



WET HOUSING

an accommodation option for people who
have experienced chronic homelessness
and long-term alcohol dependence

**A report on a study trip supported by
the Winston Churchill Memorial Trust**

Stephanie McIntyre
2009



Acknowledgements

I am very grateful for the support of The Winston Churchill Memorial Trust Board for granting me a fellowship that enabled me to travel to the USA, Canada, Ireland and England to look at examples of wet housing.

I want to acknowledge the generous support of all the projects – both staff and residents – that assisted me by allowing me to visit, by sharing information and documents, and by spending time with me discussing the benefits and challenges of this form of accommodation.

As I visited over 40 projects in total, there are too many to mention every one by name, but I want to particularly thank Anishinabe Wakiagun who gave me the unique experience of being accommodated at their wet home. I also want to thank Dave Zega from the Office of Supported Housing, Philadelphia and Bill Briscall from Triage who organised the itinerary for my visits to their cities and to the numerous other hosts who not only gave generous amounts of time, but also fed me meals.

My very special thanks to Brad Brockmann who enlisted his friends to give me a bed in a number of US cities, and to Ched Myers and Elaine Enns, Emma Tramosch, and Frances Killick and Richard Allsop who, by providing hospitality, enabled me to stretch the Kiwi dollar to cover more territory.

I also extend my thanks to Jak Wild for his assistance in preparing research questions and the Wellington wet house project team for taking up the challenge of establishing a wet house in our city.

Finally, I am indebted to the board of Downtown Community Ministry for their support and to the hard-working staff for steadfastly continuing at the coalface during my absence.

Stephanie McIntyre

Director
Downtown Community Ministry
director@dcm.org.nz

| | | |
|----|---|----|
| 1. | Executive summary | 1 |
| 2. | Introduction | 3 |
| 3. | Key learnings from the study trip | |
| | Research methodology | 4 |
| | Selection criteria | 4 |
| | Projects reported on | 5 |
| | Other projects of note | 5 |
| | Summary of key findings | 6 |
| | 1. Service philosophy and ethos | 6 |
| | 2. Entry criteria | 6 |
| | 3. Management of alcohol consumption | 7 |
| | 4. Size and demographics | 7 |
| | 5. Staffing | 8 |
| | 6. Services provided on-site | 8 |
| | 7. Liaison with emergency services | 8 |
| | 8. Behavioural issues, disciplinary processes and eviction policies | 8 |
| | 9. Turnover and retention rates | 8 |
| | 10. Residents' access | 8 |
| | 11. Management of visitors | 9 |
| | 12. Sexual relationships | 9 |
| | 13. Buildings and fittings | 9 |
| | 14. Location | 9 |
| | 15. Security and safety | 9 |
| | 16. Provision of meals | 10 |
| | 17. Recreational activities and personal development | 10 |
| | 18. Hygiene | 10 |
| | 19. Finances and funding | 10 |
| 4. | Background and context | |
| | A Wellington wet house | 11 |
| | Wellington's responses to homelessness | 11 |
| | The cost of chronic homelessness | 11 |
| | The Housing First model | 12 |
| | The limitations of independent tenancies | 13 |
| 5. | Resulting action | |
| | Media | 14 |
| | Making it happen | 14 |
| | Recommendations for the Wellington wet house | 14 |
| | Alcohol | 15 |
| | Visitors | 15 |
| | Discipline | 15 |
| 6. | Appendix | |
| | A: Questionnaire | 16 |

“Government alcohol and drug services offer short-term support. They get people from their knees to their feet then leave them – we help them to get walking.”¹

In 2004, Downtown Community Ministry (DCM) conducted interviews with over 50 people with lengthy backgrounds of both homelessness and alcohol dependence. The interviews showed that, contrary to popular thinking, most people from this environment do not choose homelessness as a lifestyle but genuinely want to be housed. Since then, DCM has had an active focus on supporting this specific group of people to achieve their housing aspirations. Adopting what is internationally recognised as the Housing First model, DCM has successfully assisted hundreds of people to access and retain rental flats.

This report centres on a housing solution for those individuals who, due to issues associated with their alcohol use, have been repeatedly evicted from their tenancies. The reality is that they become caught in a cycle between the streets, the police cells, the hospital emergency department and other people's couches because in Wellington there is no other option open to people in this category, as the accommodation alternatives all require sobriety as a condition of entry.

Despite these people repeatedly slipping through society's cracks, chronic homelessness is expensive to maintain. Studies confirm that the accumulative financial price tag of hospital admissions, police and court processing and time spent in jail, far outweighs the cost of setting up accommodation that suits the needs of people from this background.

Through receiving a Winston Churchill Memorial Trust grant in 2007, I was able to visit projects that provide accommodation for this 'hard to house' group. My focus was to observe 'wet houses': a highly effective but somewhat controversial form of accommodation that allows people with long-term alcohol dependence to consume alcohol on the premises.

I visited over 40 however, only a small portion of those projects provide permanent housing in a fully 'wet' setting. The majority offer short-term or emergency accommodation and/or, despite exercising a very tolerant attitude to alcohol and drug use, typically stop short of allowing alcohol to be consumed on-site.

I have selected 11 projects from Canada, America, Ireland and England that met my criteria of permanent, or at least long-term, and wet, and drawn on their experience and expertise. This report is primarily a collection of observations from the 11 projects in the hope that these findings will inform the establishment of a wet house in Wellington.

