Evaluation of the Melbourne Street to Home program: Baseline Report

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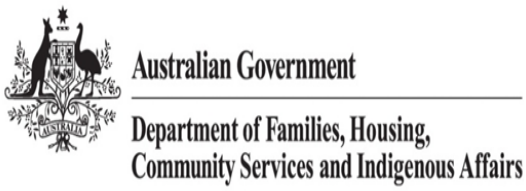

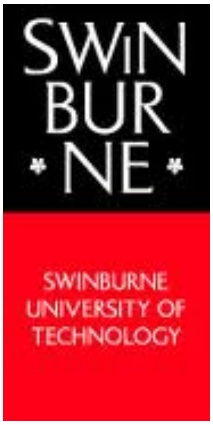

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Executive summary

The Australian Government's (2008) White Paper on homelessness identified two overarching policy goals: to halve homelessness by 2020 and to offer supported accommodation to all rough sleepers who need it. This report evaluates a new service in inner Melbourne, known as 'Street to Home'. This is the first of three reports that will track the Street to Home participants over 24 months. It is a benchmark report so it focuses on the characteristics of the Street to Home clients when they joined the program.

The first aim of this report is to establish whether Street to Home has engaged with its target group. Chapter 3 describes the basic characteristics of the participants. It reports that all the clients had slept rough on and of for at least six months, and that 79 per cent had slept rough on and off for three years or longer. The Melbourne Street to Home program has engaged with its target group.

The second aim of this report is to provide an analytical framework to understand how people become long-term homeless and to understand why it is difficult to disengage from long-term rough sleeping. This conceptual framework is outlined in Chapters 4 to 6.

Chapter 4 describes the respondents' pathways into homelessness and the following chapter develops an empirical critique of the thesis that long-term rough sleepers accept homelessness as a 'way of life'. Chapter 6 investigates how people disengage from chronic homelessness. Many of the long-term rough sleepers in this study reported that they were 'sick and tired' of sleeping rough. This is when intervention can be effective.

The third aim of this report is to establish realistic expectations as to what Street to Home can achieve. Most of the Melbourne Street to Home clients are long-term rough sleepers and their average age was 46 when they joined the program. Chapter 7 shows that 78 per cent of the clients had a chronic physical health condition and 69 per cent had been treated for a mental health disorder. Altogether, 89 per cent of the sample had one or both of these conditions. Judgments about the outcomes achieved by Street to Home should take into account the past experiences of the clients and their poor physical and mental health.

The primary goals of Street to Home are: (1) to assist clients to achieve permanent accommodation; (2) to provide them with support for up to 12 months

to maintain that housing; (3) to provide them with assistance to improve their physical and mental health; and (4) to link them in to support services to maintain their housing after completing the Street to Home program. Chapter 8 provides some preliminary information on how the program is tracking, but the main outcomes of the Street to Home intervention will be the focus of the next report when clients are interviewed 12 months after joining the program.

1 Introduction

Over the past 20 years, the major policy initiatives to reduce homelessness in Australia have focused on early intervention and prevention among young people, women and families. There have been few policy initiatives focusing on rough sleepers. The tacit assumption in the public discourse has been that chronically homeless rough sleepers are resistant to service interventions, because they accept homelessness as a 'way of life'. This report challenges that assumption.

In recent times, the policy agenda has started to change. The Australian Government's White Paper on homelessness identified two overarching policy goals: to halve overall homelessness by 2020; and to offer supported accommodation to all rough sleepers who need it (FaHCSIA 2008). There are now a number of new initiatives to assist chronically homeless people across the country. This report evaluates a new service in inner city Melbourne: the Melbourne Street to Home initiative. This is the first of three reports that will track the Melbourne Street to Home participants over 24 months.

The White Paper identified Street to Home projects as one of the key strategies to reduce chronic homelessness, and there are now Street to Home projects operating in all states. In Melbourne, a consortium of agencies was funded in 2010 to deliver a Street to Home service for three years. The agencies were HomeGround Services, the Salvation Army Adult Services, the Salvation Army Crisis Services and the Royal District Nursing Service (RDNS) Homeless Persons' Program.

The Melbourne Street to Home service operates from two locations in inner Melbourne. One part of the service is managed by HomeGround and operates in the Inner South and the Central Business District. The other part is managed by the Salvation Army Adult Services and covers the Inner West and the Inner North. A RDNS

Homeless Persons' Program Nurse is a member of each team and HomeGround and Adult Services both fund a housing options worker.

Existing programs to assist homeless people typically provide crisis accommodation and short-term support. The explicit aim of Street to Home is to assist chronically homeless rough sleepers into permanent housing and to link them in to a network of support services to help them maintain that housing. The model is based on the Housing First approach developed in the United States, but the Street to Home approach has some distinctive features of its own. This chapter describes the two models. Then the main aims of the evaluation are specified.

Housing First and Street to Home

Many countries claim to practice a Housing First approach, but the clearest articulation of the model has been in the literature from the United States (Newman and Goldman 2008; Tsemberis 2010). Up until the early 1990s, the dominant assumption in the American literature was that most chronically homeless people had mental health and/or substance abuse issues. The implication was that these people needed treatment before they could be offered permanent accommodation.

In the early 1990s, evidence began to surface that this approach was failing (Cohen and Thompson 1992; Tsemberis 1999; Tsemberis and Eisenberg 2000). The Housing First approach emerged in response to this lack of success. It argued that it is more effective to provide people with permanent housing and then to tackle their mental health and/or drug and alcohol issues. In a sense, it turned the conventional wisdom on its head. The Street to Home model is based on the Housing First approach but it has some distinctive characteristics of its own.

First, Street to Home services explicitly target the most vulnerable rough sleepers. In this context, vulnerability is understood to mean ‘at risk of premature death’. Hence, Street to Home services focus particularly on the health of their clients.

Second, it is understood that the most vulnerable rough sleepers are those who are the hardest to reach. Street to Home services use an assertive outreach approach to engage with rough sleepers.

An important aspect of both the Housing First and Street to Home approach is the provision of permanent housing. Some Housing First services such as *Common Ground* favour congregate living arrangements. However, the Melbourne Street to Home project utilises a range of housing options dispersed across the community.

A critical element in both the Housing First and Street to Home model is the provision of long-term support. The Melbourne Street to Home project provides people with intensive support before they access housing. It also provides people with intensive support for up to 12 months after housing has been secured.

The service has undergone some changes in the establishment phase. Initially it was intended that it would support 100 chronically homeless people each year, but this has been revised down to 50 people. This enables staff to have a case load of about eight to 10 people so that they can provide intensive post settlement support when this is needed. There is general agreement that post settlement support is crucial if tenancies are to be sustained.

Three aims

This is a benchmark report so it focuses on the characteristics of the Street to Home participants when they joined the program. A benchmark report is not an evaluation of how well a program is working. That will be the focus of the next report when clients are

interviewed one year after joining Street to Home. A benchmark report focuses on the characteristics of clients when they first enter the program.

The first aim of this report is to establish whether Street to Home has engaged with its target group. Chapter 3 describes the basic characteristics of the participants. It reports that all the clients had slept rough on and of for at least six months, and that 79 per cent had slept rough on and off for three years or longer. The Melbourne Street to Home program has engaged with its target group.

The second aim of this report is to provide an analytical framework to understand how people become long-term homeless and to understand why it is difficult to disengage from long-term rough sleeping. This conceptual framework is outlined in Chapters 4 to 6. It is important that services have an explicit framework to help understand the processes that result in people becoming long-term homeless.

There is a tacit assumption in more conservative public discourses that long-term rough sleepers are resistant to service interventions and that there is little point in trying to assist them. The Australian Government has rejected this contention for good reason. On the other hand, there are others who assume that if there are appropriate interventions, then chronic rough sleepers can become 'middle class' citizens, employed full-time in the labour force. The third aim of this report is to set up realistic expectations as to what Street to Home can achieve. These are discussed in Chapter 8, after the empirical information about the clients has been examined.

The structure of the report is as follows. Chapter 2 outlines how the research was carried out and the next chapter examines whether Street to Home has engaged its target group. Chapter 4 describes the respondents' pathways into homelessness and the following chapter develops an empirical critique of the argument that long-term rough sleepers accept homelessness as a 'way of life'. Chapter 6 investigates how people disengage from chronic homelessness using the concept of 'associational

distancing' (Snow and Anderson 1993). Chapter 7 asks, 'How are they now?' This chapter finds that 89 per cent of the clients had either poor physical health, poor mental health, or both conditions. Chapter 8 pulls together the main findings.

2 Method

The first task for the Melbourne Street to Home team was how to identify suitable participants for the program. This was undertaken using an approach developed in the United States known as Registry Week. Over three days, volunteers went out each morning between 3 am and 7 am to locate rough sleepers. People worked in teams and systematically searched areas where homeless people were known to sleep. When a rough sleeper was identified, the individual was asked to complete a short survey known as the vulnerability index. The purpose of this index was to identify those people who were 'most likely to die within the next five years if they do not find housing and support' (HomeGround Services 2011).

The vulnerability index generated a score from zero to eight. A positive answer to any of the following eight questions scored one point:

- More than three hospitalizations or ER visits in a year
- More than three ER visits in the previous three months
- Aged 60 or over
- Cirrhosis of the liver
- End stage renal disease
- History of frostbite, immersion foot or hypothermia
- HIV+/AIDS
- Tri-morbidity: co-occurring psychiatric illness, substance abuse and a chronic medical condition

Melbourne's first Registry Week took place in October 2010 and 166 people completed the vulnerability index. The 50 people who scored two or more points were prioritised by the Street to Home team. The Street to Home team had no pre-existing relationship with the potential participants and there were difficulties both finding and engaging people. Of the 50 who scored two or more points, nine were never found, five had either moved interstate or gone into prison, two would not engage with the

program, one person was found to be ineligible, and one person had died. The remaining 32 joined the program and were interviewed.

