the exposure of being outside, living on the streets precluded clients from receiving services that they needed, which was mentioned by a few clients interviewed for the evaluation:

> You go to an agency – mental health – I've been there before when I was on the street and I said, 'Can I get some [name of medication] cause I'm going mad' and I'm saying, 'I'm going to slit my wrists' and they said 'sorry we can't give you anything.' And they turned me away 'cause I wasn't on their registry, their list. So they turned me away. Or they say to come back – go see a doctor and then come back'. But you can't run around – you can't focus on how to get from A to B. You just want to end it. You can't get from A to B to the doctor and back to that agency. All that mucking around, you can't do it. (Female client, CL02)

Other clients said they found it hard to access stable housing because they did not have a fixed address they could list on the public housing application forms:

> The government gave me grief around getting housing – I went in and asked [for public housing] and they said what's your address? [Q; So you tried to get access before and they said you needed an address?] Yeah. (Male client, CL01)

**Life after receiving housing and/or support services**

Both stakeholders and clients reported that being provided with a safe place to live had a great deal of immediate benefits for clients, such as physical safety, less exposure to the elements, access to food and hot drinks, as well as a safe place to store their belongings:

> It's a bit warmer. I can have a cup of coffee without worrying about where it's going to come from cause I got my bank card back. I think – yes [name of support service]

> helped get my bankcard back. I lost several of them – some in [name of interstate], some in Sydney some in [name of regional centre]. (Male client, CL01)

> Mentally it's been great cause I'm not mentally tormented everyday of the week about where I have my stuff hidden, walking around in circles or in front of buses cause I'm confused. It means a lot to me – that stability, knowing that's where it is, you can go back to there. When your schizophrenia is playing up and you're getting mixed messages and you feel like garbage and people don't want you in their house – that's how you feel. And you think where can I go? You know you're not going to have to go out and get painful mosquito bites, you can put your head down and rest. Female client, CL02)

Another immediate benefit to having stable housing was that clients had somewhere to store their medication which assisted them to take their medication more regularly. Coupled with support services, some clients found it easier to access mental health services and medication they needed than when they lived on the street:

> He is much better at bringing his depo box up and asking our nurse for a top up whereas in the past – even in the beginning, you know, he hadn't taken it for 2 weeks but now he is much better at that. There are little things that he's doing – he's getting more of a structure and routine. (Case study 10, support worker interview)

> [Q: Was it easy to contact the services you needed when you were on the street] No, no. It was a lot harder on the street. It feels like everyone has turned their back on you. That's what it feels like. It feels like everyone has turned their back on you. You need a door opened mentally so you can believe they are there for you. It's very hard – it's not a matter of trust. It's like you're going mad and you say can I come and see you I need medication, I have run out of medication and they say 'I'm sorry our hours are between 8 and 3pm call back on Monday' and this is on a Saturday night. And you're thinking 'I'm out of medication I'm going to lose the plot if I don't get this medication kill someone or kill myself. Or end up in front of a bus dead or off the bridge if I don't get this medication. And everywhere you ring up has this message. And you ring up for help and everywhere you get this message: 'We're not open until Monday. It's really hard, really hard. A lot harder than people realise. So having an NGO, having it scheduled and done through these organisations is great. It's a lot easier, a hell of a lot easier. (Female client, CL02)

In addition to the immediate benefits, stable housing and support provided the foundation upon which clients could build to begin to make other changes in their lives. Stakeholders discussed a range of changes experienced by clients, including improved physical health, stabilised mental health, and improved daily living skills:

> So it's provided him with a safe environment, and that means things like, you know, any sort of outstanding medical issues and things like that can actually be addressed rather than, you know, him sort of suffering through that. (Case study 8, support worker interview)

> M: they have meals on wheels but I cancelled to do it myself. I now cook. I wasn't well enough to before. (Male client, CL01)

> His mental health is more stable definitely. He has his own place, his meds on the table, they're not going missing. He's doing much better. He's been there now for almost 6 months so it's a good achievement (Case study 10, support worker interview)

Stakeholders often noted that, while many clients had begun to experience some positive changes in their lives, many had ongoing issues that had no easy solutions, as in the following example:

> So it has provided some structure but it's not a simple answer because now he is in his own home he has more time to drink – probably drinking more constantly maybe not getting as intoxicated but he told us he is drinking up to 4 bottles a day so that's quite a bit. (Case study 10, support worker interview)