The projects range in size from 11 to 75 residents, with two providing men-only accommodation, one women-only and the remaining eight providing for a mixed-gender group. All the projects target people with long histories of homelessness and alcohol dependence and work with them in harm-minimisation settings. Their effectiveness results from creating a stable living environment and, in a non-coercive way, developing an individualised, holistic plan that includes goals for controlling and reducing drinking. Some projects have evaluations that testify to the success of this approach as alcohol consumption rates have radically dropped and quality of life significantly improved.

Safety of residents and staff is a paramount concern and is ensured through 24-hour awake staffing cover at all projects. Building design and layout, particularly in purpose-built projects, supports the model and further enhances safety. Typical features include a staffed reception desk monitoring residents' comings and goings, and controlling and restricting visitors.

Despite the high cost of delivering this kind of service, projects are predominately fully funded by government, including significant capital investment in establishing new projects in high-quality, purpose-built buildings.

Wellington is now at a stage of setting up its own wet house with a project team 'making it happen'. Both Wellington City Council and Capital and Coast District Health Board have committed funding to the establishment of this venture.

Recommendations for the Wellington wet house

1. The project is able to provide a permanent 'place to call Home' for residents and therefore no time limits are placed on occupancy.
2. The entry criteria for men and women are: a lengthy history of homelessness or serious risk of homelessness; coupled with long-term alcohol dependency; and an inability or unwillingness to address their drinking.
3. The Home is staffed 24 hours per day with a minimum of two staff on-site overnight and a higher number of staff on-site during the day.
4. The Home is a secure site with all access via a staffed reception desk situated immediately adjacent to the front entrance.
5. Residents have 24-hour access but visitors have restricted access that is managed carefully by staff.
6. The underlying philosophy is holistic and intentionally reflects Maori models of wellbeing given that a high proportion of residents will be Maori.
7. Local tangata whenua are invited to name, and have a special relationship with, the Home.
8. The Home provides a physically safe place to live for all residents, and to work in for all staff, and a culturally safe place for all, regardless of ethnicity.
9. The Home excludes from entry any person who has a history of convictions for serious violence offences and/or arson.
10. Entry is determined by a formally recognised intersectoral group made up of agencies who currently engage with the target population.
11. Policies and practice are determined that create and maintain a low-threshold/high-tolerance environment i.e. the emphasis is on ensuring residents sustain their tenancies.
12. A harm-reduction approach to alcohol consumption is employed.
13. A keyworker model is developed that could include collaboration with external agencies to provide some of this support.
14. Holistic plans are developed with each resident that move at the individual's pace.
15. The project is well integrated into, and supported by, specialised services.
16. Residents are empowered to participate in decision-making and determining the day-to-day running of the Home.
17. Meals are provided on-site but a possible liaison with, for example, the Soup Kitchen is explored.
18. Developmental and recreational activities are incorporated as an integral part of life at the Home.
19. In addition to a controlled front entry, safety features include: monitoring incidents between residents through CCTV; the provision of personal alarms (or an appropriate alternative) for staff; and restrictions on kitchen use to minimise the risk of fire and misuse of knives.
20. Given that other projects all experienced early teething problems, it would be wise to expect that there could be some volatility in the first few months after the Home opens.
21. Prior to opening, and in conjunction with the service provider and with consumer input, the specific policies and procedures are determined in detail, for example alcohol management and visitor management.

1. A view expressed by a staff member (Orlagh) from Great Places, Manchester during a personal interview on 14 June 2007.

"I'd be dead now if it wasn't for Princess Rooms. That is a fact. Having a place to go, to sleep, and relax and a place to call home."¹

In mid 2007, thanks to a Winston Churchill Memorial Trust grant, I travelled to the USA, Canada, Ireland and England to observe examples of 'wet housing'. My hope and intention was that my findings would inform the development of a similar project in Wellington. In my application to the Churchill Trust, I described the urgent need for New Zealand services to meet a critical gap that exists for a specific group of disadvantaged, marginalised, and at times despised people – namely those who have endured long histories of both homelessness and alcohol dependence.



Princess Rooms, Vancouver

Wet housing is not a new idea and various forms of wet shelters, hostels and day centres have been in place, most notably in the United Kingdom, for about 20 years. The key difference between wet and other forms of supported housing is that residents are not required to be sober as a condition of entry or for ongoing entitlement to the accommodation. Wet houses not only welcome residents who are alcohol dependent but, most significantly, allow them to openly consume alcohol on-site.

Jak Wild from Wellington's Community Alcohol and Drug Service (CADS) describes a wet service as offering "support for chronically dependent drinkers by accommodating both the drinker and the drinking. It recognises that at the point of entry into the service the individual is unable to, or unwilling to, contemplate life without drinking. It can be any service that allows drinking on the premises, but generally refers to 'wet houses', being treatment centres that offer accommodation and support for people who are chronically alcohol dependent."²

Ignorance about the wet house model has led some critics to surmise that it enables ongoing alcohol dependence. Others assume that a housing model that tolerates alcohol consumption on-site must be an unsafe or lax form of accommodation, akin to some sort of doss house. A Wellington City Council report states: "The common aim is to minimise harm by promoting controlled and less dangerous drinking and healthier and more stable lifestyles. This assumes that in tackling the consequences of long-term heavy drinking, it is possible to improve the quality and purpose of individuals' lives, and in turn reduce drinking."³

Our New Zealand experience of chronic homelessness linked to alcohol dependence resonates with countries around the globe, but we lag behind in addressing this critical social issue. I wanted to learn from other social agencies experienced in this field and was fortunate to visit numerous best-practice examples of what is a most challenging form of service to provide. It was a great privilege to meet, and spend time with, the leaders of organisations providing these services, and the staff who, on a daily basis, offer a mix of compassion, realism and professional support to people desperately in need.

