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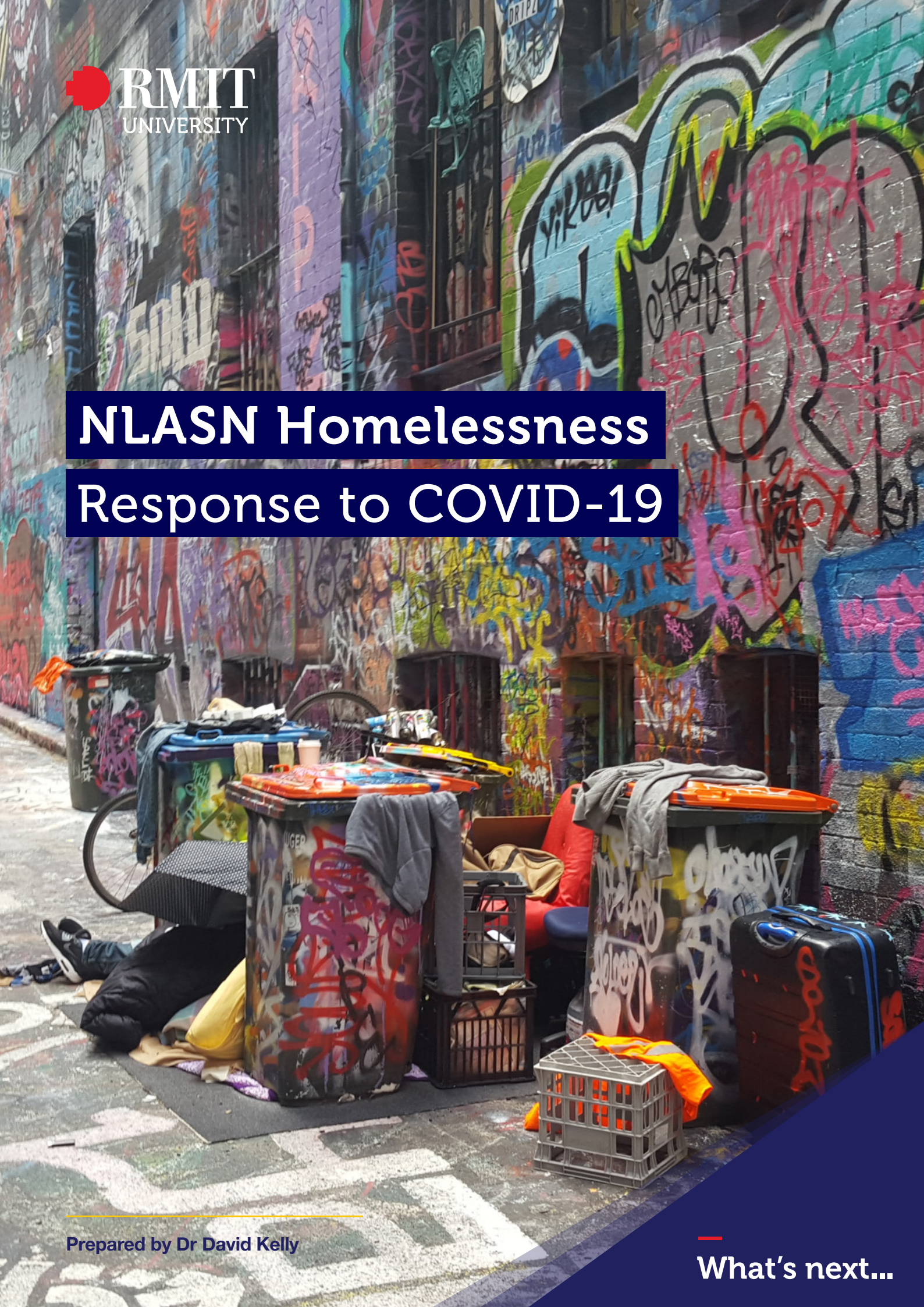
NLASN Homelessness Response to COVID-19



Prepared by Dr David Kelly

What's next...