While support workers generally positive about the Project, they stressed that once clients were housed they face ongoing challenges in maintaining their tenancy and meeting their obligations as outlined in the care plan. The primary downside to being placed in housing was that, when people are taken off the streets, they in many cases lost their existing social support networks and experienced loneliness, isolation, and boredom. This is partially to be expected given the significant life transition associated with moving into secure housing, but it also may signify that there is not enough appropriate support available to assist clients to link in with new social networks or not enough variety in the housing models to provide housing appropriate to people's needs. This ongoing challenge was discussed by both clients and support workers:

> It's small steps. This is – our team has found this that the hardest part is once you house someone – we think we've solved someone's problems we've found them their own place but that's when it becomes hard –the loneliness and isolation kick in. At least in the crisis accommodation they have people around and they have acquaintances but once they're on their own that's when the vices come in. It's very common. (Case study 7, support worker interview)

Some clients also reported that living alone can be socially isolating and were finding it hard to develop new friendships since moving:

> M: Yeah. I got people to say hello to but people I invited to come in for a cup of coffee – maybe he's not ready too. I saw him on the outside [of hospital] and invited him in for a cup of coffee but maybe he's not ready too. (Male client, CL01)

## 5.4 Conclusion

CNCP supported clients by involving the CCG in the assessing clients as well as developing care plans. The CCG was generally believed to have served a useful function in coordinating service around client needs because of its multi-disciplinary membership, the comprehensiveness of the referral process, and the individualised, comprehensive and flexible approach to service provision. Most stakeholders felt that the range of support sought for clients by the CCG created flexibility and choice for clients. The Project Coordinator also played a crucial role in facilitating coordinated support for clients.

As a result of these support processes, the Project was successful in providing coordinated services for all clients and finding appropriate accommodation for 36 clients. Clients had to wait approximately nine months to receive a property because of difficulties with: locating appropriate support and appropriate housing; negotiating debts with Housing NSW; and engaging clients, some of whom lived itinerant lifestyles and were difficult to contact. As a result of receiving housing and support services, clients felt less exposed to the elements, safer, that it was easier to access services they needed and felt like they had somewhere to turn to. While clients experienced ongoing challenges in their lives around access to children, drugs and alcohol, physical health issues, and social isolation, most of those interviewed seemed to feel that some positive change was happening in their lives. These changes cannot be solely attributed to the activities of CNCP but, given the clients' long history of homelessness before becoming clients, it is unlikely that these changes would have occurred with involvement in the Project.

## 5.5 Summary

- The CCG and the Project Coordinator provided the framework and leadership to coordinate services and to establish pathways into stable housing.
- It was difficult to conduct a thorough assessment on some clients due to their history of homelessness and their high level of complex needs and, as a result, some referring agencies struggled with the amount of time they were expected to devote to the application and referral process.
- However, the majority of support agencies interviewed felt that, while time consuming, the comprehensive assessment process was necessary to coordinate services around client needs.
- The involvement of the CCG in assessing referrals and advising support agencies was believed to be positive by most stakeholders. Support agencies particularly appreciated that members of the group have a range of expertise and could therefore provide different kinds of knowledge and information about local services relevant to each client's situation in a comprehensive manner.
- Support agencies felt that the referral and assessment process had become more streamlined over the course of the Project, and that the Project Coordinator played an important role in improving the process and reducing the amount of time it took for clients to be assessed.
- Care plans worked well because they were based on an individualised, comprehensive and flexible approach to service provision. They also created a level of accountability among agencies due to the detailed roles, tasks and timeframes defined in the plan.
- In addition to the expertise and advice provided by the CCG, the CNCP Project Coordinator played a crucial role in ensuring that services were coordinated around client needs. The coordinator acted as a de-facto case manager, followed up regarding the status of care plans, and acted as an independent arbitrator in the case of disputes.
- As a result of the high level of advocacy from the Project and the commitment of key players, all 41 clients were linked with coordinated support. This required that the Project overcome systemic barriers to accessing services.
- 36 people were housed since becoming a CNCP client. Clients had to wait approximately nine months to receive a property.
- As a result of receiving housing and support services, clients felt less exposed to the elements, safer, that it was easier to access services they needed and felt like they had somewhere to turn to.
- While clients experienced ongoing challenges in their lives around access to children, drugs and alcohol, physical health issues, and social isolation, most of those interviewed seemed to feel that some positive change was happening in their lives.

# 6 Key lessons

CNCP is scheduled to complete operations on 4 November 2010.[10] Although the Project will not continue in its current form after this date, a number of key lessons can be learnt from its experience and, perhaps, applied to future initiatives targeting this client group. This section draws out lessons learnt around coordinating existing services, supporting chronically homeless people with complex needs and, finally, gaps in the service system are highlighted.