1. Triage (undated) Princess Rooms Transitional Housing Demonstration Project, Appendix G: Tenant Survey Results. A report sourced from Triage staff on 14 May 2007.

2. Wild, J. (undated) An Intervention for a Current Alcohol Problem: A 'Wet House' for Wellington.

3. Wellington City Council (undated) "Wet Shelter": Responses to Homelessness.

Key learnings from the study trip



“Real men and women live in our hostels. They share the hopes and dreams of their fellow citizens. The Depaul Trust team work hard to make our hostels more than just four walls. Bricks and mortar don’t make a home but respect, dignity and a genuine concern for our residents does that.”¹

Research methodology

In my initial search for best-practice projects I located a number of the American sources in the *Toolkit for Ending Homelessness* published by The National Alliance to End Homelessness available on www.endhomelessness.org My copy is undated, but I first accessed this report in 2003.

The report *Strategies for Reducing Chronic Street Homelessness* (2004) prepared for the US Department of Housing and Urban Development Office of Policy Development and Research also offered numerous useful leads and an internet search identified the remainder of my other American and Canadian locations.

The various English projects I visited, I first saw referred to in *A Feasibility Study on the Provision of Accommodation for Homeless Street Drinkers in Dublin City* (Costello, L. 2000). Again an internet search identified other likely projects.



Resident’s apartment, 1811 Eastlake, Seattle

New Zealand has very little original literature on this topic but an undated report by the Wellington City Council entitled *“Wet Shelter” Responses to Homelessness* offers a useful overview of mainly British wet day centres.

I was able to secure visits to all the key projects I approached. Some then offered to coordinate additional visits to other local services.

I was assisted in my preparation by Jak Wild who prepared a questionnaire – a copy of which is included in Appendix A. Designing the questionnaire was a very useful exercise as it helped me to focus on the key issues that would need to be resolved in order to set up a project in New Zealand.

When I met with project staff, I preferred to let them tell their story from their own perspective, so I tended to use the questionnaire as a background guide only. As some of my visits were quite brief, I rarely came away with all my questions answered. The result was a mosaic of responses that collectively tell the account of the successes and challenges of the projects.

Selection criteria

Over the course of my study trip, I visited a large number of projects.

My objective was to report on projects that provide a fully wet environment in a permanent home setting, but I found that only a small handful of projects met these criteria. What I discovered is that there is a wide variation in both the degree of alcohol consumption tolerated and the length of tenure offered to residents. The projects I visited provide services on what could best be described as a continuum ranging from

- a: dry-to-damp-to-wet environment
- in a: temporary-to-transitional-to-permanent setting.

Despite my conviction that I had described my objective carefully, it was sometimes not until I was physically at a project that I discovered we had different understandings about the meaning of the term 'wet'. For example, some projects refer to their service as wet, but provide what I would describe as 'damp' accommodation as they allow residents to come onto the premises drunk but not to consume alcohol on-site. A good example of this was the Cambridge and Somerville Program for Alcoholism and Drug Rehabilitation (CASPAR) 24-hour Emergency Service Center. Case Manager Jay Matthews described the emergency shelter as "as wet as they come"² but, as the project does not tolerate alcohol on-site, in my terminology it would be more accurate to call it 'damp'.

Providing they are not already excluded from admission, prospective wet house residents tend to be repeat users of emergency shelters. A Triage report, noting high readmission rates, claims that using a shelter has not assisted this group to break the cycle of homelessness. The report states that "the data from emergency shelters clearly indicate the ineffectiveness of shelters in addressing the underlying issues of the chronically homeless"³ Because this population needs long-term housing solutions, I have not included emergency accommodation such as night shelters and safe havens in this report.

Only a small number of projects openly state that they provide a permanent home. I discovered that a significant number of projects say that they provide transitional rather than permanent housing primarily to meet government funding criteria. Quite a number of these transitional projects acknowledge that the majority of their residents are unlikely to cope with a move to independent housing, for example due to health reasons.

Providing projects offered a fully wet service, I have relaxed the criteria somewhat to include transitional services in this report.

Projects reported on

Out of the array of services I visited, I have selected the following 11 projects and drawn on their examples to inform this report as they best met the above criteria:

1. 1811 Eastlake, Seattle
2. The Princess Rooms, Vancouver
3. The Vivian, Vancouver
4. Anishinabe Wakiagun, Minneapolis
5. Aungier Street, Dublin
6. Stella Maris, Belfast
7. Edward Gibbons House, London
8. Aspinden Wood Centre, London
9. St Pancras Way, London
10. Royal Court, Manchester
11. Great Places, Manchester



Anishinabe Wakiagun, Minneapolis

Other projects of note

I visited a number of short-stay emergency accommodation projects that are delivering services that are worthy of note: CASPAR Emergency Service Center in Cambridge, Massachusetts; Women of Change Safe Haven in Philadelphia, Pennsylvania; and The Triage Centre in Vancouver.

I was impressed by the wet garden and day services at The Booth Centre in Manchester, England and The Tenderloin Housing Clinic in San Francisco, California who provide quality housing and support services through their work in single-room occupancy hotels.

I visited three American agencies that offered helpful insights into the wider issues of addressing and preventing homelessness and, in particular, the role of data collection. I want to acknowledge the value of visiting the Office of Supportive Housing in Philadelphia, Pennsylvania, the Massachusetts Housing and Shelter Alliance in Boston, Massachusetts and Pathways to Housing in New York City.

Summary of key learnings

This section sets out the specific key findings from the 11 projects referred to above, under the various headings found in the questionnaire.

