"Getting My Life Back Together"

Women, Housing and Multiple Needs

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Abbreviations

AIHW	Australian Institute of Health and Welfare
CAT	Crisis Assessment and Treatment
CURFS	Confidentialised Unit Record Files
D&A	Drug and Alcohol
NDCA	National Data Collection Agency (AIHW)
OoH	Office of Housing
PSP	Personal Support Program
SAAP	Supported Accommodation Assistance Program
SAMHSA	Substance Abuse and Mental Health Services Administration (USA)
SECAS	South East Crisis Accommodation Service (Hanover)
THM	Transitional Housing Management

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Executive Summary

This collaborative research has sought to examine the ways in which service responses for women experiencing homelessness with complex and multiple needs may be improved. The project first examined the presenting profile and housing circumstances of women currently being supported by participating services. The profile was followed by an examination of current practice and potential ways forward for improving service system responses. For the purposes of this project, a working definition of complex and multiple needs was developed based on the abilities and behaviours of the women, the underpinning issues, and the capacity of the service system to meet their needs. Adopting a triangulated methodology, the study focused on the Southern Metropolitan Region as the site of engagement of participating services and clients. The main question being investigated through the project was: In what ways can the service response for women experiencing homelessness with complex and multiple needs within the Southern Metropolitan Region be improved?

Key Findings

Service Needs, Strengths and Capacities

- The average age of the women in the study data collection was 32 years. Ages ranged from 18 to 63 years indicating the need for a continuum of appropriate strategies that reflect different stages of readiness and insight into their experiences. While most women present alone, the majority are mothers and in many instances children were not in their care at the time of support. Women in the profile were more likely to be receiving a disability support pension or medical incapacity exemption.

- Many of the women experienced extended periods of recurring homelessness, cycling from one tenuous or temporary housing situation to the next, indicating that their housing circumstances were rarely resolved. Their interactions with the housing system appeared to contribute to ongoing instability and it is not surprising that the main need of these women was for repeated episodes of housing assistance. A frequent pattern amongst the women was early home leaving, leading to repeated breakdown in all forms of accommodation and difficulty in regaining access to independent housing once it was lost. Early exit from housing support, continuing or repeat homelessness following a period of hospitalisation, incarceration, or residential drug treatment were common experiences in the homelessness cycle for women. Longitudinal investigation would add further insight into the housing cycles of women over time.

- The majority of the women in the profile presented with a combination of mental health disorders, substance use problems, self-harming, risk taking or 'challenging' behaviour. Consistent with this was the high prevalence of past and current experiences of trauma and abuse, particularly domestic violence and sexual abuse that was a critical factor leading to homelessness. The women also experienced multiple physical health conditions, with many chronic in nature.

- Despite the combination of multiple vulnerabilities, the women possessed a range of individual strengths and capacities such as being able to seek help when needed, the ability to problem solve and plan for the future, the capacity to engage well with workers, commitment to change and resilience. Many of the women, particularly those in older age groups, had a history of labour market engagement. Returning to employment was an eventual goal for many. While often characterised by fractured relationships, the ability to identify and utilise family and other support networks was recognised as a vital capacity of these women. Despite their often isolated situation, many were able to galvanise support from extended family and professionals with whom they had established a relationship.

Housing and Non-housing Outcomes

- Repeat service use in accommodation services is often one indicator of ongoing housing difficulty. It can also be an indicator of successful service engagement. Amongst accommodation services completing client review forms, 38% of women from the total sample had some prior contact with the same service apart from the current support period.

- Apart from stabilising housing crisis and improving housing affordability and safety, the most salient outcome reported for women receiving housing assistance was compilation of segment one applications for public housing, with over half the women having a segment one application in place. Fifteen percent of women exited participating services early according to an agreed case management plan. Women were more likely to exit crisis accommodation prematurely in an unplanned way, compared with other accommodation types, suggesting the inappropriateness of this setting for some women with complex and multiple needs.

- Non-housing outcomes included the development or maintenance of other support networks, with over half (53%) of the women regularly accessing three or more services, including general practitioner, mental health or general counselling, drug and alcohol counselling, psychiatrist, drop in services, and family support services. Yet, over two thirds (68%) of women were reported as having difficulty accessing services required to meet their needs, such as financial and material aid, drug and alcohol withdrawal and rehabilitation, mental health services, and domestic violence services.

- Transition into public housing often resulted in loss of professional and other support networks unless the client was connected to non-accommodation specific support that was able to follow them across different accommodation types and regional boundaries. The constraints to providing ongoing support in permanent housing appears to be based on a system assumption that once housing crisis is resolved, clients are no longer in need of support to maintain their tenancy.

Service Experiences of Women

- The limited range of short-term safe accommodation options for women was a critical factor contributing to their instability, and services that prioritised safety were therefore considered to be more effective in providing support. Housing stability was also emphasised, with the women attributing being assisted into stable permanent housing as having a significant impact on their life.

- Based on their service experiences, the women identified consistent support and being treated with respect as the most helpful elements of the support process across all service settings. Consistent support was seen as maintaining professional relationships, following up and being proactive, and being able to access support when it is needed. Being treated with respect was defined as listening and "making time for me", being non-judgemental, and understanding their needs. Women particularly noted both helpful and unhelpful experiences within drug and alcohol and mental health services.

- Drug and alcohol rehabilitation programs were recognised as helpful; however this was often viewed as an opportunity to be temporarily housed. It was maintained that rehabilitation often focussed on drug and alcohol use but that at times did not prioritise other significant needs. The women recognised that their own level of readiness was one of the biggest contributing factors for successful outcomes in drug and alcohol treatment and that the timeliness of the response from the drug and alcohol treatment provider was considered crucial for successful outcomes. After successful treatment for drug and alcohol use, one critical component cited by the women for the maintenance of cessation was sufficient activity to keep them busy to "fill the space" of drugs.

- Within mental health, an allocated outreach mental health caseworker that also focused on housing assistance rather than referral to external services was considered important. This support was considered most useful when it was able to follow the women across different accommodation sites, with the consistency of this support emphasised. Not feeling judged, feeling respected and the opportunity for input into crisis plans and treatment was considered important features for successful mental health service provision. For women who were identified as dual diagnosis clients, the problem of fitting into one or other support system was identified as significant problem.

What Approaches are Effective?

- Case management responses that were consistent, transparent, long-term, flexible, based on maintaining relationships with the one support worker, non-judgemental and non-crisis driven were considered the most appropriate approaches to assisting clients with complex and multiple needs resolve their homelessness. Maintaining strong linkages with external service providers was also identified as an element of successful case management practice. Prioritising safety, assessing and promoting a women's readiness for change was considered vital.

- The literature identified the need for women specific service approaches, which are based on the use of a trauma informed framework given the high degree of abuse and trauma women with multiple needs have been exposed to. Multidisciplinary treatment teams such as assertive community treatment teams, Intensive case management teams, and working to enhance the women's readiness for change using pre treatment outreach approaches were considered effective. Service system integration is also of critical importance, wherein the case management approaches and systems that support the practice are integrated and change fragmented service provider relationships. Identifying women's role as mothers was also considered critical in delivering effective recovery programs.

Policy and Program Implications

The profile presented in the current research demonstrates the multitude of needs amongst the women, spanning across a broad age group of women experiencing homelessness. It is also evident that there are a multitude of service providers involved in assisting women through the service system, some with success and some failing to adequately meet their needs resulting in repeated homelessness cycles. The lack of genuine coordination across sectors and services appears to perpetuate their experience of homelessness.

The current design of crisis accommodation, transitional and social housing is not based on service consistency or a seamless pathway from one stage of support to next. While these services go some way in stabilising housing or containing homelessness, women's movement through this system was rarely linear and uncomplicated. The current system fails to provide the consistency that is required for women to regain independence and exit long term homelessness. Current approaches are therefore constrained in what can be achieved in promptly rehousing women and in some instances the focus on temporarily accommodating women serves to increase safety risks as many enter the referral merry go round without adequate follow up.

The constraints for housing services to work with women in a long term capacity that is underpinned by the development of intensive therapeutic relationships undermines the effectiveness of current case management approaches in achieving positive long-term outcomes and represents a false efficiency in the system. Part of this problem relates to the historical attachment of support to service sites or residencies and not individuals. So long as this approach remains, women will continue to cycle from one accommodation type to the next. The service system response must be conceptualised beyond the bounds of the Supported Accommodation Assistance Program and public housing segmented waiting lists if significant gains into reducing homelessness amongst women is to be achieved. Questions of where responsibility lies with respect to developing service responses does little to improve practice on the ground and outcomes for the women themselves. The reality is that housing is the primary need and it is therefore a logical point of engagement, however does not mean this is simply a housing problem alone.

Service responses for homelessness must be increasingly based on the recognition of the complexity of social disaffiliation experienced by women. Policies directed at reducing homelessness amongst women should focus on both the development of early intervention and the creation of social support structures that prevent tenancy breakdowns and the creation of permanent exits out of homelessness that provide a means for women to regain their independence. This requires a skilled and integrated support workforce that is recognised through adequate funding models derived from multiple program areas and responsibilities. Some gains at service integration have been achieved through current initiatives such as the Homelessness Drugs Dependency Trial, which has demonstrated the outcomes that can be derived by combing long-term drug and alcohol and housing support. Recent complex needs initiatives will also assist in facilitating shared responsibility across sectors, however the limited focus on 'exceptional' clients will not respond to the true extent of demand for consistent and intensive support for many of those experiencing homelessness. Greater recognition needs to be directed towards enabling all services to be more effective in working with women with complex and multiple needs experiencing homelessness.

Responding within a service philosophy framework that legitimises the role of past and current trauma in the lives of women experiencing homelessness should not be considered as an add-on, rather it should underpin the approach of all services that women are likely to access. The need for gender specific approaches across the spectrum of support is continually reiterated in the practice-based literature yet it continues to be a secondary consideration as cross target service responses continue to grow.

Specific domestic violence services provide one avenue for gender specific approaches, however many women in the current profile have been excluded from this system. The lack of current trauma informed programs, particularly within the housing, drug and alcohol and mental health systems contributes to inadequately meeting their needs. Service responses will fail to adequately assist in the recovery from homelessness if they continue to fragment women into "single issue problems".

Recommendations

The following recommendations are made based on the findings of the research. These recommendations are summarised under the key themes of service system responses, assessment, long-term case management, housing, prevention and early intervention, service capacity building and further research and evaluation.

1. Service System Responses

1.1 Fund and trial a female specific, inter-agency and multidisciplinary service response that is underpinned by trauma informed practice and provides direct access to safe permanent supported housing. The model should:

- focus on the development of networks and interagency partnerships to enable shared resources for case management, training and supervision and should offer up to three years engagement and support;
- be based on assertive community treatment and intensive case management approaches;
- link into existing programs that are targeting multiple needs clients including the Homelessness Drug Dependency Trial, Community Connections, the Departmental Multiple Needs Panel, and drop in food and material aid services;
- offer a continuum of age appropriate interventions that recognise different stages of readiness for change;
- be culturally sensitive to needs through a diverse staffing mix and culturally informed practice; and
- be managed by female staff

1.2 The staffing mix and funding base within the homeless service system should be diversified to enable the development of multi-disciplinary assertive community outreach teams. This includes provision of expertise within the service structure of major housing support services, including drug and alcohol, psychological, cultural appropriateness, and sexual and physical assault.

1.3 Mainstream and specialist services responding to women with multiple needs, particularly mental health and drug and alcohol treatment services should be delivered in a way that responds to the housing circumstances of women by incorporating housing stability within treatment plans and directly linking into the homeless service system.

1.4 Individual services should seek opportunities for working collaboratively, including resource sharing and protocols, to more effectively support clients 'in common'.

2. Assessment

2.1 Develop a co-ordinated system for the early identification of women with higher support needs to prevent inappropriate accommodation referrals resulting in repeated crisis accommodation use, fragmented case management responses, and to promote timely entry into specialist case management.

2.2 Develop an assessment process that is able to differentiate between different degrees of need, and what constitutes higher order needs, particularly identifying repeat service users across an established housing network, based on common assessment.

2.3 Ensure that current initiatives aimed at developing common assessment across the homeless service system are appropriate in identifying the specific concerns of women with multiple needs, particularly relating to experiences of abuse, parenting and cultural needs.

3. Long-term Case Management

3.1 Expand the service scope of current women specific intensive support services, enabling age appropriate responses across the life course.

3.2 Long-term case management teams be sufficiently resourced to enable support for minimum of three years to continue once women resettle into permanent housing that enables women to work towards goals of independence.

3.3 Recognise in funding models the importance of case management approaches that acknowledge variation in women's readiness for engagement in the process of change. This involves realistic goal setting within case plans based on individual circumstances and a lowered expectation that women have to demonstrate change in order to be assisted. Lack of readiness to change should not preclude women from intensive case management support. Rather the goal of case management should be reframed to maximise safety, service connection, and housing stability.

3.4 Acknowledge in the case management process that many women presenting alone to support services have children, either in their care, temporarily or permanently removed. Their role as mothers should be recognised in case management and treatment recovery plans. This includes ensuring that family service support provided to women is not automatically withdrawn if children are removed from their care.

3.5 Long-term case management needs to provide a more consistent approach to support that can 'follow' women across different accommodation types and geographies. Case management support should not be catchment specific or withdrawn if the client is required to leave their accommodation placement. Support should not be limited to the accommodation, rather based on a consistent relationship that 'follows' the client.

3.6 Intensive case management should include a focus on developing connections to mainstream activities and opportunities, including education, training, employment assistance, debt management, parenting skills, and have flexible funding available to purchase relevant packages to enhance independence.

4. Housing

4.1 Expand the stock of female specific crisis accommodation, particularly in outer suburban areas. Crisis accommodation facilities need to comprise a small number of single bed and self contained units. Longer stays may be required to resolve immediate crisis and develop a trusting professional relationship.

The particular needs of this client group in respect of their privacy are essential in developing accommodation options. Enforced sharing of communal facilities such as toilets and bathrooms can be problematic for many women with complex issues.

4.2 Expansion of safe, low density, affordable and permanent social housing stock to enable more direct exit into permanent housing where support networks can be established and maintained in an area of choice.

4.3 Increase capacity for services to resolve rental arrears that prevents women re entering independent housing.

4.4 Encourage the widespread use of Centrepay as a strategy to prevent tenancy breakdown.

5. Prevention and Early Intervention

5.1 The community must give much higher priority to the prevention of child abuse and family violence through the resourcing of effective strategies that reduce the risks in family settings.

5.2 Greater priority should also be placed on effective early intervention and support to those who experience childhood abuse and violence. This should include women leaving State care and young women leaving the family home prematurely. The current pathways into chronic homelessness, substance abuse and ill health must be prevented.

6. Service Capacity Building

6.1 Improve access to specialist training and supervision for service staff working with women, particularly relating to sexual assault, trauma, mental health, drug and alcohol abuse, cultural appropriateness and crisis intervention.

6.2 Services need to acknowledge the importance of support staff having specific understanding and expertise in responding to trauma resulting from abuse or violence.

6.3 There is a need for increased recognition within funding models of the growing complexity of needs amongst women experiencing homelessness. The retention of skilled and experienced practitioners within the homeless service system can best be encouraged through the provision of adequate remuneration that recognises the diversity of skills required.

7. Further Research and Evaluation

7.1 An evaluation component be incorporated into the planning stage of the development of a female specific service model to document learnings and outcomes relating to approaches to ameliorating homelessness amongst women with multiple needs.

7.2 Longitudinal outcomes research be funded within the homeless service system to determine program effectiveness over time, particularly relating to crisis accommodation outcomes, readiness for change and reasons associated with treatment resistance.

7.3 Research be undertaken to examine the cost effectiveness of different interventions for clients with complex and multiple needs.

1. Introduction

Within the context of increasing homelessness over the past decade, the homeless service system has been required to deal with growing complexity of need amongst those presenting for housing assistance and support (Bisset et al, 1999). The Supported Accommodation Assistance Program (SAAP), funded by the Commonwealth government and administered through State Office of Housing Departments is the government's main response to homelessness.

Both the National and Victorian Homelessness Strategies have identified significant limitations within current SAAP service models in being able to adequately support those who are homeless who also have complex and multiple needs (Commonwealth Advisory Committee on Homelessness, 2001; VHS Ministerial Advisory Committee, 2002). "Complex and multiple needs" typically refers to those experiencing homelessness who also present with a range of concurrent incapacitating issues including mental health issues, disabilities, drug dependency, prior abuse and trauma and poor living skills, which contribute to ongoing difficulties in maintaining independent and stable housing without sufficient support.

The current research project emerged out of the Women's Crisis and Emergency Accommodation Network whom identified a population of long-term repeat clients of SAAP and other health and welfare services with multiple needs that are unable to be adequately supported within the current service system. The proposed project was divided into two main phases: the first phase involving developmental background research and the second phase involving the development of a submission for a collaborative service model. A Participatory Action Research approach was adopted, which was underpinned by a flexible action and review cycle at all stages of the research process. The research has focused on engaging service providers and clients who were accessing services in the Southern Metropolitan Region of Melbourne, with some services having statewide coverage. The rationale for selecting this region was based on the location of number of women services in this area, particularly in the Inner South part of the region. A further reason for selecting this area was to develop a localised service provider reference group network building on from the original Women's Crisis Accommodation Network that had a stake in the research and would continue the momentum into the next service development phase.

This report documents the findings from the phase one developmental background research. The main question being investigated through the project was: ***In what ways can the service response for women experiencing homelessness with complex and multiple needs within the Southern Metropolitan Region be improved?*** The following provided a set of secondary research questions:

- What are the patterns of needs and capacities of women over 18 years accessing homelessness and other related support services within the Southern Metropolitan Region in Victoria who require complex and multiple service responses?
- What is the housing history and service system experience of women requiring complex and multiple service responses?
- What are effective crisis and transitional case management approaches to assist women requiring complex and multiple service responses to resolve their immediate homelessness?
- What are the most appropriate supported accommodation and housing options to enable increased participation in community life for women requiring complex and multiple service responses?

1.1 Complex and Multiple Needs: An Issue of Definition

Defining complex and multiple needs remains contested in the literature, partly reflecting the divergent views across disciplines or sectors as to what constitutes complexity and how in fact this should be measured. Current definitions circulating in the literature, particularly those emerging across service systems tend reflect current service and administrative eligibility criteria; documenting the way in which clients with complex needs do not fit into their current service systems models. Within this framework, consideration of complexity may range along a continuum from low support needs at one end to 'exceptional' support needs at the other end of the 'complex needs continuum'.

Whilst there appears to be some agreement amongst certain elements that are included in current definitions, a critical divide stills exists as to whether complex needs should focus on the clinical or diagnostic aspects that underpin complexity, the complex service system and environmental deficiencies or both. Although an old debate it is nevertheless a critical one as it is likely to determine whom and at what point in time an individual makes it into the "complex category" and therefore the type of assistance attached to their needs.

Recent projects commissioned by State and Commonwealth governments have extended the ongoing debate surrounding the definition. The Victorian Government's recent profiling study defined those with multiple and complex needs as:

- *Having multiple and complex presenting problems*
- *Having high and complex needs that are not met or sustained by existing services*
- *Having challenging behaviours that place the individual at high risk to self, service staff and/or the community.*
- *Chronic or episodic behaviours and/or conditions that require long-term service responses.*
- *Requiring a service response from two or more DHS programs (or criminal justice) areas.*
- *Having a specific need for which there is no current service system response, and/or require a current tailored funding package (usually at high cost).*

(Thomson Goodall Associates, 2002:1-2)

Building on previous work undertaken within the SAAP sector by Bisset et al in 1998, the Department of Family & Community Services commissioned a further project focusing on the development of an enhanced assessment and measurement framework to be applied within the homelessness service setting. After synthesising various definitions appearing in the literature and service systems, the working definition proposed in the initial discussion paper by Thomson & Goodall (2003:13) was as follows:

> *Individuals and families experiencing and at risk of homelessness, who needs require a high level and complexity of service provision, indicate a combination of the following, according to an agreed measurement framework:*
>
> - *Repeated contact with crisis service systems*
> - *A history of chronic, long-term homelessness, and unstable housing*
> - *Ongoing, unmet needs (inability to have basic needs met, and/or needs for which there is currently no adequate service system response)*
> - *Severe to extreme risk to self*

- *Severe to extreme risk to others*
- *Significant ongoing disadvantage associated with cultural contexts, marginalisation and/or isolation*
- *Significant exposure to violence, abuse and trauma*
- *A history of institutional (statutory) involvement (self, and/or whose developmental needs have been significantly disrupted/unmet.*

Both definitions appearing above represent a generic list of potential behaviours, risks, and past and current service systems engagement. Whilst useful to some degree in providing a common understanding of how individuals with complex needs may differ from others coming in contact with the service system, the definitions do not explain underpinning issues and are very difficult to operationalise in practice. While the assessment of complexity is often contingent upon the particular skills and service models within the sector, Gillissen (2003) argues that definitions must recognise

> *'...the level of clinical complexity of these clients, how compromised many of these individuals' functional abilities are, the need for a comprehensive understanding of why they are functioning as they are, and what that might mean in terms of support required.....I would suggest that simplest description of who these 'exceptional needs' people are, is simply that they are the 'treatment resistant service users' or the non-responders to more generic forms of intervention. Their difficulties have continued despite the deployment of interventions and services (Gillissen, M, 2003:4).*

Within the UK Homeless Link Multiple Needs project, a more straightforward definition primarily based on presenting issues or diagnosis is adopted. The key criteria used to identify clients with high and multiple needs are the presence of three or more of the following concerns:

- *Mental health problems*
- *Misuses various substances*
- *Personality disorder*
- *Offender behaviour*
- *Borderline learning difficulties*
- *Disability*
- *Physical Health Problems*
- *Challenging Behaviours*
- *Vulnerability because of age*

Within this definition it is maintained, "if one were to be resolved, the others would still give cause for concern" (Homeless Link, 2002: cover page).

Each of the above definitions goes some way in furthering current discourse surrounding the issue of multiple and complex needs. From the current debates, it appears logical that definitions of complexity will at some point in the assessment process need to take into account the client's clinical diagnosis, functionality and also the structure of the existing service system that is designed to respond to them.

Therefore, a central feature of definitions should be how well the client functions in the context of various clinical concerns and in turn how receptive the service system is to these needs. As Nash (2002:6) argues, assessment of complex needs should take into account the way in which particular issues or diagnosis affects an individual's capacity to live independently.

With this in mind there needs to be sufficient flexibility for definitional criteria to allow for the temporal or dynamic nature of presenting needs recognising that individuals can move up and down the "complex needs pyramid", and along the "continuum" depending on the nature of their supports and the impact of other life events. Further, while there may be some similarities amongst females and males, the antecedent causes, ways in which behaviours and abilities interact and the experience of the broader environmental and service context amongst females is markedly different from that of males. Definitions need to reflect the particular experiences of both females and males.

1.2 Women's Project Working Definition

The current working definition adopted for the project has drawn on what it considers to be the strengths of the definitions presented above. Women with complex and multiple needs experience a combination of the factors outlined under the three headings below. While these factors are listed separately, they are interactive and combined result in complex and multiple needs that require more than one agency response to resolve issues.

Abilities and Behaviours

Abilities and behaviours that are commonly reported to be associated with higher or more complex support needs amongst women presenting to homeless support services and which compromise ability to maintain ongoing independent accommodation include a combination of the following:

- Diagnosed or undiagnosed mental health disorder, illness or borderline intellectual disability that *compromises ability to function and meet basic day-to-day living tasks.*
- Intellectual disability that *compromises ability to function and meet basic day-to-day living tasks*
- Substance use that *compromises ability to function and meet basic day-to-day living tasks.*
- Gambling problem that *compromises ability to function and meet basic day-to-day living tasks.*
- Challenging behaviour.
- Pattern of and current risk taking behaviour which may endanger self, others or property including: self harming and suicidal behaviour; development of indiscriminate relationships; involvement in prostitution; perpetration of violence; and destruction of personal, others, and or service belongings, amenities and facilities.
- Lack of apparent independent living skills.

Underpinning Issues

Many of the underpinning issues for women with complex and multiple needs are entrenched, in that they are based in a history of experiences; including abuse and neglect, which combined or alone contribute to ongoing vulnerability, normalisation of chaos and difficulty in maintaining independent and stable housing without more intensive assistance. Some of these experiences include a combination of the following:

- Victim, survivor and or witness of incest and sexual assault
- Victim, survivor and or witness of physical and emotional abuse and violence
- Victim, survivor and or witness of torture or trauma in country of origin
- Disconnected from or loss of family, friends and or significant others; including Statutory clients (or children and young people growing up in out-of-home care)
- Have children currently in their care or temporarily or permanently removed from their care.
- Mental illness, acquired brain injury, physical and or borderline intellectual disability
- Chronic physical health condition
- Long-term unemployment and limited community participation
- Patterns of institutionalised living
- Language and cultural barriers
- Intergenerational poverty
- Legal issues, prior and current convictions
- Learning difficulties

Capacity of the Service System to Meet Needs

Individuals presenting to services with complex and multiple needs are often defined as such due to the constraints of single agency service models to provide the intensive engagement, expertise, and resources that are required to address all presenting issues. The multiplicity of needs means that resolution of one presenting issue alone will still see the existence of other concurrent issues impacting on the person's ability to maintain independent accommodation in the absence of ongoing support. In particular, women with complex and multiple needs that cannot be adequately supported within current accommodation service models may experience a combination of the following:

- Are unconnected to or unable to access mainstream and specialist services that are required to meet ongoing needs.
- Repeated homeless service use and breakdown of accommodation without resolution of crisis.
- Difficulty engaging with expectations of current case management processes.

2. Method

The research design was based on a triangulated methodology combining both quantitative and qualitative data sources. Principles of a Participatory Action Research approach were employed to ensure maximum relevance to intended stakeholders and ownership of the research findings. A smaller working group and larger inter agency reference group were established. The smaller working group comprised four representatives from Hanover (see acknowledgements page) whose role was to plan and reflect on an appropriate research design through out all cycles and to engage other stakeholders in the research process. The broader reference group comprising representatives from community health, accommodation and support services, local government and Southern regional DHS office (see acknowledgements page) provided ongoing critical reflection throughout the research cycles. Members of the reference group also assisted in the collection of client review forms as part of the interagency snapshot and in the recruitment of women who were interviewed.