## 6.1 Service coordination

Research into effective responses to homelessness has demonstrated the importance of coordinating support services to meet the needs of individual homeless people, rather than expecting clients to seek support from a range of separate and disconnected services (Gronda, 2009; Meehan et al., 2002; Reynolds et al., 2002; St Vincent's Mental Health Service and Craze Lateral Solutions, 2005) (St Vincent's Mental Health Service and Craze Lateral Solutions, 2005). Service coordination is a key element of the reform of homelessness services in Australia, as outlined in both the Australian Government’s White Paper on homelessness and the NSW Homelessness Action Plan (Australian Government, 2008a; NSW Government, 2009).

The primary activity of CNCP was to coordinate existing services around the needs of chronically homeless people in Sydney. The coordination framework implemented by the Project led to improved relationships between partner agencies, improved interagency communication and awareness of other services in the community. As a result of the activities of the Project, the commitment of partner agencies to achieving results for this target group, as well as partners’ willingness to work outside of rigid operating guidelines and eligibility criteria, all 41 chronically homelessness clients gained access to coordinated support.

The experience of the Project shows that coordination works well when:

- There is strong leadership from lead agencies and project partners;
- Multiple agencies with different expertise, knowledge and networks are represented on the steering group;
- Clear roles and responsibilities are identified for Project partners and groups;
- A strong commitment is made by individuals and key organisations and services to participating in CNCP to work flexibly and to prioritise client need over operating guidelines;
- Regular meetings are held and these meetings have clear objectives;
- There are good systems for communication and information sharing; and

[10] While the Project will formally cease operations on this date, the CCG will continue to meet informally to provide support to each other and to other agencies to manage complex cases.

- Resources are dedicated to facilitating coordination.

The experience of the Project also shows that coordination is hard work and takes time and resources to actualise. The service system is structured in such a way that ensures that coordination at a systems level will always be difficult due to different: service models; physical locations; eligibility criteria; target groups; operating times; and service philosophies. As a result, service coordination models like CNCP require dedicated resources and are difficult to sustain over time.

The CNCP model was initially developed with no additional resources and therefore sought to find solutions for clients within the existing service system. It was recognised early on in the establishment of the Project that there would be difficulties achieving Project outcomes without providing some resources for a Project Coordinator position and the data shows that many of the positive outcomes experienced by clients were due to the Project Coordinator working in collaboratively with support agencies. Many stakeholders felt that the Project has shown that it is not possible to implement a true housing first approach solely through a coordination model because of the lack of capacity of the broader service system to support these clients over the long term. Therefore, the Project reinforces the need for providing one service with the capacity to respond to multiple needs, versus an approach that attempts to coordinate multiple services.

### 6.2 Engaging and supporting the chronically homeless

CNCP was established to address the needs of chronically homeless people with complex needs. The Project was successful in attracting this target group, all of whom had multiple diagnoses and were homeless for an average of 10 years before becoming CNCP clients. Interviews with stakeholders confirm that it is challenging to engage this target group because of their multiple diagnoses, lack of permanent address, and other lifestyle issues. Chronically homeless people are rarely the responsibility of one agency, and so engaging these clients required that people had to work outside of their normal operating guidelines to, for example, contact the client at suitable times and locations.

While the Project was able to overcome these barriers for 41 clients, many support providers expressed frustration at the amount of effort required to engage this group, which indicates that relying on existing services to engage this group would not be sustainable over time. Therefore, the experience of the Project shows the importance of targeted responses for this group, such as assertive outreach services that ignore service boundaries to connect clients with support when they are ready to accept it.

The CNCP attempted to arrange comprehensive support services for clients through the development of care plans. Care plans were believed to work well because they were developed with the input of a team of people with multi-disciplinary expertise, and were also comprehensive, realistic, flexible and based on an agreed timeframe. Again, the Project was successful in linking clients with multidisciplinary support but, without having resources to provide this support, clients often had to wait for long periods of time before they were able access what they need. Therefore, wrap-around services with dedicated funding would be preferred because they can improve the ability of service providers to follow transient clients; improve information sharing and retention across agencies; and can address crisis issues in a timely manner. Stakeholders reported that some of the lessons learnt by CNCP about how to

support this target group have been applied to both the Way2Home program the multi-disciplinary assertive outreach team that have recently been implemented.