RMIT Centre for Urban Research

NORTHERN HOMELESSNESS NETWORK NHN

NLASN Homelessness Response to COVID-19

November 2020

Acknowledgement of Country

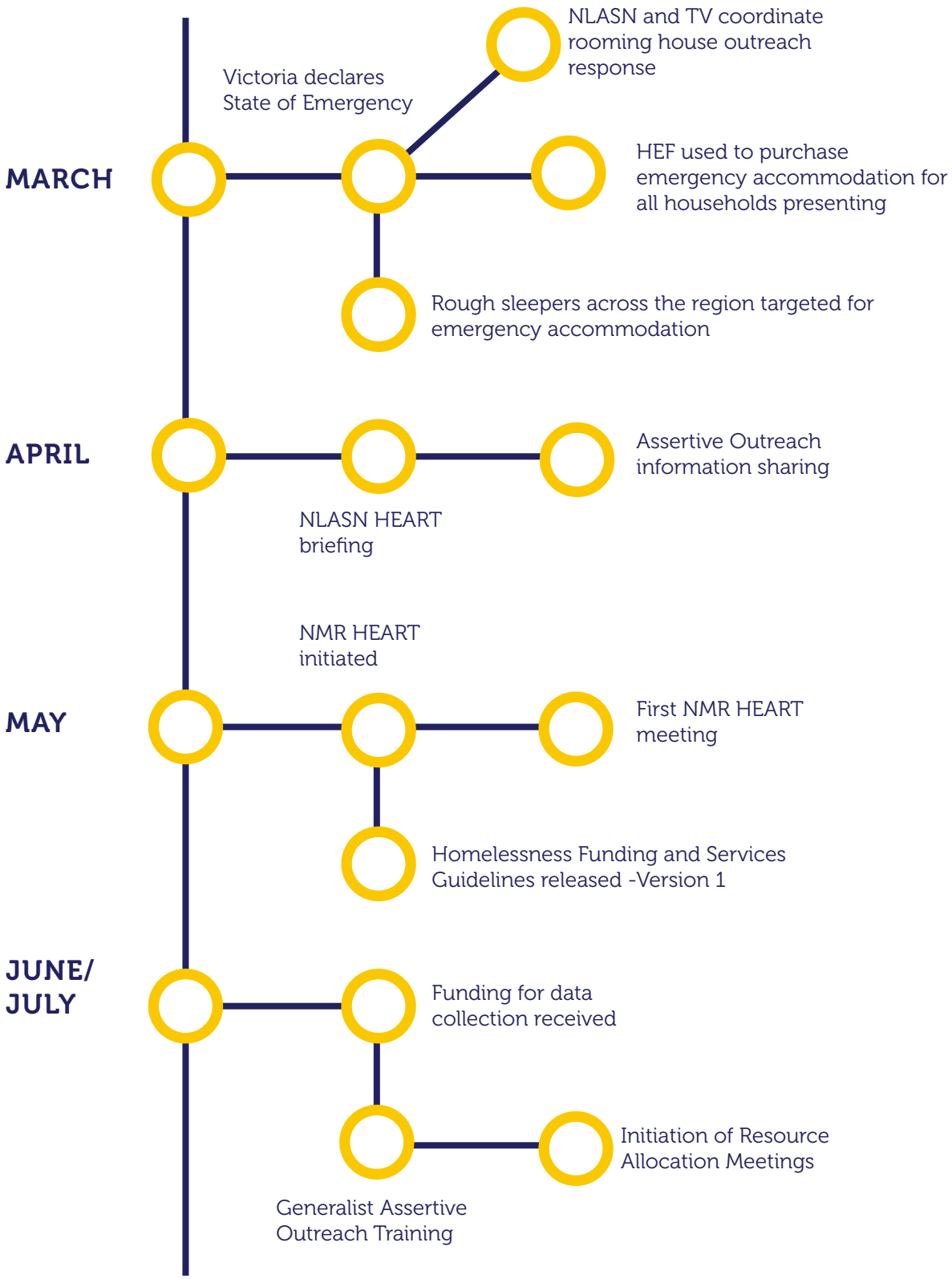
We at the Centre for Urban Research and Sustainability & Urban Planning acknowledge the people of the Woi wurrung and Boon wurrung language groups of the eastern Kulin Nation on whose unceded lands we conduct our research, teaching and service. We respectfully acknowledge Ancestors and Elders past, present and emerging who have always been caring for Country. We pay our respects to Country, the lifeworld that sustains us all.

Our research, education and service are already in a relationship with Country and the people of Country, here and in all the places we undertake our business. As mostly non-Indigenous people, we acknowledge our obligation in this relationship: to uphold the ngarn-ga [understanding] of Bundjil and practice respect for community and culture. Though there is much we still need to learn, especially about ourselves, we affirm our dhumbali [commitment] to that work. We hold as central to our business, dhumbali to a shared future with Indigenous peoples everywhere and especially Kulin Country and peoples.