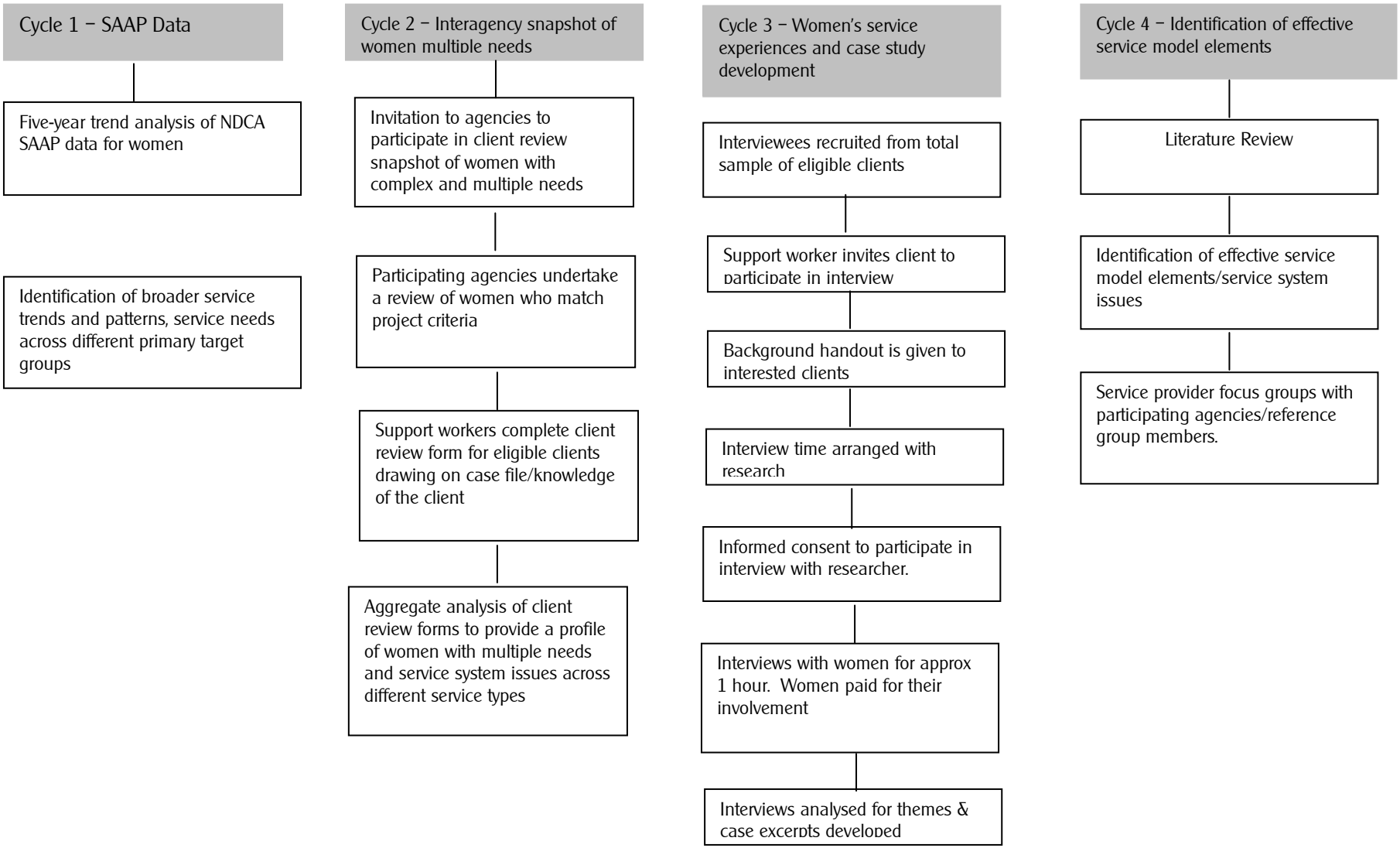
This developmental background research phase comprised four main cycles:

- longitudinal analysis of five years of Victorian SAAP data specifically relating to women. A separate report has been produced and is available from Hanover Welfare Services and Department of Family and Community Services SAAP information management website;
- completion of individual client review forms by participating agencies to provide an interagency snapshot of women with complex and multiple support needs;
- service experience interviews with women who were either experiencing homelessness or recently exiting homelessness into permanent accommodation; and
- identification of current service limitations and effective or promising practices to inform service model development, drawing on national and international literature and service provider focus groups.

A summary overview of the four cycles is presented in figure one. Each cycle will now be discussed in turn.

Figure 1. Project Method Flow Chart

Phase 1 Analysis of service needs and effective service responses



2.1 Analysis of Victorian SAAP Data

The Supported Accommodation Assistance Program (SAAP) National Data Collection Agency (NDCA) collection represents the largest national data source of homeless service use. Five years (1997-2002) of Confidentialised Unit Record Files (CURFS) were obtained from the National Data Collection Agency, Australian Institute of Health and Welfare. The analysis was predominately funded by a grant provided by the SAAP Co-ordination and Development Committee National Research Program.

The data was provided to Hanover in SPSS format. Agency participation rates and funding provided to SAAP agencies was also examined from the published reports covering the respective years provided in the CURFS. As the CURFS provide limited data relating to specific services needed and provided that correspond to question 22 on the SAAP collection form, a special request was made to NDCA to obtain a confidentialised version of the variables required that could not be linked to any other identifying variables. A descriptive analysis was undertaken focusing on the specific service patterns and trends for women accessing Victorian SAAP services over the five-year analysis period.

2.2 Interagency Client Review Snapshot

Invitation to Participate

Services participating in the reference group were invited to take part in the interagency snapshot by completing a client review form for women who met the working definition criteria (See Appendix 1). Once the client review form had been finalised, a package containing background on the research, completion guidelines, and the client review form was sent to services to present to their respective teams. Further feedback was sought from services at this stage on the questions and structure of the form. The questions in the form were trialled by the working group members and the layout and wording of the questions was further refined.

If services expressed an interest in participating in the snapshot following the invitation, ten client review packages were sent to each interested service. Services were not required to collect a set number of client review forms, rather what they could manage within the data collection period. As the client review form was quite detailed, participating agencies were provided with a payment of $20 per form in recognition of the additional time required to complete the forms.

The purpose of the snapshot was to gain more accurate insight into current service needs, housing circumstances, skills and capacities as well as approaches adopted in working with the women and the qualitative outcomes emerging as a result of the support process. This was not an enumeration exercise documenting complete case loads across each participating service, rather reflects the resources agencies were able to devote to completing the client review forms at the time. This will mean that there will be some inconsistencies across agencies and therefore the analysis should not be interpreted as an indicator for service demand by women with multiple needs within the particular services.

Client Review Forms

Client review forms were completed by support staff within participating services over a two-month data collection period, commencing 6th October, 2003 and forms returned to Hanover towards the end of December (see Table one for an overview of the number of forms completed by each participating service). All women included in the snapshot fulfilled the selection criteria according to the judgements of support staff completing the client review forms. The information obtained on each client was derived from case file information and the support staff's knowledge of their client.

As there was no identifying information on the client review form, such as name or identification code and the data was to be used for service planning, client consent was not obtained based on a similar method employed for the Victorian State Government Department of Human Services complex needs study (Bearing Point in conjunction with Department of Human Services, 2003: 6).

The review included both current clients and those who had exited the service within the defined two-month collection period. A total of 74 completed forms were returned to Hanover, which were coded and entered into SPSS for descriptive analysis. Amongst the 74 women in the snapshot, 13 (18%) had exited the participating service during the data collection period, and the remaining 61 were current clients.

Table 1. Completed client review forms by participating services

Participating Services Completing Client Review Forms	Service Delivery Type	Number of Completed Forms	% of Completed Forms
Sacred Heart Mission, Homefront	Women's supported crisis & transitional accommodation, outreach	2	5.4
Sacred Heart Mission, Women's House	Women's specific drop in support	2	
Flat Out	Women's post release support & outreach	2	2.7
WAYSS, Women's Outreach	Women's supported transitional accom and outreach	20	27.0
Verve, Salvation Army	Women's supported accom and outreach	1	1.3
Hanover, SECAS	Cross target supported crisis and transitional accommodation, outreach, D&A support	7	9.5
Hanover, Southbank	Cross target supported crisis and transitional accommodation, outreach, D&A support	15	20.3
Hanover Young Women's Intensive Support Service	Women's specific intensive outreach support	8	10.8
Hanover, Women's Service	Women's specific supported crisis and transitional accommodation, outreach	13	17.6
Hanover, Young Adults	Supported transitional accommodation, outreach	4	5.4
Total		**74**	**100.0**

Client Service Experience Interviews

In-depth semi-structured interviews were undertaken with women who were either currently experiencing or had recently moved into permanent housing, however were still accessing participating services for support (See Appendix 2 for interview schedule). As well as demographic and housing details, the interviews focused on the specific service experiences of women both within the participating services and other service providers they regularly accessed to determine what they had found helpful and unhelpful. A purposive sample of women was recruited across eight participating services. The services where women were recruited from, along with the number of interviews conducted within each service is shown in Table 2.

Women were initially recruited via their support worker who provided a brief overview of the purpose of the interviews to their clients who met the project working definition of complex and multiple needs. Support staff organized appointments for a Hanover researcher to interview the women or alternatively provided the women with the researcher's contact details, who they then made contact with to organize an interview at a time and place of their convenience. Prior to undertaking the interviews, women were provided with a background plain English statement explaining the project and their involvement, including the voluntary nature of their participation and confidentiality of their responses (See Appendix 3 for background statement). Once the researcher was satisfied that the women understood the nature of their involvement, an informed consent form was provided for signing by the women. Prior to commencing the interviews, women were asked if they felt comfortable for their interview to be taped. Eight interviews were taped and for the remaining 16 interviews extensive notes were taken, asking women to repeat points if they were missed in the note taking.

The duration of the interviews ranged from approximately 45 minutes to an hour and a half. Women were sent a typed interview transcript if they requested to see their interview. The interviews were copied and coded using a manual coding tree method and categorized into main themes in a word document. An identification code and age details were linked with each response within coded themes to enable responses to be traced back to the original interview transcript. Background demographic data was entered into SPSS.

Table 2: Recruitment sites for client service experience interviews

Interview Recruitment Sites	Service Delivery Type	Number of Interviews
Hanover Young Women's Intensive Support Service	Women's specific intensive outreach support	3
Hanover Young Adults	Supported transitional accommodation, outreach	2
Sacred Heart Mission Women's House	Women's specific drop in support	7
Hanover Women's Service	Women's specific supported crisis and transitional accommodation, outreach	1
Sacred Heart Mission, Homefront	Women's supported crisis & transitional accommodation, outreach	5
Good Shepherd Youth & Family Services	Counselling	2
Flat Out	Women's post prison release support	2
South East Crisis Accommodation Service	Crisis accommodation	2
Total Interviews		24

Identification of Service Gaps and Effective Practices

The identification of service gaps and effective practice was undertaken via a literature review, focus groups and some service practice questions on the interagency client review form. A literature search was undertaken via academic and specific issues libraries such as VICSERV, Australian Drug Foundation, Infoxchange and the Royal Melbourne Hospital. A Journal search was undertaken using a number of relevant databases including Proquest, Science Direct and Infoseek. An Internet search was also undertaken to identify relevant national and overseas literature.

Three service provider focus groups were undertaken, including one with Hanover Welfare Service Women's Service, Hanover Welfare Service South East Crisis Accommodation Service and the remaining one with members of the Reference group (See Appendix 4 for focus group questions). The focus groups were generally an hour and half.

Limitations of the Research

The findings of the current report should be based on consideration of the limitations of the research design. This study relies on the retrospective recall of service providers and women interviewed. Prospective longitudinal investigation would enable more in-depth investigation into women's transitions through the housing system. The sample of women included in the study was not obtained from a random sample, which therefore limits its generalisability. The current research design has attempted to overcome the afore mentioned limitations by drawing on a number of research methods or the use triangulation in order to provide more complete understanding of service needs and current practice issues.

3. Demographic and Housing Profile

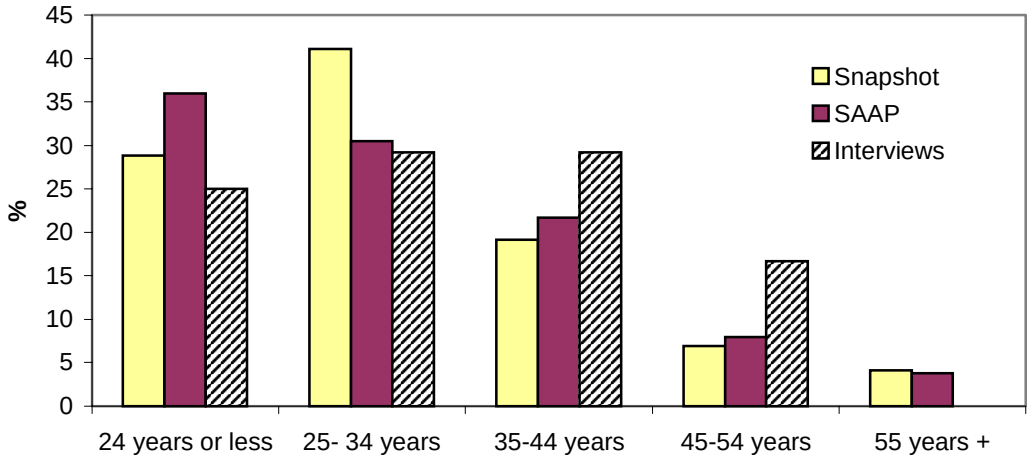
The following chapter provides an overview of the demographic and housing profile emerging from the interagency snapshot client review forms. Where relevant, data from the snapshot are compared to the broader female SAAP population. Where data are available for gender, the latest SAAP analysis period of 2002-03 will be referred to otherwise data from the stage one five year data analysis for women will be used. Case excerpts and relevant demographic and housing themes derived from the service experience interviews with women are also included in the profile.

3.1 Demographic Overview

3.1.1 Age

The age profile of the women in the snapshot was slightly older than the broader SAAP population, with a mean age of 32 years and median of 31 years compared to mean of 31 and median of 29 years respectively. The mean age of women in the service experience interview was 34 years and median of 33 years. Figure 2 provides a comparison of the main age groups in snapshot, interviews and broader female SAAP population. The largest proportion of women included in the snapshot were aged between 25-34 years (41.1%) followed by those aged 24 or less (29%). There were a higher proportion of women aged between 34-54 years included in the service experience interviews.

Figure 2: Age of women in the client review snapshot and interviews compared with broader Victorian female SAAP population, 2002-03



3.1.2 Presenting Family Type

Approximately three quarters (72%) of women in the snapshot were unaccompanied at the time of support. A further 23 percent were single with accompanying children and the remaining 5 percent were either a couple or other family group. The presenting family type differs from the Victorian SAAP 2001-02 population, with presenting females more likely to be evenly split between women alone (46%) and women with accompanying children (43%).

Whilst the majority of women in the snapshot presented alone, over half (51%) were reported to have children. Amongst those women with children, 29 percent had their children in their primary care at the time of support. A further 13% had older children. Of the women who had younger children, 34% were known to have had their children temporarily removed, while 18% had them permanently removed.

There were a total of 47 accompanying children amongst women presenting with children in their primary care. Over half of children (53%) were aged between 0-4 years, 30% aged between 5-11 years, and the remaining 17% were aged over twelve years.

3.1.3 Cultural Diversity

The cultural profile of the sample is relatively consistent with the broader SAAP population. The majority (81%) of women in the snapshot were born in Australia, with 5% from an Indigenous background. The main language spoken at home was English by 95% of women in the snapshot sample. Other first languages included Greek, Polish, Tagalog, and Tigrinya. No women were reported to require an interpreter. Apart from Australia, the main countries of birth were NZ (4%), followed by Philippines (3%). There were 11 different countries of birth amongst those from culturally and linguistically diverse backgrounds including Asia, Middle East, Africa, Europe and the US. The cultural identity of interviewees was predominately Anglo-Australian (87%), followed by Hungarian, New Zealander, and Koori for 4% respectively.

3.1.4 Main Source of Income

Compared to women in the general SAAP population (2001-02), a greater proportion of women in the snapshot received a disability support payment or had an exemption for medical incapacity. Specifically, over a third of snapshot clients (34%) were in receipt of disability support pension compared to 11% of the broader Victorian female SAAP population. The interview sample comprised a higher proportion of women in receipt of Disability Support Pension (62%) indicating very high needs amongst those interviewed and also possibly reflecting the slightly older age profile. A further 10% of snapshot clients were receiving a medical certificate exemption for incapacity compared to 1% of female SAAP population. A smaller proportion of the snapshot sample was receiving parenting payment (18%) compared to the female SAAP population 38%. This difference in income status illustrates that there is a large proportion amongst women with complex and multiple needs with either ongoing or temporary conditions that impact on their capacity to participate in labour market activity.

Table 3: Comparison of main source of income for client review snapshot sample and broader Victorian female SAAP population 2001-02 %

Main income	Interviewees	Snapshot Clients	SAAP 2001-02 Support periods
	%	%	%
No income	0	2.8	9.8
Newstart/Youth Allowance	20.9	30.1	27.5
Parenting Payment	8.3	17.8	38.7
Disability Support Pension	62.5	34.2	10.8
Medical Incapacity	8.3	9.6	0.9
Other benefit/pension	0	4.1	6
Other income	0	1.4	6.3
Total	**N=24**	**N=73**	**N= 23,600**
	100	***100.0***	***100.0***

1. Missing values client snapshot -1

3.2 Housing Profile

The housing status of clients prior to seeking accommodation assistance can often be an indicator of the degree of exclusion they have experienced, with those living in independent housing immediately prior to support more likely to be experiencing recent housing crisis and less likely to have experienced multiple accommodation service use. In comparing the housing status of women in the snapshot to women in the broader Victorian SAAP population some important differences emerge.

Table 4 presents the type of accommodation immediately prior to accessing accommodation support for both women in the snapshot and the broader female SAAP population. Women's interview responses have not been included in the Table as not all women were recruited from accommodation specific services. As illustrated, prior to seeking support 38% of women in the Victorian SAAP population were living in independent housing compared to 19% of women in the snapshot. Amongst those living in independent housing, no women in the snapshot sample were living in housing that they were either purchasing or owned outright.

A higher proportion of women in the snapshot were experiencing 'literal' or primary homelessness compared to women in broader SAAP population at the time of seeking support, with 11% and 4% respectively. Further, 41% of snapshot clients were experiencing either secondary or tertiary homelessness prior to service contact compared to 21% of broader female SAAP support periods. This suggests that women with complex and multiple needs as defined in the current study are more likely to have experienced extended periods of homelessness moving from one tenuous housing circumstance to the next. The qualitative housing history profiles provided in the client review forms and service experience interviews supports this assertion and will be further explored in the following section on housing pathways.

Table 4: Type of accommodation prior service contact client review snapshot and SAAP comparison

	Snapshot		SAAP 2001-02 Support Periods
	Number	%	%
Primary Homeless			
Sleeping out/car/tent/park/street/ squat	8	11	4.2
Secondary Homeless			
SAAP and non-SAAP crisis and medium emergency accommodation	22	30.1	18.2
Tertiary Homeless			
Boarding at rooming house/hostel/hotel	8	11	3.2
Marginal Housing			
Renting – caravan park	1	1.4	3.5
Boarding in private home		0	15.9
Independent Housing			
Renting - public housing	5	6.8	9.3
Renting – private rental	9	12.3	20.5
Renting – community housing			1
Purchasing or own home			7.4
Other			
Living rent free	16	21.9	14.9
Institutional setting	4	5.5	1.9
Total	**73** 74	**100.0**	**100**

1. Missing value client snapshot - 1

The current housing profile of interviewees at the time of interviews is shown in Table 5. As illustrated the largest proportion of interviewees were residing in transitional housing (38%) followed by public housing (29%). The interviews particularly focused on recruiting women who had moved onto more stable housing arrangements, however were still being supported by participating agencies. This was based on two premises, first being that they were likely to have insight into a range of service experiences and second that they were more likely to be in a 'personal space' where they were able to share their experiences with some reflection.

Table 5: Current housing status of clients interviewed

Type of housing	Number	%
Transitional Housing	9	37.5
Public Housing	7	29.2
Crisis accommodation	3	12.5
Rooming house	2	8.4
Street	1	4.2
Institutional	1	4.2
At risk in own home	1	4.2
Total	24	100.0

3.2.1 Homelessness Cycles

For the majority of women included in the snapshot, the current period of support was not their first encounter within the homeless service system. Amongst the women interviewed, three women reported that this was their first experience of homelessness, however examination of recent and past accommodation history revealed that they had utilised other crisis accommodation services prior to the current service they were recruited from. While the pathways into homelessness are many and varied amongst the women in the snapshot and those interviewed, the majority share a similar experience of recurring homelessness characterised by the use of various types of temporary accommodation options.

It is generally recognised that there is no single cause of homelessness. Typically homelessness amongst women arises from the interaction of both personal experiences of trauma and the reproducing structures related to the feminisation of poverty and inequality, and the dynamics between housing and labour market systems (Doherty, 2001; Edgar, 2001). The current research has not attempted to undertake an in-depth analysis of the broader structural forces at play, rather to identify what is known about the individual housing cycles and the trigger events that have influenced the housing stability of those seeking assistance.

Casey (2002), in describing women's pathways into and out of homelessness distinguishes between three groups of experiences; those whose homelessness is situational, long-term, and chronic. Using these groupings, the cyclical nature of homelessness can be demonstrated. Those in situational homelessness experience "single or short term crisis" (Casey, 2002: 5) but are able to find accommodation, while the long-term homeless experience a series of events that may lead them into years of homelessness. Those who are chronically homeless may "has never had a home, their childhood spent in multiple placements, whilst in the care of the state leading onto a lifetime of adult homelessness" (Casey, 2002: 5).

Trigger Events

The homelessness cycle for women is often triggered by a distinct range of events that are "associated with the dependent position of women within male dominated nuclear household" (Edgar & Doherty, 2001:4). The changing social structure that has seen an increase in single parent families has exacerbated the vulnerability of some women to these triggers, increasing their risk of homelessness.

There were some common pathways and experiences across the service system amongst the snapshot sample of women emerging from the housing history profiles provided by support workers and service experience interviews conducted with women. The main trigger events precipitating a loss of stable housing are listed below. Many women experienced a combination of trigger events and some have experienced close to all them through out their homelessness cycles.

- Sexual Assault
- Substance misuse
- Deterioration in mental health functioning/Acquired Brain Injury
- Financial hardship
- Rent arrears in private rental market
- Rent arrears in public housing
- Sale of property of residence
- Incarceration of themself or partner
- Conflict with neighbours
- Domestic violence
- Family conflict
- Death of family member
- Refugee/Immigration

While the above trigger events point to some of the underlying factors influencing instability they do not fully help to illustrate what is happening at the interface of housing and support systems. The following discussion of housing cycles focuses on the various entry and exit points into different types of housing crisis as a way of highlighting the cycling that occurs for this client group.

As the majority of women within the snapshot and interviews have generally experienced repeated homelessness, housing cycles are a useful way of conceptualising this interaction. This approach exemplifies the journey experienced by the women once their housing becomes unstable and the extreme difficulties in regaining their independence in an increasingly competitive and polarised social system. While not all women interviewed or within the snapshot had transitioned through all cycles, many of the women with complex and multiple needs have experienced all of these cycles throughout their homelessness career.

Early Home Leaving

A frequent pattern amongst the women in the snapshot and interviews was early home leaving, with the experience of homelessness beginning a very young age. For some young women their homelessness career is relatively short, moving from only a few different types of accommodation before securing longer term transitional accommodation. For others their break from dependent family occurred when they were a child and had been removed from home into the State care system. Early home leaving generally occurred as a result of family conflict, sexual and physical abuse, substance misuse, death of parent, or being removed from their parents' care and exiting State care system.

Those who left home prematurely as an adolescent tended to move into temporary accommodation often with a partner at the time, or staying with extended family members or friends. Some may have experienced brief episodes within shared rental accommodation or renting, however many were reported as not having their details on a lease that would secure their housing. Whilst this was the most common pathway there were those who moved from their main home directly into a primary homelessness situation where they may have been detected by police or outreach services. This was most common amongst young women from the out of home care system or those with limited support networks.

The common thread amongst those who left home prematurely was a repeated breakdown in all forms of accommodation. Frequently, the temporary accommodation in which they resided was particularly unsafe. Their accommodation needs were not resolved during the initial breaks from permanent housing and they did not appear to access transitional housing in the early stages unless directly linked in through crisis accommodation services. As most young women were likely to use informal networks and have limited understanding of the availability of ongoing support options, a number of years typically passed before being appropriately engaged. Readiness to confront underpinning issues and peer networks was also a barrier to engaging in longer-term support with accounts from women's interviews and by support workers about not being 'ready' to deal with what was going on at the time. Also many young women talked about the difficulties and conflict they experienced whilst sharing supported accommodation with others.

A prevalent theme for those leaving home early amongst this sample group was substance misuse, sex work and exploitative relationships with males that have left them extremely vulnerable to further harm and instability. Many early home leavers, if not using substances problematically prior to leaving home, had come into contact with illicit substances through a relationship or other associates leading to further housing instability. Amongst those early home leavers heavily involved in drug culture many became involved in sex working. Most of those leaving home prematurely, whom were reported to have misused substances, also had episodes of detox and drug rehabilitation.

The following excerpts from snapshot client reviews forms and interviews in Boxes 1, 2 and 3 demonstrate these themes....

Box 1. Excerpt from housing profile provided by support staff...

Cate has a long history of homelessness. Cate moved out of family home due to family violence, sexual assault and drug usage by family members at the age of sixteen, moving many times during the next few years, residing with friends where possible. Cate was in a domestic violence relationship for 6.5 years and was evicted from private rental in November 2002. From this point, she accessed several crisis accommodation services and slept rough for approximately one month. Cate found some of this accommodation unsuitable due to feeling unsafe. Cate was housed in a THM on the 1st of May 2003 and was evicted in October 2003, due to domestic violence causing neighbour complaints. Following this she accessed several emergency/crisis accommodation services and is currently residing in a rooming house. The main issues around her homelessness are: domestic violence; substance usage issues; family breakdown and abuse; financial management [*Age 23, Rooming House*].

Note fictitious names have been given to the women to personalise the extracts and protect their identity

Box 2. Excerpt from client service experience interview....

My current accommodation - it's not a rooming house; I don't think it's transitional, or, you could call it that. It's in a private house, which I got through [the service]. I've been in that accommodation for about 6 months. I have moved twice in 12 months. I was homeless living in squats before that for about a month or two when I found out I was pregnant. Before living in squats I was in and out of rooming houses. And prior to that I was at [crisis accommodation service] I got kicked out of [the service] when I was a naughty girl. I've never lived in private rental housing; I was homeless when I was 13 so it's been pretty bad. When I left home I went to a RCU in [regional town] when I was 13, and that led me on to two transitional places. From 13 to now I have lived in a few squats, boarding houses, crisis accommodation and transitional and that's basically why I don't have my son, it's been too transient [Age 20, Transitional Housing].