Street to Home recruited another 10 people who were initially provided with short-term support through the Intake and Assessment program. These people had scored one on the vulnerability index but were found to have similar problems to those who had scored two or more. All 10 were interviewed. Finally, three people were interviewed who completed the vulnerability index after Registry week, but scored two or more points. The total number of interviews was 45.

The interviews were arranged by Street to Home staff and were usually conducted on-site. On average, the interviews lasted between 45 minutes and 1.5 hours. There were two parts to each interview. The first part involved a structured set of questions that elicited quantitative material. Basic demographic material was collected, as well as information on the participants' housing histories, their physical and mental health, and their sense of social connectedness.

All of the participants were asked if they would be willing to answer some in-depth questions and 30 participants agreed to do so. Responses to the in-depth questions were tape recorded and transcribed. Narrative and thematic analysis was used to organise this information (Labov 1997), paying particular attention to people's housing histories and their engagement with other homeless people. People were also asked about their housing aspirations and the impact of homelessness on their health.

Approval for the study was obtained from RMIT University's Ethics Committee[1]. In this report, people's names and various personal details have been changed to ensure confidentiality.

[1] Register number CHEAN A – 2000407-09/10.

3 Was this the target group?

The aim of the Melbourne Street to Home program is to engage with chronically homeless people who have slept rough for significant periods of time. This chapter starts by defining long-term homelessness. Then it examines the demographic and health characteristics of the study participants. After that it assesses whether the program has accurately identified and engaged with the target group.

The target group for the Street to Home program is chronically homeless rough sleepers. There is an emerging consensus in the United States and Australia that 12 months is an appropriate threshold to define long-term homelessness and this convention is adopted here (U.S. Department of Housing and Urban Development 2007; Johnson and Chamberlain 2008; Chamberlain and Johnson 2002). The terms 'long-term' homelessness and 'chronic' homelessness are used interchangeably.

Demographic characteristics

Most of the participants were male (89 per cent) and most of these men (37 out of 40) were single. It is unusual to find women sleeping rough because of the risk of physical and sexual assault. Women who are long-term homeless develop different survival strategies to get by (Liebow 1993; Casey 2001; Hopper 2003: 138). Nonetheless, there were five women in the program, including three who had slept rough on and off for six years or longer. Three of the women had partners.

The mean age of the sample was 46, which is 14 years older than the mean age for people accessing specialist homelessness services across Australia (Australian Institute of Heallth and Welfare 2009). It is also 10 years older than the participants in another study of long-term homelessness (Johnson, Parkinson, Tseng and Kuehnle 2011). Table 3.1 shows that one-third (33 per cent) of the participants were aged 30 to

39, 29 per cent were between 40 and 49, another one-quarter (25 per cent) were 50 to 59, and 11 per cent were aged 60 or older.

Table 3.1: Age of participants

	N = 45
	%
Under 30	2
30 - 39	33
40 - 49	29
50 - 59	25
60 or older	11
	100

The educational attainment of the participants was low in comparison to the Victorian population. These days, 81 per cent of students in Victoria complete Year 12 (Australian Bureau of Statistics 2010: 31), but only 24 per cent of the participants in *Street to Home* had finished Year 12. Another 36 per cent had completed either year 10 or year 11, and 40 per cent had left school earlier than this. Of course, the mean age of this sample was 46. This means that many of them were about 18 in the mid 1980s when approximately 45 per cent of school leavers completed Year 12 (ABS 1988).

All but one of the participants was receiving a Centrelink payment and two-thirds (64 per cent) were on Disability Support pensions. Most of the respondents (89 per cent) had been on a government support payment for three years or longer.

Health

The Melbourne Street to Home program has a particular focus on health. Table 3.2 shows that 78 per cent of the sample reported a chronic physical health condition and 43 per cent reported three or more chronic health conditions. Forty-six per cent had

used a community health service in the three months prior to the baseline survey and 40 per cent had used a hospital emergency department. Currently, 70 per cent were taking some form of prescribed medication. More than two-thirds (69 per cent) had been treated for a mental health disorder and seven per cent had been to admitted psychiatric unit in the last three months. Sixty-nine per cent reported intravenous drug use at some point during their lives and 88 per cent were currently cigarette smokers. Overall, their health was poor. Chapter 7 examines their physical and mental health in more detail, including a discussion of their self-esteem.

Table 3.2: Selected health characteristics of participants*

Report a chronic physical health condition (%)	78
Report three (3) or more chronic physical health conditions (%)	43
Used emergency department, last three months (%)	40
If used emergency department, mean number of times last three months	2.72
Used hospital, last three months (%)	27
If used hospital, mean number of times last three months	1.83
Used community health service, last three months (%) (N=41)	46
Currently takes prescribed medication (%) (N=43)	70
Been treated for a mental health disorder (%)	69
Used psychiatric unit, last three months (%) (N=42)	7
If used psychiatric unit, mean number of times last three months	1.00
Report IV drug use, ever (%)	69
Currently smoke cigarettes (%) (N=43)	88

* N = 45 unless otherwise indicated

Target group?

Has the program identified the right target group? This section demonstrates that the participants had been homeless for a long time and some had first become homeless in their teenage years. For example, Josh, aged 45, said:

> When I was 16 my father kicked me out … I slept in a bus stop and the police pulled up. They took me back home and made me sneak into the house. I fell asleep on the couch

> in the lounge room. When Dad woke up, he kicked me out again … After that, I slept on the streets.

Mandy was 15 when she left home. She remembered:

> … sleeping in a brotherhood bin because it was raining … I ripped open the bags and put the clothes on … It was better than sleeping in the fucking rain (Female, 32).

On average, 21 years had elapsed between people's first experience of homelessness and their current experience. This does not mean they were continually homeless. Most had moved out of the homeless population a number of times, but these returns to conventional accommodation had subsequently broken down. Overall, it appears that most people in the sample had been at the margins of the housing and labour markets for a considerable amount of time.

When the participants undertook the vulnerability index, everyone reported that they were sleeping in parks, squats or on the streets, and had been doing so for a substantial amount of time. The participants reported that it had been, on average, just over nine years since they last had their own housing.

Table 3.3: Length of time sleeping rough*

	N = 39	
	%	
Between 6 – 11 months	8	
1 - 2 years	13	
3 – 4 years	13	
5 – 6 years	18	79
7 – 9 years	15	
10 years or longer	33	
	100	

* No information on six people

Participants were asked to indicate how long they had slept rough. Table 3.3 shows that eight per cent had slept rough 'on and off' for between six and 11 months,

13 per cent had slept rough on and off for one to two years, and 79 per cent had slept rough for three years or longer. One-third of the clients (13 people) reported having slept rough on and off for 10 years or longer. These findings indicate that the program has accurately identified and engaged with chronically homeless people, a hard-to-reach group.

Most of the Melbourne Street to Home clients are long-term rough sleepers. Their average age is now 46 and many of them are in poor health. Judgements about the outcomes achieved by Street to Home should take into account the past experiences of the clients and their poor physical and mental health.

4 Pathways in

It is generally accepted that between 10 and 25 per cent of the homeless population have a long-term problem, whereas most people are homeless for a short period of time. Thus, it is important to ask why some people become long-term homeless when others do not. This chapter focus on pathways into homelessness because research indicates that a person's pathway has a bearing on their experience of homelessness.

The Street to Home participants were chronic rough sleepers and two-thirds (65 per cent) of them were now aged 40 or older. Thus, it is counter intuitive to think that chronic rough sleeping has anything to do with homeless teenagers. Nonetheless, young people who became homeless as teenagers were significantly over-represented in this sample.

Table 4.1: Pathways into long-term homelessness

	Journey to Social Inclusion (N=83)	*Melbourne Street to Home* (N=45)
	%	%
Youth to adult pathway	53	49
Alternative adult pathway	47	51
	100	100

Table 4.1 compares the findings from another program for chronically homeless people known as the Journey to Social Inclusion (J2SI) with the findings from this research. In both programs, about half of the participants had their first experience of homelessness when they were 18 or younger and subsequently made the transition to adult homelessness. We refer to this as a 'youth to adult' pathway. The other half of the respondents in both studies became homeless when they were 19 or older. We refer to these as 'adult pathways' into chronic homelessness.

This chapter begins by examining the experiences of people on the youth to adult pathway. Then it examines the experiences of those who first became homeless as adults, but subsequently made the transition to long-term homelessness.

Youth to adult pathway

Numerous studies have identified a link between childhood trauma and long-term homelessness (Calsyn and Morse 1991; Bassuk, Buckner, Weinreb, Browne, Bassuk, Dawson and Perloff 1997; Zugazaga 2004; Johnson et al. 2011). Researchers have noted that family relationships among young people who make the transition to adult homelessness are volatile and commonly characterised by traumatic experiences such as abuse and neglect. Many people on the youth to adult pathway disclosed emotional, physical and/or sexual abuse.

When young people are abused or neglected by their parents it often leads to the involvement of Child Protection authorities. In a large study of young people (n=1677) who made the transition from youth to adult homelessness Johnson and Chamberlain (2008) reported that 42 per cent had been in state out-of-home care. Among the people on the youth to adult pathway in Street to Home, a similar number (41 per cent) reported that they had spent time in out-of-home care when they were growing up (Table 4.2).