Suggested citation

Kelly, D. 2020. *NLASN Homelessness Response to COVID-19*. Centre for Urban Research, School of Global, Urban and Social Studies, RMIT University: Melbourne.

Timeline response



Introduction

On 16 March 2020, a State of Emergency was declared in Victoria to combat the spread of COVID-19 throughout the community. As part of the public health response, the homelessness services sector was instructed by the Government of Victoria to provide ongoing emergency accommodation for rough sleepers and other homeless households. Homelessness sector professionals were classified as essential workers and instructed to assertively engage unsheltered people not currently engaged, and to accommodate and support all people presenting to access points for regional systems.

This report details the key aspects of this response in the Northern Metropolitan Region (NMR) of Melbourne, Victoria. Drawing upon information gleaned from three focus group interviews with key stakeholders and workers who were part of the response in the region, it articulates:

- the governance framework employed;
- methods of engagement and support coordination; and
- key lessons learned from sector organisations and workers.

Background

Prior to COVID-19, the capacity of the NMR homelessness service system was only able to support approximately 11% of households seeking assistance. The primary mechanism to offer this support was the Housing Establishment Fund (HEF), initially intended to fund a suite of responses that would allow households to exit homelessness into stable housing. Over time, HEF's primary function has been to purchase very-short-term emergency accommodation, which is triaged for only the most vulnerable and at-risk households.

Over 300 new households present to three access points in the NMR every month, however only 25 transitional housing vacancies and 50 case managed support vacancies are available. Households not matched with accommodation vacancies join a burgeoning prioritisation list, and as at September 2019 3,000 households were on lists, including 2,200 children, 666 young people (16-24 yrs.) and 1,403 adults.

For high risk and vulnerable households not successful in attaining transitional housing, purchased emergency accommodation is offered if funding is available. During normal circumstances, some emergency accommodation options in Melbourne have been identified as "extremely unsafe and typically of a very poor standard".

During March 2020, three key challenges were evident across the system:

- that public health measures aimed at the general population to contain and support people were not realistic for people living in purchased emergency accommodation – rooming houses and low-end motels – with shared facilities;
- that a large number of rough sleepers and unsheltered households that were not currently in purchased emergency accommodation, or who were not engaged in any support programs, would need to be engaged and supported; and
- that households normally unsuccessful in attaining accommodation and support due to the lack of funding available, would need be accommodated and supported.

To meet these challenges, the Northern Homelessness Network and Tenants Victoria began considering a coordinated response to the dozens of legal or illegal rooming houses in the northern and western metropolitan regions, resulting in the provision of health advice and PPE to a number of private rooming houses. The Victorian Department of Health and Human Services (DHHS) instructed access point agencies – Launch Housing, Haven Home Safe and VincentCare – to purchase emergency accommodation for all households presenting to access points; and for Assertive Outreach programs such as the Rough Sleeper Initiative to focus on assertive engagement to support hard-to-reach households currently sleeping rough on the streets. This was enabled by the sector undertaking significant advocacy with DHHS to ensure that the costs incurred during this process would be covered by an increase to the HEF.

To ensure that households accommodated and supported throughout the State of Emergency, and for the duration of extraordinary public health measures, the Government of Victoria planned localised coordinated responses to support all homeless households. A local Homelessness Emergency Accommodation Response Team (HEART) comprising of the Homelessness Networker, regional access point agencies, support providers and representatives from local DHHS area offices was established in each local area to lead the response. The Northern HEART response aimed to 1) prevent a return to homelessness for people currently in emergency accommodation and 2) prevent a return to unsafe, low amenity, private rooming houses.

HEART was initiated in May 2020 and is due to sunset in April 2021 – business as usual operations are being recommenced from November 2020.

Homelessness Emergency Accommodation Response

As part of the Government of Victoria's public health response, the Department of Health and Human Services (DHHS) established a framework for local responses to people in purchased emergency accommodation. Local Area Service Network (LASN) Homelessness Networkers, DHHS local areas and all service providers were directed to coordinate localised responses to ensure people experiencing homelessness residing in emergency accommodation are supported during the pandemic, above and beyond business-as-usual.

All responses were localised and specific to the regional LASN in which they are located. For all key agencies, inclusion in the response was mandatory as per funding guidelines. Each homelessness service network was required to redirect existing resources and adopt new methodologies of service delivery to ensure the ongoing support for homeless households.