1. Service philosophy and ethos

A critical success factor is that the service philosophy and ethos underpinning the project is transparent, consistent and made real. For example it is modelled by the staff, inherent within the service delivery contract requirements and explicit in policies and procedures.

The service philosophies and ethos underpinning the projects include the following key features:

- They are built on a strong set of underlying values that recognise the dignity and worth of each resident
- They establish that the project will provide a low-threshold/high-tolerance environment for residents
- They espouse the goal of keeping residents housed by providing a permanent place to call home
- They employ a harm-reduction approach to alcohol consumption
- Planning for residents is individualised, and moves at the individual's pace
- Providing a culturally based environment is a key focus for Anishinabe Wakiagun. This includes having native staff, including recruiting from the neighbourhood and recognising cultural issues such as hospitality.



Stephanie with the cook at Anishinabe Wakiagun who lives locally

2. Entry criteria

Entry tends to be needs-based rather than based on the time spent on a waiting list. Entry criteria prioritise prospective residents who have:

- A lengthy history of homelessness coupled with long-term alcohol dependency
- A history of frequent use of night shelters and/or high hospital emergency room admissions and/or arrests for alcohol-related disorderly behaviour
- An inability or unwillingness to address alcohol dependency
- Been housed but find it difficult to sustain a tenancy or are vulnerable in their tenancy due to a chaotic lifestyle related to the above

Prospective residents must be over the age of 21

A Canadian report, while not strictly describing entry criteria as such, offers useful entry indicators by describing a typical prospective resident as someone with:

- Deteriorating mental and physical health
- Poor connections with mental and physical health services
- An almost exclusive reliance on emergency services and minimal-barrier community services that can offer few if any real opportunities for health and change
- An erosion of pre-existing life skills and social skills
- A reliance on coping skills (e.g. substance abuse, anger and intimidation) that can exclude one from opportunities to stabilise one's life and move forward
- An isolated lifestyle which is the result of the collapse of social and support networks
- A fundamental lack of hope for the future⁴

All projects state they exclude those with histories of violence and arson.

Projects have comprehensive referral processes and assessment/admission processes.

3. Management of alcohol consumption

There is no one model for managing alcohol consumption. Each project varies according to the approach that best suits the needs of their residents but, despite the differences, evaluations indicate similarly encouraging, and at times dramatically effective, results.

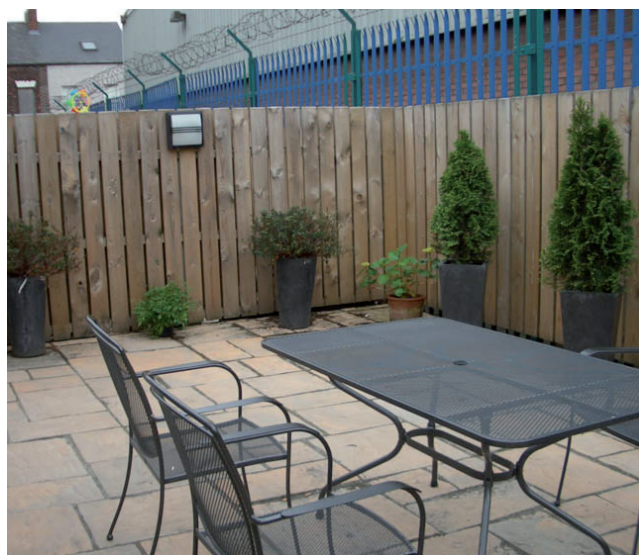
All projects state a commitment to a harm-reduction approach which is non-coercive and is based on coaxing residents towards stabilising drinking behaviours, eliminating the most harmful beverages, and reducing the amount consumed.

Each project has policies that seek to address:

- who is able to purchase alcohol for residents
- whether visitors can bring alcohol on-site
- whether there are hourly and/or daily limits to consumption
- where alcohol can be consumed on-site

4. Size and demographics

- Projects vary in size from 11 to 75 residents
- Most are for mixed gender
- One project is culturally specific for Native Americans



Wet garden, Stella Maris, Belfast

| Project | Location | No. of Residents | Gender |
|--|-------------|------------------|--------|
| Royal Court, Positive Lifestyles | Manchester | 11 | Men |
| St Pancras Way, St Mungo's Housing Assoc | London | 17 | Mixed |
| Aungier Street, Depaul Trust | Dublin | 20 | Men |
| The Vivian, Triage | Vancouver | 20 | Women |
| Stella Maris, Depaul Trust | Belfast | 22 | Mixed |
| Aspinden Wood Centre, Equinox | London | 24 | Mixed |
| James Street, Depaul Trust* | Dublin | 30 | Mixed |
| Edward Gibbons House, PRHA | London | 35 | Mixed |
| Great Places | Manchester | 36 | Mixed |
| Anishinabe Wakiagun | Minneapolis | 40 | Mixed |
| The Princess Rooms, Triage | Vancouver | 44 | Mixed |
| 1811 Eastlake, DESC | Seattle | 75 | Mixed |

* I only saw floor plans for James Street as construction was about to commence at the time of my visit

5. Staffing

- All have 24-hour awake cover
- Staff cover on daytime shifts varies amongst projects from two to several staff on duty
- Projects in UK have higher ratios of staff to residents than US and Canadian projects; US and Canadian projects tend to be larger
- In the UK in particular, issues of 'care' are complex as care is funded separately from support

6. Services provided on-site

- All have a keyworker model with support plans for individual residents
- Physical and mental health services visit regularly
- When an individual resident qualifies for higher level 'care' (generally this is provided by an external agency) it often proves difficult to coordinate effectively as the resident often requires care when the agency is not on-site

7. Liaison with emergency services

- Two projects have had fires
- Call-outs to police and ambulance are frequent and these services are responsive