Being removed from one's family is often a traumatic experience in its own right. But, there was also evidence that some teenagers' experiences in out-of-home care were traumatic and damaging. In some cases, this was the result of poor or unstable placements. In other cases, young people were placed in institutions with harsh disciplinary regimes:

> Going through the boys home was the worst … They were trying to teach us how to tell the time. I still remember it … It might have been 9.15 and I though it was 8.15 … I don't

know … It was 9.15 and I said, 'A quarter past eight'. 'WRONG!' WHACK! … across my head … There were lots of beatings (Ted, 52).

Table 4.2: Time in state out-of-home care and/or juvenile justice system

	Youth (N=22)	Adult (N=23)
	%	%
In state out-of-home care	41	13
In juvenile justice system	46	22
In one or both of the above	59	26

Table 4.2 shows that just under half (46 per cent) of the people on the youth pathway had also been involved with the criminal justice system before they were 18 years of age. Young people who spend time in out-of-home care and/or juvenile justice commonly face serious difficulties accessing housing, education and employment when they leave. Many young people are simply discharged directly into homelessness (Mendes 2005; Stein 2006; Johnson, Natalier, Thoresen, Liddiard, Mendes, Bailey and Hollows 2010)**.**

Although time in out-of-home care or involvement with the juvenile justice system are strong indicators of adverse childhood experiences, other people on the youth to adult pathway experienced significant problems at home, but they avoided the attention of the Child Protection authorities. John became homeless at 16:

I felt rejected by my family … I was treated as a bastard child and brought up as one.

When young people's experience of home involves abuse or neglect they often look for alternative places to stay. But their housing options are limited because they have little education, few job prospects and no meaningful family support. When young people from a disadvantaged background become homeless, their ability to 'break the cycle' is often limited because they have few economic and social resources to draw on.

Alternative pathways

There was much greater variation in the pathways of those who were adults when they first became homeless. However, there appeared to be four main routes.

For some people the main reason why they became homeless was because *mental health* problems created difficulties interacting with their friends, their families and also mainstream institutions. When Elsa was in her early twenties, she was diagnosed with schizophrenia. Her illness created problems at home and eventually her relationship with her parents broke down. Elsa told us that as a result of her illness she had 'no relationships with [her] family … they don't want anything to do with me'. Without family support Elsa soon became homeless.

Others became homeless because of *substance misuse* problems. Tom had a good job as a mechanic. He also used heroin. When he started using heroin he did so occasionally, but over time his heroin use escalated. It got to the point where he had a serious problem with heroin. He ended up losing his job:

> …because of drugs. I had to start stealing stuff from work and I got caught … The boss said, 'Look, I know you've got a drug problem. Instead of sacking you, I'll let you resign. But if you ever need a reference, you've got to prove to me you've been through detox and you're clean' (Tom, 39).

In other cases, people lost their accommodation following a *housing crisis*, typically precipitated by a loss of income. Ed's world changed after he was injured in a car accident:

> The injuries I sustained from the car accident prevented me from working as a chef which led to financial hardship … as well as me abusing alcohol for pain relief … that was the start of my homelessness (Ed, 43).

We also found that a number of men became homeless following *family breakdown*. In some cases, they had lived a 'normal' life prior to becoming homeless

with a steady job, a home and a family. However, when things went awry the consequences were often devastating. Adrian, 61, told us:

> I was bringing up two children and I had an invalid wife… I was happy, contented. The two kids were involved in sports and doing all that sort of stuff. They had friends stopping over, or they stopped over at friends. We were an average suburban household in a way.

The pressure of looking after an invalid partner for four years, as well as raising a family, was too much for Adrian. Without any support he eventually 'hit the wall'. His mother-in-law contacted the 'Department' and his life changed abruptly when:

> The wife was taken away and put into palliative care. The children were put into foster care …. I wasn't allowed near the house … I ended up on the streets with no identification and no money.

In some cases, the transition from 'housed' to 'homeless' involved more than an unexpected change in housing circumstances. The trauma was magnified for the participants because they lacked the emotional resources to cope with the loss of their most intimate relationships.

Understanding pathways into homelessness is important because research shows a link between people's pathways into homelessness and the length of time they are homeless. To illustrate this point, information is drawn from a study of 3900 homeless adults known as the 'pathways study' (Chamberlain and Johnson 2011). Table 4.3 shows that two-thirds (65 per cent) of those in the pathways' study who had a short-term problem (defined as homeless for less than three months) were from adult family breakdown or housing crisis backgrounds. In contrast, amongst those who were long-term homeless (operationally defined as one year or longer), only 16 per cent came from family breakdown or housing crisis backgrounds, whereas 83 per cent were from either a substance abuse, mental health or youth to adult pathway.

Table 4.3: Pathways into short-term and long-term homelessness

	Short-term (less than 3 months) (N=770)		Long-term (one year or longer) (N=2562)	
	%		%	
Housing crisis	42	65	9	16
Family breakdown	23		7	
Substance abuse	11	31	18	83
Mental health	9		19	
Youth to adult	11		46	
Other	4		1	
	100		100	

Source: Chamberlain and Johnson (unpublished data)

Three things stand out from these findings. First, those who become long-term homeless come from a diverse range of backgrounds. Second, people who enter the homeless population on a substance abuse, mental health or a youth to adult pathway are at far greater risk of becoming long-term rough sleepers than other people. Third, while most of those on the housing crisis and family breakdown pathways have a short experience of homelessness, a small number do make the transition to long-term homelessness.

Conclusion

At the outset to this chapter, it was pointed out that it is counter intuitive to think that chronic rough sleeping has anything to do with teenagers. Nonetheless, it has been shown that young people who become homeless were significantly over-represented in this sample of chronically homeless adults. Half of the participants had made the transition from youth to adult homelessness.

Amongst those who first became homeless as adults we saw four patterns. In some cases, mental health issues preceded homelessness and in other cases

substance abuse was involved. A lack of money precipitated a housing crisis for some, and for others it was the breakdown of family relationships. People on the youth to adult pathway are over-represented amongst the chronically homeless, but there is also considerable diversity in the population.

The aim of the Street to Home program is to assist long-term rough sleepers into permanent housing and to help them maintain that accommodation. In order to do this, it helps to understand the events that preceded their first experience of homelessness and how these experiences influence the length of time people remain homeless.

5 Chronic homelessness

Theorising long-term rough sleeping

Researchers have theorised why some people become chronically homeless by focusing on how people relate to the homeless sub-culture. We call this the social adaptation account. In most versions of the argument, it is implied that long-term rough sleepers accept homelessness as a 'way of life' (Sosin, Piliavan and Westerfelt 1990; Pears and Noller 1995; Wasson and Hill 1998; May 2000; Auerswald and Eyre 2002; Chamberlain and Johnson 2002; Van Doorn 2005). This argument appears in popular discourses which claim that rough sleepers are resistant to service interventions and there is no point in trying to assist them.

This chapter examines two interconnected propositions in the social adaptation argument. The first proposition contends that people engage with the homeless sub-culture in boarding houses and emergency accommodation (Hirst 1989; Smith 1995; Fitzpatrick 2000; Mallett, Rosenthal and Myers 2001; Johnson, Gronda and Coutts 2008). In these sites, as on the streets, they share alcohol and drugs with other homeless people. These recreational activities make it difficult for people to get out of homelessness. The second proposition contends that the longer people are homeless, the more likely they are to sleep rough and accept homelessness as a 'way of life' (Wallace 1965; Chamberlain and Mackenzie 1998; Wolch, Dear and Akita 1998). This chapter shows that the evidence does not support this proposition.

Boarding houses

The social adaptation thesis argues that people engage with the homeless sub-culture in boarding houses and emergency accommodation. Here they start to build more solid friendships with other homeless people and to engage in recreational practices that are

common in the homeless sub-culture, such as sharing alcohol or drugs with other homeless people. These recreational activities assist homeless people to cope with the uncertainty of being homeless and living in a stressful environment. At the same time, they make it more difficult for people to get out of homelessness. People start to identify increasingly with other homeless people and to develop a sense of solidarity with them. Boarding houses and emergency accommodation are important sites where this sub-cultural activity takes place.

When people remain homeless for long periods of time, the differences between them become less obvious. Their material circumstances tend to converge because they have low incomes and few accommodation options. Most people are forced to rely on emergency accommodation or boarding houses for much of the time, although they sleep rough when they cannot afford that accommodation, or when there are no vacancies available.

Table 5.1: Ever stayed in emergency accommodation, by pathway

	Youth (N = 22)	Adult (N = 23)	Total (N = 45)
	%	%	%
Yes	77	78	78
No	23	22	22
	100	100	100

Table 5.1 shows that over three-quarters (78 per cent) of the respondents had stayed in emergency accommodation including refuges, crisis services and transitional accommodation. People had entered the homeless population on different pathways, but there was no discernible difference in their patterns of service use.

However, it is well-known that access to emergency accommodation is limited and it is common to find that most services are full. One consequence of this is that boarding houses are an essential part of the system of emergency accommodation in

the capital cities. Welfare agencies often provide homeless people with vouchers for short-term stays in boarding houses. Table 5.2 shows that 84 per cent of the respondents had stayed in a boarding house, and once again there was no discernible difference between people on different pathways.

Most of the respondents had stayed had stayed in boarding houses at the bottom end of the private rental market. Mandy reported that:

> I pay $280 per fortnight at Flinders Lodge and it's a fucking dog box … Most days, I go to a meals program in Fitzroy … It beats sitting at home in that fucking little depressing room.

According to Eddie:

> The last time I stayed at *The Circle* they gave me a room that was infested with bed bugs … The hygiene in most boarding houses is very poor.