Box 3. Excerpt from housing profile provided by support staff.....

Julie has been in and out of crisis accommodation services for some years. She has had a history of sexual and emotional abuse while in the care of her family and has lived a transient lifestyle since leaving home in her adolescent years. This has been apart from instances when living with a partner in private rentals. Julie also has strong links with psychiatric services on top of chronic drug and alcohol abuse. A combination of domestic violence, drug abuse, psychiatric issues have all contributed to her current state of homelessness, abuse and self neglect [*Age 31, Crisis Accommodation].*

Independent Housing

Independent housing refers to housing that generally has security of tenure and includes public housing, private rental and also purchaser or home owner. Whilst some of those who have left home early have not had any experience in independent housing, the majority of women have had some experience of their own housing or sharing with others in an ongoing way. Independent housing typically broke down as a result of financial difficulty leading to rent arrears, property being sold and unable to re enter the private market, violence and conflict with either their spouse, other tenants or neighbours, substance misuse, hospitalisation, incarceration, poor mental health functioning or any combination of the above. There were some women living in independent housing contributing to rent and household expenses however did not have their name on a lease and therefore no legal security.

Some women within the snapshot had recently moved out of independent housing in the past year or two and have generally maintained their housing up until this point, with the current experience of homelessness being their first episode. Another group have been excluded from independent housing for many years, residing in other forms of marginal housing such as boarding houses. The majority of women however, have had short bursts in and out of independent housing characterised by frequent moving. Most women accessed friends, family or crisis accommodation as a starting point. Many had experiences of 'sleeping rough'. Some were fortunate to secure a transitional property during the early stages of their housing crisis while others spent a considerable amount of time (up to 16 years) in temporary accommodation, squatting and 'sleeping rough'.

Difficulty in regaining access to independent housing once it was lost was reoccurring pattern amongst the women. Once housing had been lost women rarely re entered straight away. Financial difficulties in raising money for bond and rent in advance and loss of possessions often precluded women from re entering housing. The existence of rental arrears and office of housing debts may preclude some from re entry into private rental market and even public housing. Women who were able to be linked into transitional accommodation were most likely to re enter independent housing via a segment application, which prioritises entry to public housing on the basis of their homelessness. Very few women return to the private rental market as the first exit out of homelessness. While public housing provides a more affordable avenue into independent housing, the risk of losing the property is high unless adequate support networks are in place to ensure that the tenancy can be sustained as indicated by the following statistics from women in the snapshot:

- Over a third of women in the snapshot (35%) have previously lived in public housing before their current period of homelessness.

- At the time of support, 23% of women in the snapshot had previous public housing rent arrears that may prevent them re entering public housing. For 9.5% of women public housing rental arrears history was unknown.

- At the time the client review forms were completed, 51% of women in the snapshot had a segment one application in place.

The following excerpts from snapshot client reviews forms and interviews in Boxes 4, 5 and 6 demonstrate these themes....

Box 4. Excerpt from housing profile provided by support staff.....

Trish was in private rental from 1995-2000. During that time she was frequently assisted financially by her church to sustain this. The pastor referred Trish to the [the service] in early 2000. She moved into a THM in [the country] in March 2000. In early 2002 she was transferred to another THM because of fears for her safety. An early housing (Seg 3) was approved in 2000 however due to an exemption location because of physical and mental health issues she is still quite some time away from being made an offer [*Age 53, Transitional Housing].*

Box 5. Excerpt from client service experience interview...

I'm currently staying onsite at [the service]. Before that I was living in [another State] with my girlfriend in private rental. I left a conflict situation with my partner - pretty violent. If I didn't get out I think I would be dead – she just went psycho. I wasn't on the lease so basically I was the one who had to go. I have mainly been living in the private rental market before this. It is a new experience being in Melbourne. I have not been homeless before. My friend brought me a ticket to Melbourne to get out – had no choice really. I didn't have anywhere to stay in Melbourne and domestic violence services couldn't help because I had already fled the state – dv services said to go to [service]. I stayed with [a Crisis Accommodation Service] and then got a place at [at this service] – it been six weeks [*Age 36, Crisis Accommodation].*

Box 6. Excerpt from housing profile provided by support staff.....

Emma came into contact with our service after being involved with a HIR service. She was staying with various different 'friends'. Prior to this she was in private rental on her own. Emma left her family home at age 18, lived in public housing, received an inheritance payout and purchased her own home/apartment. After legal/criminal charges this home was sold and she lived with her sister's family and was often asked to leave, so would stay with friends, eventually being able to secure her own private rental. This broke down at the end of 2003 and since being supported by the service, she has stayed in 3 crisis accommodation services, lived with friends, and then secured a transitional property [*Age 24, Crisis Accommodation].*

Crisis and Transitional Accommodation

The most common experience amongst women in the snapshot and service experience interviews was cycling around different crisis accommodation services, indicating that housing circumstances were rarely resolved upon first service contact. Repeat service use is often one indicator of ongoing housing difficulty. Amongst accommodation services completing client review forms, 38.3% of women from the total sample had some prior contact with the same service apart from the current support period.

Crisis accommodation services participating in the snapshot were more likely to report repeat service usage. In particular, from the total number of 15 responses from Hanover Southbank, two thirds (10 clients) had previously been to the service. From the 20 responses from WAYSS (predominately transitional) just over a third (7 clients) were repeat clients. From Hanover Women's Service – under a third were repeat clients (4). Amongst clients who had some previous contact with the service, 39% had between 2-3 support periods and 11% had four or more support periods in the past 12 months. Approximately a quarter of clients (23%) who had some previous engagement with the participating services had contacted the service over a year ago, indicating long-term housing difficulties. A further 27% had moved into a different support period from crisis to transitional accommodation or long-term support.

Whilst repeat service usage within the same service is one indicator of unresolved housing crisis, it is likely to greatly underestimate the extent of cycling that occurs across different types of crisis accommodation and also transitional accommodation amongst the women. The service experience interviews particularly reinforced this trend, with women describing using various types of crisis accommodation including subsidised hostel/motel stays. Some women also described having up to three different transitional properties before securing public housing.

Early exiting from either crisis or transitional housing was a further theme emerging. For some women their accommodation ended abruptly as result of conflict with other residents or staff or fears for their safety either from those also residing in accommodation or an ex partner. Women experiencing domestic violence combined with substance misuse who were unable to access women's refuge accommodation were particularly vulnerable to their transitional housing breaking down. Some women who were participating in sex work also experienced difficulty maintaining crisis accommodation due to incompatible hours of their work and service curfews. The following excerpts from snapshot client reviews forms and interviews in Boxes 7, 8 and 9 demonstrate these themes:

Box 7. Excerpt from housing profile provided by support staff.....

Prior to moving into transitional housing, Mary had not accessed private rental. She had found it extremely difficult to live within a group context, having been asked to leave both residential drug rehabilitation and crisis accommodation services on multiple occasions. Her complex dual diagnosis issues have resulted in extended periods of transience. According to Mary, she was 'on the streets' from 18-22. On entry into [the program]', Mary was residing at a rooming house. She first became homeless at 18, when her parents moved from Sydney to Melbourne [*Age 26, Transitional Housing].*

Box 8. Excerpt from housing profile provided by support staff.....

Sarah has a long history of domestic violence and for the last 7 years she moved in and out of her partner's house due to domestic violence. She lived temporarily with friends and family members in overcrowded conditions and then lived temporarily in a THM until she obtained public housing. Subsequently her housing broke down as a result of conflict with neighbours and she is currently residing transitional housing once again and is awaiting a priority transfer for the Office of Housing [*Age 31, Transitional Housing].*

Box 9. Excerpt from housing profile provided by support staff.....

Anna has been extremely transient and has been evicted from numerous hotels/boarding houses and emergency accommodation services. She is currently banned from refuge referrals. Anna contacted [the service] in 1999 and is now engaged in [the program]. Anna first came to service due to domestic violence concerns and has continued to experience domestic violence throughout contact with [the service]. During contact with [the service] Anna has been in transitional housing, supported accommodation, D&A rehab, detox and other forms of accommodation. Anna has been evicted due to rental arrears and for substance abuse related behaviour [*Age 34, Transitional Housing].*

Rooming Houses, Motels, Squats and 'Sleeping Rough'

Amongst the women who have accessed boarding or rooming houses, two groups emerged; those who accessed as a temporary arrangement and those who reside there for extended periods of time. Women accessing on a short-term basis appeared to do so in the midst of crisis and chaos resulting from trauma and substance abuse. Those who had resided for longer periods were more likely to have ongoing mental illness including bipolar disorder, ABI and have not been able to secure any other form of accommodation due to affordability and alienation from the private rental market. Amongst the women interviewed who reported experiences of staying in rooming houses, they generally considered them to be unsafe and isolating. While rooming houses were not the accommodation 'of choice', there was a perception that they at least offered some sense of security compared to sharing in the private rental market, perhaps providing a sense of autonomy that the women have not been able to obtain in other living arrangements. Some of these themes are reflected in the following excerpt in Box 10.

Box 10. Excerpt from client service experience interview...

I'm in an all women's rooming house at the moment, but it's very isolating. The women sleep all day and there's some mentally ill women in there so it's not a great environment, its very isolating..... a women moved in and upset the whole environment and everyone went quite crazy. I find it hard to have a home life in a rooming house, and a relationship in a rooming house is hard. [What's the main reason why you've been living in a rooming house?] Poverty, poverty from not working and I've had mental health issues. I've tried [accessing private rental] when I was living at [Crisis Accommodation Service] I tried to get into a shared house but people didn't accept me because I didn't have a job and I couldn't get into a shared house, and because of my upsets in my accommodation I quit my job so I didn't have the job to get into the shared housing. And it's hard to leave a rooming house once you've got used to it. Its secure, you can't be thrown out, and with shared housing there's not a lot of security. And the rents very high these days, years ago the rent was cheaper. It's very high. It's very hard for women not working to get shared housing. A lot of the people in rooming houses don't have furniture for a shared house. They don't have facilities to move all the furniture around all the time [*Age 37, Rooming House].*

As part of the housing cycle many women in the snapshot, particularly those with problematic substance use have experienced periods of living on the street or substandard and unsafe accommodation without any regular form of support. Often the only contact during this cycle may be with an outreach worker, drop in service, or police. Women involved in sex work were particularly likely to be subjected to such living arrangements due to lack of other safe alternatives at the time and difficulty 'fitting in' with existing crisis accommodation models. Another group of women 'slept rough' because they were unaware of accommodation services that they could access at the immediate point of crisis.

Box 11, Excerpt from client service experience interview....

I'm currently living in transitional housing. I have been living in transitional housing property for past 11 months and this is the 2nd time I've moved in the past 12 months. Before that was staying at [Crisis Accommodation Service]. I was brought to [Crisis Accommodation Service] by the police – I was sleeping in the toilet block when I got kicked out by my aunty – we had an argument. I had to get out of the toilets before the cleaners came. This is my first time being homeless. My parents are in [Another country]. I came to Australia to work - I was looking after the kids whilst my aunty was working [*Age 22, Transitional Housing].*

Box 12. Excerpt from client service experience interview...

I'm staying in transitional housing – been there since October, about two months. I have been moving around heaps in the past 12 months. I have mainly been living in my car. I was living in my car for four months, friends back and forth. I have been moving around for 2 years mainly staying with friends' houses. I had to move out of my friends place because there were too many drugs and ended up in my car. I was last living in stable accommodation about two years ago in a ministry of housing property. I came to [the service] because I was six months pregnant and sleeping in a car. I can't afford private rental. Private rental is too expensive, but it is also expensive living in your car because you have to have take away and also keep moving all the time so you use lots of petrol. I built up rent arrears in public housing – owed money to them and therefore couldn't get bond assistance [*Age 30, Transitional Housing].*

Post Prison Release, Rehabilitation or Institutionalisation

Continuing or entering the homelessness cycle following a period of hospitalisation, incarceration, or detox and rehabilitation was a common experience amongst women with multiple needs in the snapshot sample and interviews. Some women entered treatment or prison without pre existing accommodation while others directly lost their accommodation as a result as they were unable to maintain it, or in the case of public housing and incarceration were no longer eligible. Whilst some women reported being linked in housing or crisis accommodation at the point of release, others have had to find their own way into the supported accommodation system or other temporary forms of accommodation, with the cycle beginning once again.

- 41% of women had been previously hospitalised within a psychiatric institution (a further 20.3% of cases were unknown).
- 18 % of women required support for a psychotic episode whilst accessing participating services.

For many women, housing instability was associated with periods of low functioning or sudden deterioration in mental health marked by occurrences of family conflict, domestic violence and or relationship difficulties, and drug use. Fluctuating mental health status made it increasingly difficult to maintain accommodation. Some women experiencing poor mental health were reported to experience difficulty living with others in a crisis and transitional housing setting, which was characterised by conflict with staff, residents or neighbours; however at the same time were unable cope when isolated from others.

Box 13. Excerpt from housing profile provided by support staff.....

Melissa had to leave the family home because she threatened her mother in 2001. Since then she has been extremely transient with multiple hospital admissions for self harm and suicide ideation. During this period she has also stayed in numerous crisis accommodation services. Also staying on friends couches and sleeping rough. She also moved to [Country] to live with sister for 3 – 4 months. Melissa became unwell again and decided to move back to Melbourne to be close to supports and family. While she does stay at mum's house when accommodation breaks down, this usually causes conflict [*Age 19, Psychosocial Rehabilitation].*

Box 14. Excerpt from housing profile provided by support staff.....

Carina was born and raised in South Africa and moved to Australia with her two children and husband in 1970s. Carina's husband passed away in the 80s. Carina remarried in 2001, however experienced emotional abuse and one significant episode of physical abuse whilst on honeymoon. She terminated the relationship in late 2001. Following this she became depressed and suicidal and was hospitalised following an attempted overdose. Carina was always financially secure, however due to marriage breakdown she became financially insecure. Her family could not cope with her emotional state and she entered into [the Service] from hospital [*Age 63, Transitional Housing].*

- 54% of women in the snapshot were known to have accessed substance treatment in past 12 months.

Some women entered into substance treatment from independent housing and became homeless when they left treatment, while others entered treatment whilst experiencing homelessness and returned to homelessness upon exiting treatment. For some of those experiencing homelessness at the time of accessing substance treatment, entry into detox and rehabilitation was considered a place to rest and be safe for a while. Women in the service experience interviews talked about reusing once they left or not being ready at the time to stop using however they considered that there was no other alternative for them at the time. Some women, particularly older women in the sample had repeated this cycle a number of times, accessing a range of substance treatment services when in need of respite from their experience of homelessness.

Box 15. Excerpt from client service experience interview...

I had nowhere to go once I exited rehab. I was homeless. I had no family support, no furniture, had nothing at that point. I was living in private rental and then went into rehab. The only place at the time was [Service]. I had tried a number of services. I have moved eight times in the past 12 months – during this period I have been living in 2 private rentals, family member, 2 D&A Rehabs, 2 Women's Shelters, and transitional housing. Before that I was mainly staying in private rental [*Age 35, Transitional Housing]*.

Box 16. Excerpt from client service experience interview...

Before the transitional housing I have been homeless for 16 years – I never stayed in one place for longer than one month. I didn't know [the Service] existed. I got out of rehab and was hit by a car and the Salvos suggested [the Service] to me. I have always managed on my own without the ongoing support of services - only knew of the Salvos and services like that, which I used to use for food. I have mainly lived in a lot of squats over these years. I had some time in jail, was at Mum's friend place for a while. I have also been in and out of detox over the years. I was in drug and alcohol rehab during 2001 two times. I was last living in secure housing in 1983 – which was a ministry of housing flat [*Age 44, Transitional Housing]*.

- 10% of women within the snapshot were known to require support with post prison issues.
- 19% of women within the snapshot have been previously been incarcerated.

Women exiting prison were particularly vulnerable to re entering the homelessness cycle if not properly linked into post release support prior to their release. Women in the snapshot and interviewees who had been incarcerated generally had limited family and support networks from which to draw on upon release. Once entering prison, even for short periods those living in public housing at the time lost their property. Upon release they entered into the homelessness support system, eventually gaining access to another public housing property and generally relocating into an area that they have not resided in before.

The interview excerpt in Box 17 illustrates the extreme transience prior to and following a period of incarceration for one women, and the implications of not being able to access accommodation support prior to release.

Box 17. Excerpt from client service experience interview...

I have now been housed in this house for 5 months. It's the first public housing I've had since exiting jail. Before jail I was not eligible for any segments or priorities and was just on the normal waiting list. I was in caravan parks, done private rental till the arrears caught up and the tenancy tribunal and you get kicked out etc and then you change your name and get another private rental place and same thing again and then you get something cheaper, caravan parks and stuff. In the past four years I have changed addresses 32 times. I had to get that documentation for my segment for priority housing. I had to go to Centrelink and ask how many times - 32 times, that is extraordinary.

Jail was my main uprooting. I did four and a half months and once exiting jail I didn't feel I had the requirements to get along in life, I didn't know how to pay bills, my lifeline was gone I just didn't think I was capable of doing anything. I didn't want to go back to crime, I didn't want to go back to drug abuse, and I didn't want to go back to any experimentation which was what it was previously. My daughter had grown having been without me for 5 months. But a lot of the services are just stretched to the limit. I was ringing every day. A lot of the services would say call back on a daily basis to try to fit you in because they knew I was a family desperately in need. But the best they could help me with was subsidising the accommodation though motels, hostels etc. That was all they could do. Every day I rang and rang and it took three months for me to get through to [the Service], and by this time I was dependent on drugs again. So I linked into [drug treatment through the Service], they referred me, and got clean again and I still keep contact with both of those services [*Age 32, Public Housing*].

3.3 Chapter Summary

This chapter focused on the demographic and housing characteristics of women in the interagency snapshot and service experience interviews. The mean age of women in the snapshot was 32 years, while the mean age of women in the service experience interview was 34 years. While the majority of women present alone, many of the women were mothers who did not have their children in their care. Disability Support Pension was the main source of income for the women, illustrating that there is a large proportion amongst women with multiple and complex needs with either ongoing or temporary conditions that impact on their capacity to participate in labour market activity.

There were common trigger events precipitating a loss of stable housing, usually interacting with one another. Many of the women experienced extended periods of recurring homelessness, cycling from one tenuous or temporary housing circumstance to the next, indicating that their housing circumstances were rarely resolved upon first service contact. Their interactions with the housing system appeared to contribute to ongoing instability.

4. Service Needs Profile

4.1 Summary of Overview

Findings contained within the following chapter are derived from the snapshot client review forms. In accordance with the project working definition, women included in the snapshot were selected on the basis of presenting with *two* behaviours and abilities and *one* service system issue appearing in Table 6 below. This chapter commences with a summary overview of the results from the above selection process, followed by a more detailed discussion of the main needs reported and co-occurring patterns.

As illustrated in Table 6, amongst women in the snapshot over three quarters (77%) presented with a diagnosed or an undiagnosed mental health disorder impacting on their capacity to live independently. A further two thirds of women had a substance use problem impacting upon their capacity to live independently (68.9%). Over two thirds of women (68.9%) engaged in risk taking behaviour that endangered them. More than half of the women (55%) presented with behaviour that was considered 'challenging' within the current service context.

In terms of service system needs appearing as part of the selection process, repeated homeless service use was identified for over three quarters of the women in the snapshot (77%), followed by difficulties living within rules and boundaries (65%). Half of the women (50%) were reported to have experienced difficulties with current case management practices. Difficulty accessing mainstream or specialist services was reported for just over two fifths of women.

Table 6: Abilities, behaviours and service system needs according to multiple needs project selection criteria

Abilities and Behaviours	*Number*	*%*
Diagnosed or undiagnosed mental health disorder	57	77.0
Intellectual disability	6	8.1
Substance use	51	68.9
Gambling problem	2	2.7
Challenging behaviour	41	55.4
Risk taking behaviour endangering self	51	68.9
Risk taking behaviour endangering others	12	16.2
Lack of apparent independent living skills	29	39.2
Service System Needs		
Difficulty accessing mainstream services	30	40.5
Difficulty accessing specialist services	32	43.2
Repeated homeless service use	57	77.0
Difficulty with case management process	37	50.0
Difficulty living within rules and boundaries	48	64.9

1. Multiple responses – percentages do not add up to 100

Table 7 below provides a comparison between women who had one to two *service system difficulties* with those with three or more. As illustrated, the presence of three or more service system difficulties corresponded with an increased likelihood of experiencing poor mental health, problematic substance use, challenging and risk taking behaviour and having lower independent living skills.

In particular, amongst those with three or more service system needs, 90 percent had a diagnosed or undiagnosed mental health disorder/illness affecting their capacity to live independently. A further 82 percent of women experienced problematic substance use and risk taking behaviour that endangered them. A greater proportion of women with three or more service system difficulties (23%) compared with those with one to two service system difficulties (6%) engaged in risk taking behaviour that endangered others.

Table 7: Comparison of selection criteria abilities and behaviours according to the presence of
one to two or three or more service system needs for women in client review snapshot

Abilities and Behaviours	One to two service system issues %	Three or more service system issues %
Diagnosed or undiagnosed mental health disorder/illness	62.9	**89.7**
Intellectual disability	5.7	10.3
Substance use	54.3	**82.1**
Gambling problem	2.9	2.6
Challenging behaviour	37.1	**71.8**
Risk taking behaviour endangering self	57.1	**82.1**
Risk taking behaviour endangering others	5.7	**23.1**
Lack of apparent independent living skills	34.3	**43.6**
Service System Difficulties		
Difficulty accessing mainstream services	17.1	61.5
Difficulty accessing specialist services	22.9	61.5
Repeated homeless service use/breakdown	65.7	**87.2**
Difficulty with case management process	17.1	79.5
Difficulty living within rules and boundaries	34.3	**92.3**
Total Cases	35	39

Based on the 13 key selection criteria issues, figure 3 illustrates a continuum of needs, which have been divided into three main groupings including those with 3 to 5, 6 to 8, and 9 to 11 coexisting issues. As shown in figure 3, the proportion of women decreased as the number of concurrent issues increased, suggesting varying degrees of complexity amongst the sample of women included in the snapshot. Specifically, the largest proportion (45%) of women within the snapshot had three to five concurrent issues according to the project selection criteria, a further third (36%) had six to eight concurrent issues, and the remaining 19% had nine to eleven. Whilst all the women fall within the project working definition, over half (55%) had six or more service system and personal obstacles to living independently and gaining support required.

Figure 3: Pyramid of complex and multiple needs (n=74)

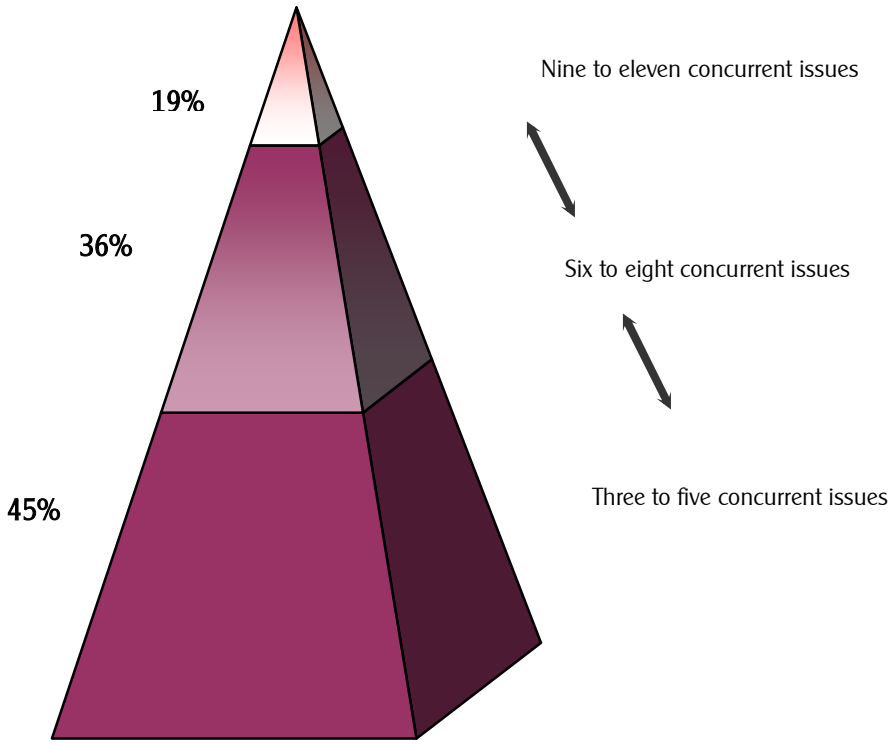


Table 8 provides a comparison of the 13 selection criteria abilities and behaviours and service system needs according to the type of accommodation women in the snapshot were residing or moved into during the data collection period. While the numbers vary according to different accommodation types, some notable differences are evident when examining the proportion of women in each category. Specifically, women residing in crisis accommodation at the time were less likely to have a diagnosed or undiagnosed mental health disorder. This may possibly relate to the short duration of crisis accommodation stays, with mental health issues becoming more apparent over the longer periods of engagement once immediate housing crisis has been resolved. Women within the crisis accommodation group were more likely to experience problematic substance and challenging behaviour compared to other housing groups.

Women residing in transitional or permanent accommodation (most notably public housing) were more likely to demonstrate a lack of independent living skills and difficulties living within rules and boundaries compared to women in crisis accommodation. These data suggest that different combinations of needs are likely to be more prominent or come to the attention of support staff at different points of service engagement and could be a reflection of what is prioritised in different service settings. Whilst it is recognised that women can cycle in and out of differing degrees of 'complexity' depending on external support networks and individual functioning at any given time a point in time analysis does not provide meaningful insight into the intensity of needs or capacity to function over time. Further outcomes research would reveal potential changes as women progress through different stages of the housing service system.