8. Behavioural issues, disciplinary processes and eviction policies

- All projects have evicted residents for violent assault
- Eviction is mandatory in cases of assault of a staff member
- Eviction for dealing in drugs is also mandatory
- Abandonment of the tenancy and consistent non-payment of rent may result in eviction
- Disciplinary processes are slow moving, consistent with ethos and service philosophy
- Staff must be equipped to cope with abusive behaviour from drunk residents
- Most projects experienced more difficulty in their early phases

9. Turnover and retention rates

- Retention rates are high
- Turnover rates are around 20% per year
- Transitional projects must move residents on, therefore their turnover is higher
- Reasons for turnover are mixed but are generally 50/50 evictions and other
- Other reasons include: death from alcohol-related illnesses; moving to a care facility; moving to independent housing; returning to the street

10. Residents' access

- Residents have unrestricted 24-hour entry
- Residents do not have keys or swipes for external doors
- Generally entry is gained through a manual system operated by a duty staff person



Reception desk, Anishinabe Wakiagun

11. Management of visitors

- Effective visitor policies are critical to the success of projects
- Visitors are usually allowed throughout the day and evening but the length of visits is limited in most projects
- The number of visitors per resident is limited to one or two at any given time
- Visitors must check in through the reception desk
- Some projects require ID
- Projects vary as to whether visitors can bring and consume alcohol
- Visitors must adhere to rules
- Residents must accompany their visitors at all times
- Projects may restrict which part of the building visitors can be in
- Some projects allow an overnight visit e.g. once per week

12. Sexual relationships

- Sexual relationships are accepted as a resident's right
- Relationships forming between residents are quite common
- Very few projects provide accommodation in double rooms as this leads to difficulties if the couple separates and then each resident wants a single room

13. Buildings and fittings

Building and layout play a strategic role in supporting the wet house model. Key features include:

- Locating a staffed reception desk at the entranceway/foyer so that staff can regularly interact with residents, monitor their activity and levels of intoxication, and ensure the visitors are managed

Older buildings tend to be:

- Poorly laid out and create hazards for staff safety
- Cramped with insufficient bedroom and communal and office/support facility space

Newer buildings tend to be:

- Of a very high standard with ensuite bathrooms or even bedsit apartment accommodation for residents plus excellent communal and office/support facility space
- Attractive places to live

14. Location

- Location is rarely in the central city
- Projects are generally located in mixed commercial and residential neighbourhoods
- When setting up a new project, many encountered the NIMBY syndrome, including protracted legal battles

15. Security and safety

- Most projects have CCTV
- Newer projects have considerably more and better-positioned CCTV cameras than do older projects
- Cameras are particularly useful in providing a record of incidents between residents
- Cameras are also useful for recording when a resident falls over
- Although assaults on staff are infrequent, staff safety is improved through having cameras
- Other devices such as pagers also enhance staff safety
- Two projects have had fires in their buildings
- Intercoms and methods of monitoring residents enhance their safety

16. Provision of meals

- Food is very important in stabilising residents' health
- Most large projects provide at least two and generally three meals per day for residents in communal dining rooms
- Some projects have individual kitchenettes for residents
- Most small projects are now using frozen ready-meals
- This maximises opportunities for residents to receive a meal
- It is a cost-effective option for small projects

17. Recreational activities and personal development

- Engagement in recreational activities can lead to overall improved health outcomes
- Residents' ability to cope with external activities can exceed expectations

18. Hygiene

- Personal hygiene is often poor at time of admission but improves
- Managed through support/care plan

19. Finances and funding

- Funding models vary internationally but all projects set-up and operational costs are predominately fully funded by government
- Residents contribute approximately one-third of their income towards costs
- Costs are heavily subsidised by government
- US projects take people who have no income as prospective residents may not be entitled to any welfare benefit
- UK models tend to describe their services as transitional in order to qualify for funding



Exercise facilities, Anishinabe Wakiagun

1. Depaul Trust (2004/2005) A Place to Call Home Depaul Trust Annual Report 04/05, p3.
2. Matthews, J. (2007) Personal interview with Jay Matthews, Case Manager at CASPAR Inc, 23 May 2007.
3. Triage (undated) Princess Rooms Transitional Housing. A Report sourced from Triage staff on 14 May 2007.
4. Ibid

“Simply running soup kitchens and shelters allows the chronically homeless to remain chronically homeless.”¹

A Wellington wet house

Considerable research, thought and discussion have gone into identifying that Wellington needs a wet house and numerous articles have been published² demonstrating support for a proposed wet house in Wellington.

While Downtown Community Ministry (DCM) provided the initial impetus for setting up a wet house, this project has become a collaborative effort and is now a platform of Wellington’s Homelessness Prevention Strategy. The project has been endorsed by the Capital and Coast District Health Board (C&CDHB) and the Wellington City Council (WCC) that have both committed funding to the project. For a period of time the project team had the resource of a paid part-time project manager.

The background to this progress lies in the city’s responses to chronic street homelessness.

Wellington’s response to homelessness

Over the past few decades, as is the case in many large cities, Wellington has grappled with the issue of homelessness and the related issue of street drinking. Various responses to these issues have emerged including the contracting of DCM by WCC in 2005 to address homelessness in Wellington city. Another significant development has been the establishment of the intersectoral Homelessness Prevention Group in Wellington that brought together community and government agencies to collaborate on both strategy and action to address this critical social issue.