Table 5.2: Ever stayed in a boarding house, by pathway

	Youth (N = 22)	Adult (N = 23)	Total (N = 45)
	%	%	%
Yes	86	83	84
No	14	17	16
	100	100	100

In boarding houses, as on the streets, social interactions are often structured around drinking and drug use and friendships based around these activities are common. Jayden told us that every time he stayed in boarding houses he 'hooked up with the wrong crowd'. Others talked about groups of friends sharing alcohol or people 'shooting up' together.

All respondents were asked whether they had received treatment for either an alcohol or a drug problem. Table 5.3 shows 85 per cent of those on the youth to adult pathway had been treated for an alcohol and/or drug problem, as had 75 per cent of people on the adult pathways.

Table 5.3 Ever been treated for an alcohol or drug problem, by pathway*

	Youth (N = 20)		Adult (N = 20)		Total (N = 40)	
	%		%		%	
Yes, alcohol problem	20		35		27.5	
Yes, alcohol and drugs	25	85	30	75	27.5	80
Yes, drug problem	40		10		25	
No	15		25		20	
	100		100		100	

* No information on five people

Sixty-five per cent on the adult pathways had a problem with alcohol and 40 per cent had a problem with drugs. This pattern was reversed around for those on the youth to adult pathways: 65 per cent had a drug problem and 45 per cent had an alcohol problem. Teenagers were often introduced to heroin soon after they became homeless. Mandy told us:

> After I left home I got introduced to smack … Then I moved up to the City where it was cheaper and there was shitloads of it.

Drug and alcohol problems create significant barriers to getting out of homelessness. When people have a drug problem, raising money has a significant influence on their day to day lives. Men are more likely to engage in petty crime to raise money, whereas women are more likely to engage in street sex work. When people have a major drug or alcohol issue, they have no time to think about organising permanent housing which requires planning and financial resources.

The social adaptation argument contends that homeless people develop a sense of solidarity with other homeless people. However, the thesis glosses over some of the tensions in the homeless sub-culture. In many interactions between homeless people, there are volatile undercurrents of hostility and resentment. When these tensions come to the surface, they usually manifest themselves in people ‘ripping each other off’ or in verbal and physical aggression. Jayden was staying in a boarding house:

> I was watching the news on TV. There was a neighbour making a lot of noise so I knocked on his door and asked him to be quiet … Then he started kicking the wall between our rooms. I knocked on his door again and told him to stop banging … then he stabbed me in the lower abdomen (Male, 39).

Erik said:

> I was alone in the kitchen about 2 o'clock in the morning putting some food on my plate when someone came from behind and smashed me over the head (Male, 53).

According to Jacques, the best 'survival strategy' in a rooming house is to keep a low profile:

> It's a bit like being in gaol in some of the rooming houses …You've got to pull your head in, keep your shit to yourself … and then you'll get along all right.

Unfortunately, 'keeping a low profile' is not always possible in crowded rooming houses where there are shared facilities and limited private space. Tom said:

> You can never really keep to yourself. Everybody wants to know who you are and when is your next payday?

The social adaptation account correctly points out that certain sub-cultural practices lock people into homelessness, but it over-emphasises the sense of solidarity that homeless people have with each other:

> You've got to pick and choose your friends and just be careful who you're hanging out with. That's what I reckon (Rick, 32).

> My friendships have only ever been fleeting ... I have learnt not to trust anybody but myself (Warren, 58).

Sleeping rough

The final strand in the social adaptation account contends that the longer people are homeless, the more likely they are to sleep rough. Sleeping rough occurs because people have exhausted their limited accommodation options. When people start to

sleep rough their physical appearance starts to decline and this further undermines people's self-esteem. For some people sleeping rough becomes a 'way of life' (Wallace 1965). These individuals are said to have made the 'transition to chronic homelessness' (Chamberlain and MacKenzie 1998; Wolch, Dear and Akita 1998).

In Chapter 3, it was reported that 79 per cent of the Street to Home clients had slept rough on and off for three years or longer. If the social adaptation account is right, we would expect that this group would endorse rough sleeping.

In fact, there was little evidence to support this argument. Most Street to Home clients did not endorse street homelessness as a way of life. Jerry did not like sleeping rough because he detested the violence that he had encountered on the streets:

> One morning I woke up because this guy was screaming, 'You low transient bastard' … When I got out of my van he bashed me … Then he bolted down the street (Jerry, 64).

Josh had been attacked on the streets a number of times, usually when he was asleep. Ziggy, 48, was:

> … living in an old factory and a couple of guys came in … and they just started kicking me.

According to Damien, 36:

> I have been on the streets since I came out of gaol … I was attacked by a group of young guys who were drunk … I suppose I was an easy target … fancy being robbed for a blanket.

There was little evidence that this sample endorsed sleeping rough as their preferred accommodation option:

> It's not good to sleep out. It's not good for your brain and it's not good for your health … It's horrible … You never know who's around the corner … You just sleep on the street and hope for a house to come up (Josh).

Most people in this sample had been long-term rough sleepers, but they did not accept rough sleeping as a 'way of life'. Most people pragmatically accepted their

situation because they felt they had no alternative. Chronic rough sleeping is not a characteristic of people, but rather a situation in which people find themselves at certain points in time (Blasi 1990, p.209).

Conclusion

The social adaptation argument implies that long-term rough sleepers accept homelessness as a way of life. It is true that long-term homeless people often form friendships with other homeless people and engage in recreational activities that make it difficult to get out of homelessness. However, the social adaptation argument misses some of the tensions in the homeless sub-culture. The argument also contends that the longer people sleep rough, the more likely they are to accept this as a ‘way of life’. The evidence from this study indicates that most people did not accept sleeping rough. If people are given the opportunity and the right level of support it is possible to assist them to return to conventional accommodation.

6 Disengaging

> (There is the) possibility of movement off the streets and into conventional society … even long-term homeless individuals cannot be written of definitively (Snow and Anderson 1993: 275-276).

This chapter focuses on how people attempt to get out of chronic homelessness, utilising Snow and Anderson's (1993: 215-219) concept of 'associational distancing'. Snow and Anderson argue that when people have to enact roles, associate with others or utilize institutions that imply they have a social identity that is inconsistent with the person they desire to be, then it is common for people to develop strategies to distance themselves from those roles, association or institutions. They refer to this process as 'associational distancing' and we use this term synonymously with the terms 'disengaging' and 'distancing'.

This chapter covers three issues. First, it examines how many of the participants in the Street to Home project had begun to distance themselves from their homeless peers. Then it examines how they had started to disengage from important sub-cultural practices. Finally, it returns to the argument that when people start to sleep rough for long periods of time, this indicates that they have come to accept homelessness as a way of life. The chapter show that in some cases people sleep rough to get away from the damaging effects of long-term involvement in the homeless subculture. When people sleep rough for this reason, it does not denote acceptance of homelessness as way of life; rather it is a strategy to distance themselves from other homeless people.

Social networks

The social adaptation thesis contends that when people become homeless they start to develop friendships with other homeless people who provide them with a sense of 'belonging' that is often missing in their lives, as well as important information about

how to survive homelessness. For those who become long-term homeless, these social networks take on added significance in their lives. This is because the long-term homeless gradually lose contact with their friends and relatives in the housed population. As we saw in Chapter 5, this account glosses over some of the tensions in the homeless sub-culture.

Many of the participants in Street to Home had started to actively distance themselves from other homeless people. After years of hustling and scamming to get by, many people did not trust their 'friends'. Josh said:

> I no longer trust (homeless) people. I just don't trust them. You know they've all out for themselves … You send them down the street to get you a packet of smokes and they'll run off with your money and your smokes.

Ted told us he was sick of being taken advantage of by his 'friends':

> Yeah, I reckon I could have had some reasonable friendships, but most of the people that I've thought were friends were users … People take advantage of you if they can … They deceive you … That's happened to me.

Helen, 33, said:

> Most of them are into drugs. The only time they want anything to do with you is on payday.

As a result, many of the people in Street to Home had started to re-shape their social networks through a process of careful selection. Sergei said:

> You've got to be very wary with (homeless) people. You have to try to pick the right ones. … There's a lot of people out there that will take advantage of you.

Helen said that she knew lots of homeless people but: 'Most of them are not the sort of people I want to keep in my life'.

Sub-cultural practices

The social adaptation argument contends that homeless people learn strategies from other homeless people that help them to survive homelessness. Recreational activities in the homeless sub-culture are often organised around drinking and drug use. These can be strategies for coping with a stressful environment, but they can also undermine people's ability to exit from homelessness. Next we show that associational distancing involves detaching from these sub-cultural practices and establishing new routines.

Table 6.1: Frequency of drug use

	N = 45
	%
Have injected drugs	69
Have injected drugs in the past four weeks	22
Have injected drugs *daily* in the past four weeks	7

Table 6.1 shows that 69 per cent of those in the Street to Home program had injected drugs, and we know that 53 per cent of the sample had been treated for a drug problem (Table 5.3). However, many people in Street to Home reported they were 'worn out'. They could no longer manage the chaotic lifestyle that is part of the drug taking scene.

For those who had long-term substance abuse issues, heroin in particular had lost its allure. Many people had seen friends die from overdoses and this had a deep symbolic impact on them. Helen said:

> I had lots of friends on the streets when I was younger but … most of them have passed away now.

According to Dino, 46:

> I have friends who have died … I've watched people die around me … I know I could be a statistic.

People do not stop using drugs entirely when they withdraw from the homeless subculture, but their frequency of using drugs certainly changes. Although 69 per cent had injected drugs at some point in their lives, only 22 per cent (10 people) had injected drugs in the last month (Table 6.1). Of those 10, seven were occasional users and three were daily users.