Homelessness Networker

The Homelessness Networker's role with the LASN is to assist catchment regions to engage stakeholders across the service system to collaborate in the provision of services and responses. Central to this is the mapping of resources – where data is able is to be provided by DHHS – and assistance in governance of the LASN. This role was adapted to fully focus on secretariat functions of the HEART response, including convening regular meetings of the HEART working group, monitoring the capacity of access points and service providers, and to regularly report the demands and needs of the service system.

Access Points

Access points conduct initial assessments of households contacting the homelessness service system or that are referred from state-wide entry points. As per the Homelessness Services Guidelines, each access point agency was instructed to apply existing prioritisation frameworks to clients in the HEART and to manage a register of resources and vacancies in their local geography in order to allocate households services to match their level of need, risk and vulnerability.

Support Services

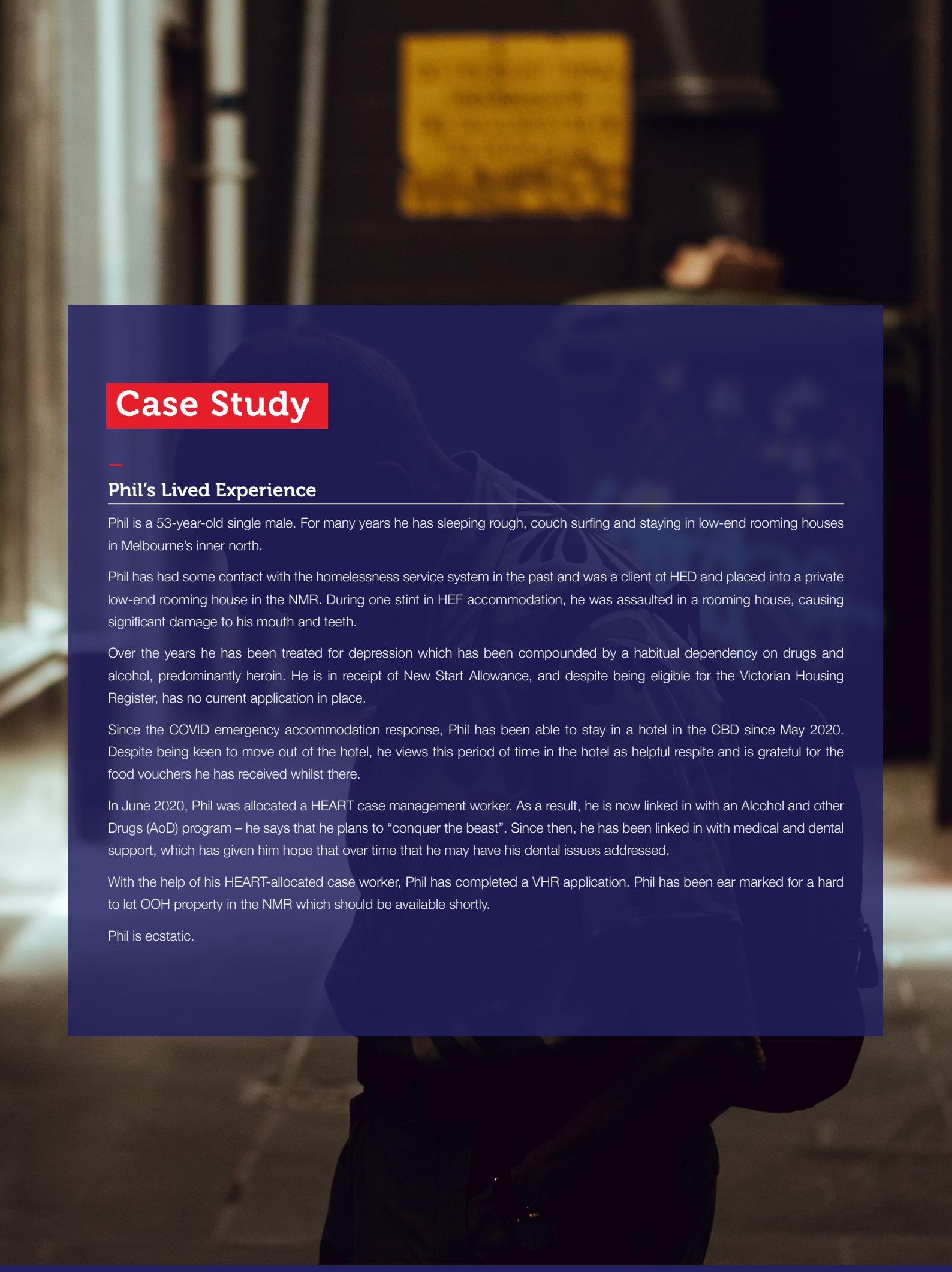
Homelessness support service providers accepted referrals from the access point to support clients in purchased emergency accommodation, based on their identified needs. This also includes facilitating access to health services and ensuring clients have essentials.