In order to better understand the key drivers of homelessness, DCM staff interviewed over 50 service users with lengthy backgrounds of homelessness and addictions and explored their histories and their current aspirations for housing. Thirty of these interviews were subsequently analysed by students from the Wellington School of Medicine and published in the report *Slipping Through the Cracks: A Study of Homelessness in Wellington* (May 2005).

The majority of people interviewed wanted a home but had experienced significant barriers to accessing and maintaining housing and had ultimately lost hope of being housed. A repeated theme was the impact of addiction and, in particular, alcohol dependence and an ensuing chaotic lifestyle that significantly affected and undermined the individual’s ability to sustain a tenancy.

The cost of chronic homelessness

Various studies have demonstrated the economic cost of keeping people in a state of chronic homelessness. A New Yorker magazine article by Malcolm Gladwell: *Million-Dollar Murray why problems like homelessness may be easier to solve than manage* (2006)³ focused on one person who was well known to the Reno Police Department, Murray Barr. Concerned at the regularity of their contact with Murray, two police officers, Steve Johns and Patrick O’Byrne, investigated the cost of his repeated hospitalisation.



Damaged HNZN flat

“Johns and O’Bryan realised that if you totted up all his hospital bills for the ten years that he had been on the streets – as well as substance-abuse-treatment costs, doctor’s fees, and other expenses – Murray Barr probably ran up medical bills as large as anyone in the state of Nevada.

“‘It cost us one million dollars not to do something about Murray’, O’Bryan said.”⁴

The article goes on to quote a San Diego study that describes in detail why the medical cost of chronic homelessness is so high:

“‘They are drunk and they aspirate and get vomit in their lungs and develop a lung abscess, and they get hypothermia on top of that, because they’re out in the rain. They end up in the intensive-care unit with these very complicated medical infections... They often have neurological catastrophe as well. So they are prone to just falling down and cracking their head and getting a subdural hematoma, which, if not drained, could kill them... Meanwhile, they are going through alcoholic withdrawal and have devastating liver disease that only adds to their inability to fight infections. There is no end to the issues. We do this huge drill. We run up big lab fees, and the nurses want to quit, because they see the same guys come in over and over, and all we’re doing is making them capable of walking down the block.’” (p.101)

The New Yorker article also makes reference to the research of Dennis Culhane. Culhane found that the chronically homeless form a relatively small group in the overall number of homeless people in the USA “but that this group costs the health-care and social services systems far more than anyone had ever anticipated.” (p.101)

These findings come as no surprise to New Zealanders working with people with lengthy histories of homelessness and chronic alcohol dependence. Our experience confirms that these are sound economic arguments for finding a solution to the high cost of cycling between the street, hospital emergency rooms, police cells and prison.

The Housing First model

DCM’s primary approach to addressing Wellington’s homelessness has been to embrace what is internationally recognised as the ‘housing first’ model. The housing first approach is premised on the notion that having shelter is both a primary human right and is an absolute necessity in order to experience wellness. The model was pioneered by Pathways to Housing whom I was able to visit on my study trip. Set up in 1992 in New York City, Pathways to Housing “seeks out the most visible and vulnerable segment of New York’s homeless...and offers them immediate access to an apartment of their own, because that is what they want, without requiring participation in treatment or sobriety.”⁵

Triage in Vancouver also describes their practice as housing first and their website explains that they “accept that the chronically homeless will have active addictions, undetermined or untreated mental illness, and survival behaviours that will challenge our attempts to build community and achieve stability. Housing First, then, is a model of housing that has few barriers to access, accepts and works with survival barriers, and respects people’s choices in regards to mental health treatment and substance use. Importantly, while the focus is on providing ‘housing first’, the goal is not simply to get people off the streets but to provide a comprehensive array of supports that assist people in achieving stability and moving on with their lives.”⁶

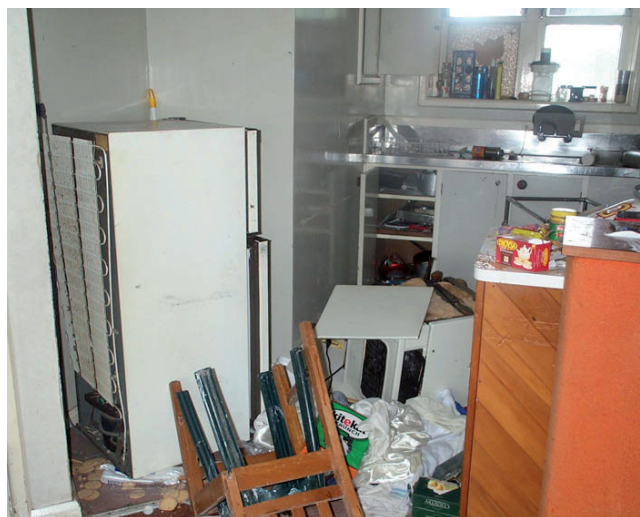
DCM’s commitment to the housing first model has seen around 75 people each year⁷ move directly from homelessness, including rough sleeping, into their own independent tenancies, most frequently bedsit apartments. These are generally rented from Wellington’s largest social housing provider, WCC’s City Housing, followed by a smaller number in Housing New Zealand Corporation (HNZC) flats.

What differentiates this housing model from Wellington’s previous attempts at housing people directly from homelessness is the degree and variety of supports provided by DCM and other appropriate agencies linked to the new tenant. Utilising this approach, similar to the Pathways to Housing and Triage programmes, DCM has proved extremely successful at assisting new tenants to maintain their tenancies.

Significantly, the project has shown that a number of people with long-term alcohol dependence can successfully maintain their tenancies.