Kevin was a regular heroin user in the past. A change in his drug using practices was firmly linked to changes in his social networks. He told us that because he was no longer using heroin, that he didn't hang around with 'that crowd'. Helen had been spending $1000 per day on heroin and cocaine, but now she had no contact with her former drug using acquaintances.

Table 6.2: Frequency of alcohol use over the past four weeks

	N	%	
Daily use	11	24	
Every two to six days	5	11	
Once or twice every two weeks	6	13	31
About once a month	3	7	
Have not drunk alcohol	20	45	
	45	100	

Alongside the decline in drug use, there was a shift in the pattern of alcohol use, although this is a more complex issue because we know some people changed from drug use to alcohol use. Our data on alcohol use is also limited because we have information only on the frequency of use.

Table 6.2 shows that 24 per cent of the sample had drunk alcohol every day during the preceding month. Unfortunately, we have no information on the quantity consumed, and this is needed to assess the significance of daily consumption. Another one-third of the sample (31 per cent) drank alcohol occasionally, ranging from a few times a week to about once a month. Again we have no information on the quantity

consumed but it seems likely that many of these people were moderate drinkers. In contrast to the popular stereotype of the homeless alcoholic, just under half (45 per cent) of our sample had not consumed alcohol in the preceding month.

Most people in the Street to Home project had been heavy drug and alcohol users in the past, but many of them were now disengaging from these cultural practices. Most people had stopped injecting drugs on a daily basis. About half (45 per cent) had not drunk alcohol in the past month and about one-third were occasional drinkers.

Rough sleeping

The social adaptation argument contends that when people start to sleep rough for long periods of time, this indicates that they have come to accept homelessness as a way of life. Next it is shown that some people sleep rough to get away from the damaging effects of long-term involvement in the homeless subculture. When people sleep rough for this reason, it does not denote acceptance of homelessness as way of life, but it is a strategy to distance themselves from other homeless people.

Boarding houses are an important part of the system of emergency accommodation and this is where homeless people often meet others in a similar predicament to themselves. However, some people in our sample preferred to sleep rough rather than use boarding houses. This was often a distancing strategy to avoid encountering drugs.

Adrian had been sleeping rough during a period of inclement weather, a few months after first becoming homeless. A welfare agency had given him a voucher for one week in a boarding house:

> I decided to take the voucher because it had been really wet and cold ... but when I got to the place. My God! ... They just weren't my type of people. There were people shooting

> up. Others were drunk .... I lasted one day. I went back to sleeping rough. At least I had my privacy.

Ziggy no longer uses drugs or alcohol. He said:

> I can't handle living in boarding houses … It was okay when I had the drink and drug problem, I could live with the same people as myself. That was okay for many years and I didn't mind that environment. Now things have changed and I just can't handle that environment any longer.

However, long-term homeless people have few resources and rarely have alternative housing options available to them. In some cases, the practice of associational distancing is accompanied by more frequent and lengthier periods of rough sleeping. Ted had been homeless for over a decade and he had occasionally slept rough throughout this time. It was only when Ted disengaged from his social networks that he started to sleep rough on a more constant basis. Ted told us that he had 'only become a street person over the last few years'.

Using sleeping rough as a strategy to get away from the harmful effects of the homeless subculture is a double edged sword as people are then routinely exposed to the dangers of street life. Altogether 76 per cent of our sample had been a victim of physical violence while they had been homeless and just under half (44 per cent) had been a victim of a criminal act in the three months prior to the survey.

The threat of violence can make it difficult to sleep properly and this can have negative consequences for people's health. Dusan said that he suffered:

> …from insomnia related symptoms, tiredness, fatigue, stress … your stress levels increase if you haven't had a proper night's sleep … it takes its toll on your health.

To address the impact of sleepless nights and also to reduce their vulnerability to assault, people often started to look for more secure places to stay. After being assaulted Ziggy was:

> …more selective on where I stayed. I'd make sure if I found a place that it was more secure. People just couldn't walk in on me out of nowhere. Yeah, I became very security conscious after that happened.

Cookie had seen a knife fight when he was sleeping in a park. After that, 'I didn't sleep anywhere where people could see me'.

Many of the long-term rough sleepers in this study reported that they were 'sick and tired' of sleeping rough. This is when intervention can be effective:

> When you get to a certain age, you don't want to go back on the streets anymore. It's just too hard. When Frank (Street to Home worker) told me what he was doing I was very appreciative … I suppose without him I would be dead (Adam, 54).

7 How are they now?

The third aim of this report is to set up realistic expectations as to what Street to Home can achieve. Chapter 3 pointed out that the participants' mental and physical health was poor. This chapter examines their physical and mental health in more detail, including a discussion of their self-esteem.

People who sleep rough rarely have access to basic amenities such as bathrooms and kitchens. As a result their diet, hygiene and appearance can suffer. When poor diet and unhygienic conditions are combined with an ongoing fear of violence and a profound sense of isolation, there is often an adverse impact on people's mental and physical health.

Table 7.1 shows that 78 per cent of this sample had a chronic physical health condition and 69 per cent had been treated for a mental health disorder. Altogether, 89 per cent of the study participants' had one or both of these conditions. Of the 40 people who had one or both conditions, five had a mental health disorder, nine had a chronic physical condition, and 26 had both a physical condition and a mental health problem.

Table 7.1: Physical or mental health condition

	N = 45	
	%	
Physical health condition	20	
Physical and mental health condition	58	89
Mental health condition	11	
Neither	11	
	100	

78 = Physical health condition + Physical and mental health condition

69 = Physical and mental health condition + Mental health condition

Physical health

For some people, their physical health problems could be traced back to their heavy drug use. For instance, of the 31 people that had injected drugs 15 (or 48 per cent) reported that they had Hepatitis C. Jane, 32, said:

> My health has sort of been shit for a long time. I think I lost all faith in that when I first found out I had Hep C … At that time I was thinking, shit, I'll just go back to Sydney and do more drugs … Now I think differently.

For other people, their chronic health problems were probably a consequence of heavy drinking. Daniel told us:

> I used to drink. That was the only thing I ever did, drink and eat. I used to drink a lot of alcohol and that has affected my liver.

The participants were suffering from a range of chronic health conditions including: diseases of the digestive system such as Hepatitis C and cirrhosis of the liver (57 per cent); diseases of the respiratory system such as emphysema and bronchitis (20 per cent); diseases of the musculoskeletal system such as chronic back and neck pain, and arthritis (31 per cent); and diseases of the circulatory system such as heart disease and strokes (11 per cent).

Of the 35 people who reported chronic physical health problems, 74 per cent had two or more illnesses, and 43 per cent had three of more. Tom is a 39 year old whose physical health is poor:

> At the moment, I've got liver problems, which is from the alcohol. I got Hep C in gaol from sharing needles … I've also got cirrhosis of the liver from hitting the grog really hard. When you're on the piss, other things happen. I had an operation on my leg. I broke my wrist and I've had my gall bladder taken out.

Poor physical health impacted on their lives in other ways. Many of the informants had worked in the past, often in jobs requiring physical strength. However, most of the

participants were no longer capable of manual labour because of poor health. Cameron, 61, said:

> I did a lot of seasonal work …I used move from place to place. I'd go to Griffith, then to Shepparton, then to Mareeba … Sometimes, I'd go over and sow wheat in Western Australia. But I had to finish all that because the pain got to me … I have arthritis, the hips and shoulders aren't good … Sometimes I take painkillers … but the pain always comes back.

As people get older, poor health makes living on the streets increasingly untenable. Cookie said: 'When you're 55, like me, it's harder and harder to sleep out'.

Mental health

Years of exclusion from society and the stigma of being homeless had taken its toll on the mental health of our participants. Earlier, it was reported that 69 per cent of the sample (31 people) reported they had received treatment for mental health problems.

We used the Depression, Anxiety and Stress Scale (DASS) to assess the emotional and mental well-being of participants. The DASS is a standardised tool that measures levels of depression, anxiety and stress. Participants were read 21 statements such as 'I found it difficult to relax' and were asked to circle a number between zero and three to indicate how well the statement applied to them over the last week. A zero indicated that the statement did not apply to them, while a three indicated that it applied very much. A higher score indicates more severe psychological distress.

Table 7.2 compares the mean scores of the Street to Home clients with the cut off scores for various levels of stress, depression and anxiety as measured in the general community. The respondents had a mean score of 19.5 on the stress which ranks as 'moderate'. This score might appear to be incongruous given the circumstances of our respondents. But other studies have reported similar findings (Snow and Anderson 1987; Wong and Piliavin 2001). It may be that lower levels of

stress reflect the fact that the long-term homeless find homelessness less psychologically strenuous than those who are more recently homeless. In short, while they may not accept homelessness as a way of life they are more or less used to it.

Table 7.2: Depression, Anxiety and Stress Scale (DASS), cut-off scores

	Stress	**Depression**	**Anxiety**
		Score	
Normal	0-14	0-9	0-7
Mild	15-18	10-13	8-9
Moderate	19-25	14-20	10-14
Severe	26-33	21-27	15-19
Extremely severe	34+	28+	20+
Street to Home clients	**19.5**	**15.0**	**15.9**

The respondents had a mean score of 15.9 on the anxiety scale which ranks as 'severe' when compared with the general community. However, they had a mean score of 15.0 on the depression scale which only ranks as 'moderate'. This was somewhat surprising as when we spoke to people depression was a relatively common theme. Ziggy told us:

> Yeah, every second or third day I'll have the blues … out of nowhere I'll have a bad day where I just want to stay in my tent and sleep … I don't even have the energy to go for a walk … I start feeling sorry for myself … It just gets worse if I keep thinking about it.