Table 8: Select abilities, behaviours and service system needs according to accommodation type
for women in the client review snapshot

Abilities and Behaviours	*Crisis*	*Transitional*	*Permanent*	*Other*	*Row Total*
Diagnosed or undiagnosed mental health disorder	10	29	14	4	57
	67%	*81%*	*78%*	*80.0%*	*77%*
Intellectual disability	0	4	2	0	6
	0%	*11%*	*11%*	*0%*	*8%*
Substance use	12	25	11	3	51
	80.0%	*69%*	*61%*	*60.0%*	*69%*
Gambling problem	2	0	0	0	2
	13%	*0%*	*0%*	*0%*	*3%*
Challenging behaviour	12	18	9	2	41
	80.0%	*50.0%*	*50.0%*	*40.0%*	*55%*
Risk taking behaviour endangering self	11	26	12	2	51
	73%	*72%*	*67%*	*40.0%*	*69%*
Risk taking behaviour endangering others	3	6	2	1	12
	20.0%	*17%*	*11%*	*20.0%*	*16%*
Lack of apparent independent living skills	3	14	10	2	29
	20.0%	*39%*	*56%*	*40.0%*	*39%*
Service System Needs					
Difficulty accessing mainstream services	8	14	6	2	30
	53%	*39%*	*33%*	*40.0%*	*41%*
Difficulty accessing specialist services	8	16	5	3	32
	53%	*44%*	*28%*	*60.0%*	*43%*
Repeated homeless service use	12	26	14	5	57
	80.0%	*72%*	*78%*	*100.0%*	*77.0%*
Difficulty with case management process	7	21	9	0	37
	47%	*58%*	*50.0%*	*0%*	*50.0%*
Difficulty living within rules and boundaries	8	26	11	3	48
	53%	*72%*	*61%*	*60%*	*65%*
Total Cases	15	36	18	5	74

1. Multiple responses

4.2 Mental Health

The mental health needs, including specific services required was recorded for women in the snapshot. According to completed review forms, 53% of women in the sample had a diagnosed mental health issue whilst 32% had an undiagnosed mental health issue. Six women had both diagnosed and undiagnosed mental health issues recorded.

Amongst women with a diagnosed mental health issue, the most commonly identified included mood disorders (54%) followed by psychotic illness 26%. A further 14 percent had a diagnosis for anxiety disorders, while 6 percent had a personality disorder diagnosis. Women with an undiagnosed mental health issue predominately displayed symptoms of a mood disorder (53%) followed by neuroses (37%), personality disorder (32%), and psychotic illness (5%). Five percent of women had been diagnosed with an acquired brain injury and a further 4% were currently being assessed for suspected acquired brain injury.

Support staff commented on the types of mental health support that was required by their client whilst accessing the participating services. The most commonly reported service type relating to their mental health that was accessed by women (13 clients) was a general practitioner for medication maintenance. Six women were linked into a private psychiatrist. Further diagnostic assessment was reported to be required for eight women, including ABI, dual diagnosis, CAT scan and depression. The need for further counselling was identified for eight women. Community mental health services were provided to five women in the snapshot. A further five women were hospitalised and four women received assistance from a CAT team whilst accessing the participating services.

4.2.1 Risks to Personal Safety

Support staff was asked to comment on women's experiences of self harm and any behaviour that they deemed had placed the client at risk of harm, with over half women (58%) reported to have engaged in self-harming and or risk taking behaviour during their current service access. The most commonly reported risk taking behaviour amongst women in the snapshot was unsafe illicit drug use practices and combining prescription medication, illicit substances and alcohol. Being verbally and physically abusive was considered another form of risk taking behaviour by seven women, some initiated through alcohol use. Self-mutilation, mainly in the form of cutting wrists and arms was the next frequently reported for six women. Four women in the snapshot were known to be currently/recently engaged in sex work. Other risks included not adhering to medical regime for chronic health issues such as diabetes and liver transplant, excessive spending, and reckless driving.

Over a third of women (38%) had talked to their support worker about wanting to commit suicide. The main emerging theme amongst the women who discussed suicide with their worker was the need to relieve feelings of hopelessness and emotional pain, as reflected in following comments by support staff...

> *Twice the client has spoken of 'not wanting to go' and 'not being able to keep going'.*
>
> *Not to end their life but to take a rest from pain and suffering felt.*
>
> *She sometimes feels that everything is too hard and asks why she bothers.*
>
> *The client has stated that at times she'd like her 'life to end' but that she 'would never do it' because of fear.*

Support staff indicated that eight percent of women in the snapshot had attempted suicide whilst accessing accommodation support. This included attempted hanging, cutting wrists and overdosing. More than a quarter of women (28%) were reported to have attempted suicide in the past, mainly via an overdose.

4.3 Past and Current Experiences of Violence, Abuse and Trauma

The prevalence of past and current experiences of abuse and violence amongst women in the snapshot is staggeringly high and appears to be a critical factor influencing their trajectory towards homelessness.

Table 9 illustrates three main types of abuse and violence experienced by the women as a child and as an adult along with the main perpetrator groupings. It should be noted that support staff reported on known cases only and therefore figures shown are likely to be an underestimation of the extent of trauma experienced by women in the snapshot sample. Each type of violence will be discussed under the headings below.

Table 9: Experiences of childhood and adult sexual, physical and emotional abuse for women in the client review snapshot

Type of Abuse/ Violence	Disclosed Childhood Victim					Disclosed Adult Victim				
	Number and percentages of clients		Perpetrator			Number and percentages of clients		Perpetrator		
			Family Member	Unrelated Person	Partner			Family Member	Unrelated person	Partner
	N	%	%	%	%	N	%	%	%	%
Sexual	30	41.1	46.8	50	3.2	29	39.7	3	59.3	37.5
Physical	34	45.9	77.5	22.5	0	48	65.8	14	29.8	56.1
Emotional	46	63	86.9	13.1	0	47	64.4	26	28.3	45.6

1. Number and percentages based on known cases of abuse, which have been disclosed to support workers. Above figures may therefore underestimate extent of abuse experienced. Unknown cases for childhood abuse: sexual 16.4%; physical 15.1%; and emotional 9.6%. Unknown cases for adult abuse: sexual 19.2%; physical 8.2%; and emotional 12.3%.

4.3.1 Sexual Abuse

Emerging from the snapshot there were 30 women (41%) who had disclosed being a victim of sexual abuse as a child. Sexual abuse history as child was unknown for 16 percent of women. A similar proportion of women (40%) had known experiences of sexual abuse as an adult, with 19% of cases unknown to support staff. Amongst those who have experienced sexual abuse, 17 clients (23%) both had childhood and adult experiences of abuse. The main perpetrator of childhood sexual abuse for women was an unrelated person (50%) followed by a member of their family (47%). Sexual abuse experiences as an adult was most commonly perpetrated by an unrelated person (59%) or their partner at the time (38%).

When examining bivariate associations or relationships between age and sexual abuse, some interesting patterns emerge. The highest proportions of women experiencing sexual abuse as a child were found in the 18-24 (52%) and 25-34 (52%) age groups, suggesting that this could be major contributing factor contributing to their homelessness. Experience of sexual assault as an adult was also highly concentrated in the 18-24 years age group (52%) and those aged between 45-54 (60% although there are smaller numbers in this age group).

4.3.2 Physical Abuse

Approximately half of the women (46%) in the snapshot had experienced physical abuse as a child and two thirds (66%) had experiences of physical abuse as an adult. Twenty-six (26%) of women experienced physical abuse both as a child and an adult. Family members (78%) were most likely to be the perpetrator of violence for childhood experiences of physical abuse. Partners (56%) were most likely to be the perpetrator of physical violence amongst adult women, however there was also a high proportion of physical abuse encountered from unrelated persons (30%)

When examining the relationship between age and physical abuse, similar patterns emerge as for sexual abuse. Women aged between 18-24 years (62%) and 25-34 years (52%) were more likely to have been reported to have experienced physical abuse as a child. There appears to be no particular relationship between age and adult experiences of abuse with similar proportions identified across all age groups.

4.3.3 Emotional Abuse

Emotional abuse was the most common experience of abuse amongst the women when they were children, with just under two thirds (63%) reporting that they had experienced this type of abuse. Family members were the main perpetrators (87%) of emotional abuse for the majority of childhood cases. A similar proportion of women experienced emotional abuse as an adult (64%). Whilst the main perpetrator in instances of adult emotional abuse was their partner (46%), family members (26%) and unrelated persons (28%) represented over quarter of instances respectively.

Two women had experiences of trauma in their country of origin. One woman witnessed her father's murder and experienced time in a refugee camp. Another woman was imprisoned by her uncle.

4.3.4 Experiences of Sexual and Physical Abuse Whilst Experiencing Homelessness

Women as a Victim of Abuse

The experience of homelessness, characterised by temporary and often unsafe living environments generates new or further vulnerability to exposure of abuse and violence. Amongst women in the snapshot, 53 percent were known to have been a victim of physical and/or sexual abuse whilst experiencing homelessness or residing insecure and temporary living arrangements.

Domestic violence perpetrated by a partner or male acquaintance that they were temporarily residing with or an ex partner who located where they were staying in transitional or crisis accommodation were the most frequently reported experiences of abuse during periods of homelessness. Violence related to sexually exploitative relationships, usually with unrelated persons or acquaintances, or sex work clients was a common theme amongst women in the snapshot. Support staff reported that some women had discussed "having to have sex with men to stay at their homes" and being threatened if they did not follow through.

Violence including sexual assault perpetrated by other residents living in temporary accommodation, most notably boarding/rooming houses was another reoccurring theme emerging for women in the snapshot who had been victims of violence. This usually resulted in the client having to leave the accommodation due to fears for their safety. Assault by other women, including residents was also reported for a few clients.

Women as a Perpetrator of Abuse

A smaller proportion of women in the snapshot were known to have perpetrated abuse. Whilst accessing participating agencies, support staff reported that 11 percent of women in the snapshot had been a perpetrator of abuse. Most instances of violence were directed to unrelated persons including other residents or acquaintances. Two instances were noted where the client had been violent towards their partner. Eight % of women had made threats of violence or harm. Generally threats of harm were reported to have been made to other residents and in some instances to staff.

4.4 Substance Use

Participating agencies were asked to comment on the substance use patterns of women profiled in the snapshot. An overview of the main substances regularly used is presented in Table 10. Regular use was defined as using the substances once a week or more. As shown, over half women (55%) used illicit substances regularly. The most commonly used illicit substance was cannabis (63%), followed by heroin (58%). A third of women (33%) regularly used alcohol. Poly drug use was common amongst women using substances.

Age appears to play some part in the type of illicit substances used. Women aged between 18-24 years were more likely to use heroin (64%) and/or cannabis (64%). A high proportion of women in the 25-34 year age group used cannabis (68%), however they were less likely to use heroin (47%) and more likely to used speed (32%), compared with younger women. Women aged 35-44 years had the highest proportion of heroin use (71%) and speed (57%) compared to other age groups. No women aged 45 years or over were reported to be using illicit substances.

Nearly three quarters of women were using some kind of prescription medication, typically for a mental health issue or drug and alcohol replacement treatment. Some women had a combination of different prescription medications. The most frequently reported medication was benzodiazepines (41%), followed by anti depressants (37%) suggesting poor mental health functioning amongst women in the sample. Drug and alcohol replacement medication was also frequently reported such as opioid analgesics (Methadone, Morphine) (14%) and opioid antagonists (Buprenorphine, Naltrexone) (18%).

Table 10: Main substances used by women in the client review snapshot

Substances Used	Number of clients	% of Clients
Regular use of illicit substances	40	54.8
Main illicit substances used		
Heroin	23	*57.5*
Cannabis	25	*62.5*
Amphetamines	12	*30.0*
Ice	1	*2.5*
Poly drug use	40	*54.8*
Regular use of prescription medication*	51	*69.9*
Main prescription medicines used		
Opioid Analgesics (Methadone, Morphine)	7	*13.7*
Opioid Antagonists (Buprenorphine, Naltrexone)	9	*17.6*
Antidepressants	19	*37.3*
Benzodiazepines	21	*41.2*
Antipsychotic	3	*5.9*
Other	4	*7.8*
Regular use of alcohol	24	*32.9*
Other substances	4	*5.5*
Total	N=73	

*Does not include contraception
1. Multiple responses

Table 11 illustrates the main substances that women required treatment for whilst seeking assistance at participating agencies and what type of drug and alcohol treatment they have received in the past 12 months. Amongst the women who were using substances regularly, the main substances requiring treatment as indicated by support workers was heroin (58%), followed by amphetamines and cannabis for 23 percent of women respectively. A further 20 percent of women were reported to require treatment for alcohol and 15 percent of women required treatment for problematic use of benzodiazepines.

Table 11: Main substances requiring treatment and types of substance use treatment accessed in the last 12 months by women in the client review snapshot

	Number of clients	% of clients
Requiring treatment for substance use*	**40**	**54.8**
Main substances requiring treatment		
Heroin**	23	57.5
Amphetamines	9	*22.5*
Alcohol	8	*20.0*
Cannabis	9	*22.5*
Benzodiazepines	6	*15.0*
Buprenorphine	2	*5.0*
Methadone	2	*5.0*
Type of treatment required		
Withdrawal	24	60
Counselling	29	72.5
Rehabilitation	12	30
Peer Support/NA/AA	6	15
Specialist Methadone Program/ Naltrexone/ Buprenorphine	20	50
Other	6	15
Access Substance treatment in past 12 months	**39**	**54.2**
Type of treatment accessed		
Withdrawal	14	35.8
Counselling	8	20.5
Rehabilitation	6	15.3
Supported Accom/HDDT	4	10.2
Peer Support/NA/AA	4	10.2
Specialist Methadone Program/ Naltrexone/ Buprenorphine	13	33.3
Other	2	5.1

*from total sample – 1 missing response. ** from sample requiring treatment from substance use
1. Multiple responses

According to support worker knowledge, more than half of women (54%) in the snapshot have accessed drug and alcohol treatment in the past twelve months. Amongst those accessing treatment, withdrawal was the main service type utilised (36%) followed by a specialist methadone program/ naltrexone/ buprenorphine (33%). A fifth of women (21%) had accessed counselling and 15 percent had accessed rehabilitation.

4.5 Financial Support Needs

As the main income sources for women were Disability Support Pension, Newstart or Parenting Payment, financial issues was identified as concern for the majority of women (73%). The most commonly identified financial issue for women related to financial hardship and being able to manage or have the necessary skills to budget on the income that they received. Eleven percent of women were known to have utility debts or other outstanding bills. Outstanding public rentals arrears were discussed in section 3.2. The cost of substance use, including purchasing prescription medication was considered by some support workers to add to financial difficulties.

Eighteen percent of women were known to have a Centrelink debt at the time the client review form was completed. The Centrelink debt either arose from $500 loan repayments or repaying past incorrect payments. A further seven percent of women had their Centrelink payments reduced as result of breach. Two women were not in receipt of any Centrelink payment, one due to ineligibility due to refugee status. Another client was reported to be entitled to a disability support pension however as they have been an Australian resident for 10 years they are unable to claim special benefit resulting in lower overall income and support.

4.6 Legal Support Needs

Assistance with legal matters was reported to be required amongst half of the women (51%) in the snapshot. This included supporting the client through current proceedings in regaining custody of their children whom had been removed from their care. Assisting the client to find legal representation for past crimes committed against them and dealing with fines/charges/warrants was also commonly reported. Attending court with the client as a support person was also frequently identified. Assisting with intervention orders was also identified as a legal support requirement. One client was assisted with the residency application process through the Department of Immigration and Multicultural and Indigenous Affairs.

4.7 Assistance with Daily Living Skills

Support with day to day tasks was required for over half (57%) of the women in the snapshot. This assistance mainly related to providing budgeting advice, such as setting up systems to manage bills or payment plans and assisting with completing and understanding forms. Time management support was also provided, particularly in reminding clients of important appointments. General household management tasks such as shopping and home maintenance were also required for some women. A few women were reported to have difficulties utilising public transport or going outside due to phobias.

A particular aspect of daily living that over half the women (58%) experienced, was difficulty living with others, particularly other residents in a crisis accommodation or shared housing context. It is not clear to what extent this experience is situational or a reflection of broader difficulties in forming interpersonal relationships or both. As reflected by the some of following comments from support staff....

> *[She] finds it challenging to be around people all the time; not having enough individual space and/or independence.*
>
> *[She] was moved to a one bedroom property due to vulnerability with interactions with co-tenants.*
>
> *[She] found it difficult to maintain boundaries and has engaged in arguments with other residents.*

In general, the majority of women in the snapshot (66%) were considered to require ongoing support in order to maintain their housing, especially the ongoing emotional support that enabled them to create a sense of structure in their lives. The most commonly identified support included the following:

- General house management - shopping, cooking, cleaning, paying bills and rent on time
- Advocacy and liaison with other services
- Adherence to medical treatment, including drug replacement treatment
- Skills development in living with/near others and managing interpersonal conflict and behaviours relating to experiences of trauma, poor mental health and substance use.
- Time management

Less frequently reported issues included:

- Addressing health concerns and at risk behaviours that impact on personal safety.
- Assistance with parenting
- Assistance with reading and writing and completing forms

4.8 Physical Health Needs

In addition to poor mental health, women in the snapshot also experienced a combination of physical health concerns, with 44 percent requiring access to medical services. In particular, 15% of women required services to assist with pregnancy. One woman was reported to have experienced a miscarriage and two women were supported through a pregnancy termination. Other pregnancy related support included transportation to general practitioners. One woman was reported to have experienced complications with her pregnancy and required further tests.

A fifth of women (21%) in the snapshot were reported to require support for an ongoing or chronic health condition, including diabetes, migraines, infectious disease, kidney and liver problems, thyroid, urinary incontinence, emphysema, and obesity. Support for gynaecological/women's health issues was reported for 8 percent of women. Four percent of women were reported to require assistance with a physical disability. A further five percent of women were reported to require support assisting chronic back pain or pain associated with fibroids. Four percent of women had required support for injuries sustained. One woman required an ambulance on four occasions for injuries sustained to her and her children. The health effects of poor nutrition, substance misuse and frequent moving, as well as susceptibility to colds and other short-term conditions were also highlighted.

4.9 Dual Diagnosis

Dual diagnosis refers to the coexistence of a substance use disorder (SUD) and a psychiatric disorder. A dual diagnosis can vary according to severity of both substance use and mental health functioning, with the four quadrant rating model commonly used to distinguish different dual diagnosis groups (Geppert, 2004). Major depressive illness and personality disorders are included in definitions of dual diagnosis as well different types of licit and illicit substances.

Many of those presenting with complex and multiple needs will by definition come under the classification of dual diagnosis, however not all women in the snapshot had a formal diagnosis for their presenting mental health issues that were witnessed by support staff. This is an interesting finding in itself and potentially adds to the complexity of providing appropriate support to this group of women, some of whom were reluctant to engage in a formalised psychiatric assessment. From the total number of women in the snapshot, 36 per cent of women had a diagnosed mental health issue combined with problematic substance use. Including women who had an undiagnosed mental health issue takes this figure to 49 percent of women in the snapshot.

A focus on dual diagnosis as a distinct group was included to ascertain whether there are any particular differences in their experience compared with the broader snapshot sample. The main diagnosed mental health issues included mood disorders 57% (including bi polar) followed by psychotic illnesses (22%). Examining substance use patterns, the majority (85%) were poly substance users, with the main illicit substances including cannabis (74%), heroin (53%), and amphetamines (47%). Over half regularly used alcohol (54%). The combination of diagnosed mental health issues and substance use appears to increase the likelihood of having experienced the underpinning issues and service needs that have been discussed in the previous sections. In particular, women with dual diagnoses were more likely to have:

- Experienced sexual assault as a child (44%) and adult (50%)
- Currently using prescription drugs (80%), most notably antidepressants (52%) and benzodiazepines (43%)
- Require permanent ongoing support (69%)
- Experience difficulty living with others (65%)
- Engage in self harming behaviour (77%)
- Have attempted suicide in the past (62%) and attempted suicide whilst residing with the service (19%)
- Have been imprisoned for prior conviction (24%)
- Previously been hospitalised in psychiatric institution (65%)
- Repeated homeless service use (89%)
- Accessed drug treatment in last 12 months (73.1%)

4.10 Chapter Summary

An overview of the service needs of women in the client review snapshot has been presented in this chapter. Over three quarters of the women presented with a diagnosed or an undiagnosed mental health disorder impacting on their capacity to live independently. Approximately two thirds engaged in risk taking behaviour during their current service access, while more than half of the women presented with behaviour that was considered 'challenging'. More than half of women were reported to have engaged in self-harming, many had a history of suicide attempts. Consistent with this, was the high prevalence of past and current experiences of trauma and abuse, particularly sexual abuse that was a critical factor influencing their trajectory towards homelessness.

Further, two thirds of women had a substance use problem impacting on their capacity to live independently. Poly drug use was common, and nearly three quarters of women were using some kind of prescription medication, typically for a mental health issue or drug and alcohol replacement treatment. More than half of women in the snapshot have accessed drug and alcohol treatment in the past twelve months.

In terms of service system needs, repeated homeless service use was identified for over three quarters of the women, followed by difficulties living within rules and boundaries. Half of the women were reported to have experienced difficulties with current case management practices, while difficulty accessing mainstream or specialist services was reported frequently. The presence of three or more service system difficulties corresponded with an increased likelihood of experiencing poor mental health, problematic substance use, challenging and risk taking behaviour and having lower independent living skills.

5. Strengths and Capacities

The snapshot client review form contained an open-ended section on their client's main strengths and capacities that they have witnessed during the support process. The following chapter provides an overview of the key themes emerging from support staff comments relating to individual capacities and skills and also significant family and others whom the women have been able to draw on for support. Women with complex and multiple needs seeking assistance at participating services were reported to possess many strengths and capacities that were considered an important foundation for building a support based relationship. The personal strengths and capacities identified below are very much framed from the perspective of this support relationship as that has been the interaction experience of the support workers. Different strengths and capacities are likely to emerge in different environmental contexts.

- **Seeking help when needed**

The most frequently identified strength amongst women in the snapshot, reported by 59 percent support workers, was the ability to identify when support was required and to be able to utilise the supports available to them. This ranged from progress towards "beginning to trust" services to "being extremely assertive with service providers and keen to find appropriate assistance". It also ranged from seeking help only when at the point of crisis to always being receptive to support.

- **Ability to problem solve and plan for the future**

Support staff identified that the ability to problem solve and plan for the future was a particular strength for a third (33%) of the women in the snapshot. Again the capacity to problem solve and plan for the future varied amongst the women, ranging from beginning to be able to make some future plans such as taking out an intervention order or undertaking "minimal set tasks one at a time" to achieving all stated goals enabling them to move on with life and commence study or employment.

- **Engages well with workers**

Being receptive to support or "engaging well" with the support process was considered a "strength" of the women in the snapshot by over a quarter of support workers (26%). Some support workers commented that the willingness of the client to engage in the support process has improved over time and as their trust in the service has increased

> *[She] has linked herself into services that support her artistic expression.*
>
> *[She] has engaged well with internal and external supports.*
>
> *[She] has become more communicative and will take help when offered (before she would not). Client engaged with workers and GP (more trusting).*
>
> *[She] has remained engaged in process for over 2 years.*

➢ Commitment to change

Commitment to change was identified as a strength for just under a quarter of women (23%) in the snapshot. Women in the sample were at different stages of the change process from being accepting of the need to change to being demonstrably motivated or "determined" and actively creating a new life for themselves and their children. The diversity of the women's experience of change is reflected in the following comments by support staff....

[She] was able to utilise her support worker in recognising and addressing her anger management issues. [She] displayed attempts at adhering to a support agreement made between herself and worker.

[She] has a lot of willingness to change and an incredible sense of survival. [She] has shown difficult behaviour at times yet extremely understanding and willing to understand and change her inappropriate behaviour.

[She] has managed to be drug free for 3.5 years (except methadone). [She] has managed to keep her children in her care after DHS became involved. [She] has kept paying rent in current THM and has kept in contact with support worker.

[She] has achieved all goals and has moved on with life and is now in full time study. [She] now has very high level of ability to problem solve, seek help when needed and plan for future.

[She] has managed to have her children returned to her care and they are now priority in her life. She has been drug free for nearly 12 months.

➢ Resilience

Resilience or the capacity to bounce back from adversity was a further strength frequently identified by support staff (23%) for the women profiled in the snapshot.

[She] also has the ability to carry a lot of stress and has resilience and courage.

[She] has displayed an amazing amount of strength and endurance in dealing with psych services as she has been diagnosed on three different occasions with three different illnesses.

[She] has undergone many different psych medical regimes and has been able to maintain her positive strength.

[She] has a determined and strong character.

➢ Insight into problems

The capacity for self awareness and understanding or reflection of behaviours, actions and experiences was reported frequently by support workers, with 18% of support workers commenting that this was a particular 'strength' of their client.

[She] has been able to identify the effect of domestic violence and substance usage issues on her ability to manage day to day living.

At times this woman was able to see that the massive amount of loss she'd suffered had impacted on her mental well-being. This however took time and the support period mentioned in this survey is actually the second time she was supported by us.

Very bright woman, able to be very insightful, integrate new information and strategies

Well educated, professional vocational history, seeks to support self through personal and emotional development.

➢ Other reported strengths

The following strengths were less frequently identified by support staff:

- resourcefulness
- positive outlook
- sense of humour
- compassion/empathy of others

5.1 Known Skills

The skills possessed by the women included in the snapshot are incredibly diverse, with a large proportion having prior employment experience and have untaken previous or currently participating in further study. Many women also have demonstrated specific creative talents in arts and craft, drama and sporting activities.

➢ Participation in the labour market

Over a third of the women (34%) profiled were known to have employment related skills. Three women were currently working (at the time the forms were completed) in part-time or casual positions mainly in customer service areas.

The labour market experience of the women ranges from highly skilled to low skilled, although the majority of experience has been in low skilled positions from what has been indicated from support staff based on their existing knowledge. The duration of engagement with the labour market over the women's life cycle is unknown, however this profile does illustrate that many women have 'participated' economically at some point in their lives.

The employment experience amongst women who had skilled qualifications included nursing, welfare, accounting and a chef. Other known employment experience amongst the women included customer service and retail, administration/ secretarial and manual work such as horse strapping, building, cleaning and factory work.

➢ Creative skills

Over a quarter of the women (26%) in the snapshot were known to have specific creative skills and abilities/interests, with many women partaking or being competent in a number of different creative areas. These included

- Drawing and painting (9)
- Writing (including poetry and short stories) (6)
- Drama, visual arts and music (5)
- Sewing and dressing making (3)
- General art and craft (including jewellery making, photography) (3)

➢ Recent study activity

Three women in the snapshot were reported to have recently commenced studying. One woman has started to study sociology and anthropology, another has begun a diploma of community services and the third is currently studying to be a youth worker. Two women were reported to be planning to undertake study, with one returning to her childcare course.

➢ Other skills identified

- Parenting skills
- Negotiation and assertiveness
- Financial competence on a small income
- Competent at sports
- Ability to survive / streetwise
- Fluency in a number of Languages
- Reading novels
- Ability to keep busy
- Linking into Community
- Cooking and cleaning skills

Sources of Support

➢ Family members drawn on for support

Part of the engagement process with clients is to establish an understanding of their existing support networks including immediate and extended family and significant others who are important sources of support. The following section focuses on the support networks known by support staff. The support from family members of women in the snapshot ranged from no contact at all with any family members to having regular supportive contact with their immediate family network.

➢ No support from immediate family

Twelve percent of women in the snapshot were reported to have no support from their immediate family. This was predominately a result of estrangement; parents and/or siblings had deceased, or they had been raised as a "Ward of the State" from a young age.