The limitations of independent tenancies

Although only a relatively small percentage of those newly housed have been unable to cope with the demands of this form of housing, nevertheless a pattern emerged. Those who are unable to hold down a tenancy tend to have chronic alcohol dependence and/or solvent addictions. For these individuals, numerous serious incidents of antisocial behaviour revolving around the management and control of visitors results in noise and damage complaints to the landlord and call-outs to the Police. Both Wellington social housing providers, City Housing and HNZA, work collaboratively with DCM staff to address and overcome these problems but ultimately some of these, unfortunately, end in eviction.



Damaged kitchen, HNZA property

For a person in this situation, a higher level of on-site support is required, but supported accommodation in Wellington generally conforms to a specific model that has entry criteria requiring sobriety. At the most lenient end of the scale, being drunk is tolerated but residents are generally not allowed to bring alcohol on-site. Therefore, effectively, Wellington has only dry and damp supported accommodation options.

Other locations I visited described a similar scenario. "The majority of the current supported housing system in Vancouver requires tenants achieve a substantial measure of 'housing readiness' before they can access the housing. Typically this means being stable, linked with treatment services and having minimal levels of challenging behaviour. This effectively bars chronically homeless individuals from accessing the majority of housing programmes".⁸

There is widespread support amongst projects for the housing first model, but with the clear proviso that it is backed with sufficient support for the new resident. However, I also encountered skepticism and cynicism about the model, with some projects expressing the view that the housing first model is gaining currency with government funders primarily because it is a cheaper option, and also because it fits philosophically with the notion of "moving people to independence".⁹

In support of this view, I heard stories of people whom project staff felt had been pushed out into independent housing with disastrous consequences. For example, Jay Matthews from CASPAR described a person who was found dead in his apartment after three months, surrounded by empty vodka bottles.

At DCM, while retaining our commitment to supporting people to access their own independent tenancies as our primary means of moving people from homelessness, we recognise that a small handful of people need a completely different model. If we are to continue to make significant inroads into addressing homelessness in Wellington, alternative and more appropriate forms of accommodation need to be identified and set up. Consequently, in 2004, DCM began exploring the possibility of establishing wet housing in Wellington.

1. Mangano, P. (2006). Executive Director of the U.S. Interagency Council on Homelessness quoted in Million-Dollar Murray Why problems like homelessness may be easier to solve than to manage, *The New Yorker* (Feb 13 & 20, 2006) p. 102.
2. For example: Alcohol Advisory Council of New Zealand (2007) *Wet House a step closer* alcohol.org.nz Vol. 7, No. 4 (March 2007) and the WCC and Jak Wild reports referred in previous chapters of this report.
3. Gladwell, M. (2006) *Million-Dollar Murray Why problems like homelessness may be easier to solve than to manage*, *The New Yorker* (Feb 13 & 20, 2006).
4. *Ibid* p 97.
5. Pathways to Housing Inc. (undated) *A Snapshot*. Handout sourced from Sam Tsemberis, Executive Director, Pathways to Housing on 1st June 2007.
6. Triage Website: http://www.triage.bc.ca/index.php?option=com_content&task=view&id=355&Itemid... Sourced from internet 14/03/2007.
7. Project Margin (2005 to 2008) DCM reports to WCC.
8. Triage (undated) *Princess Rooms Transitional Housing*. Article sourced from Triage staff on 14th May 2007.
9. Humphrey, F. (2007). Personal interview with Fiona Humphrey, CEO at Providence Row Housing Association on 11 June 2007.

“Everyone is on a continuum from jail, which is one place to live, through to home ownership. What’s important is to provide lots of stops along the way. Every city should have an Anishinabe Wakiagun and maybe we need one in the suburbs too.”¹

Media

The possibility of a Wellington wet house has been reported in local print media since 2004. Articles have appeared in the Dominion Post, the Wellingtonian, Capital Times, the WCC newspaper Absolutely Positively and the Alcohol Advisory Council’s magazine alcohol.org.nz

After returning from my study trip, I was interviewed live on the Nine to Noon show on Radio New Zealand National (23 August 2007) and Triangle Television’s In Conversation (2 May 2008). Both interviews included discussion about the wet house solution.

Making it happen

At the time of writing this report, the project team has identified a list of priorities:

1. Determining an appropriate service model for our New Zealand context that draws on international best practice and consumer and tangata whenua consultation and feedback.
2. Completing a more detailed needs analysis of potential residents/consumers.
3. Securing a location for the Home.
4. Designing a collaborative ongoing structure and framework along with policies and processes to ensure successful management of the whole project, i.e. the service delivery contract, including management of potential risks and evaluation as well as of the building.
5. Entering into a service delivery contract with a provider.
6. Securing ongoing funding.

Recommendations for the Wellington wet house

Based on observations of international projects, the following points are key to establishing a successful wet house in Wellington:

1. The project provides a permanent place to call ‘Home’ for residents and therefore no time limits are placed on occupancy.
2. The entry criteria are: men and women with lengthy histories of homelessness, or serious risk of homelessness, coupled with long-term alcohol dependency, and an inability or unwillingness to address their drinking.
3. The Home is staffed 24-hours per day with a minimum of two staff on-site overnight and a higher number of staff on-site during the day.
4. The Home is a secure site with all access via a staffed reception desk situated immediately adjacent to the front entrance.
5. Residents have 24-hour access but visitors have restricted access that is managed carefully by staff.
6. The underlying philosophy is holistic and intentionally reflects Maori models of wellbeing given that a high proportion of residents will be Maori.
7. Local tangata whenua are invited to name and have a special relationship with the Home.
8. The Home is a safe place to live for all residents, and to work in for all staff. This includes a culturally safe place for all, regardless of ethnicity, and a physically safe place for both women and men.