Some people made the link between life on the street and their depression. Danny said that, 'I think I got depression while I was on the streets because I was there for so long'. Others reported that it was extremely difficult to overcome depression:

> It doesn't matter what people tell you, you can't just throw it off. It's a fucking hole, man. Once you get out of that hole, you never want to go back (Cookie).

For many, their long-term exclusion from society had an impact on their self-esteem. Kevin said:

> People look down on us, just because they got a house they think they are better than us . . . they just think he's just a piece of trash, his life is going nowhere, he is going to end up in a pine box.

Tommy said:

> Your self-esteem gets low. I look at couples and business people and I think what if that were me? Would I have a better life? … Then you resort back to the drugs and alcohol to get rid of the pain.

Overall, 78 per cent of the sample thought that 'some people look down on me because of my homelessness'.

Summary

This chapter has provided clear evidence of the poor health of long-term rough sleepers. Poor health is generally a consequence of sustained exposure to homelessness itself – both the abject physical conditions people are forced to endure and also the social practices that people engage in to survive. When people 'hit' the streets their health typically gets worse. It is important that policy makers have realistic expectations of what can be achieved. The biggest challenge for Street to Home is to improve the health and housing circumstances of its clients and to help people maintain those improvements. It is not realistic to expect clients to return to the labour force.

8 Conclusion

This report had three aims. The first aim was to investigate whether Melbourne's Street to Home project had engaged with chronic rough sleepers. It was found that eight per cent of the participants had slept rough on and off for between six and 11 months, 13 per cent had slept rough for one to two years and 79 per cent had slept rough on and off for three years or longer. One-third of the clients had slept rough for 10 years or more.

There was clear evidence of widespread social and economic disadvantage amongst the participants. All but one of the clients was receiving Centrelink payments and most (89 per cent) had been on a government pension for three years or longer. Seventy-eight per cent of the sample had a chronic physical health condition, 69 per cent had been treated for a mental health disorder, and 89 per cent had one or both of these conditions. There was also evidence of widespread alcohol and drug abuse: 80 per cent of the participants reported having one or both of these problems at some point in their lives. The Melbourne Street to Home project has clearly engaged with its target group.

The second aim of the report was to investigate whether long-term rough sleepers had developed a sense of solidarity with other rough sleepers and had come to accept homelessness as a way of life. Some versions of the social adaptation thesis refer to this as the 'transition to chronicity' or the 'acceptance' of chronic homelessness.

The findings from this research were not consistent with the social adaptation thesis. First, it was found that the thesis overstates the extent to which rough sleepers develop a sense of solidarity with one another. There are major tensions in the homeless sub-culture. In many interactions between homeless people, there are volatile undercurrents of hostility and resentment. When these tensions come to the surface,

they usually manifest themselves in people 'ripping each other off' or in verbal and physical aggression.

The evidence indicated that most people did not endorse rough sleeping as a 'way of life'. They pragmatically accepted their situation because they felt they had no alternative. Chronic rough sleeping was not an ingrained characteristic of the participants in this study, but rather a situation in which they found themselves at a particular point in time. These findings challenge the widespread assumption that chronically homeless people are resistant to service interventions.

The process of disengaging involves people re-shaping their social networks, changing their cultural practices and re-organising their daily routines. When chronic rough sleepers engage in associational distancing, they are ready to return to conventional accommodation. However, it is common for long-term rough sleepers to lack the financial resources and long-term support necessary to make this transition without assistance.

Many of the Street to Home participants were attempting to disengage from the homeless sub-culture. Shane first became homeless when he was 16 and has been in and out of the homeless population for over 20 years. He has been in and out of prison a number of times and he has had a major problem with substance abuse:

> Well, I come from the old school of drug usage … back then we didn't have sterile this and sterile that … I wasn't clean you know … I'd use old syringes, I'd share needles … that was a big factor in me ending up in hospital.

When Shane was recruited into Street to Home he had been living in his car. A few months later, Shane said:

> Street to Home have been a blessing in disguise … I don't take drugs. I've got a roof over my head. My daughter (aged 13) is back in my life.

Helen had been on the streets for more than 15 years. She said:

> I am just too old for the streets these days … I don't think I could have handled it for much longer.

A Street to Home worker has assisted Helen into permanent housing:

> I can finally get my life in order and work on things like seeing my kids.

But most people also need long-term support:

> Working with (Jock) has made me realise that I can do a lot better with my life. He has made me realise that I am a worthwhile person … I've got a lot more confidence … It's the best thing that's ever happened in my life.

Helen is now thinking that she could return to the workforce:

> I'd love to work even if it was only part-time … just to contribute something to society … and for my own sense of self worth. That counts for a lot too.

There are promising signs for both Shane and Helen, but it is still early days. Moving on from chronic homelessness is difficult and there can be set backs along the way. The depth of the participants' disadvantage and their poor health means that we must be realistic about what Street to Home can be expected to achieve. The primary goals of Street to Home are: (1) to assist clients to achieve permanent accommodation; (2) to provide them with support for up to 12 months to maintain that housing; (3) to provide them with assistance to improve their physical and mental health; and (4) to link them in to support services to maintain their housing after completing Street to Home. Whether Street to Home has achieved its goals will be the focus of the next report.

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Appendix 1: Interview Schedule

MELBOURNE STREET TO HOME

BENCHMARK SURVEY

CONTENTS

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RMIT UNIVERSITY

ADMINISTRATION

Date: ____/____/_____	
Code:_____	
Survey: 1 2 3	
Plain language statement provided	☐
Participant understands their right to withdraw	☐ Yes ☐ No
Consent obtained	☐ Yes ☐ No
Consent form filed	☐
Data entered	☐ Yes
Payment made If yes, payment form signed, dated and filed	☐ Yes ☐ Not required ☐
Researcher reimbursed	☐
Hardcopy filed	☐ Yes

Survey start time:

Survey finish time:

This survey is to be given to all participants.

BACKGROUND to the Research project

This research is being conducted by RMIT University. The research is aimed to evaluate the Melbourne Street to Home project.

You have been approached because you are involved with the M2SH services or one of the MS2H partner agencies. You will be asked to complete three interviews over a period of two years. This interview will take approximately an hour to complete.

You have the right to pull out of the research at any time. This will not have any impact on any services you may currently be receiving from M2SH or a partner agency. You have the right to have any unprocessed data withdrawn and destroyed. You also have the right to have questions answered at any time.

I am interested in finding out about your experience of homelessness and the effect being homeless has had on your relationships with friends, family and your health and well being. I will also be asking you some general questions about employment and finances.

I'll be asking two types of questions. In some cases you will be asked to answer in your own words. In other cases, I will give you a list of answers and ask you to choose the one that fits best. If you don't understand any of the questions, please ask me. Also, if you feel uncomfortable with a question, please feel free to skip it and move onto the next question.

1. DEMOGRAPHIC INFORMATION

1.1) Date undertook VI: _____/_____/_____

1.2) Date became M2SH client: _____/_____/_____

1.3) What is your date of birth? ____/____/_____ ☐ **Age (interviewer to complete)**

1.4) What gender do you want to be classified as/referred to?

1. ☐ Male
2. ☐ Female

1.5) What is your current household type?

1. ☐ Single
2. ☐ Couple
3. ☐ Single parent
4. ☐ Couple with children
5. ☐ Other (specify) _____

1.6) In which country were you born? _____

1.7) If Australian, do you describe yourself as:

1. ☐ Aboriginal
2. ☐ Torres Strait Islander
3. ☐ Both Aboriginal and Torres Strait Islander
4. ☐ Neither

1.8) What is your highest level of completed education?

1. ☐ Year eight or below
2. ☐ Year nine or equivalent
3. ☐ Year ten or equivalent
4. ☐ Year eleven or equivalent
5. ☐ Year twelve or equivalent
6. ☐ Didn't go to secondary school

1.9) Are you currently enrolled in any study or training?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

Go to NEXT SECTION

2. INCOME SOURCE and DEBT

2.1) Are you currently doing any paid or unpaid work? 

1. ☐ Paid only
2. ☐ Unpaid only
3. ☐ Both
4. ☐ No

2.2) Have you ever done paid work? 

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

2.3) Are you currently receiving Centrelink payments?

1. ☐ Yes
2. ☐ No – go to Q2.6
3. ☐ Unsure - go to Q2.6

2.4) If yes, which one

1. ☐ New Start Allowance (NSA)
2. ☐ Disability Support Pension (DSP)
3. ☐ Parenting Payment – Single (PPs)
4. ☐ Parenting Payment – Partnered (PPp)
5. ☐ Aged pension
6. ☐ Workers compensation
7. ☐ Other_____

2.5) How long has government support been your main source of income?

1. ☐ 0-5 months
2. ☐ 6 – 11 months
3. ☐ 1-2 years
4. ☐ 3 years or longer

2.6) Have you been receiving income from any of these sources in the past 3 months?

Pokies / Gambling	☐ Yes – Amount (approx) $_____	☐ No	☐ Don't know / unsure
Begging	☐ Yes – Amount (approx) $_____	☐ No	☐ Don't know / unsure
Family/friends	☐ Yes – Amount (approx) $_____	☐ No	☐ Don't know / unsure
Drug dealing	☐ Yes – Amount (approx) $_____	☐ No	☐ Don't know / unsure
Sex work	☐ Yes – Amount (approx) $_____	☐ No	☐ Don't know / unsure
Other informal earnings	☐ Yes – Amount (approx) $_____	☐ No	☐ Don't know / unsure

2.7) Do you owe anyone money?