➢ Has limited support from immediate family and ongoing contact usually results in conflict

A further eleven percent of women were reported to have some support from their immediate family, however ongoing contact or residing with them typically resulted in conflict and a tenuous relationship, where the client had to leave or withdraw contact.

- **Parent/s as main support in family**

Twenty-nine percent of women were reported to be able to draw on their parents for support, predominately from their mother. Amongst those who had support from their immediate family, support staff described this relationship as "strong", "ongoing" or "regular" for 62% percent of women. The remaining was described as having "some" or limited support, relating to distance away from family or boundaries put in place by parents.

- **Sibling/s as main support in family**

A sibling or siblings, usually sister, was considered a main support for fourteen percent of women. Again the nature of the support varied from being a support in the sense that they are the only family still in contact with to that of a mentoring, role model relationship.

- **Extended family member main support person**

Extended family members such as an aunty, uncle or grandparents were identified as the main support person for 10 percent of women. In three instances, women were described as providing a source of support for their extended family including looking after cousins, who made the client feel 'important' and 'needed'.

- **Support from own children**

Eleven percent of women reported to consider their children as a form of support. Children who provided support were generally adults or teenagers.

Significant others drawn on for support

- **Friends**

Over a quarter of women (27%) were known to have friends that they could draw on for support, however the nature of the support provided in the relationship varied from recently met acquaintances to long lasting stable friendships who were a strong source of emotional and practical support. A prominent theme emerging from the comments from support staff is that the main peer group often comprised those in similar circumstances or with a drug use history and that many friendships are "short lived".

- **Professional support**

In some instances, support provided by a professional was the only form of support that the women in the snapshot were known to have access to. Although the majority of women had at least some one other than a professional person they could turn to this varies from very limited to consistent or ongoing support. Outside of family networks, in 22 percent of cases it was identified that professional staff, including priests & nuns were considered as the main source of support in the woman's life. For some women the relationship formed with professional staff has been the first time the women have learnt to trust, had structure, and guidance, particularly for young women engaged in ongoing support.

- **Spouse**

Nineteen percent of women were reported to receive support from a boyfriend, girlfriend or partner. Whilst this was considered a major source of emotional support, support staff indicated that over a third of these relationships were characterised by controlling abuse or violence.

Chapter Summary

The women in the snapshot sample possessed a range of strengths and capacities that were identified through the client review process and were based on observations emerging out of the support relationship. The main strengths and capacities that were assessed to promote their successful journey through the housing support system were: seeking help when needed; ability to problem solve and plan for the future; engaging well with workers; committed to change; and resilience. The reported skills of the women demonstrated the manner in which these strengths materialise, and the vital role of these skills and capacities in the survival and recovery of the women with complex and multiple needs. The most commonly identified skills of the woman included previous participation in the labour market; creativity; past and current study; and parenting skills.

The role of family and other support networks was explored in the study, with nearly a third of the women identifying their parents as the main family support. Siblings and other extended family members were the main support for a smaller proportion of women. For a fifth of women it was identified that professional staff were the main source of support. A small proportion of women were reported to have no support from their immediate family. Friends were identified as the main source of support for over a quarter of women.

6. Current Case Management Approaches

Within participating services, case management was the main approach to providing support. The following chapter details the main case management strategies adopted by participating agencies, which have been collated from their open ended responses in the client review forms. Perceptions of effective and ineffective case management practices along with the barriers to developing support plans with women with complex and multiple needs are also reported.

Most Frequently Identified Case Management Strategies

Amongst the women in the sample, 92 percent had a case management plan. Assistance with obtaining and maintaining accommodation was the main response provided within a case management framework. The type of accommodation support provided generally reflected the stage at which the women had progressed through the housing system pathway. Those in crisis accommodation were generally assisted to progress into transitional housing and those in transitional housing were assisted in accessing public housing or other longer term affordable housing options. While this pattern reflects the common goals within the case management process, not all women followed this pathway in a prescribed linear fashion. For further discussion on this point see section 7.1 on housing outcomes.

Apart from the provision of accommodation and support, outreach was a key approach adopted (56%) in working with women in the sample who were not residing within the crisis accommodation setting. Outreach provided ranged from needs based contact to intensive support that involved visiting women on a number of occasions during the week to provide both practical (i.e. transportation) and emotional support (i.e. counselling). A critical component to outreach, particularly intensive support was ensuring that the women remained engaged in the support process, especially those who had difficulty readily accessing support within a centre-based environment.

Linking women into other support services was another frequently identified case management strategy. Over half participating services (53%) reported liaising with other service providers or providing a direct referral (often accompanied) to services that were considered necessary to enabling the client to progress through the case management support plan. The most frequently identified services that women were linked into during the support period included drug and alcohol services (12%) and mental health (8%). It should be noted that some clients were already engaged with other service providers prior to accessing participating agencies. Less frequently identified external service providers included grief and loss, financial, sexual assault, and gambling counselling. Referrals for material aid were also reported.

Additional approaches to case management included the following:

- Harm minimisation – development of contracts and identification of strategies to reduce drug and alcohol use, or reduce to the risk of other self harming behaviour including sex working, or harming others i.e. anger management.

- Assistance with budgeting on a small income, including linking into Centrepay to assist with rental payments

- Time management and journaling to assist with creating a sense of structure, including assistance with remembering key dates and strategies to enable the client to leave the house during the day.

- Assisting with legal issues including intervention orders and attending court cases.
- Role modelling
- Assistance with parenting skills
- Safety strategies relating to domestic violence
- Increasing skills for employment

6.2 Case Management Approaches Reported to be Successful

Participating agencies were asked to comment on specific case management approaches that have been the most successful in working with the women they were completing the review form for. Support staff was also asked to qualify why given approaches were likely to be successful. The responses (n=68) were open-ended and have been collated into broad elements or underpinning principles. It is worth noting that the frequency of an identified element does not necessarily indicate that one is more effective over the other, rather frequency can be indicative of direct experiences of support staff in particular approaches or what was recalled by staff in an open-ended format.

➢ Service consistency

Whilst outreach was one of the main approaches adopted in supporting women in the snapshot, the reason underpinning this approach is that it enabled consistent contact with the client. Being able to provide consistent support was identified as a key element to working successfully with women with multiple needs by approximately half (49%) of support staff completing client review forms. Service consistency had a number of dimensions:

- providing support on an ongoing or long-term basis in order to gain trust and appropriately address multiple issues in a case management support plan;
- flexibility in maintaining contact with the client even if they are no longer accommodated within the service, has missed appointments, or moved out of the region;
- maintaining relationship with the one support worker over time to establish trusting relationships, understand their particular circumstances, and witness their progress over time; and
- providing non-crisis driven response.

➢ Transparent support plans

The necessity of service transparency was another frequently identified element to successfully supporting women in the snapshot, with 25 percent of support staff responses related to this overall theme. As with service consistency, transparency also had a number of dimensions, which are listed below:

- establishing clear boundaries around the nature of support, which seeks to minimise the development of unrealistic expectations regarding the support relationship and services provided;
- clarification of "rules and responsibilities" for both service provider and the women presenting to the service;

- client involvement in the case planning process that emphasises open and honest dialogue and agreement between client and worker; and

- monitoring and reflection of the case plan to ensure support is relevant to current circumstances and to maintain progress towards agreed goals.

➢ Strong linkages with external service providers

Creating and maintaining links with all relevant supports was identified by eight percent of support staff as an element of successful case management practice for women in the snapshot.

➢ Non-judgemental support

A non-judgemental approach to providing support was considered by eight percent of support staff to contribute to successful case management outcomes. This was believed to assist in fostering trust and contributing to feelings of emotional safety amongst the women.

➢ Promoting individual responsibility

Assisting the client to understand the consequences of actions or "owning their behaviour" was identified by 7 percent of support staff as element of effective case management practice.

➢ Enabling women to engage according to their readiness for intervention

Successful case management strategies also appear to be contingent on the stage of change experienced by the client and their receptiveness to the support process. Enabling the women to participate at their own pace or "meeting them where they are at" was identified by seven percent of support staff as an element of successful case management. This included allowing the women to focus on what they felt comfortable with at the time and within the bounds of duty of care not pressuring them into any particular course of action. It also included ceasing opportunities as and when they are presented from the client

➢ Additional elements reported

Additional successful elements identified by support staff included the following:

- Prioritising safety of client and worker
- Combining housing with other support within the one setting
- Accessibility of flexible funds
- Harm minimisation
- Proactive advocacy
- Focusing on strengths
- Holistic support
- Creating regular structure
- Access to information and resources
- Separating support sessions for 'practical' and therapeutic support
- Providing family-based support including parenting skills
- Ensuring case notes are complete

6.3 Case Management Strategies Reported to be the Least Successful

Approaches reported to be least successful according to support staff were in a sense the flip side of those considered successful. There were two strong reoccurring themes emerging from support staff responses (n=60). Case management strategies were predominately considered least successful when the support process was not tailored to individual circumstances and readiness for change. Case management was also considered to be least successful when the support process was inconsistent.

➢ Not tailoring approaches to individual circumstances and receptiveness

Case management strategies that do not focus on the specific individual needs of women are unlikely to be successful. Nearly two thirds of the service staff (62%) completing client review forms identified elements of least successful case practice that related to this theme, including:

- Not working at the women's pace of change; setting unrealistic goals and outcomes
- Being too task focused and directive by providing too many options in a short period of time
- Not having the flexibility to adapt the service response if needed and working in an environment that the women feel comfortable in.
- Linking clients into mainstream and or specialist supports prior to readiness for participation and willingness to engage in a therapeutic relationship

➢ Inconsistent support

Case management strategies were also considered to be least successful when the support process was inconsistent, by a quarter (27%) of support staff completing the client review form. Inconsistent support was considered to undermine trust in the support process and therefore inhibit openness, resulting in conflicting goals when there are multiple case plans, and contribute to service cycling. Inconsistent support related to the following dimensions:

- Short duration of support i.e. crisis responses, infrequent occasions of support, and or premature service exit before goals identified in case management plan have been able to be achieved.
- Frequent changes in support staff and accommodation types.
- Client only engaging when in immediate crisis and therefore not able to benefit from ongoing case management plan.

➢ Additional strategies

Additional strategies less frequently reported included

- Rigid service rules and curfews
- Not maintaining client worker boundaries
- Insufficient structure related to addressing drug use

Barriers to Achieving Support Plan Goals

➢ Mental health functioning

Poor mental health functioning was identified as the main barrier to engaging and achieving outcomes that were identified in the support plan. 31 support staff commented on aspects of mental health functioning that influenced outcomes. Essentially this meant that the case management process had to move according to the capacity of the women to engage and stabilise their support networks. The type of factors relating to mental health functioning identified by support staff included:

- difficulty attending appointments resulting from short term memory loss, poor concentration, social phobias, low literacy and/or crisis;
- not being able to get client to assessment due to need to respond to ongoing crisis;
- low motivation to achieve identified goals influenced by depressed state;
- observed undiagnosed mental health issue that client is unwilling to address and engage in assessment;
- non-compliance with medication;
- presenting very unstable and extreme behaviour yet unable to engage CAT or other mental health services;
- some clients requiring high level of guidance and dependence on service, particularly in instances of self harming; and
- combined impact of drug and alcohol and mental health issues, including being affected by substances during appointments and not wanting to work on support issues.

➢ Less frequently identified barriers

- Unable to link into intensive support/ not enough time to spend with the client
- Not able/committed to changing current lifestyle
- Not staying connected with supports/ difficulty accessing supports
- Not able/committed to changing current lifestyle
- Changing support workers
- Not trusting finding support process intrusive
- Co-dependency issues
- Loss of accommodation/ early exit from service
- Time management
- Legal Issues
- Lack of women specific activities
- Family connections
- Maintaining connection with partner/friends who are influential
- Anger issues/Anti social behaviour
- Refugee Status
- No regular income / money management
- Lack of accommodation/ Safety concerns in some areas
- Not knowing client's history

6.5 Chapter Summary

Current case management practices were discussed in this chapter. Case management was the main approach to providing support, with 92 percent of the women having a case management plan. Assistance with obtaining and maintaining accommodation was the main response provided within a case management framework, with outreach the key approach adopted to access women who were not residing within the crisis accommodation setting. Consistent support was identified as a key element to working successfully with the women, which entailed providing long term support, flexibility in maintaining contact with the client even if they are no longer accommodated within the service, maintaining relationships with the one support worker, and providing non-crisis driven response. Service transparency based on establishing clear boundaries, clarifying "rules and responsibilities", client involvement in the case planning, monitoring and reflection of the case plan, was considered essential. Creating and maintaining strong linkages with external service providers too was identified as an element of successful case management practice.

A non-judgemental approach to providing support was assessed to contribute to successful case management outcomes, in conjunction with consideration of the stage of readiness for change experienced by the client and their receptiveness to the support process. Additional successful elements identified by support staff included prioritising safety, combining housing with other support within the one setting, accessibility of flexible funds, harm minimisation, proactive advocacy, focusing on strengths, holistic support, creating regular structure, access to information and resources, separating support sessions for 'practical' and therapeutic support, providing family-based support including parenting skills and ensuring case notes are complete.

Case management strategies were predominately considered least successful when the support process was not tailored to individual circumstances and readiness for change. Case management was also considered to be least successful when the support process was inconsistent, or when it was not working at the women's pace of change; setting unrealistic goals and outcomes, being too task focused and directive by providing too many options in a short period of time, not having the flexibility to adapt the service response if needed and working in an environment that the women feel comfortable in. Linking women into mainstream and or specialist supports prior to readiness for participation and willingness to engage in a therapeutic relationship was also considered least effective. Inconsistent support was characterised by short duration of support, infrequent occasions of support, and or premature service exit before goals identified in case management plan have been able to be achieved, frequent changes in support staff and accommodation types, client only engaging when in immediate crisis and therefore not able to benefit from ongoing case management plan.

7. Outcomes from the Support Process

The sampling strategy intended to capture women at differing stages of support from crisis, transitional and those who had moved into long-term affordable housing in order to examine different outcomes emerging from the support process. The outcomes reported in the following chapter are qualitative and are not based on pre and post comparisons, however do provide insight into transitions through the housing support system and exit pathways for women along with the types of outcomes that arose from the case management support process.

Table 12 illustrates the broad categories of support provided to women during their support period with the service. As indicated approximately half of the women in the snapshot had been provided with transitional housing (46%), followed by a third (34%) being provided with crisis accommodation. The remaining 20 percent had moved into or were being supported in public housing during the data collection. Please note that this does not necessarily reflect women's current type of accommodation at the time of data collection. Outreach support was the most commonly identified form of support. Other services provided included post release support and priority transfers.

Table 12: Main type of support provided to women in the client review snapshot during data collection period

	Number	%
Crisis Accommodation	24	34
Transitional Accommodation	32	46
Outreach Support	39	56
Crisis Support	18	26
Transitional Support	17	24
Other	8	11

1. Multiple responses

7.1 Reported Housing Outcomes

The following section examines the way in which the housing circumstances of the women in the snapshot have changed as a result of support provided by the participating agencies. This is a point in time assessment of outcomes and does not follow their service history over time. The outcomes achieved generally reflect the type of support received and responses have therefore been analysed separately for those in crisis, transitional and public housing. The majority of women were residing in transitional housing, which they generally entered via the crisis accommodation system.

7.1.1 Premature Service Exit

According to client review responses from support staff, 15% of women exited participating services early according to an agreed case management plan. Seven women exited from crisis accommodation, four women exited their transitional housing, and one woman exited an 'other' accommodation type prematurely. The main reasons identified for leaving crisis accommodation early for five women related to behavioural difficulties including aggressive behaviour towards others in the service and not complying with service protocols, including not returning to the service for a number of days. Another woman residing in crisis accommodation abandoned her case plan upon her partner's prison release. The remaining two women had their immediate housing crisis resolved, however were not prepared to engage in the support process.

The main reasons why the housing placement in transitional housing ended early according to the case plan for three women related to returning to their partner following an episode of domestic violence or disclosing their address to an ex partner whilst residing in the transitional property. The remaining woman exited her transitional housing early due to a breach of lease, leaving no forwarding address.

7.1.2 Residing in Crisis Accommodation during Data Collection Period

Approximately a fifth of women (20%) were residing in crisis accommodation during the data collection phase. At the end of the data collection period, seven women had exited the crisis accommodation service prematurely according to their case plan. Three women had exited crisis accommodation in accordance with their case plan, while the remaining five were still current clients. Of the three women who exited the service during the period according to their case plan, two went onto drug and alcohol detox and rehabilitation respectively, whilst the other moved into a transitional property awaiting a place within the interagency homelessness drug dependency trial. Whilst there were unequal proportions of women across service types, approximately half (47%) of all crisis accommodation residencies ended prematurely. This highlights that women are more likely to exit the crisis accommodation environment prematurely compared to other service types, potentially indicating the inappropriateness of this setting for some women with multiple needs. Further investigation based on a larger sample size is warranted in order to further explore this pattern observed.

Amongst the women who were current clients within crisis accommodation, their immediate housing situation was reported to have stabilised. For some recent arrivals it was reported to be "too early to tell". Four of the 'current' women had applications for transitional housing and were in the process of compiling a segment one application. One woman was currently being supported to re enter the private rental market, as she was ineligible for public housing due to a recent relationship settlement.

7.1.3 Transitional Housing

The largest proportion of women (49%) was residing in transitional accommodation at the time of data collection. The analysis of outcomes has been divided into two sections for those who maintained transitional accommodation for longer than twelve months and those who have maintained accommodation for less than 12 months.

- **Maintained stability in transitional twelve months or longer**

Amongst those in transitional accommodation, eight women had maintained their accommodation for over twelve months with some up to three years. All the women in this group were current clients. Women attached to the homelessness drug dependency trial tended to be in supported transitional housing for the longest period of time coinciding with the commencement of the trial or soon after. This may explain why this particular group have not moved into permanent accommodation via a segment one application or other arrangement.

- **Transitional housing less than 12 months**

Over a third of the women (38%) in the snapshot had been supported in transitional accommodation for less than twelve months. Apart from three women who exited transitional accommodation prematurely according to their case management plan, the remaining women in this group were current clients at the end of the data collection period. Women in transitional accommodation were mainly supported through outreach programs.

Apart from stabilising housing crisis and increasing housing affordability and safety, the most salient outcome reported for women in transitional housing was compilation of segment one applications for public housing. Seven women in transitional accommodation had recently had a segment one approved and were awaiting an offer, while four had their application in place still awaiting for approval. Another outcome reported by some support staff related to women being able to adhere to rental payment budget.

7.1.4 Moved into Permanent Accommodation

Approximately a quarter of women (24%) had moved into permanent housing or were currently being provided with intensive support within permanent housing in order to maintain their accommodation. All women in this group moved into public housing, except for one who moved into permanent accommodation with Wintringham. The majority of women were still current clients, although with the exception of the intensive support service, capacity to provide longer term support to women entering into public housing was limited as the service would be required to withdrawal support in order to manage their transitional case loads. The length of time taken to move into public housing was not identified for all cases and it is not clear from the data at what point all women had moved into public housing during the support period. Notwithstanding this, some support staff did provide an indication of timelines, which ranged from eight months to three years.

7.1.5 Other Accommodation

The remaining seven percent of women were residing in other types of accommodation including rooming house and psychosocial rehabilitation, with one woman exiting prematurely according to their case management plan from this accommodation type.

7.2 Non-housing Outcomes Reported

Numerous short and long-term outcomes from the support process were identified from staff completing the client review forms. This section is not intended to be a formal outcomes evaluation, rather to identify the types of outcomes that are believed to emerge for women who access support. The outcomes identified are qualitative and have emerged from the open-ended responses from support staff and are therefore based on their observations of their client. Some outcomes identified relate to processes, while others relate to staff perception of interpersonal changes witnessed in their client over the duration of support.

7.2.1 Process Outcomes

- **Development and maintenance of other professional support networks**

  The most frequently identified process outcomes identified by support staff related to the development or maintenance of other support networks in addition to the participating services. From those who responded to this section of the client review form, 53 percent of women were reported to have initiated or maintained supports whilst experiencing instability in their housing. This highlights the critical role for case management in facilitating access to specialist and mainstream services for women with multiple needs. The most commonly reported external services women were linked into during the support process included general counselling (7), mental health (6), D&A (4), ongoing health support (4), and legal support (4).

- **Client is engaging with the service**

  A further commonly identified process outcome for women supported by the participating agencies was that of service engagement. This was identified as a main outcome for 22 percent women. For some women, particularly those in younger age groups, engaging with the service was considered a major achievement for those who previously had difficulties trusting support staff.

- **Rebuilding relationship with family**

  Four women were reported to have begun the process of reconnecting and rebuilding relationships with family members.

- **Reconnecting with study/employment**

  During the support process, two women were identified as commencing further study, while a further three had training goals in place. One woman was identified as securing employment.

- **Recreational activities**

  A further two women were identified as connecting creative/recreational activities within the community.

7.2.2 Interpersonal Outcomes

- **Increased self-awareness**

  An increase in self awareness or being able to 'make sense' of experiences and understanding consequences was the most commonly identified (22%) interpersonal outcome observed during the support process. The types of phrases used by support staff relating to this theme included:

  [She] was able to acknowledge presenting issues and recognise need for support around these.

  Recognising that [She] required help with drug and alcohol issues.

  [She] gained insight into cycles of behaviour.

  Ability to sit with abuse and delve into these issues for the first time

  [She] is learning to say 'no'. She is becoming more aware of when others are taking an advantage over her and developing better insight in terms of seeing the effects of her behaviour on others.

- **Reduced harm associated with drug and alcohol use**

  The next most commonly identified (18%) interpersonal outcome related to an observed reduction in the harm caused by problematic drug and alcohol use. Amongst this group, eight were reported to have reduced their drug use, two maintained methadone, and the remaining three ceased all illicit drug use.

- **Improved parenting skills resulting in increased access to children**

  An improvement in parenting skills leading to increased contact with their children who had been placed in care was an outcome for seven women (10%). Amongst those, two women had their children returned to their full-time care.

- **Increased budgeting skills**

  An increase in budgeting skills was identified as an outcome for seven women (10%). Part of budgeting skills included direct debiting for utilities and rent.

- **Improved self-esteem**

  Increased self esteem was identified as an interpersonal outcome for seven women (10%)

  [She] has general sense of accomplishment (that she has made positive changes).

  [She] feels ready to go back to work and look towards the future.

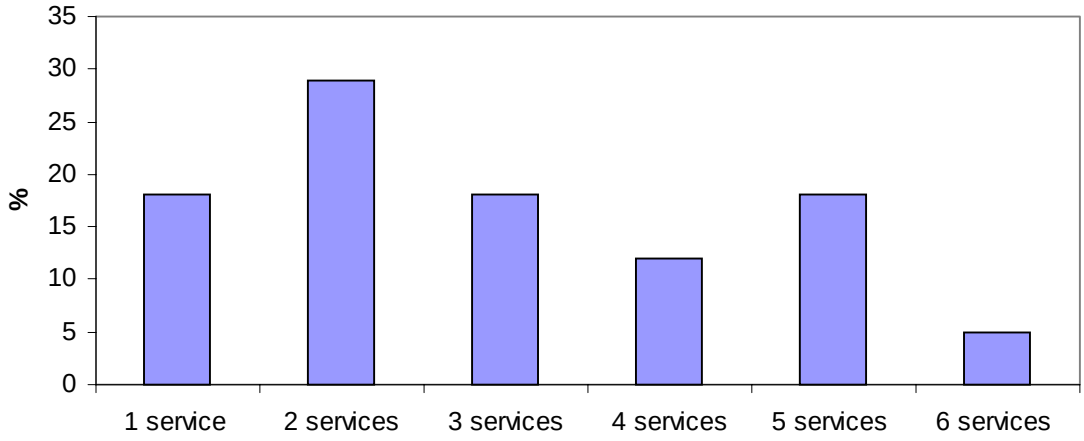
- **Increase in protective behaviours**

  Seven support staff reported that they observed an increase in protective behaviours, which mainly related to a reduction in sex working and not returning to abusive relationships, and reduction in self harm.

7.3 Utilisation of other Support Services

As part of the client review process, support staff detailed other support services accessed by their client. According to support staff, 82 percent of women regularly accessed other support services in addition to the participating services. Figure 4 depicts the total number of services recorded for women, including participating services. This demonstrates high usage of services, with over half (53%) of the women profiled regularly accessing three or more services. While multiple service use appears to be high, there is no clear pattern in the distribution of services used, with 13 women (18%) accessing one service, three services, and five services respectively. The most frequently identified number of services used was two services (29%).

Figure 4: Number of support services regularly accessed by women in the client review snapshot



Amongst the women engaged in one service (that being the participating agency), support staff generally indicated that this was related to an unwillingness to engage/follow up on referrals and/or difficulty accessing support, not as a result of not requiring additional support.

Table 13 identifies the main service types accessed by women in the snapshot. The services most commonly accessed have been shaded and include general practitioner (30%), mental health or general counselling (25%), drug and alcohol counselling (23%), psychiatrist (20%), drop in services (20%), and family support services (15%). Despite the high proportion of women experiencing past and current episodes of sexual and physical abuse as discussed in section 4.3, there appears to be low engagement in this type of support.

Table 13: Main service types accessed amongst women in the client review snapshot in addition to participating services

Service Type	No.	%	Service Type	No.	%
Drug & alcohol			Sexual assault counselling	5	8
D& A counselling	14	23	Personal Support Program/CRS	3	5
D&A other	6	10	Church Group	2	3
Mental health			Family support services	9	15
Counselling	15	25	Hospital (Medical)	3	5
Psychiatrist	12	20	Domestic violence specific	1	2
CAT	4	7	Disability	3	5
Homeless specific	3	5	Legal Services	6	10
Other	4	7	Cultural specific	2	3
General Practitioner	18	30	Community/recreational	4	7
Drop in services	12	20	Volunteering	2	3
Nursing Outreach	4	7	Other	7	12
Other housing support	7	12			
N=60					

1. Multiple responses

7.3.1 Difficulties Accessing Service Providers Required

Participating agencies were asked to comment on whether the women they were supporting had any difficulties accessing other services required throughout the duration of support. Over two thirds (68.5%) of women were reported as having difficulty accessing services required to assist their needs. A further 11 percent of cases were unknown. Table 14 presents the main service types required that women were unable to access or unwilling to engage with at the time of support. Amongst those women who had difficulty (N=50), basic needs services such as accommodation and financial and material aid rated most highly. In particular, 40 percent of women had difficulty accessing long term permanent accommodation, while 34 percent had difficulty accessing transitional housing at the time it was required. The main reasons provided for not being able to access permanent and medium transitional accommodation related to "no vacancies/waiting lists", for 60 percent and 59 percent respectively. Service "not matching needs" was also a commonly reported reason for not being able to access permanent (25%) and medium/transitional (29%) housing. A quarter of women (24%) who had difficulties accessing services were unable to access crisis accommodation at the time it was required, with the main reasons "being barred from using the service" (42%) and "no vacancies/waiting lists".