### 6.3 Gaps in the broader service system

As was demonstrated in Section 5, the Project had to overcome a multiplicity of systemic barriers to link clients with housing and coordinated support. These systemic barriers include:

- There is a lack of flexibility in the service system and willingness of organisations to take ownership over clients with multiple needs and diagnoses.

- Some existing specialist health services that have flexible times and locations rely on health professionals who are doing rotations and only remain in the position for six months. This rapid turn over can have deleterious effects on the many vulnerable clients who would benefit from longer engagement with the clinicians.

- Difficulty getting adequate assessment and treatment. For example, long term street drinkers find it very difficult to get appropriate neuropsychological testing because they need to be sober for a period that many find difficult to sustain. People without fixed addresses cannot be issued community treatment orders.

- Without formal assessment at the appropriate time, people can be denied access to services, such as in the case of Michael whose intellectual disability was not diagnosed until he was over 18 years of age, which precluded him from receiving high level ADHC services.

- Proactive follow up is needed when people transition out of institutional care (e.g. prison or psychiatric facilities) or are discharged from hospital to prevent people from cycling through the service system.

- Prevention and early intervention services are needed to stop people from accruing debt when people are living in a HNSW property, as this jeopardises their ability to access long term housing in future.

- Placing people with complex needs in HNSW properties without support can, in some cases, set a person to fail in their tenancy, which also can prevent them from accessing stable housing later on.

- There are shortages in the availability of support services with the skills and capacity to engage and work with this target group.

- There is a lack of appropriate, affordable housing for this target group. Private rental accommodation (i.e. headlease) is difficult to source for this client group, and there are few alternative housing models that can support people with behavioural issues or who have difficulty living independently.

- More housing models that have support packages attached are needed.

The experience of the Project points to the necessity of broader service system reform to address the needs of this group. System reform is key element of recent policy initiatives such

as the NSW Homelessness Action Plan (NSW Government 2009) which aims to prevent people from becoming homeless, improve coordination within the existing service system, and to provide long term housing and multi-disciplinary support services .

# 7 Conclusion

The CNCP was established in September 2007 to address an unmet need in the community. It was initially implemented with no additional resources except for the passion and commitment of partner agencies to assist chronically homeless people in inner Sydney to access long term housing and support services.

The landscape of homelessness services looked different in 2007 than it does in 2010. At the time there was an increasing recognition that traditional approaches to homelessness were not working to reduce the number of homeless people in Australia, and that new ways of approaching the problem were being successfully trialled elsewhere. These studies provided evidence that traditional models of short-term and transitional housing for homeless people are less effective than providing long-term housing solutions, together with appropriate levels of support, even for those who have been most entrenched in homelessness. A housing first philosophy, which emerged from the US, emphasises the provision of permanent, rather than transitional, housing for chronically homeless people along with comprehensive and multidisciplinary support services on site (Gordon, 2007; Gulcur, 2003; Stefancic and Tsemberis, 2007). One of the cornerstones of this philosophy is that people are provided with stable housing and support without prerequisites related to treatment and compliance because this enables people to address other aspects of their lives more effectively than if they are living on the street or provided with temporary accommodation.

CNCP was inspired by the success of housing first approaches that were implemented in the US and aimed to integrate the spirit of this approach into the work of the Project. One of the challenges that faced CNCP while it was being established was convincing people in the service sector that this target group can be successfully supported in long term housing rather than transitional housing. Since the Project's inception, housing first has become widely recognised as a viable approach to combat homelessness and is reflected in the Australia Government's White Paper on homelessness, *The Road Home* (Australian Government, 2008b) and in the NSW Homelessness Action Plan. Housing first initiatives are now being trialled across Australia.

Given the lack of dedicated resources and the reorientation of the broader service sector, it was decided not to continue CNCP into 2011. The CCG will, however, continue to meet to support each other to manage complex cases and to provide advice to other agencies. However, many of the lessons learnt from the Project have relevance to other homelessness projects. For example, the experience of the Project shows that service coordination works well when there is leadership and committed organisations, roles and responsibilities are clear, there are systems to promote communication, and resources that are dedicated to facilitating coordination. However, the experience of the Project also shows that coordination is takes time and resources and is difficult to sustain over time. Therefore, the Project reinforces the need for providing one service with the capacity to respond to multiple needs of this target group, versus an approach that attempts to coordinate multiple services. Furthermore, engaging and supporting this target group could be done more effectively by targeted services such as assertive outreach and in supportive housing. Finally, service sector reform is needed to make to address the needs of this group more quickly and efficiently.

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