1. ☐ Yes
2. ☐ No - go to 2.9
3. ☐ Unsure - go to 2.9

2.8) If yes, can you tell me who (tick as many as applicable)

- ☐ Centrelink – Amount (approx) $_____
- ☐ Ex landlord – Amount (approx) $_____
- ☐ Current landlord – Amount (approx) $_____
- ☐ Electricity, water, other utility company – Amount (approx) $_____
- ☐ Mobile phone company – Amount (approx) $_____
- ☐ Employer – Amount (approx) $_____
- ☐ Your children – Amount (approx) $_____
- ☐ Siblings – Amount (approx) $_____
- ☐ Friends – Amount (approx) $_____
- ☐ Parents – Amount (approx) $_____
- ☐ Other government agency
- ☐ Credit card – Amount (approx) $_____
- ☐ Other – Amount (approx) $_____

2.9) Have you used cash converters (or similar short term money lender) in the last 3 months?

1. ☐ Yes
2. ☐ No – go to next section
3. ☐ Unsure – go to next section

2.10) if, yes how many times _____

Go to NEXT SECTION

3. HOUSING GENERAL

I am now going to ask you some questions about your housing. This is a very important part of the research, so take as much time as you need with each question. If there are any questions that you do not understand, just let me know and I will explain them to you more clearly.

3.1) Can you remember about how old you were when you first became homeless? _____ years old

We define homelessness as

. . . people without conventional accommodation (streets, squats etc); people staying temporarily with other households (because they have no usual address); people in emergency accommodation (refuges, shelters etc); and people in boarding houses.

3.2) Were you with your family? (ONLY ASK if first homeless 18 years or younger)

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

3.3) Where did you stay last night?

1. ☐ Public Housing or Community Housing
2. ☐ Community Rooming House
3. ☐ Private Rental
4. ☐ Private Hotel/Boarding House/motel
5. ☐ With family members
6. ☐ Friends
7. ☐ Squatting
8. ☐ Sleeping Rough – Car/Tent/Park/Street
9. ☐ Caravan Park
10. ☐ Refuge - Domestic Violence
11. ☐ Refuge - Youth
12. ☐ Crisis Accommodation - short term
13. ☐ Transitional/emergency accomm – medium term
14. ☐ Rehabilitation Centre – Drug and Alcohol
15. ☐ Hospital - psych or emergency
16. ☐ Prison
17. ☐ Other _____

3.4) How long have you been living in your present situation? ____ years_____months____days

3.5) Where have you been living in the last year? (tick as more than one)

1. ☐ Public Housing or Community Housing
2. ☐ Community Rooming House
3. ☐ Private Rental
4. ☐ Private Hotel/Boarding House/motel
5. ☐ With family members
6. ☐ Friends
7. ☐ Squatting
8. ☐ Sleeping Rough – Car/Tent/Park/Street
9. ☐ Caravan Park
10. ☐ Refuge - Domestic Violence
11. ☐ Refuge - Youth
12. ☐ Crisis Accommodation - short term_____
13. ☐ Transitional/emergency accomm – medium term
14. ☐ Rehabilitation Centre – Drug and Alcohol
15. ☐ Hospital - psych or emergency
16. ☐ Prison
17. ☐ Other _____

3.6) Have you ever stayed in the any of the following (tick more than one)?

1. ☐ Public Housing or Community Housing
2. ☐ Community Rooming House
3. ☐ Private Rental
4. ☐ Private Hotel/Boarding House/motel
5. ☐ With family members
6. ☐ Friends
7. ☐ Squatting
8. ☐ Sleeping Rough – Car/Tent/Park/Street
9. ☐ Caravan Park
10. ☐ Refuge - Domestic Violence
11. ☐ Refuge - Youth
12. ☐ Crisis Accommodation - short term
13. ☐ Transitional/emergency accomm – medium term
14. ☐ Rehabilitation Centre – Drug and Alcohol
15. ☐ Hospital - psych or emergency
16. ☐ Prison
17. ☐ Other _____

3.7) When was the last time you had your own housing? _____(Years ago)_____(months ago)

(*e.g the person responsible for paying rent or mortgage)

3.8) What is the total length of time you lived on the streets or slept rough*? _____(Years)____(mths)

(*includes squats, living in tents, other makeshift arrangements, car etc)

Cumulative duration – eg over the course of their life

4. SERVICE USAGE

Now I am going to ask you a few questions about the services you might use. This information will help us get a better picture of the impact of homelessness on your health as well as helping us get a better picture what type of services you use.

4.1) What services have you used in the past 6 MONTHS?

	No times last 6 months		No times last 6 months
1. Crisis accommodation facility	_____	8. Parenting support service (eg Family First, Child Protection, Family Life)	_____
2. Homelessness Service	_____	9. Neighbourhood house/community centre	_____
3. Job Services Australia – job network	_____	10. Gambling support service	_____
4. Job Services Australia – personal support program (PSP)	_____	11. Consumer or tenancy service (eg tenants union)	_____
5. Job Services Australia – other	_____	12. Meals Program	_____
6. All other employment services (specifiy) _____	_____	13. Family violence services	_____
7. Disability employment network	_____	14. Other _____	_____

4.2) Have you been unable to access any of the services listed above in the last six months? *(eg; Used service before/not eligible for service)*

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

4.3) Do you currently have a case-worker you see each week?

1. ☐ Yes ☐ No. of case-workers
2. ☐ No – go to next section

4.4) If yes, specify types of case-workers and hours you see them per week:

1. _____ , ____hours per fortnight
2. _____ , ____hours per fortnight
3. _____ , ____hours per fortnight
4. _____ , ____hours per fortnight

5. CONTACT WITH THE JUSTICE and STATE CARE SYSTEM

5.1) When you were growing up did you spend any time in out-of-home care (eg residential care, respite, foster care, kinship care – extended family)?

1. ☐ Yes
2. ☐ No – go to Q5.3
3. ☐ Unsure – go to Q5.3

5.2) If yes, how old were you when you had your first experience of care? _____ (age yrs)

5.3) Do you have a public guardian or state trustee?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

I am going to ask you some questions about you experiences with the justice system. Remember the information you give me is completely confidential

5.4) When you were 18 or younger were you ever in a juvenile justice facility or youth detention centre?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

5.5) Have you ever been in a police holding cell?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

5.6) If yes, how many times in the last 3 months (if any at all)?_____

5.7) Have you ever been in prison as an adult?

1. ☐ Yes
2. ☐ No – go to next section
3. ☐ Unsure – go to next section

5.8) If yes, how many times have you been in prison?_____

Go to NEXT SECTION

6. VIOLENCE AND SAFTEY

6.1) Have you been a victim of physical violence while you have been homeless? 

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

6.2) Have you been threatened with violence while you have been homeless?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

6.3) Have you been a victim of crime (including violence?) in the last three months?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7. GENERAL HEALTH

We would like to know if you have had any medical complaints and how your health has been in general, *over the past few weeks.* Please answer ALL the questions on the following pages simply by underlining the answer which you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past.

It is important that you try to answer ALL the questions.

7.1) In general, would you say your health is: 

1. ☐ Very good
2. ☐ Good
3. ☐ Neither poor or good
4. ☐ Poor
5. ☐ Very poor

7.2) Compared to 12 months ago, how would you rate your health in general now?

1. ☐ The same
2. ☐ Better
3. ☐ Worse

7.3) During the past 4 weeks, how much have your health condition(s) interfered with your day to day life?

1. ☐ Not at all
2. ☐ Slightly
3. ☐ Moderately
4. ☐ Quite a bit
5. ☐ Exteremely

7.4) Do you have a physical or other disability?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.5) If yes, how much has it interfered with your day to day life?

1. ☐ Not at all
2. ☐ Slightly
3. ☐ Moderately
4. ☐ Quite a bit
5. ☐ Exteremely

7.6) Do you have a chronic health condition? 

1. ☐ Yes
2. ☐ No -– go to Q7.7
3. ☐ Unsure -– go to Q7.7

RESEARCHER TO CODE THE LIST BELOW. (TICK ALL THAT APPLY)

☐ Heart disease	☐ Stroke	☐ Diabetes
☐ Asthma	☐ Chronic lung disease	☐ Bronchitis
☐ Cancer	☐ Arthritis	☐ Epilepsy
☐ Schizophrenia	☐ Bi-polar Affective Disorder	☐ Chronic neck or back problem
☐ Kidney Disease	☐ Hepatitis C	☐ Emphysema
☐ Renal Disease	☐ Cirrhosis of the Liver	☐ Intellectual disability

☐ Physical disability –Vision impairment
☐ Physical disability – Mobility impairment
☐ Physical disability – Hearing impairment
☐ Other

7.7) Do you have a health care card?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.8) How many times have you been to a hospital emergency department in the past 3 months?_____

7.9) How many times have you been admitted to hospital in the past 3 months? _____

7.10) If admitted, when you were discharged from hospital the last time, did you receive any housing assistance following your discharge?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.11) Have you used a community health service in the last 3 months?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.12) Have you ever received treatment for mental health issues?

1. ☐ Yes
2. ☐ No – go to Q7.18
3. ☐ Unsure

7.13) Are you currently receiving treatment for mental health issues?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.14) Have you ever been hospitalised because of mental health issues?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.15) How many times have you been admitted to psychiatric unit in the past 3 months? _____

7.16) If admitted – When you were discharged from the psychiatric unit the last time, did you receive any housing assistance following your discharge?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.17) Have you ever lived in a place where you had to stay in mental health treatment in order to keep your housing?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.18) Did someone tell you that you must undertake mental health treatment to be part of this program?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

7.19) Have you had a serious brain injury or head trauma requiring hospitalisation or surgery?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

8. ALCOHOL AND SUBSTANCE USE

I am now going to ask some questions about your use of alcohol and other drugs. Remember, the answers you give will be treated in the strictest confidence and you do not have to answer any questions you do not want to.