Approximately a third of women in this group had difficulty accessing financial and material aid, with "unable to provide immediate response/appointment required" (36%) and "client not eligible for the service" (29%) the main reasons identified. Difficultly accessing Centrelink was identified for just under a quarter of women and the main reasons related to "unable to provide immediate response" for 50 percent and "service not matching needs" for 33 percent of women. Generally, for those requiring financial counselling the main reason not being able to access the service related to an unwillingness to engage (70%).

An equal proportion of women (26%) had difficulty accessing drug and alcohol withdrawal and rehabilitation. The most frequently identified reasons for difficulty accessing withdrawal and rehabilitation included "unwillingness of the client to engage with the service" for 92 percent and 77 percent of women respectively. This was followed by "no vacancies/waiting lists" for 31 percent for both withdrawal and rehabilitation and also "service not matching needs" for 31 percent requiring rehabilitation, and 23 percent requiring withdrawal.

Mental health services were also difficult to access for approximately a quarter of women, with psychiatric assessment rating the highest (28%). The reasons provided for not being able to access psychiatric assessment/support were spread amongst "unable to provide immediate response" and "unwillingness to engage" for 36 percent each followed by "service not matching needs" and "client not eligible for the service" at 29 percent each.

A further quarter of women (24%) had difficulty accessing specific domestic violence services when required, with "client unwillingness to engage with the service" identified for over half (55%) of the women. Difficulty accessing sexual assault services was reported for a fifth (20%) of the women, with "unwillingness to engage with the service" reported as the main reason for 70 percent of women. Other reasons provided relating to access included "unable to provide an immediate response" (30%), service not matching client needs", no vacancies/waiting lists, and no access to transport for 20 percent respectively.

The general pattern emerging from these data suggest that the reasons for not being able to access basic needs services such as accommodation and material aid relate mostly to their unavailability at the time they are required. For other service types that require specialist issued focused responses such as psychologist, drug and alcohol, sexual assault, and domestic violence service barriers tend to relate more closely to clients preparedness to engage. It is unclear whether this relates to an unwillingness to work through underpinning experiences and trauma or whether the service models within these services are not particularly suited to this group of women. This raises further questions that need to be examined more closely with women with multiple needs experiencing homelessness. The service experience interviews undertaken with women discussed in detail in the next chapter provide some insight into women's own perceptions of services.

7.4 Chapter Summary

This chapter examined both housing and non-housing outcomes for women in the snapshot. Women were more likely to exit crisis accommodation prematurely according to their case management plan compared with other accommodation types, potentially indicating the inappropriateness of this setting for some women with complex and multiple needs. Further investigation based on a larger sample size is warranted in order to explore this pattern observed. Women in transitional accommodation generally maintained their accommodation until moving into permanent accommodation. Apart from stabilising housing crisis and increasing housing affordability and safety, the most salient outcome reported for women in transitional housing was compilation of segment one applications.

The most frequently identified non-housing process outcomes related to the development or maintenance of other support networks in addition to housing services, highlighting the critical role for case management in facilitating access to specialist and mainstream services for women with multiple needs.

For some women, engaging with the service was considered a major achievement for those who previously had difficulties trusting support staff, while other women were reported to have begun the process of reconnecting and rebuilding relationships with family members.

Other identified interpersonal outcomes included commencing further study or engaging in recreational activities, securing employment, increased self awareness, reduced harm associated with drug and alcohol use, improved parenting skills, increased budgeting skills and improved self-esteem.

High usage of other support services apart from housing support was identified, with over half (53%) of the women regularly accessing three or more services, including general practitioner, mental health or general counselling, drug and alcohol counselling, psychiatrist, drop in services, and family support services. Whilst use of multiple services was high, over two thirds (68.5%) of women were reported as having difficulty accessing services at the time they were required, particularly accommodation, financial and material aid, drug and alcohol withdrawal and rehabilitation, mental health services, and domestic violence services.

Table 14: Services required that women in the client review snapshot were unable to access/or willing to engage with at the time of support

Services required			Service Reason Code (Multiple response)										
			1	2	3	4	5	6	7	8	9	10	11
Service Type	N	%	%	%	%	%	%	%	%	%	%	%	%
Crisis/short accom	12	24		8.3	41.7		8.3		41.7		8.3		25.0
Medium/transitional accomm	17	34	29.4	23.5	58.8		5.9	11.8	5.9	11.8			5.9
Permanent/long term housing	20	40	25.0	10.0	60.0		5.0	10.0	5.0	10.0		10.0	
Financial & Material Aid	15	30	7.1	35.7	14.3			14.3	14.3	28.6	7.1		14.3
Financial counselling	11	22	10	10	20			70					
Centrelink	12	24	33.3	50.0						16.7			25.0
Drug & alcohol withdrawal	13	26	23.1	15.4	30.8		7.7	92.3		7.7	7.7		7.7
Drug & alcohol rehabilitation	13	26	30.8	7.7	30.8		7.7	76.9	7.7	15.4	7.7		7.7
Psychologist	10	20	10.0	10.0	10.0			60.0				30.0	
Psychiatric assessment /support	14	28	28.6	35.7	21.4			35.7		28.6	7.1	14.3	
Crisis Assessment & Treatment Team (CAT)	5	10		40.0				60.0					
General counselling	12	24	16.7	16.7	16.7		8.3	75.0				8.3	
Sexual Assault Counselling	10	20	20.0	30.0	20.0		20.0	70.0					
Domestic Violence Support	12	24	18.2	9.1	9.1		9.1	54.5	9.1	18.2			9.1
Police	5	10		60.0		20.0							40.0
Legal services	9	18	33.3	44.4		11.1		22.2		22.2		22.2	
Disability services	4	8		50.0	25.0					25.0			
Medical services	10	20	10.0	10.0			20.0	70.0	10.0				
Culturally appropriate support	2	4	50.0							50.0			
Family support	8	16		14.3	14.3			57.1					42.9
Maternal and child health	2	4		50.0			50.0	100.0					
Child protection	2	4						100					

N=50, Multiple response

Service Reason	Code number	Service Reason	Code Number	Service Reason	Code Number
service not matching client needs	1	no access to transport	5	out of catchment area	9
unable to provide immediate response/appointment required	2	unwillingness of client to engage with the service	6	unable to afford service fees	10
no vacancies/ waiting lists	3	client barred from using the service	7	Other	11
cultural barriers	4	client not eligible for the service	8		

8. Getting My Life Back Together: What Women Say is Important and Helpful for Them

The following chapter focuses on the direct experiences and perspectives of the 24 women who were interviewed across participating services. In particular, this section provides an account of what women considered to be priorities for themselves and the service experiences they have found to be helpful and not so helpful through out their journey through the service system. Particular agencies have not been identified rather the key principles that underpin approaches and experiences within different service types are emphasised.

No matter what stage of housing crisis experienced by the women, the expressed need for emotional and physical safety and stability within their housing was paramount. While both these themes constitute universally recognised needs, from the service experiences documented from the women, it is surprising how frequently this was missing in the way the service system has been established to deliver support.

8.1 A Sense of Safety

The experiences that women shared as being unsafe ranged from staying within mixed gender environments that were considered intimidating and threatening, and being sent to cheap motel accommodation, rooming houses, and public housing in areas that were perceived to be unsafe. The limited range, particularly of short-term safe accommodation options for women appears to be a critical factor contributing to their instability and the need to keep moving on. Women felt very strongly about this aspect of service provision and the language they used of "being sent" or "being placed" in describing their experiences indicates the perception of limited power and choice at the time. It is also demonstrates that over time women in the housing support system develop their own insight or agency into what will help them to stay safe and maintain their survival, as illustrated in the following excerpts.

Box 18. Excerpt from client service experience interview...

When I was homeless, the only place they could recommend for me here to go was [the rooming house], which was actually very dangerous. There wasn't enough help and then I stayed at [the accommodation service] and they couldn't help me with accommodation either. The only way I got into a safe rooming house was because I knew the housing worker, the people who could put me up. That's a heavy issue. What they should have told me was to go to [the service] and they would have put me up. Sometimes they're not that knowledgeable, because they don't know the ropes regarding accommodation. They've never had to stay in the places. They wouldn't stay at [the rooming house] but they say that's the only place you can stay. And my neighbour threatened to murder me at [the rooming house] so I was very unsafe there *[Age 37]*.

Box 19. Excerpt from client service experience interview...

I'm moving into a new public housing place via segment one – but I don't like the area and it is going to add to my anxiety problem. It is in [suburb] and there is a high crime rate. It is really pocky and people wouldn't put their own families in these houses. Since I found out about the property I have not had much sleep. I feel like if we tell the service about it I don't want them to think that we don't appreciate it. I want to try and get some medical certificate *[Age 30]*.

Box 20. Excerpt from client service experience interview...

I do have a problem with some charities – while they do a good job they need to do their research before they place their clients in some types of accommodation. I thought that was inappropriate. [The service] put me in hotel in St Kilda and that was one of the scariest experiences of my life. People want somewhere stay but it needs to be thought through a little more. Some of the places I ended up in were unsafe on my own and in a vulnerable spot in life *[Age 22].*

Services that prioritised safety in their approach were therefore considered to be more effective in providing support according to the women interviewed. Women reported feeling more comfortable in approaching such services for support. When women referred to the service providing a sense of safety, they were generally women specific services. A safe space not only meant "being protected from men" but also those that provided emotional safety by demonstrating a respect for the women in the way the service looked and the attitudes of staff. A safe place to drop in was considered particularly critical amongst women who were currently or had previously been sex working. While the presence of service rules that aimed to ensure the safety of all women was recognised as important way of enhancing safety amongst the women, being breached or rejected from a service was perceived to undermine emotional safety and security for some women.

Box 21. Excerpts from client service experience interviews...

Drop in/counselling services

I come to [the service] every week to my wash clothes – it is a place to just be. Just to be alone if you like. Place to go where you not looked at like you are a piece of meat *[Age 23].*

The most important part of [the service] is that it is a safe place for women to come to get away from the men. And you've got freedom to come and go when you please. And I think it has improved in regards to the women treating each other better here, they've got stricter making it safe for all women, because some women got too frightened to come here. I don't feel like I'm going to end up in police matters coming here. It's pretty good like that, the women give you space to sort yourself out *[Age 37].*

It is a safe space – you can feel it when you walk in here – treating people with respect. I know that it is there and I know that I could ring and come and see whenever - it can be ongoing – the breached client protocol thing hasn't happened to me here *[Age 34].*

Accommodation services

Security – has been the most impact. – I feel safe here. The weight seems to be lifted. It is a bit of breather when I first came here *[Age 53].*

If there are any problems they are right onto it. If you come in totally off your face they will not let you in the door – the security here is fantastic, you could not wish for a safer place *[Age 35].*

8.2 Housing Stability

Closely linked to the concept of safety is housing stability. Women attribute being assisted into stable permanent housing as having a significant impact on their life that has enabled them to begin to work through other aspects of their lives and for some to re enter the work force. When women talked positively about housing assistance they referred to the benefits of practical support such as assistance with furniture and initial establishment costs and assistance with their segment one applications for public housing (eleven women had a segment one application in at the time of interview).

Box 22. Excerpt from client service experience interview...

Housing has been my biggest issue – when you are a women alone in crisis it is hard. I had been turned away by nuns and they are supposed to be Christians. You have to try and carry your bags of clothing – you lose all your clothing things get taken and then you get accused of being over the top when you spark up. If you are in a family it is easier because they don't want kids without a roof but when you are single it is harder. It is finally good to be in a place that is mine – my place now. I can start getting things that make it feel like a home. Before that I didn't care – wasn't worth it – now it is changing a bit. If I had to move again it would really spin me out *[Age 49]*.

Box 23. Excerpt from client service experience interview...

Once you don't have to hassle for basic needs it is a lot easier – you can't think for yourself it is a very stressful way to live. Secure housing has made the biggest difference for my life – direct debit is a help as I don't have to worry. Housing has always been a stress – you are vulnerable to every sick dog and then they get you working and rape you *[Age 34]*.

Box 24. Excerpt from client service experience interview...

[The service] has helped me out the most with stable housing and not moving around so much I could start to work again. Can't work if I haven't got stable accommodation – having housing is important to deal with issues *[Age 22]*.

8.2.1 Crisis Accommodation

The provision of crisis housing was considered both helpful and unhelpful. It was considered helpful in sense that "at least I had a roof over my head" and unhelpful in the sense that it did not enable long term planning and was often unavailable at the time it was needed. Some women who had been homeless for extended periods of time also talked about the difficulty they had accessing crisis accommodation because they had already been in receipt of housing assistance on previous occasions, however were still in need of accommodation as reflected in the excerpt below.

Box 25. Excerpt from client service experience interview...

Just the unavailability is unhelpful. When you're down and out you need help there and then, not next week is the earliest appointment I can give you. When you're in need you need help then and there not in a fortnight's time, not when they can fit you into their books, where do you live until then? And you have to ring these every day to be active or whatever they call it, to be up in the priority. Where do you get the funds to ring? There's not enough availability, there's not enough out there. There's not enough help. I wasn't being choosey because I was prepared to go to refuges. A couple of them had to knock me back coz I was homeless for so long I stretched my resources to the limit. I'd already seen the majority of places that would pay for a week's accommodation. I tried accessing a number of these accommodation places prior to release from the jail. I think that I don't like how you're allotted an amount. I think everyone should be evaluated on their individual situations not on you've already been helped once this three months, that's it bad luck see you later. I don't think the allotment per person should be like that, people should be assisted on their immediate merits what they have then and there *[Age 32]*.

Based on their experiences of using various crisis accommodation services, women talked about a number of aspects of the service environment that they found unhelpful, which were considered to impact on their overall stability within the service. These included problems encountered with other residents including conflict, "being a bit rough" and being "easily influenced" by them. Being barred from or asked to leave the service prematurely was also a strong theme emerging that was considered to impact stability. Women reported being excluded from the service as a result of abusive behaviour, being drug affected, repeatedly returning to service past "curfew time", and "sneaking some one into their room".

Box 26. Excerpt from client service experience interview...

[The service] has a really evil influence I think because it is just full of people doing the wrong thing – but at the same time it has a lock on the door and you don't have to share a room with anyone. It has its good points and bad points but you have to try and keep your head about you. But if you are easily influenced like me that place will get to you *[Age 25]*.

8.2.2 Transitional Housing

Women who entered into transitional accommodation generally came across as being happy with the accommodation provided and the support that accompanied it. The main concern emerging related to the temporary nature of the accommodation. Some women who had been residing in transitional accommodation for extended periods of time (some up to two years) talked about the difficulties they faced in having to move from an area that they have established supports in and housing that they have grown to like to a public housing property that they were unhappy with. On the other hand other women were happy to be "getting out of this area" and considered the move to be an opportunity to maintain change. Problems of "matching" people in a shared transitional housing environment, particularly with younger women also emerged as a theme and concern was expressed about the way in which differences amongst clients were resolved, particularly as confidentiality had to be maintained for both parties.

Box 27. Excerpt from client service experience interview...

The transitional housing – I love where it is – if I could stay there longer it would be great – if I had more choice for office of housing. I just had a baby and the day that I get out of hospital we were offered the place in [suburb] – I hate the place and it wasn't our first preference. The services that I am linked to are in [suburb] and not [suburb] [Age 30].

Most of my supports in the [suburb] area. I will be moving out to [suburb] on my segment one application. This will be miles from exiting supports and train station but I am looking forward to being isolated and moving out of the area that has triggers for me going back to drugs *[Age 44].*

8.2.3 Capacity for Early Intervention Responses

While not a common experience amongst the women interviewed, the eligibility for housing assistance for those who are currently residing in their own accommodation paying off a mortgage however are at risk of losing the property raises significant questions for the scope of early intervention responses to those experiencing financial difficulty. The following excerpt is from an interview with one woman who inherited money and purchased a property, however is now at risk of losing it as a result of drug related debt and regularly accesses welfare drop in services for food.

Box 28. Excerpt from client service experience interview...

There's not the assistance in the area that I need it. I feel like the problems I have are not addressed by anyone unless I'm prepared to get off the drugs, obviously that's the problem and I'm not trying to step around that but part of me is continually using is because I'm terrified of what lies beyond it financially. If I had some idea of what I'm going to face, like you'll get fined or whatever- there is no one around here who can advise me of that kind of stuff. I told you I went to [the service] for money, bills, financial support. I got really behind in my mortgage but they couldn't pay that. They couldn't help pay a mortgage, which is fair enough but one day I might be back there to get bond and rent. I don't want to sound like I'm whinging, but because I have a mortgage I qualify for no assistance yet I have as many outgoing bills as any one else, and less income because I don't get rental assistance. My outgoings would be nearly two hundred a week and that would be an expensive rental thing. I need help to keep it at the moment. I don't feel entitled to able to voice these problems because I can't say poor me, I own my own flat. There isn't that freedom to talk about my problems *[Age 39].*

Aspects of the Support Process

Being consistent	Treating me with respect
Maintaining professional relationships	*listening & making time for me*
Following up and being proactive	*non judgemental*
Being able to access when needed	*understanding*

When women discussed aspects of the support process across a range of service types that they found both helpful and unhelpful two key themes emerge; being consistent and treated with respect. While these two principles were articulated in a number of ways, when women discussed their experiences that were unhelpful the above elements were missing and when support was helpful they were present. These two principles along with the elements will be discussed in turn.

8.3.1 Consistent Support

- **Maintaining professional relationships**

Being able to maintain a supportive relationship overtime with the same person who they felt comfortable working with was a key component of a consistent approach to support, whether it was with a generalist counsellor, drug and alcohol, mental health or welfare and housing support. Women who considered themselves to be in a beneficial supportive relationship had been engaged with the support over an extended period of time and had an understanding that the support was based around their growth and could be maintained as long as it was needed, however also had a sense of the professional nature of the relationship. They were also relationships where a level of trust had been established that if there was some regression in their circumstances, they did not feel ashamed to return and try again.

Box 29. Excerpt from client service experience interview...

I am sick of starting working relationships again so it is good to be able to maintain the relationship with [support person]. I don't have to prove myself – don't have to feel bad. She knows me really well. I am trying to develop more healthy relationships so that I don't need counselling so much. I can now understand a lot more and put things in place *[Age 30]*.

There was also recognition from many women that the relationship was reciprocal and the more they were prepared to engage the more they were able to gain from support. Women talked about learning that being angry or defiant towards others did not help with their circumstances and that "even the slightest bit of respect for someone goes a long way". Central to this was women feeling they were in the emotional space where they could be receptive to help. This realisation however usually came over time and was underpinned by a trusting relationship.

Box 30. Excerpt from client service experience interview...

You have to be ready and you have to have a good relationship with your counsellor – you have to have a relationship with all workers – that is the most important thing. It has to be a two way process. If you put in they will help you – you have to pull your weight and they will help you *[Age 44]*.

When the support process had not worked for women there was a perception of mixed messages that led to unrealistic expectations of the relationship both in terms of the nature and duration of support and blurring of professional boundaries. This was reported to set women up for disappointment when the support relationship was terminated or their wishes for friendship were unable to be reciprocated. Other instances where the support relationship became unhelpful or difficult for the women were in instances where there was a perception that there were too many professional people involved in their lives and "in my head".

Box 31. Excerpt from client service experience interview...

[The support person] was really bad – really inappropriate. Used to tell me she would always be there for me and she would say that she would move us all into her house if she could – she was really unprofessional *[Age 25]*.

Box 32. Excerpt from client service experience interview...

Since I left home I've had nothing but counsellors etc, trying to do the right thing but it's overloading my brain. That's why I try to keep it to a few people, here and at [the service]. [They are] trying to put all these people on to me but I cant do it *[Age 20]*.

➢ Following up and being proactive

A reoccurring theme amongst the women interviewed who found the support process to be helpful were in instances where service staff were able to 'follow up' with them either phoning or calling in to make sure they were okay.

Box 33. Excerpt from client service experience interview...

I think they should be a lot more hands on. They don't follow up enough, if you don't keep in contact with them well adios amigos. That may be because their resources are tight. But with [support person] it is different, that's why she made such an impact on me, she goes out of her way to ring me and she genuinely cares, or I think she genuinely cares and that's all that matters. Without her I don't think I could stay clean. A couple of times she's called me and I've been at the teller machine and it has been going through my mind *[Age 32]*.

Many women also felt that in some instances support staff should be a little more proactive in initiating or engaging with them or encouraging them to become involved in things. While on the one hand women were appreciative for the respect of their space and coming and going when they liked, there were times when they felt a "little ignored by staff" and that those who made the "most noise" tended to get the most attention.

Box 34. Excerpt from client service experience interview...

I feel like that being a client here we tend to get all lumped into the same kind of group, and I think the more pathetic you are the more assistance you get and the more you're entitled to so I get annoyed because I can do certain things for myself I get a lot less assistance, and I feel that because I've taken the initiative I should be rewarded but it actually works the other way *[Age 39]*.

Box 35. Excerpt from client service experience interview...

If you choose to stay in your flat they don't really encourage you to get out – they leave it up to the person to do it for themselves. There is only so much a worker can do – they sit back and observe and let person work out whether they need support *[Age 35]*.

➢ Being able to access support when I need it

Women found the support process particularly helpful when it was flexible enough to increase in intensity during periods of lower functioning or "crisis" and decrease in intensity when things were going well, however knowing that they were still able to maintain connection with the same service over time.

Box 36. Excerpt from client service experience interview...

The fact that they have given me extra attention when I needed it – times when I seen my worker twice a week they have seen me through so much stuff – [Support person] sat by my side after I tried to kill myself *[Age 25].*

A strong theme emerging from women with children was the fluctuating nature of support that was based around whether they had their children in their care or not. Women talked about "getting more support from services" when they had their children in their care and the support disappearing once their children had been removed even though they were still in need of support. This contributed to feelings of isolation and loneliness and potentially magnified the loss experienced from the removal of children they were unable to care for. Similarly, women who regained care of their children or grandchildren reported "having a lot more support now I have the kids". This suggests that having children in their care meant increased support options were available to them or that they were more easily able to attract support when they have children then when they are on their own.

Box 37. Excerpt from client service experience interview...

I have a mental health problem - I need for a good counsellor who can deal with one issue at a time. I have difficulty cleaning the house. Sometimes I don't feel supported – there is no one I can really call in those times when I am on a downer. I can ring Lifeline but it doesn't really help. I need support that I can access 24 hours that is more intensive. When I had my kids I tended to get more support. I had [a number of family support services]. I had a lot more support. Now that the kids have gone I don't get the support that I used to. When I lost my kids [the service] helped me to get through it. It has been the hardest adjustment- I still have toys and clothes and don't know what to do with them. I hate it when I am home because it reminds me of the kids so I try and get out of the house and come here – there is no rush to get home *[Age 31].*

Box 38. Excerpt from client service experience interview...

Since I have had the kids they have really helped a lot. You seem to get a lot more support when you have kids in your care *[Age 44].*

8.3.2 Treated with Respect

Just to know that I am being heard – treated like an equal. Not treated like an idiot - treating people with respect. She never pulls the power thing with me...other services often does that. The breached client protocol thing hasn't happened to me here [Age 34].

- **Listening and making time for me**

Having some one to talk to when it was needed was considered one of the most helpful aspects of the support process. Many of the women discussed needing staff that were able to spend sufficient time with them to be able to talk and feel listened to. Feeling listened to equated to the women having the confidence to contact staff for advice or support when it was needed, with such comments as "the fact that there is always some one there to sit down to talk to is helpful".

Feeling listened to also related to support staff remembering discussions from previous contacts, which facilitated continuity in communication. The women commented that it was important that staff made the time and waited for the right context to listen, rather than combining tasks such as talking in the car, with one women stating "they said that I could talk to them in the car while they were doing something else. I would have preferred to be able to talk in a room - it wasn't the right place" [Age 36].

➢ Non-judgemental

Central to the idea of being treated with respect was the sense from interviewees that the services did not judge them. The women discussed feeling trust towards those services that they felt were non-judgemental, and this appeared to enhance the capacity to build rapport and establish working relationships between clients and agency staff. For those women who were seeking stable housing after spending time incarcerated, the non judgemental approach was particularly important, with these women commenting that they wanted to focus on the future, and being judged for past made this more difficult.

> *Box 39. Excerpt from client service experience interview...*
>
> I've been very lucky with my workers, the first workers I came into contact with I've built up a really good rapport, the trust value has been there, I've never felt judged which a lot of my peers have said they have, I've never found any of my workers, none of them have ever judged me. . Basically I want to be treated like a person and not a leper. I know I did something wrong and I know I went to jail, but I'm out now *[Age 32].*

➢ Understanding

Feeling understood by service providers was also critically important to the women. The feeling that their situation was understood appeared to engender a sense of security, and protection for some of these women, with some describing feeling very comfortable in those environments where they felt understood. They also emphasised the importance of staff being sensitive to how much and how soon the women were required to disclose personal information. Helping women to understand different processes or words by explaining in terms that can be understood as one woman commented "she is very helpful. She breaks up words very clearly, helps me to understand what the other person is talking about". Particularly important for women who had experienced sexual assault, or using substances was being able to talk to some one who understands "what it is like". In the instances of sexual assault this involved feeling more comfortable talking with women.

8.4 Experiences within Specific Service Types

In considering both helpful and unhelpful experiences within specific service types, the women frequently referred to drug treatment and mental health services. The following section focuses on the women's experiences within these settings.

8.4.1 Drug and Alcohol Treatment Services

- **Pharmacies**

The role of pharmacies was recognised in the interviews as an important collaborator in the care and support of women who were on drug replacement programs. As a crucial treatment component, negative experiences at pharmacies were reported to disrupt good progress, while a positive connection with the pharmacy was reported to assist the women feeling less stigmatised about their drug use. As articulated by one woman...

> *Box 40. Excerpt from client service experience interview...*
>
> Chemists...play a big part in my life at the moment – they tell me not to use dugs and it matters because they care about me – I will do what they say because they care and that is the main thing – just knowing that someone cares. They are like a family. The chemist where I went to before - they were so rude, the whole attitude.... This chemist, they trust me and I will keep going there. The chemist can be really life altering *[Age 25].*

- **Rehabilitation as an accommodation option**

Drug and alcohol rehabilitation programs were recognised as both helpful and unhelpful, and serving the purpose of both treatment and temporary accommodation. Spending time in rehab for some was an opportunity to be temporarily housed, before returning to unstable accommodation, and the crisis housing circuit. It was reported that rehabilitation focussed on drug and alcohol use but that at times did not prioritise other significant needs such as accommodation that, if not addressed, serve to undermine the rehabilitation success, as expressed by one women...