9. Entry is determined by a formally recognised intersectoral group made up of agencies who currently engage with the target population.
10. Entry into the Home is excluded to any person that has a recent history of convictions for serious violence offences and/or arson.
11. Policies and practice are determined that create and maintain a low-threshold/ high-tolerance environment, i.e. the emphasis is on ensuring residents sustain their tenancy.
12. A harm-reduction approach to alcohol consumption is employed.
13. A keyworker model is developed that could include collaboration with external agencies to provide some of this support.
14. Holistic plans are developed with each resident that moves at the individual's pace.
15. The project is well integrated into, and supported by, specialised services.
16. Residents are empowered to participate in decision-making and determining the day-to-day running of the Home.
17. Meals are provided on-site but a possible liaison with, for example, the Soup Kitchen is explored.
18. Developmental and recreational activities are incorporated as an integral part of the life of the Home.
19. In addition to a controlled front entry, safety features include: monitoring incidents between residents through CCTV; the provision of personal alarms (or an appropriate alternative) for staff; and restrictions on kitchen use, to minimise the risk of fire and misuse of knives.
20. Given that other projects all experienced early teething problems, it would be wise to expect that there could be some volatility in the first few months after the Home opens.
21. Prior to opening, and in conjunction with the service provider and with consumer input, the following specific policies and procedures are determined in detail:

Alcohol

Some of the questions to explore include:

- Will residents be encouraged to adopt hourly/daily limits to consumption?
- How will this sit with a non-coercive approach?
- Will staff be permitted to purchase alcohol on behalf of residents?
- Who will be able to bring alcohol into the Home?
- Will visitors be allowed to consume alcohol?
- Where on-site will alcohol be able to be consumed?

Visitors

Some of the questions to explore include:

- What will be the visiting hours and the length of time a visitor can stay?
- What will be the maximum number of visitors on-site at any one time?
- What areas will visitors be allowed to access and will visits to individual residents' rooms be acceptable?
- Will residents be allowed occasional overnight visitors and, if so, how often and how will this be managed given that bathrooms may be shared facilities; what will be visitors' access to meals, etc?
- Will minors be able to visit and how will access to children/mokopuna be managed?

Discipline

Some of the questions to explore include:

- How can the disciplinary policy ensure that there is a slow warning path that will ensure residents are not pushed towards eviction?
- What will be the grounds for eviction?
- How will abusive behaviour towards staff be managed?
- What will be the 'house rules' that residents will sign up to as part of their tenancy agreement?

No doubt these policies will need to be adapted and refined as we learn more about what will work for the residents and staff in the Wellington Home.

Appendix A: Questionnaire



Project Name **Contact Person**

Address **Email/phone**

..... **Date visited**

.....

General Questions

How long has the project been in operation?

What is your entry criteria? (Policy provided?)

Comment

Alcohol

What is the philosophy?



Alcohol

How is alcohol purchased?

Comment

Who can bring alcohol onto premises?

Comment

Can visitors drink? Y N

Are there personal searches and why?

Comment

At what times and in which places is drinking allowed?

Comment

How much alcohol can be consumed by the individual?

Comment

How much per day

Residents' Behaviour

Is there an eviction policy? Y N Policy provided?

What gets a resident evicted?

Drugs Alcohol Violence Vandalism Sex Self Harm

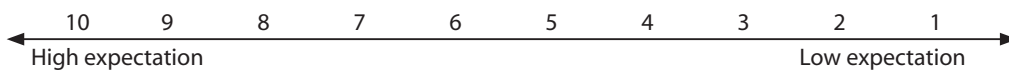
Comment
(Stats available?)

Is smoking allowed? Y N Designated areas

Hygiene

Are there hygiene standards? Y N

Personal hygiene expectation



Hygiene of premises expected



Finance

How much does the client pay? \$.....

What does this cover? Full board Alcohol Food Clothing Medical

Does the resident have any money left over for personal purchases? Y N

Liaison with other services

Health Services On-site Off-site

Comment (Primary care? / Specialist outreach? / Palliative care)

Alcohol and Drug Services On-site Off-site

Comment (Counsellors? / group / 12 step?)

Mental Health Services On-site Off-site

Comment

Social Services On-site Off-site

Comment (Social workers? / Benefit support? / Employment assistance? / Housing?)

Emergency Services On-site Off-site

Comment (Police? / Fire? / Ambulance? / Council?)

Personal Development

Activities On-site Off-site

Comment (Sport? / Art?/ Fitness? / Cookery?)

Developmental Pursuits On-site Off-site

Comment (Literacy? / Budgeting? / Health? / Nutrition?)

Hours/Visitors

Open hours Visiting hours Are visitors allowed? Y N

Stats (Estimates)

Entry Stats Did not meet entry criteria %.....
Number of Beds

Turnover stats Average length of stay
Greatest length of stay

Exit stats? Exit to own accommodation %.....
Exit via eviction %.....
Exit to return to streets/rough sleeping %.....
Exit on medical grounds %.....
Length of time allowed before loss of room/bed

Resident Demographics

Do you also accept woman? Y N
If so, are sexual relationships allowed? Y N
Are there any age requirements? Y N
Are demographic stats available? Y N

After-visit checklist

Building Specifications

Purpose-built or modified Y N
Location

Layout
Single floor Lounge Outdoor area/Garden
Single rooms Y N comment.....

Fixtures, fittings or furnishings

Comment

Security? CCTV Y N Fire Safety Secure staff area Y N

In-house provision

Kitchen? Y N Meals tea/coffee

Comment (in room? / Separate area?)

TV / DVDs / Music / Pool / Gym equip / etc

Comment (in room? / Separate area?)