Performing a case management function, support service workers provide general support by phone or face-to-face contact, and refer clients to allied support services (including Alcohol and Other Drug, and mental health support) for the duration of their stay in purchased emergency accommodation.

HEART Client Snapshot

As at 3 July 2020 and since 16 March 2020, 1,757 households have been assisted with some form of accommodation through the NMR HEART program, and approximately 280 were assisted with specialist support services. A breakdown of this cohort is as follows:

- 1,492 (81%) single person households
- 92 (5%) households with dependent children
- 1,210 (68%) male, 541 (31%) female, 6 households prefer to self-describe
- 747 (42%) of all households assisted have a history of chronic homelessness including rough sleeping.



Case Study

Phil's Lived Experience

Phil is a 53-year-old single male. For many years he has sleeping rough, couch surfing and staying in low-end rooming houses in Melbourne's inner north.

Phil has had some contact with the homelessness service system in the past and was a client of HED and placed into a private low-end rooming house in the NMR. During one stint in HEF accommodation, he was assaulted in a rooming house, causing significant damage to his mouth and teeth.

Over the years he has been treated for depression which has been compounded by a habitual dependency on drugs and alcohol, predominantly heroin. He is in receipt of New Start Allowance, and despite being eligible for the Victorian Housing Register, has no current application in place.

Since the COVID emergency accommodation response, Phil has been able to stay in a hotel in the CBD since May 2020. Despite being keen to move out of the hotel, he views this period of time in the hotel as helpful respite and is grateful for the food vouchers he has received whilst there.

In June 2020, Phil was allocated a HEART case management worker. As a result, he is now linked in with an Alcohol and other Drugs (AoD) program – he says that he plans to "conquer the beast". Since then, he has been linked in with medical and dental support, which has given him hope that over time that he may have his dental issues addressed.

With the help of his HEART-allocated case worker, Phil has completed a VHR application. Phil has been ear marked for a hard to let OOH property in the NMR which should be available shortly.

Phil is ecstatic.

Methodology

During April-May 2020, a period of consultation between the DHHS and NLASN preceded the initiation of the NMR HEART on 5 May 2020. This consultation resulted in: confirmation of LASN members to join the NMR HEART governance group; finalisation of the Terms of Reference; gathering data from all three access points, noting the constitution of households currently in emergency accommodation since 16 March 2020; and, to consider the ethics of the current client consent process and discern its applicability to the HEART response.

Prior to the pandemic response, and operating under business-as-usual conditions, clients presenting to any access point in the NMR are requested to provide informed consent for their personal details to be recorded and shared with appropriate support and accommodation providers who held vacancies in the network. This consent period lasts 6 months and pertains to the transfer of information between access point agencies and specific specialist homelessness support and accommodation services for the purpose of ending the clients' homelessness. All NMR Heart agencies are cognisant of the value which clients place on their personal information, as it is often the last control they have available to exercise in many aspects of their lives. Therefore, the issue of consent to share information was given deep and due consideration.

The consensual sharing of client information was central to the success of the HEART response, enabling a more targeted and prompter allocation of support services to clients. Each access point manages a prioritised list of clients based on needs, risks and vulnerabilities, and is used to allocate specialist support and accommodation resources. Whilst initially there was a desire for all three access point allocation lists to be amalgamated into a single list of HEART clients, this sat outside the existing consents which access points held for clients placed into emergency accommodation. The initial consent that clients provided only covers referrals between access point agencies and specialist support and accommodation services, it was therefore determined that permission was not gained in sharing this list beyond this relationship.

Without a mechanism for the free (de-identified) and frequent sharing of client information between access point agencies and specialist support services across the entire NMR, the response would be protracted, disjointed and result in poorer outcomes for clients. The governance group resolved to create a working group of 'priority list workers', consisting of representatives of access point agencies responsible for each priority allocation list, and representatives from select specialist support services that deal with over-represented cohorts such as Aboriginal and Torres Strait Islander people.

Priority list working group

Two inhibiting factors were evident when considering the establishment of the priority list working group 1) the difference in operational structures of prioritisation frameworks across the three access points, and 2) the contemporariness of the resource register that is used to source specialist support services.