> *Box 41. Excerpt from client service experience interview...*
>
> I put up with the rehab because it was somewhere safe to stay. There was no follow up when I got out and I went back down again – rehab did nothing to help with housing and housing was my big concern. I had only one experience of rehab and I ended up clearing up on my own. While I was in there I saved my money and then when I left it all went up my arm. *[Age 22]*

Some women commented that a personalised response from drug and alcohol treatment services made a positive difference, where staff was able to connect with the women's individual needs, and to address the wider concerns of the women, not just the presenting problem, including assistance with food, material aide and consideration of children's needs as well.

➢ Being ready

A common theme emerging amongst the women who discussed their experiences of drug and alcohol treatment was the recognition that their own level of readiness was one of the biggest contributing factors for successful outcomes for them. This related to both the manner in which they interacted with service providers and their capacity to make changes.

> *Box 42. Excerpt from client service experience interview...*
>
> When I was scattered, coming down I would argue with everyone and they wouldn't help me....I realised you don't get anywhere doing it [Age 20].
>
> The thing that made the most difference was me in the end. Was not really ready at that time to respond to the treatment. It is not effective when you are not ready to stop using.... You have to be ready and you have to have a good relationship with your counsellor.... It has to be a two way process – if you put in they will help you – you have to pull your weight and they will help you [Age 44].

Consistent with this theme, the women did not find it helpful to participate in counselling or treatment when it was not voluntary. Similarly, some interactions with their drug and alcohol counsellors were considered unhelpful when it was perceived that the counsellor was 'lecturing' them about their drug use, with the women seeing themselves as the experts of their own use.

> *Box 43. Excerpt from client service experience interview...*
>
> They just piss me off - because they keep telling me I have a drug problem. I know I have a drug problem; they don't have to keep telling me. Partly because I am made to see them I don't have a choice in that it is part of my contract with Rehab to see a drug and alcohol worker [Age 19].
>
> I have had the same drug and alcohol worker for about five years. I feel like I am limited from what I can gain from it – I know what I have to do. It is a matter of being ready to be able to take the steps *[Age 30]*.

It was also important that services did not discriminate against the women based on a history of failed treatment interventions, and that when they were at a stage of readiness to resume treatment that they did so without feelings of guilt for past unsuccessful use of the service.

> *Box 44. Excerpt from client service experience interview...*
>
> The first time I gave up drugs I thought I don't need you no more... when I relapsed I was too ashamed to call her again... but she was there with open arms and more than willing to take me on again *[Age 32]*.

➢ Immediate access

The timeliness of the response from the drug and alcohol treatment provider was considered crucial for successful outcomes, with the women reporting that they need available treatment options when they are ready to address their substance use problem. It is generally understood that the window of opportunity to capitalise on the readiness for change in substance users can be short.

The capacity of the service system to be able to respond immediately to these women was emphasised in the interviews. Some responses demonstrated how directly the immediacy of access to services impacts on the success of substance use treatment. Another theme was the availability of prescribing doctors for the provision of Methadone or Buprenorphine. For one woman, 24 hour availability of services was important, so that accurate advice and support can be provided when it is required.

Box 45. Excerpt from client service experience interview...

Detox centres and rehab, when people want to get off they want to get off straight away, when they go to try and it takes a couple of days and they're back here. They need something quicker; they shouldn't have to wait to get into detox [Age 20].

I went to the Smith Street to detox from speed and I couldn't get any help so I went out and continued to use [Age 44].

I had a bit of a hard time because I was on Bup. The doctor I was seeing went away and didn't leave a script. I find that to be a breach of duty of care. When a prescribing doctor leaves you should be able to have someone who understands your situation. It was really difficult to get the next script because he is one of the only prescribing doctors in the area *[Age 22].*

➢ Responding to underpinning needs

The role that drug use played in suppressing underpinning trauma was raised by some women. There was a perception that drug treatment services had not adequately focused on what they considered to be contributing to their substance use in the first place. This was expressed very passionately, as reflected in the following excerpt...

Box 46. Excerpt from client service experience interview...

The D&A support didn't really have any impact. They are able to provide support when you are using but when you stop using and you really start too freak out because everything comes to the surface – you can't hide anymore. There is no one with the experience to help you through that – they use their authority instead to terminate your time with the service. I had a lot of anger issues – once I got myself clean I couldn't put it down to addiction anymore. D&A need to learn to cater for the cat and caboodle – everyone I know with mental health problems they are all addicts so no one really gets one without the other. It is a health issue but it becomes a moral issue. People use drugs and alcohol because it is a health problem; they are not doing to get up people's noses. It is not under mental health but a lot relates to post traumatic stress – I suffered mentally but it is not covered at all in D&A support *[Age 34].*

Another theme emerging related to the role that substance use takes in occupying the day. In one instance it was equated to a full time job "rorting" in the morning for a first hit and then going back out to "rort" for the afternoon to get through the evening. One critical component cited by the women following detox was being linked into sufficient activity to keep them busy, and fill in the gap, both in time and purpose, left by ceasing drug use. While potential employment was considered to be something that could fill the void, some women perceived that they did not possess the skills "to even know where to start". Successful engagement with support workers appeared to play an important role in this respect.

Box 47. Excerpt from client service experience interview...

I'm scared the boredom will beat me and I'll do that [drugs]...There's an empty spot and I don't know how to fill it exactly....before the day was filled up running around scamming people and now I'm sitting her twiddling my thumbs...I just don't know what to do to fill in that gap so thank god [support worker] is there *[Age 32].*

➢ **Qualifications of drug & alcohol staff**

Some women expressed concerns regarding the age and experience of the counsellors/workers with whom they participated in their drug and alcohol treatment. Staff expertise or perceived credibility was cited as a concern by women who did not believe that academic qualifications meant as much as 'real life experience'. What this suggests is that some women are able to feel empathised with and therefore benefit from the treatment if those providing the support have past experience of substance use or are in a 'peer' based relationship.

Box 48. Excerpt from client service experience interview...

There are so many young inexperienced workers deciding your fate...the majority of people are educated by schooling and not life. They try to understand you but you know when they are not understanding [Age 35].

The counsellor has helped - finally talking to some one who has been there and done that – I see her weekly. [We have] both done jail, she has been there and it is good to talk to another mother about child being on drugs. She understands what it is like *[Age 44].*

8.4.2 Mental Health

➢ **Ongoing support combined with housing assistance**

Mental health support was described as being particularly helpful when it had a homelessness specific focus provided on an outreach case management basis. One woman reported being linked into this type of mental health service, which provided consistent support to her over a five year period. This support also focused on her housing needs as reflected in the following excerpt.

Box 49. Excerpt from client service experience interview...

I have a caseworker in the homelessness team: they encourage me to take my medication so it doesn't affect my daily activities. They visit you so you don't have to go chasing them.... And they help you find accommodation if you're not well enough and can't look after yourself... they have stood by me the whole time. They've been like family to me *[Age 37].*

➢ Not being judged/attitudes

Not feeling judged and feeling respected was considered an important feature for successful mental health service provision. This was a consistent theme amongst women who had accessed mental health services, with many women discussing feeling threatened particularly in hospital settings. Critical elements for women relating to mental health services was transparency of decision-making and communication, trust between clients and staff, understanding of individual issues rather than judgement, staff familiarising themselves with the clients history to avoid repeated 'story telling', and consultation about treatment options.

Box 50. Excerpts from client service experience interview...

I had a psych doctor who said that I had nothing to be angry about – that is why I hate doctors. It made me feel even more angry. I had lost my youngest daughter at the time. I didn't like him telling me how I should be feeling. Attitude stuff can have a big impact *[Age 36].*

I'm currently at [the Mental health service]. They change the doctor all the time; they don't bother to look at my file so I have to go over the story all over again. I said to them don't you read the file? I don't feel that they respect me; I need to be respected before I can respect them. I feel I get respect here otherwise I wouldn't come. A sense of community is also important. I feel more at ease with my case worker at the [Mental health service]. I trust them more than the doctor. He used to be a pysch nurse so can see from the bottom up. He has more hands on contact. He seems to have a wiser head on his shoulders – he speaks logic to me *[Age 49].*

➢ Accessibility

Having good access to mental health service expertise within housing services was considered important, rather than referrals to external services which was considered by some to be time consuming and complicated. Or, at least involving the support worker closely in the referral process was considered helpful, as someone in poor mental health may not be able to effectively relay sufficient information to inform diagnosis.

Box 51. Excerpt from client service experience interview...

They weren't able to help me much when I had psychosis because they can't access mental health services very easily – they can't do it themselves.... Services like this need to be able to access those services directly and liaise with each other... wasn't able to access the service unless I told them everything and making myself vulnerable and I couldn't do it with my worker. It would have been better to go with my worker; if the service was more open to seeing the both of us I would have been able to get a diagnosis *[Age 25].*

➢ Non-voluntary admission/medication

As to be expected women did not like being admitted non-voluntarily to psychiatric hospitals. Most of the women who had a non-voluntary admission to a psychiatric hospital or enforced psychotropic medication did not report such to be helpful for their healing. For some it was the isolation while in hospital, the side effects of the medication, or the inconsistency of service provision within mental health services that were considered to be the least helpful.

Box 52. Excerpt from client service experience interview...

Unhelpful....being locked up in isolation so you don't kill yourself and treated like a child. When I am there I have to be a good girl – there is nothing wrong – I get depressed like every body else and have highs and lows. But the drugs make it hard to stay awake and fluid retention makes my eyes sore and I can't read a book because I find it hard to concentrate [Age 49].

I don't function well in hospital. All the mental health teams – putting me in hospital or trying to put me into hospital. Just the inconsistencies for most of them across the services *[Age 19].*

On the other hand one women who was hospitalised for major depression reported that her experience within hospital was beneficial and assisted her to gain insight to her situation and learn to identify the warning signs that indicated when her mental health was deteriorating

Box 53. Excerpt from client service experience interview...

Being in psych hospital made me realise what was important – gave me some perspective – it was about three years ago. Spent about 2 weeks in the hospital. I started to have another break down but I put supports in place to help with the situation *[Age 36].*

- Case planning

Central to what was perceived as helpful in case work approaches regarding the management of mental health, was the opportunity for input from the clients into the decision making about crisis plans and treatment. For one woman, her involvement with a mental health case management team had been a useful and positive experience on past occasions, and when her involvement was not sought in subsequent case planning she was feeling excluded and powerless in her own recovery process.

Box 54. Excerpt from client service experience interview...

All the case managers I have had included me on their crisis report, crisis planned hospital admissions, but this Centre hasn't and it has caused a lot of crap that was unnecessary if they would just let me be part of the process, which I asked to be and they said that they don't usually let clients be part of the process. I have always been part of my own crisis plan case management plan. And they wonder why it is going wrong, because they have no input from me. They just make you take anti depressants and feed you Valium and I hate that *[Age 19].*

8.5 Chapter Summary

This chapter focused on the direct experiences and perspectives of the women who were interviewed, including what they found to be helpful and not helpful through out their journey through the service system. The limited range of short-term safe accommodation options for women was a critical factor contributing to their instability, and services that prioritised safety were therefore considered to be more effective in providing support. Housing stability was also emphasised, the women attributing being assisted into stable permanent housing as having a significant impact on their life. When women talked positively about housing assistance they referred to the benefits of practical support such as assistance with furniture and initial establishment costs and assistance with their segment one applications for public housing.

The provision of crisis housing was considered helpful in providing "a roof over my head", yet unhelpful in that it did not enable long term planning and was often unavailable at the time it was needed. Women in transitional accommodation were generally satisfied with the accommodation provided and the support that accompanied it, with the main concern relating to the temporary nature of the accommodation.

In discussing aspects of the support process that they found both helpful and unhelpful, the themes of consistent support and being treated with respect emerged. Consistent support was seen as maintaining professional relationships, following up and being proactive, and being able to access support when it is needed. Being treated with respect was defined as listening and "making time for me", being non-judgemental, and understanding their needs.

In considering both helpful and unhelpful experiences within specific service types, the women frequently referred to drug treatment and mental health services. Drug and alcohol rehabilitation programs were recognised as helpful, but this was often as an opportunity to be temporarily housed. It was reported that rehabilitation focussed on drug and alcohol use but that at times did not prioritise other significant needs. The women recognised that their own level of readiness was one of the biggest contributing factors for successful outcomes in drug and alcohol treatment, yet felt that the timeliness of the response from the drug and alcohol treatment provider was considered crucial for successful outcomes. After successful treatment for drug and alcohol use, one critical component cited by the women for the maintenance of cessation is sufficient activity to keep them busy to fill the space after drugs.

An allocated outreach mental health caseworker that also focused on housing assistance rather than referral to external services was considered important. This support was considered most useful when it was able to follow the women across different accommodation sites, with the consistency of this support emphasised. Not feeling judged, feeling respected and the opportunity for input into crisis plans and treatment was considered important features for successful mental health service provision. For those women who were identified as dual diagnosis clients, the problem of fitting into one or other support system was identified as significant problem.

9. Towards Improved Service Practices for Women

Recent reviews and forums have identified a number of potential service models for effectively engaging individuals with complex and multiple needs, with a number of initiatives currently being explored by both State and Federal governments (Bisset et al 2002; Thompson & Goodall, 2002; Thompson & Goodall, 2003; Department of Human Service, 2003). Whilst these initiatives have advanced current understanding, there has been limited attention directed towards the development specific service models that take into consideration the unique needs of women. The following chapter commences with an overview of current service gaps relating to women with complex and multiple needs identified in the literature and focus group consultations. This chapter aims to identify current thought within the emerging literature as it relates specifically to women and presents an overview of therapeutic and case management approaches, which have demonstrated successful or promising outcomes.

9.1 Limitations of Current Service System Responses

> *Where are the services that deal with the underpinning issues – where are the services that maintain support and acknowledging that there are long term issues – where is the next person who is going to follow through?* [Women's support staff]

A recent review of the literature pertaining to service gaps for those with complex and multiple needs compiled from Thomson Goodall Associates (2002) reported on numerous service gaps across the service system (for discussion, please refer to this report). While a myriad of service system weaknesses were identified, there has been limited focus in the literature on the specific issues that impact directly on women. During an earlier review of complex needs undertaken in the SAAP system, Bisset et al summarised the overall weakness in the current homelessness service system response for women as follows:

> *Homeless women with complex needs are seen to be particularly disadvantaged as traditional single male services are not designed for women, and domestic violence and family services generally do not accept homeless single women, particularly those with complex needs. The service gaps exist in terms of actual lack of services for this group, as well as lack of sufficient research and model development on effectively meeting their needs* (Bisset et al 2002: 73).

On Census night 2001, approximately 42,000 women experienced homelessness. From this count, a higher proportion of women were found to be residing in SAAP services compared to males (Chamberlain & MacKenzie, 2003). While this partly reflects the specific allocation of funding to women specific domestic violence services, a significant proportion of women also access family and cross target SAAP services. A review SAAP data undertaken during the first stage of this project indicated that while there has been an overall increase in recurrent expenditure in Victorian during 1997-2002, this funding has been disproportionably directed towards cross-target and family services compared to women specific and domestic violence services. Over the five year period there was an increase in the proportion of women as a percentage of all support periods accessing non-gender specific cross-target and family services. At the same time there has been an overall decline in the proportion of expenditure to male specific services, with males therefore more likely to be accessing cross-target services. The high proportion of males accessing cross-target SAAP services, particularly onsite residential accommodation services, is likely to have implications for women accessing these services (Parkinson, 2003).

Many of the current cross target service models have emerged to respond to single men experiencing homelessness and in many instances provide an inappropriate accommodation and support option for women. The Commonwealth Advisory Committee on Homelessness report that:

> *".....while single women are increasingly at risk of homelessness, only 46 of the 1126 SAAP agencies focus exclusively on their needs and less than 4 per cent of the annual SAAP budget is spent on services for single women."* (Commonwealth Advisory Committee on Homelessness, 2000: 61).

9.1.2 Themes from the Focus Groups

In relation to current service limitations, the following dot points below summarise the main issues identified from the three service provider focus groups undertaken as part of the current research. The issues have been themed according to the main headings and are not necessarily ranked according the perceived priority of the issue. The gaps identified were from agencies and providers working in the SMR as that was the focus area of the study, therefore some issues may be region specific while other represent broader systemic limitations that may be applicable across all areas.

- **Safe accommodation & external environments**
  - There are very few safe and secure crisis accommodation options for women, particularly in outer South Eastern Metro Areas. Crisis accommodation placements are often organised night by night, with service often having to resort to motels. Caravan parks in the area are becoming too expensive and are not viable options for women because of the risk of violence. There are virtually no places that will take children. This was perceived as an unsafe option for women with multiple needs and reduces the capacity for effective engagement to work through needs. Resources to undertake longer term work are significantly constrained.
  - Access to safe accommodation that creates some sense of community and responsibility for their own space. There is a need to deinstitutionalise crisis accommodation settings and offer a diversity of accommodation models that treat women with respect.
  - There are limited affordable and safe housing exit points. The model of public housing, particularly high rise units, is often considered very traumatic for women. Support time is spent skilling women up to deal with the isolation they experience once they move into the public housing system. Placing women with multiple needs in a public housing environment with other residents experiencing similar difficulties can be particularly damaging.
  - While many of the women with multiple needs accessing accommodation support are fleeing experiences of family violence, it is almost impossible to gain access to domestic violence support unless the violence was experienced on the same day they seek assistance. The combination of substance use and mental health issues also creates difficulties in gaining access for women.
  - Crisis accommodation services have limited capacity to work within an early intervention framework in maintaining at risk tenancies for women with multiple needs, as they are unable to access the service until their circumstances become worse and lose their housing.

➢ **Service approaches**

- There is a lack of specific women responses. Many women come to the Women's service and have not experienced any gender specific support in the past. Women are likely to have experienced a mental health response to the trauma in their life.

- Clients often identify their priorities according to the language and way services are structured. Whilst a client might require ongoing support they do not generally approach the service and say "I want a relationship with you" they approach the service around the issue of housing crisis or whatever the issue may be at the time. The service system engages around the presenting issue and once that is dealt with the client is referred somewhere else to address all their other "issues". Holistic support is often framed in terms of multiple issue responses such as mental health, drug and alcohol, sexual assault etc. Too much attention is directed to the presenting issues. Other aspects of the client's life are important to consider in a holistic response including connectedness to community and having a sense of belonging.

- Women with multiple needs often like to access generalist support because it doesn't have an issues label such as domestic violence attached to it. However, generalist services often find it difficult to attract funding because they don't have an 'issue' to attach funding to as most funding is issue based.

- There is a need to recruit more culturally specific workers to improve cultural responsiveness around women's issues. All services should provide culturally appropriate responses and provide links into relevant cultural networks where appropriate.

- Services need to be able to engage women in some part of the mainstream otherwise they will continue to live outside it. Services have to move from always providing an issue focused response. Having longer-term strategies such as mentoring that parallels support and engages women into the community. Once the worker withdraws support there is something in place that is meaningful. Being able to link with community development activities that create a sense of connectedness to community is important.

- The provision of flexible funds to enable people to participate in normal day-to-day activities can have a significant impact on building hope and enabling people. Flexible funding provides additional tools to work with the client.

➢ **Duration of support**

- Short-term support is problematic because the pattern of repeated experiences with services – clients are often reluctant to engage in discussing underpinning 'issues' because they know that the support is not going to continue. For women who have been in a cycle of repeated service use it takes longer to establish trust, often requiring extended periods of time focusing primarily on engagement. There needs to be a longer term view to providing support for those with multiple needs – view to supporting clients for up to three year period with brokerage money.

- The duration of support needs to be based on the recognition that women with multiple needs are experts of the system – they know what to expect, which can provide a barrier to effective engagement. Sometimes six months is still not enough to gain trust.

- **Staffing issues**
  - Gender of the worker needs to be female.
  - Staff working with women who have experienced ongoing homelessness with multiple needs need to be experienced in the field. Women are very quick to "pick some one who is green". Clients are often more experienced of the service system and often have to start all over again with some one who is beginning their career, which can be perceived by the client as not having much to offer them.
  - Increased emphasis needs to be directed to improving capacity of current support staff within the homelessness support system. Training opportunities in advanced practices are limited within the SAAP system. There is a critical need for regular access to specialised training and supervision in working with women with complex and multiple needs for frontline staff in housing and support services.
  - The high turnover of staff in the system is a major barrier to effective engagement with women. Turnover is influenced by inadequate remuneration.
- **Linkages**
  - Being able to work to together with other providers – not just personalities. Different agency agendas limit effectiveness of agency linkages.
  - Being able to get the right response for the client is incredibly difficult. Having access to an in house drug and alcohol worker has greatly enhanced accessibility, however it is still difficult linking into mental health services at the time they are needed, particularly if the mental health issue is considered "behavioural".
  - Access to affordable long-term counselling especially around domestic violence and sexual assault is difficult.
  - Lack of continuity with workers as women move around the system.

9.2 Strengthening Women Specific Service Approaches

9.2.1 The Need for Specific Responses for Women

The profile presented in the earlier sections clearly demonstrates the complexity and interacting nature of needs amongst women in the snapshot. The particular issues that stand out from this profile is the high proportion of women reported to have experienced sexual and physical abuse both in childhood and as adults and the potential links that abuse has to both substance use and mental health issues. This exploratory investigation indicates that there is an association between emotional, physical, and sexual assault, mental illness and substance use.

Research has linked substance use, poor mental health and dual diagnosis to underpinning trauma resulting from experiences of sexual and physical assault (Goodman et al, 1995; Harris, 1996; Liebschutz et al 2002). In investigating abuse histories of formally homeless women accessing a mental health centre, Goodman et al (1995:473) found that 65% had experienced childhood sexual abuse whilst 87% experienced physical abuse as a child, with the majority of the abuse experiences falling into the severe category.

As an adult, 87% of women with serious mental illness experienced physical abuse whilst 76% experienced sexual abuse. Only three women out of a sample of 99 had no experiences of abuse.

Similarly, Liebschutz et al (2002:124) found from inpatients surveyed in a detoxification unit, 81% of women disclosed experiences of physical and/or sexual abuse, with 70% experiencing both sexual and physical abuse. Liebschutz et al (2002:121) report that "a history of interpersonal trauma increases the risk for substance abuse, and substance abuse increases the risk for interpersonal trauma".

In addition to experiences of trauma, specific differences between men and women with co-occurring mental health and substance use difficulties identified in the literature include:

- *women are more likely to present at mental health or primary care services for psychological difficulties rather than for any associated substance misuse problem;*
- *women therefore tend to access drug and alcohol services later than men, and this may explain their more severe presentation; and*
- *women may have children, or want children, and this can deter them from contact with statutory services for fear of their children being removed.*

  (U.K. Department of Health, 2002:19).

9.2.2 Trauma Informed Service Models

Whilst is it commonly understood that sexual and physical violence represent major underpinning experiences for women presenting with multiple needs to homeless services, there has been little attention in the recent complex needs literature of appropriate theoretical frameworks to guide service model development. The weight of current evidence suggests that trauma is important in the context of women specific approaches and that it should not just be a secondary consideration to that of the immediate presenting issues, rather it should represent the foundation of any service model, especially for women with substance use and mental health issues. The critical importance for trauma informed practices in addressing both mental health and substance misuse amongst women in particular is becoming increasingly recognised in the literature. As defined by Harris & Fallot (2001:4)

> *First, to be trauma informed means to know the history of past and current abuse in the life of the consumer with whom one is working. Such information allows more holistic and integrated treatment planning. But second, and more important for this volume, to be trauma informed means to understand the role that violence and victimization play in the lives of most consumers of mental health and substance abuse services and to use that understanding to design service systems that accommodate the vulnerabilities of trauma survivors and allow services to be delivered in a way that will allow consumers to participate in treatment*

A lack of trauma informed practices it is argued is often a significant factor contributing to the fragmentation of service responses that continue to focus too much attention on the presenting issues and too little on the underpinning trauma. Failing to understand the role of trauma in the lives of women who are substance using and experience poor mental health results in service practices that further contribute to feelings of powerlessness and re-victimisation, thus limiting the effectiveness of the intended treatment program (Harris & Fallot 2001).

One of the challenges with women with multiple needs has been the involvement of many practitioners who do not necessarily approach the presenting issues with an understanding of the role the behaviour or presenting issues have in managing the trauma response. While service providers have long been advocating for holistic responses, there have been limited means in which to achieve this in current service configurations. For women experiencing housing instability, a trauma informed approach it is argued permeates all aspects of the service delivery response, from the initial screening and assessment, case management and appropriate accommodation models and is based 'genuine collaboration' (Harris & Fallot, 2001).

Trauma informed screening and assessment

Fallot and Harris (2001:23) argue that a major barrier to working with a trauma informed approach relates to the professionals' concern about methods of enquiring and whether broaching the topic will cause the client distress. This can be a valid concern if there is limited expertise within the staff profile that has capacity to respond. Therefore a critical component of screening and assessment within a trauma informed approach is to ensure that support staff is well equipped to both identify and respond to potential disclosure of trauma related experiences.

By using clear and direct language and providing the rationale for asking such questions in the screening stage, straightforward and accurate responses from the client are encouraged (Fallot and Harris, 2001: 24). With the development of safety and trust, the assessment stage focuses on gaining a more in-depth understanding of the trauma experienced. Those with experiences of trauma are more likely to present with a diagnosis of depression, anxiety, substance use or personality disorder rather than a diagnosis or assessment of post traumatic stress disorder (Fallot and Harris, 2001: 26), potentially masking the extent of underpinning experiences. According to Fallot and Harris (2001:28-30), the assessment process should focus on:

- *the range of abusive or traumatic experiences;*
- *dimensions related to severity of impact;*
- *life domains affected by trauma;*
- *identification of current triggers or stressors; and*
- *identification of coping resources and strengths.*

Trauma informed case management

For case management practice to be trauma informed, and work most effectively with those experiencing traumatic stress, the case management process must be aware of the often subtle dynamics of abuse of power, and prevent those dynamics being replicated in the helping relationship (Freeman, 2001:75). Effective case management must acknowledge the need for reflective practices and mechanisms to ensure workers are supported and supervised to minimise the risk of transference in the therapeutic relationship (Halpern and Henry 1995). A number of domains have been proposed by Freeman (2001:75 – 79) to guide trauma informed case management, each comprising elements of trauma sensitive case practice. These are summarised below.