PAST AND CURRENT DRUG USE, TYPE OF DRUG(S) USE

8.1) Have you consumed alcohol in the last four weeks?

1. ☐ Yes
2. ☐ No – go to Q8.7
3. ☐ Unsure – go to Q8.4

8.2) If yes, how often?

1. ☐ Every day
2. ☐ Every two days
3. ☐ Every three to six days
4. ☐ Once a week
5. ☐ Once a fortnight
6. ☐ Once in the past four weeks

8.3) How much did you spend? $_____

8.4) Do you feel that you have a problem with alcohol?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

8.5) Have you ever been treated for alcohol problems?

1. ☐ Yes
2. ☐ No – go to Q8.7
3. ☐ Unsure – go to Q8.7

8.6) If yes, how recently have you received treatment?

1. ☐ Currently receiving treatment
2. ☐ In the last three months
3. ☐ In the last four to 11 months
4. ☐ Over 12 months ago
5. ☐ Unsure

8.7) Have you ever injected drugs?

1. ☐ Yes
2. ☐ No – go to Q8.15
3. ☐ Unsure – go to Q8.11

8.8) Have you injected drugs in the last four weeks?

1. ☐ Yes
2. ☐ No – go to Q8.15
3. ☐ Unsure – go to Q8.11

8.9) If yes, how often?

1. ☐ Every day
2. ☐ Every two days
3. ☐ Every three to six days
4. ☐ Once a week
5. ☐ Once a fortnight
6. ☐ Once in the past four weeks

8.10) How much did you spend? $_____

8.11) Do you feel that you have a problem with drugs?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

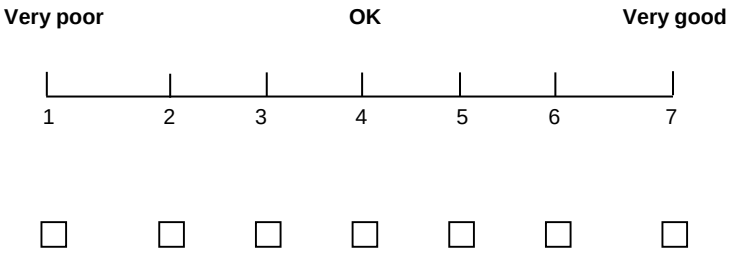
8.12) Have you ever been treated for drug problems?

1. ☐ Yes
2. ☐ No – go to Q8.15
3. ☐ Unsure – go to Q8.15

8.13) If yes, how recently have you received treatment?

1. ☐ Currently receiving treatment
2. ☐ In the last three months
3. ☐ In the last four to 11 months
4. ☐ Over 12 months ago
5. ☐ Unsure

8.14) On a scale of 1 to 7, where 7 is very good and 1 is very poor, how would you rate the treatment you have received for your substance abuse problems?



8.15) Have you ever lived in a place where you had to stay in drug or alcohol treatment in order to keep your housing?

1. ☐ Yes
2. ☐ No – go to next section
3. ☐ Unsure – go to next section

8.16) Did someone tell you that you must undertake drug or alcohol treatment to be part of this program?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

8.17) Have you ever inhaled substances?

1. ☐ Yes
2. ☐ No – go to Q8.19
3. ☐ Unsure – go to Q8.19

8.18) If yes, can you tell me what you have inhaled?

1. ☐ Petrol
2. ☐ Glue
3. ☐ Paint
4. ☐ Speed
5. ☐ Other (specify)_____

8.19) Have you smoked in the last month?

1. ☐ Yes
2. ☐ No – go to Q8.22
3. ☐ Unsure – go to Q8.22

8.20) What do you smoke (tick all that apply)?

1. ☐ Cigarettes (including roll your own)
2. ☐ Chop-chop
3. ☐ Marijuana
4. ☐ Other

8.21) Do you view smoking as a problem?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

8.22) Do you take prescribed medication?

1. ☐ Yes
2. ☐ No – go to questions at the end of this section
3. ☐ Unsure - go to questions at the end of this section

8.23) If yes, (tick more than one)

1. ☐ Is it prescribed for you
2. ☐ Buy from others
3. ☐ Other
4. ☐ Unsure

8.24) Do you take more than the daily prescribed amount?

1. ☐ Yes
2. ☐ No
3. ☐ Unsure

9. DEPRESSION, ANXIETY AND STRESS SCALE (DASS $_{21}$)

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you **OVER THE PAST WEEK**. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

****NOTE: Every question MUST BE ANSWERED****

9.1)	**I found it hard to wind down**	0	1	2	3
9.2)	**I was aware of dryness of my mouth**	0	1	2	3
9.3)	**I couldn't seem to experience any positive feeling at all**	0	1	2	3
9.4)	**I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)**	0	1	2	3
9.5)	**I found it difficult to work up the initiative to do things**	0	1	2	3
9.6)	**I tended to over-react to situations**	0	1	2	3
9.7)	**I experienced trembling (eg, in the hands)**	0	1	2	3
9.8)	**I felt that I was using a lot of nervous energy**	0	1	2	3
9.9)	**I was worried about situations in which I might panic and make a fool of myself**	0	1	2	3
9.10)	**I felt that I had nothing to look forward to**	0	1	2	3
9.11)	**I found myself getting agitated**	0	1	2	3
9.12)	**I found it difficult to relax**	0	1	2	3
9.13)	**I felt down-hearted and blue**	0	1	2	3
9.14)	**I was intolerant of anything that kept me from getting on with what I was doing**	0	1	2	3
9.15)	**I felt I was close to panic**	0	1	2	3
9.16)	**I was unable to become enthusiastic about anything**	0	1	2	3
9.17)	**I felt I wasn't worth much as a person**	0	1	2	3
9.18)	**I felt that I was rather touchy**	0	1	2	3
9.19)	**I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)**	0	1	2	3
9.20)	**I felt scared without any good reason**	0	1	2	3
9.21)	**I felt that life was meaningless**	0	1	2	3

Go to NEXT SECTION

10. SOCIAL NETWORKS, SUPPORTS AND RELATIONS SURVEY

The following set of questions refers to your social networks. If you are unsure about the questions, just tell me and I will explain them more clearly.

QUESTIONS ABOUT YOU AND OTHER PEOPLE

Please tell us how much the following statements apply to you

10.1) In the last six months would you say:

	Not at all	**Not particularly**	**Yes a bit**	**Yes definitely**
a) I have friends I see or talk to every week (*SI & SA)*	☐	☐	☐	☐
b) I have been involved in a group, club or organisation that is not just for people who use welfare services (*SR)*	☐	☐	☐	☐
c) I have felt accepted by my friends (*SI)*	☐	☐	☐	☐
d) I have felt accepted by my family (*SA)*	☐	☐	☐	☐
e) I have felt accepted by society (*SA)*	☐	☐	☐	☐
f) I have felt that some people look down on me because of my homelessness (*SR &SA)*	☐	☐	☐	☐
g) I have felt clear about my rights (*SA)*	☐	☐	☐	☐
h) I have felt that I am playing a useful part in society (*SR & SI)*	☐	☐	☐	☐
i) I have felt that what I do is valued by others (*SR)*	☐	☐	☐	☐

SI = Social isolation
SR = Social relations
SA = Social acceptance

QUESTIONS ABOUT YOUR FEELINGS ABOUT YOUR RELATIONSHIPS AND SATISFACTION WITH THEM

10.2) The following statements have been used by many people to describe how much support they get from other people. How much do you agree or disagree with each.

****NB This is not counting any relationships with support workers.****

		Strongly disagree 1	2	3	4	5	6	Strongly agree 7
a.	People don't come to visit me as often as I would like	☐	☐	☐	☐	☐	☐	☐
b.	I often need help from other people but can't get it	☐	☐	☐	☐	☐	☐	☐
c.	I seem to have a lot of friends	☐	☐	☐	☐	☐	☐	☐
d.	I have people I can confide in	☐	☐	☐	☐	☐	☐	☐
e.	I have some I can lean on in times of trouble	☐	☐	☐	☐	☐	☐	☐
f.	There is some one who can always cheer me up when I'm down	☐	☐	☐	☐	☐	☐	☐
g.	I often feel very lonely	☐	☐	☐	☐	☐	☐	☐
h.	I enjoy the time I spend with the people who are important to me	☐	☐	☐	☐	☐	☐	☐
i.	When something's on my mind, just talking with the people I know can make me feel better	☐	☐	☐	☐	☐	☐	☐
j.	When I need someone to help me out, I can usually find someone	☐	☐	☐	☐	☐	☐	☐

Go to QUALITATIVE Questions

11. ANCHOR POINTS

In 12 months time I would like to interview you again. What is the best way to find you?

Follow Up Details

Mobile number _____

Landline _____

Post Office Box/Agency _____

Other _____

Support service 1: _____

Support Service 2: _____

Support Service 3: _____

Support Service 4: _____

Email address: _____

CRN Details: _____ (Office)

_____ (Number)

Do you have any family members or friends who I could get in touch with, if necessary, to find out where you are living?

Family & Friends

Relative/friend Details 1

Name _____

Address _____

Contact Number_____

Other _____

Relative/friend Details 2

Name _____

Address _____

Contact Number_____

Other _____

Relative/friend Details 3

Name _____

Address _____

Contact Number_____

Other _____

Relative/friend Details 4

Name _____

Address _____

Contact Number_____

Other _____

END Interview – Participant to sign payment form