Within the NMR HEART, only two access points had well-established operational structures for prioritisation, and it was determined the most sophisticated structure, developed by Launch Housing (the primary agency responsible for the Collingwood access point), would be adopted by other access point agencies for HEART allocations. Launch Housing made their structure available for adoption and provided an online training workshop for allocation workers at on other access point.

The first resource allocation meeting of the priority list working group took place 10 June 2020 and was convened by the Homelessness Networker and the Hume-Moreland DHHS regional project officer. Initially, three two-hour meetings were held each week during June, July, August and part of September, before the number of meetings was reduced to two one-hour meetings per week. Typically, between 10-20 support allocations were filled in each working group meeting, with a range of 3 to 24 vacancies.

Throughout the process, case management programs would frequently refer to the existing resource register, but workarounds

were established alongside the resource register to ensure that vacancies were accurate and up-to-date. The resource register is a cumbersome IT platform that is updated manually, and as such is a labour-intensive task that could be made more efficient to better service client needs. Specialist support services are mandated to post their vacancies on the resources register, however this process is often ad hoc and non-standardised.

Through the establishment of the priority list working group, each access point compiled prioritised lists of households from whom 'consent to refer' had been obtained and made visible the resources available within their local area. This facilitated a speedy and accurate allocation model that was synergised across the NMR, allowing for a better fit of service due to the broader range of services available to clients. Clients of services are more likely to retain them if they are better suited to their manifest needs, risks and vulnerabilities.

Specialist support services

Once a client has been accommodated in purchased emergency accommodation and a support vacancy identified, a designated specialist support service will begin to actively engage the client and commence case management.

Due to the increased complexity of need in the cohort of predominantly single adults with histories of trauma and rough sleeping, clients accessing purchased emergency accommodation under HEART, as compared to the period pre-COVID, were far more complex. The average profile of clients involved prolonged chronic homelessness, alcohol and other drug issues, domestic and family violence and severe mental health issues. This was compounded by long periods of disengagement with the homelessness services system and a distrust of authorities. As a result, case workers where often presented with clients with challenging behaviours and a series of complex needs, with staff working with instances of aggression and violence, and in unsafe working environments. For some case workers these scenarios where new and confronting.

Over time it became evident that many specialist support services required capacity building to ensure clients were not disengaged. The Homelessness Networker coordinated assertive outreach and engagement training for case managers and service providers that were not familiar with such a range of client cohorts nor direct engagement.

Every effort was made to ensure that no client was denied ongoing opportunities for support service, even if they repeatedly declined support. The tenacity and perseverance of the specialist support service sector resulted in some clients eventually accepting support, often for the first time in their recent or long-term history of homelessness.

Client-focussed approach

When the State of Emergency was declared in Victoria, the homelessness service system was compelled to adopt a wartime-footing to house and support people experiencing the most precarious forms of homelessness, including rough sleeping. HEART emphasised a client-focussed approach for all agencies in the NLASN, and in so doing, enabled the broad-scale engagement of homeless households with the service system. A majority of homeless households in the NMR were engaged by the system, accommodated and approximately 280 provided access to specialist support services.

External forces that provided the conditions for such a response should be acknowledged, not least the event of global pandemic that gave rise to a health-led response; the subsequent rise in available purchased emergency accommodation due to the collapse of the tourism sector; and the lack of affordable market rentals and public or community housing.

The expansion of the HEF to envelop the early (pre-May 2020) response allowed access point agencies the capacity to offer comfortable, safe and relatively secure accommodation to a broader range of clients. Given that HEF has most commonly been used sparingly and on occasions for accommodation in unhealthy and unsafe emergency accommodation, this was a major redirection of resources in order to service the needs of a wider client cohort. Prior to COVID, HEF was prioritised to assist households with accompanying children, the increase in the HEF allocation allowed the system to reduce the rationing threshold and assist a greater number of single person households.

Although membership and participation in the LASN is mandatory for government funded agencies in the homelessness support system, the compulsory reallocation of organisational resources to the HEART program facilitated the redirection of focus toward the client. The expansion of funding to match the needs of the client, resulted in the removal of organisational and systemic practices that are the product of resource scarcity. This was particularly evident in the priority list working group, where clients were allocated to services

Case study

Aboriginal Community Controlled Organisation

Although an extremely rare occurrence, in highly complex and rapidly moving situations couples can be accommodated together that perhaps should not have been.

In the initial assessment and planning conducted by an access point, there was no reported indication, nor overt or passive indication that one particular client, an Aboriginal woman, was the victim of domestic violence. They didn't know that she was a victim of domestic violence and that the person she was being accommodated with was her abuser.

At the priority allocation working group their name and case was raised. Our insight as an Aboriginal organisation, meant that we were able to feed that information back, that we knew she was a victim and that he was a perpetrator of violence. We were able to provide advice in how to engage her and how supports were offered to her in the past.

We were also able to feed information back to the access point and then the accommodation onsite staff were made aware. The hotel onsite workers could covertly get her aside and make sure that she was okay and build up a relationship with her.

Separate support services were able to be arranged for her and him rather than a couples' worker. At the time, this female client also had an injury, which raised some red flags for us. We were able to visit on the pretext of the injury and her Aboriginality, which allowed us to assess the client situation and continue engagement.

Without the web of contact and information sharing that HEART offered, this client may have been one of the very instances of a victim of domestic violence in purchased emergency accommodation slipping through the cracks.

on a needs/risks/vulnerability basis, regardless of their status on any of the individual access point prioritisation lists. For instance, there were frequent occasions where no clients on one or two of the priority allocation lists were allocated a vacancy on the resource register at the end of a priority list working group meeting.

Having a joint team of priority allocation list workers and support workers all providing assertive case management support created a client focus, agencies came second. Whilst there was an acknowledgement that some access points were under increased pressure to clear clients from their priority waitlists, that heightened pressure experienced at specific access points was subjugated to the needs of the virtually combined priority list, even if the client with the highest need was located at an access point under less pressure. Pressure from agencies to clear priority lists was marginalised at meetings.

There were instances where clients completely disengaged from specialist support services. This is common within the system, however given the pandemic context, disengagement was actively resisted among workers in the system. The priority list working group assumed a topographic perspective to clients with multiple safety nets built into their practice. If clients disengaged from support workers or accommodation, and then presented to the system through a separate access point in the region, the priority list working group were able to identify this and troubleshoot new arrangements to ensure that client was supported.

With the creation of the HEART governance group and the priority list working group, clients were able to access the most appropriate accommodation and services to their needs, risks and vulnerabilities. Cohorts of clients that frequently disengage from the system were given more sustained attention and expert insight. For instance, Aboriginal and Torres Strait Islander (ATSI) people are over-represented in the homeless population in most Australian geographies, however this is pronounced in the NMR. Through the convergence of the Indigenous and mainstream homelessness support systems in the NMR, expertise of cohorts was brought into the system as a whole and a range of tailored case management approaches were able to be pursued. This resulted in lower rates of attrition for ATSI clients and potentially better longer-term outcomes.

Outcomes and learnings

Integral to the coordination of the HEART implementation was the Homelessness Networker (HN). The HN was responsible for brokering policy information and guidelines to the three access points and 28 specialist homelessness service providers; convening a working group of representative organisations in the network; coordinating the operations of the priority list working group to ensure a blanket and net approach to client support; and raising priority areas of attention for the Department of Health and Human Services to action.

According to all agencies, providers and workers consulted for this report, the most effective and impactful coordination tool was the HN. Good will among the different members of the LASN and working teams was also an essential aspect of the outcomes achieved through HEART, but coordination was the key feature of the response. Without high-level and topographic coordination from a dedicated and competent entity or person, agencies would have been consumed by their own core business and likely fail to maintain a whole-of-system response.

No ongoing service coordination issues were identified during the HEART response, aside from initial minor issues associated with becoming accustomed to a standardised communication and information sharing approach. Standard prioritisation frameworks and resource registers, as well as common forums for HEART governance and practice were utilised and maintained throughout the HEART response. The benefit of having a variety of organisations meant that the expertise and best practice of one, could be shared among the rest. No new systems had to be established from scratch and there was evident openness of organisations to readily share proprietary knowledge and to divert resources to building the capacity of other organisations.

Organisations and service providers have collectively and significantly built the capacity of the system to address homelessness, especially complex case management. VACSAL, for instance, brought all Aboriginal services together to provide a collaborative approach with HEART, picking up support vacancies and providing greater insight to the needs of Aboriginal people on waiting lists. Additionally, if the Indigenous support service sector were not involved, the response would not have been as successful and outcomes for ATSI clients would have been inadequate.

Existing relationships and mandatory inclusion were key to bringing together the HEART response. VincentCare and Launch Housing had existing prioritisation and allocation procedures that were able to be rolled out to Haven Home Safe in order to standardise the system. This standardisation was swift, because for some providers this was business-as-usual. For some services, elements of the HEART response, such as assertive outreach and engagement, was not their core business.

Capacity building and willingness to assume new responsibility and accountability measures was a positive outcome of the collaboration. The building of capacity was often in-motion, and for organisations such as VincentCare this was a challenge given that only a limited number of their programs were familiar with assertive outreach. The added layer of COVID-safe measures meant that the homelessness response was also a health response performed by a sector that was not specifically aligned to health protocols, such as using PPE, which added complexity and resulted in increased risk for frontline workers.

Part of the overall collaboration success was that the Northern Metropolitan Region had a well-coordinated, cooperative and robust LASN in effect since 2008. Trust between service providers, access points and the DHHS was well-established and information sharing common place as a matter of process. In recent years, the homelessness system in the northern region has been well-coordinated and understood, yet grossly under-resourced. Scarcity of resources, including the direct funding of wrap-around support services, access points and the provision of affordable and appropriate housing, has created an atmosphere of competition for individual organisations. This has meant that client group needs are systemically unable to be met. The subjugation of organisational fidelity to the needs of the client and system, has provided a baseline precondition for coordinating the HEART response. Without uncompetitive collaboration, the response would have failed to meet any of the individual guidelines set out by DHHS and failed to allocate available resources to people who require them most.

Key messages

A base recommendation of this report is to support and maintain ongoing regular meetings of the priority list working group, as a central feature of specialist homelessness support coordination in the NMR.

For members of the Northern Metropolitan Region's Homelessness Emergency Accommodation Response Team, the following understandings need to be incorporated into homelessness service sector programs going forward:

- Rough sleeping is a policy failure, not an intractable social problem;
- New service coordination tools such as a vacancy management system is essential;
- Active Aboriginal participation within service systems where Aboriginal people are involved is essential if meaningful outcomes for the client group are the objective;
- Engaging people who have not been engaged with specialist homelessness services for a significant period of time is a major outcome that should be built upon with continued access to support and secure accommodation;
- An ethic of tenacious assertive engagement with clients resulted in better outcomes for them, this needs to be supported by matching HEF expenditure to client-focussed needs – the 13-week support period for clients of HEART is not suitable to ensuring client-focussed outcomes;
- The continuation of policy and programs, including organisations that inherit the legacy of HEART, need to understand the coordinated nature of the service system – the geography is specific and the relationships well-established; and
- A longer-term case management paradigm has demonstrated that there are critical points within a client's recovery period that harnesses substantial outcomes for the clients – these leverage points are often achieved beyond the life of business-as-usual approaches.

In the process of the HEART response, the NLASN has fundamentally understood that the accumulation of people in purchased emergency accommodation, who are experiencing homelessness, further highlights enormous gaps in the homelessness service system. The delivery of client-focussed outcomes will continue to be unattainable unless policy is attuned to acknowledge:

- That there is a significant number of people requiring intensive, cross-sector, wrap-around responses to work through complex issues, before they will be in a position to access and sustain housing; and
- That there is an exasperating lack of housing and support options for single people, young people, people with no income and people leaving prison.

Pathways to housing for people experiencing homelessness also need to be better understood within the context of the homelessness service system. There is currently a major gap in knowledge of lived experience and outcomes for people who receive funded support for emergency accommodation (HEF). Building upon a strong understanding of the status of emergency accommodation in the region, and taking into account the complexity and diversity of client cohorts, the Northern Metropolitan Region is primed to seek these understandings. A deep and systemic interrogation of how homeless people might be better supported to access longer-term housing is critically needed.

[i] Northern Homelessness Network. (2019) Resolving / Responding to Homelessness in Melbourne's North. Retrieved 12 November 2020, from: https://www.parliament.vic.gov.au/component/rsform/submission-view-file/2f2b8db6afe66934a108dd678c2f95c9/ed8e2c3c46069b86164ecb256873f3d2?Itemid=527

[ii] Turton, P., Langmore, S., Bennett, D. and Gorman, M. (2019, p. 2). A Crisis in Crisis The appalling state of emergency accommodation in Melbourne's north and west. Western and Northern Local Area Services Network. Retrieved 12 November 2020, from: http://www.nwhn.net.au/admin/file/content2/c7/A%20crisis%20in%20crisis%20doc%20final%20040219_1550142202053.pdf

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Acknowledgment of Country

RMIT University acknowledges the Wurundjeri people of the Kulin Nations as the traditional owners of the land on which the University stands. RMIT University respectfully recognises Elders both past and present. We also acknowledge the traditional custodians of lands across Australia where we conduct business, their Elders, Ancestors, cultures and heritage.