Power & Control

This refers to the attention paid in case management practice to the power and control dynamics inherent in the staff/client relationship, with the focus clearly being on limiting any further experiences of powerlessness and loss of control for the trauma surviving client. The equilibrium of power and control is maintained via the following elements of case practice:

- *Management versus empowerment:* in which the case management power and control which typically lies with the profession is vested instead with the consumer to promote collaboration and cooperative decision making.
- *Problems and disabilities versus strength:* in which clients are defined by strengths and capacities rather than their deficiencies and problems.
- *Symptom management and reduction versus skills building:* in which the focus is on the acquisition of skills and competencies rather than the reduction of certain behaviours which are seen to be problematic.

Authority and responsibility

This refers to the attempt to reduce inappropriate apportion of blame, so that the client is not beleaguered by a sense of abuse of authority.

- *Expert intervention versus psycho education:* to avoid recreating a relationship where staff exercises authority, case management ought to be interactive and flexible to accommodate what the consumer thinks is important, building trust in their own perspectives. Psycho-education views current behaviour in the context of past abuse, and is understood as means of coping with past abuse.

- *Allocation of resources driven by the system versus the consumer:* in which the allocation of resources and intervention planning is informed by client requests and involvement in decision making.

Goals

Goals within a trauma informed model of case management may differ from traditional service goals, in recognition of the underlying trauma and impact this has on behaviour.

- *Stabilization versus growth and change:* in which behavioural and emotional outbursts are understood as attempts to cope with past or current traumatic experiences, and conceived as an opportunity for growth and change rather than problematic behaviour that needs to be stabilised and treated.

Language

Language within this approach is aimed at aiding the empowerment of the client and their recovery from trauma.

- *Clinical language versus everyday language:* emphasising a reduction in the inherent power promoted by professional jargon, in preference for plain, everyday language.

Trauma informed housing approaches

Many trauma related behaviours such as sleep disturbances, challenging and coping behaviours are encountered in the residential environment more frequently and often at greater intensity than in other support related settings. This necessitates the availability of highly skilled practitioners to resolve the trauma reaction and promote positive change without unintentionally recreating a power imbalance that further exacerbates maladaptive behaviour. Bebout (2001:48-52) promotes the provision of specialised training and supervision in trauma related issues and strategies for staff working in these settings.

One of the main priorities in ensuring a trauma informed approach to housing supports, is maximising the choice for the client in preparing their support plan, and providing a range of housing options from which to choose, particularly when there are safety concerns. Along with emphasising respecting client privacy, clear program expectations, and single sex housing, Bebout (2001: 54) believes a critical component is collaborative decision making, whereby staff and clients are full partners in determining the following:

- where to live;
- levels of supervision and support;
- with whom they will live with;
- when/whether meetings occur with case managers; and
- when moves will occur.

Housing services working from a trauma informed approach are

> *"...uniquely positioned to facilitate the recovery process of abuse survivors. Housing settings that are genuinely trauma informed offer trauma survivors the opportunity to acquire and practice new self management and relationship skills and to experience "home" in new ways"* (Bebout 2001:55).

9.3 Service System Integration

There is growing body of research that points to the critical importance of integrated service delivery responses for individuals with multiple vulnerabilities experiencing homelessness (Dennis et al 1998; Dennis et al, 2000; Stevens & Rielly, 2000). Within the current literature distinction is made between services integration and system integration, with both types of integration required to ensure effective outcomes for those with multiple needs. According to Dennis et al (1998:3), service integration focuses on the coordination of care, while the relationships within existing service structures remain largely unchanged. Examples of service integration include case management, case conferences, individualised service planning, and assertive community treatment. Systems integration on the other hand redevelops relationships between agencies focusing on the sharing of information, clients and resources. Examples of system integration include interagency coordinating bodies, pooled or joint funding, cross-training, co-location of services, and interagency agreements.

Stevens and Rielly (2000:4) maintain that services integration is insufficient for women with multiple needs as the service network options are 'undeveloped' in relation to gender specific 'problems' including trauma. According to Stevens and Rielly (2000:4) "*...systems integration strategies for this population must not only develop networks of care, but must also address the structural characteristics within those systems of care that fragment, retraumatize, and fail to address the needs that women themselves express*".

9.3.1 What Approaches are Effective?

Multidisciplinary Treatment Teams/Intensive Case Management

As identified above case management is one component towards an integrated approach to working with women and currently represents the most widely used method of support across all client groups within the homeless service system. Two commonly identified case management approaches that have demonstrated promising outcomes for those experiencing homelessness with multiple vulnerabilities are Intensive Case Management and Assertive Community Treatment (Morse, 1998; SAMHSA, 2003).

Intensive Case Management (ICM)

As the name implies, Intensive Case Management entails a very focussed and targeted case management approach in which a key worker plays an active role in assisting clients to meet multiple needs. The style is based on assertive outreach, very frequent contact with the client, and long term, consistent service provision that typically moves with the client. ICM often has an enhanced capacity to access resources for clients, and by virtue of a reduced case load per worker delivers an intensive and relatively high quotient of contact time. This enables the case manager to build a trusting therapeutic relationship with the client, and has been demonstrated as successful with those clients who have had past difficulty working with mainstream services. The other features of the model are typically some specialist clinical training for staff. Case management goals can relate to accessing various forms of housing, or drug and alcohol/mental health rehabilitation.

Assertive Community Treatment (ACT)

Similar to, but distinct from ICM is Assertive Community Treatment. ACT teams are compromised of a range of multidisciplinary specialists, typically mental health, substance use and social work practitioners who provide direct clinical treatment. This team is responsible for attending to the holistic needs of the client, typically those who are both homeless and exhibiting mental health disorders, or accessing services as required. As with ICM, client to staff ratios are low so that the intensive nature of the service is not compromised, and clients are often able to establish relationships with several ACT members with a range of expertise (SAMHSA, 2003: 63).

The key to the success of the ACT service appears to be the 'in house' provision of specialist services such as drug and alcohol or mental health, in contrast to brokering external service providers, as clients are able to build a relationship with these specialists in the context of a familiar team, while the other practitioners are able to benefit from the secondary consultation of their colleagues of different discipline to inform their own practice (SAMHSA, 2003: 63).

In an extensive review of various case management practices for those experiencing homelessness, Morse (1998:7.15) concluded that the body of research "strongly supports ACT as a 'best practice' for those experiencing homelessness who also experienced severe mental health issues. Some studies have also pointed to Intensive Case Management as a promising practice for those experiencing homelessness with mental health issues according to Morse (1998). Holloway et al (1995), in reviewing the case management outcome literature concluded that case management strategies that included direct clinical components are more likely to result in beneficial outcomes compared to other case management approaches.

Outcome evaluations of programs targeting those experiencing homelessness with dual diagnosis have also identified integrated drug treatment and mental health assertive community treatment teams as contributing to effective outcomes including a reduction in hospitalisations, substance use, and mental illness symptoms while increasing housing stability (SAMHSA, 2003:63).

Integrated support models for multiple needs

With respect to individuals with multiple vulnerabilities much of the evidenced-based literature has focused on effective practices for those with dual diagnosis, however often individuals included in such services have a number of concurrent needs including homelessness (SAMHSA, 2003). The broad consensus emerging in this literature is that integrated treatment models result in superior client outcomes, demonstrating reduced substance use and homelessness and improved mental health functioning. While there any many variations of the integrated model, the approach generally involves a concurrent focus on both mental health and substance use, combined with assertive or intensive outreach and case management that are underpinned by stages of change or motivational interviewing approaches. Often the integrated model is provided within the single service setting (Geppert, 2004; SAMHSA, 2003).

Geppert (2004:3) maintains that more effective integrated models are those that take into the different stages and severity of both mental health illness and substance use amongst individuals based on the four-quadrant framework of severity. Outcomes research identifies that "it takes approximately four years" to obtain abstinence using integrated community treatment approaches Geppert (2004:4). Other models that have demonstrated success for those experiencing dual diagnosis and homelessness include modified therapeutic communities, self help programs, and involvement of former clients in the service delivery process (SAMHSA, 2003).

Pre Treatment Outreach

Outreach has long been recognised as an effective strategy for engaging difficult to reach clients including those experiencing homelessness and was one of the main case management strategies adopted within the current agencies participating in the snapshot for engaging women with multiple needs. A significant challenge documented in the literature and emerging from the current snapshot is working with the client's readiness to engage with other needed support services that have been identified in a case management support plan.

To overcome the obstacle of a client's stalled readiness for change, Levy (2000) recommends that the outreach process to those experiencing homelessness ought work from a 'pre treatment' approach, in order to promote a client's readiness for treatment and change. This involves enhancing their readiness to participate in and benefit from treatment through "supportive therapeutic intervention, which facilitates problem recognition and increases client motivation for positive change" (Levy, 2000:362).

Levy (2000: 363-371) outlines five principles to guide a pre treatment approach when providing outreach to those experiencing homelessness:

- Promote safety – including harm minimisation, and money management
- Relationship formation – including pre engagement, engagement, and contracting
- Develop a common language
- Promote support and change
- Focus on cultural and ecological effects

Levy (2000: 373) recognises that such service provision requires well trained staff who possess the practice sophistication to "promote a gradual process toward positive change", so that the client is prepared incrementally for change which is then likely to have more lasting benefit than if it is attempted prematurely.

Readiness to change

Prochaska and DiClemente's (1983) stages of change model has been the basis of much work in the area of behavioural change, and along with the motivational interviewing technique developed by Miller (1983) is typically used to promote readiness for change with substance abusing clients. Brown et al (2000) have modified these approaches specifically for women with multiple needs, and present such in the Steps of Change Model, which has been used in the Prototypes Women's Outreach Service.

This model assumes that women may wish to make a number of changes simultaneously across different spectrums of her life, and that she will prioritise the need for change according to the level of threat the behaviour or situation poses to her life. The Steps of Change model proposes that women may seek to make changes in four key domains to promote sufficient stability that will enable more substantial change via a treatment process. These areas include:

a. *readiness to change a domestic violence situation*
b. *readiness to change sex risk behaviours*
c. *readiness to change substance abuse behaviours*
d. *readiness to deal with emotional problems*

(Brown et al 2000:232)

The model assumes that women will seek to make changes to the most threatening facets of their life first, and as such guides the therapeutic efforts towards those most immediate problems that a women is most likely to be ready to commence the change process. Using a sample of 451 women, (Brown et al, 2000:237) found that entry into drug treatment for example, "appears to be related to domestic violence treatment readiness, drug treatment readiness and readiness to deal with emotional problems" concluding that the immediacy of the readiness for change will be strongly related to safety concerns, for instance if substance use is keeping a women safer in a violent relationship when her partner also uses than she will continue to use. The findings in the above study suggest that women with multiple needs do not have a "generalized readiness to change" across all areas of their lives, rather change may occur at different rates, and at different times for different problems (Brown et al, 2000:238).

Parenting

Recognising that many women with multiple needs have children or are in the process of regaining custody of their children is crucial to effective service delivery. The need for ongoing support to women whose children have been removed from their mother's care was an emerging theme from the consultations. According to SAMHSA (2001:1) for those women with complex needs, current mental health or substance use difficulties and a history of trauma, parenting assumes an accentuated role of importance in their life, and represents "a major source of identity and self worth and a sense of shame and guilt."

For women who are mothers or expectant mothers, it is argued that treatment and recovery must also focus on their role as a parent within all aspects of service delivery. While it is argued that the threat of losing children can act as a barrier for seeking treatment, services that seek to develop parenting skills, extend the parenting relationship and emphasise existing parenting competencies have demonstrated positive outcomes both for the women and their children (SAMHSA, 2001: 2-3).

Housing

There is little doubt that the provision of stable and affordable housing is the most critical component in any integrated response. Whilst the establishment of permanent housing or resettlement should be the ultimate goal, women experiencing complex and multiple needs should have a continuum of support that follows them through the housing system. Casey (2002:13) based on her study of women's homelessness suggests that ideally women should be able to move into long-term housing directly from crisis accommodation. The limited availability of affordable social housing stock under the current segment one arrangements appears to limit more prompt exit from homelessness for women. The absence of ongoing support when women do move into permanent housing creates a continued risk for unsuccessful tenancy outcomes.

Gale (2003) maintains that unless adequate support is provided to individuals with complex and multiple needs in maintaining their tenancies once they re-enter independent housing, they will continue to experience a homelessness cycle or housing system 'revolving door'. Tenancy data from the South Australian Housing Trust reveals that approximately half of those who lose their tenancy return within six months to be rehoused. In recognition of the growing concerns of vulnerable tenancies, the South Australian Housing Trust conducted six demonstration projects to identify effective ways of maintaining tenancies.

A critical finding of the demonstration projects was the need for various levels of support, including debt management, and other early intervention strategies to be linked to housing. It was recommended that the support relationship be formalised between support agencies and housing providers by protocol agreements. The demonstration projects also highlight that early intervention is a key component to reducing rent arrears and debt (Gale, 2003: 6).

A recurrent theme emerging from the consultations has been the importance of supportive environments that strengthen the women's personal safety and connectedness. Recognition needs to be given to the environmental context in which women live, including their housing, neighbourhood and community. The effectiveness of services in enabling long-term outcomes for women with multiple needs is contingent upon the broader social infrastructure that facilitates community connectedness and builds resilience.

9.4 Chapter Summary

This chapter presented findings from stakeholder focus groups and the literature relating to current service system limitations and reviewed approaches to providing support to women experiencing homelessness, which have demonstrated successful or promising outcomes. The chapter emphasised the need for service models to be underpinned by a consistent theoretical framework that is appropriate to working with women with complex and multiple needs experiencing homelessness.

Many of the current cross target service models have emerged to respond to single men experiencing homelessness and in many instances provide an inappropriate accommodation and support option for women. The need for women specific service approaches is well documented, with the profile presented in earlier sections clearly demonstrating the complexity and interacting nature of the needs amongst women experiencing homelessness. Trauma underlies many of these complex needs, and providing a trauma informed service model is argued to be vital to adequately contribute to treatment and recovery. A trauma informed service model can be used in screening and assessment, within housing approaches and throughout case management practice, and has been shown to achieve positive results with this client group.

Service system integration is also of critical importance, wherein both the services provided, such as case management are integrated and the systems that support the practice, such as relationships between agencies and resources, are well connected as well. Approaches seen to be effective are multidisciplinary treatment teams, Intensive case management teams, assertive community treatment teams, and working to enhance the women's readiness for change using pre treatment outreach approaches.

10. Conclusion & Recommendations

The current research has sought to examine the ways in which service responses for women experiencing homelessness with complex and multiple needs can be improved. The project first examined the presenting profile and housing circumstances of women currently being supported by participating services. The profile was followed by an examination of current practice and potential ways forward for improving service system responses. For the purposes of this project, a working definition of complex and multiple needs was developed based on the abilities and behaviours of the women, the underpinning issues, and the capacity of the service system to meet their needs. Adopting a triangulated methodology, the study focused on the Southern Metropolitan Region as the site of engagement of participating services and clients.

The profile presented in the current research demonstrates the multitude of needs amongst the women, spanning across a broad age group of women experiencing homelessness. It is also evident that there are a multitude of service providers involved in assisting women through the service system, some with success and some failing to adequately meet their needs resulting in repeated homelessness cycles. *The lack of genuine coordination across sectors and services appears to perpetuate their experience of homelessness.*

The current design of crisis accommodation, transitional and social housing is not based on service consistency or a seamless pathway from one stage of support to next. While these services go some way in stabilising housing or containing homelessness, women's movement through this system was rarely a linear and uncomplicated. The current system fails to provide the consistency that is required for women to regain independence and exit long-term homelessness. Current approaches are therefore constrained in what can be achieved in promptly rehousing women and in some instances the focus on temporarily accommodating women serves to increase safety risks as many enter the referral merry go round without adequate follow up.

The constraints for housing services to work with women in a long term capacity underpinned by the development of intensive therapeutic relationships undermines the effectiveness of current case management approaches in achieving positive long-term outcomes and represents a false efficiency in the system. Part of this problem relates to the historical attachment of support to service sites or residencies and not individuals. So long as this approach remains, women will continue to cycle from one accommodation type to the next. The service system response must be conceptualised beyond the bounds of the Supported Accommodation Assistance Program and public housing if significant gains into reducing homelessness amongst women is to be achieved. Questions of where responsibility lies with respect to developing service responses does little to improve practice on the ground and outcomes for the women themselves. The reality is that housing is the primary need and it is therefore a logical point of engagement. However it does not mean this is solely a housing problem.

Service responses for homelessness must be increasingly based on the recognition of the complexity of social disaffiliation experienced by women. Policies directed at reducing homelessness amongst women should focus on both the development of early intervention and the creation of social support structures that prevent tenancy breakdowns and the creation of permanent exits out of homelessness that provide a means for women to regain their independence. This requires a skilled and integrated support workforce that is recognised through adequate funding models derived from multiple program areas and responsibilities. Some gains at service integration have been achieved through current initiatives such as the Homelessness Drugs Dependency Trial, which has demonstrated the outcomes that be derived by combing long-term drug and alcohol and housing support.

Recent complex needs initiatives will also assist in facilitating shared responsibility across sectors, however the limited focus on 'exceptional' clients will not respond to the true extent of demand for consistent and intensive support for many of those experiencing homelessness. Greater recognition needs to be directed towards enabling all services to be more effective in working with women with complex and multiple needs experiencing homelessness.

Responding within a service philosophy framework that legitimises the role of past and current trauma in the lives of women experiencing homelessness should not be considered as an add on, rather should underpin the approach of all services that women are likely to access. *The need for gender specific approaches across the spectrum of support is continually reiterated in the practice-based literature yet it continues to be a secondary consideration as cross target service responses continue to grow.* Specific domestic violence services provide one avenue for gender specific approaches, however many women in the current profile have been excluded from this system. The lack of current trauma informed programs, particularly within the housing, drug and alcohol and mental health systems contributes to inadequately meeting their needs. *Service responses will fail to adequately assist in the recovery from homelessness if they continue to fragment women into "single issue problems".*

Recommendations

The following recommendations are made based on the findings of the research. These recommendations are summarised under the key themes of service system responses, assessment, long-term case management, housing, prevention and early intervention, service capacity building and further research and evaluation.

1. Service System Responses

1.1 Fund and trial a female specific, inter-agency and multidisciplinary service response that is underpinned by trauma informed practice and provides direct access to safe permanent supported housing. The model should:

- focus on the development of networks and interagency partnerships to enable shared resources for case management, training and supervision and should offer up to three years engagement and support;
- be based on assertive community treatment and intensive case management approaches;
- link into existing programs that are targeting multiple needs clients including the Homelessness Drug Dependency Trial, Community Connections, the Departmental Multiple Needs Panel, and drop in food and material aid services;
- offer a continuum of age appropriate interventions that recognise different stages of readiness for change;
- be culturally sensitive to needs through a diverse staffing mix and culturally informed practice; and
- be managed by female staff

1.2 The staffing mix and funding base within the homeless service system should be diversified to enable the development of multi-disciplinary assertive community outreach teams. This includes provision of expertise within the service structure of major housing support services, including drug and alcohol, psychological, cultural appropriateness, and sexual and physical assault.

1.3 Mainstream and specialist services responding to women with multiple needs, particularly mental health and drug and alcohol treatment services should be delivered in a way that responds to the housing circumstances of women by incorporating housing stability within treatment plans and directly linking into the homeless service system.

1.4 Individual services should seek opportunities for working collaboratively, including resource sharing and protocols, to more effectively support clients 'in common'.

2. Assessment

2.1 Develop a co-ordinated system for the early identification of women with higher support needs to prevent inappropriate accommodation referrals resulting in repeated crisis accommodation use, fragmented case management responses, and to promote timely entry into specialist case management.

2.2 Develop an assessment process that is able to differentiate between different degrees of need, and what constitutes higher order needs, particularly identifying repeat service users across an established housing network, based on common assessment.

2.3 Ensure that current initiatives aimed at developing common assessment across the homeless service system are appropriate in identifying the specific concerns of women with multiple needs, particularly relating to experiences of abuse, parenting and cultural needs.

3. Long-term Case Management

3.1 Expand the service scope of current women specific intensive support services, enabling age appropriate responses across the life course.

3.2 Long-term case management teams be sufficiently resourced to enable support for minimum of three years to continue once women resettle into permanent housing that enables women to work towards goals of independence.

3.3 Recognise in funding models the importance of case management approaches that acknowledge variation in women's readiness for engagement in the process of change. This involves realistic goal setting within case plans based on individual circumstances and a lowered expectation that women have to demonstrate change in order to be assisted. Lack of readiness to change should not preclude women from intensive case management support. Rather the goal of case management should be reframed to maximise safety, service connection, and housing stability.

3.4 Acknowledge in the case management process that many women presenting alone to support services have children, either in their care, temporarily or permanently removed. Their role as mothers should be recognised in case management and treatment recovery plans. This includes ensuring that family service support provided to women is not automatically withdrawn if children are removed from their care.

3.5 Long-term case management needs to provide a more consistent approach to support that can 'follow' women across different accommodation types and geographies. Case management support should not be catchment specific or withdrawn if the client is required to leave their accommodation placement. Support should not be limited to the accommodation, rather based on a consistent relationship that 'follows' the client.

3.6 Intensive case management should include a focus on developing connections to mainstream activities and opportunities, including education, training, employment assistance, debt management, parenting skills, and have flexible funding available to purchase relevant packages to enhance independence.

4. Housing

4.1 Expand the stock of female specific crisis accommodation, particularly in outer suburban areas. Crisis accommodation facilities need to comprise a small number of single bed and self contained units. Longer stays may be required to resolve immediate crisis and develop a trusting professional relationship. The particular needs of this client group in respect of their privacy are essential in developing accommodation options. Enforced sharing of communal facilities such as toilets and bathrooms can be problematic for many women with complex issues.

4.2 Expansion of safe, low density, affordable and permanent social housing stock to enable more direct exit into permanent housing where support networks can be established and maintained in an area of choice.

4.3 Increase capacity for services to resolve rental arrears that prevents women re entering independent housing.

4.4 Encourage the widespread use of Centrepay as a strategy to prevent tenancy breakdown.

5. Prevention and Early Intervention

5.1 The community must give much higher priority to the prevention of child abuse and family violence through the resourcing of effective strategies that reduce the risks in family settings.

5.2 Greater priority should also be placed on effective early intervention and support to those who have experienced childhood abuse and violence. This should include women leaving State care and young women leaving the family home prematurely. The current pathways into chronic homelessness, substance abuse and ill health must be prevented.

6. Service Capacity Building

6.1 Improve access to specialist training and supervision for service staff working with women, particularly relating to sexual assault, trauma, mental health, drug and alcohol abuse, cultural appropriateness and crisis intervention.

6.2 Services need to acknowledge the importance of support staff having specific understanding and expertise in responding to trauma resulting from abuse or violence.

6.3 There is a need for increased recognition within funding models of the growing complexity of needs amongst women experiencing homelessness. The retention of skilled and experienced practitioners within the homeless service system may best be encouraged through the provision of adequate remuneration that recognises the diversity of skills required.

7. Further Research and Evaluation

7.1 An evaluation component be incorporated into the planning stage of the development of a female specific service model to document learnings and outcomes relating to approaches to ameliorating homelessness amongst women with multiple needs.

7.2 Longitudinal outcomes research be funded within the homeless service system to determine program effectiveness over time, particularly relating to crisis accommodation outcomes, readiness for change and reasons associated with treatment resistance.

7.3 Research be undertaken to examine the cost effectiveness of different interventions for clients with complex and multiple needs.

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APPENDICES

Appendix 1: Snapshot Client Review Form

Attachment 1: Selection Criteria for Inclusion in the Project

The ***Women, Housing and Multiple Needs*** project is targeting women who are 18 years or older and are currently residing in temporary or unstable housing, and/or are transient. The current project is a targeted piece of research that is seeking to examine effective service models for women who experience difficulty negotiating their way through the complex and multiple service responses required to address their needs. Based on the current working definition underpinning the research, the following selection criteria (as shown in Boxes 1 and 2) for inclusion in the project have been established.

Selection criteria for inclusion in the project includes:

- The presence of ***two or more abilities or behaviours*** as listed in Box 1.
- Combined with the presence of ***one service system needs*** as listed in Box 2.

Box 1. Abilities and behaviours (Please tick all relevant boxes)

- ☐ Diagnosed or undiagnosed mental health disorder or illness that compromises ability to function and meet basic day-to-day living tasks
- ☐ Intellectual disability that compromises ability to function and meet basic day-to-day living tasks
- ☐ Substance use that compromises ability to function and meet basic day-to-day living tasks
- ☐ Gambling problem that compromises ability to function and meet basic day-to-day living tasks
- ☐ Challenging behaviour
- ☐ Pattern of past and current risk taking behaviour that may endanger self
- ☐ Pattern of past and current risk taking behaviour that may endanger others
- ☐ Lack of apparent independent living skills

Box 2. Service system needs (Please tick all relevant boxes)

- ☐ Unconnected to or unable to access mainstream services that are required to meet ongoing needs
- ☐ Unconnected to or unable to access specialist services that are required to meet ongoing needs
- ☐ Repeated homeless service use and breakdown of accommodation
- ☐ Difficulty engaging with expectations of current case management processes
- ☐ Difficulty living within rules, boundaries and structures

Please return completed forms to your co-ordinator to forward onto Hanover Welfare Services Research & Development Unit. Please ensure completed checklist is attached to the front of the client review form before forwarding to Hanover. Thank you for your assistance in this project.

Client Review Form
Needs of Women Accessing Support

CONFIDENTIAL

This form is to be completed for female clients meeting the project selection criteria attached. The form is for existing and new client service contacts during the collection period, which commences on the 6th of October and ends on the 5th of December.

SECTION 1: ORGANISATION DETAILS

Organisation Name:……

Service Delivery Type (i.e. women's crisis accommodation etc.)……..

Client service contact date ☐☐ ☐☐ ☐☐
(For most recent contact during 6/10/03 – 5/12/03 D D M M Y Y

Client service exit date ☐☐ ☐☐ ☐☐
(If client exited the service during 6/10/03 – 5/12/03) **D D M M Y Y**

Name of support worker completing form……

SECTION 2: CLIENT BACKGROUND DETAILS

S2_1. Age: ☐☐ **S2_2. D.O.B** ☐☐☐☐☐☐ D D M M Y Y

S2_3. Presenting family unit:

Single person ☐ 1 Person and child(ren) ☐ 2
Couple ☐ 3 Couple and child(ren) ☐ 4
Other family group ☐ 5

S2_4. Does the client have children?

Y ☐ 1 N ☐ 2 not known ☐ 3

If yes, is child/ren:

a. currently in their primary care **Y ☐ 1 N ☐ 2**

b. temporarily removed from their primary care by DHS protective services Y ☐ 1 N ☐ 2

c. permanently removed from their primary care by DHS protective services Y ☐ 1 N ☐ 2

S2_5. If presenting with children, record number of accompanying children in each age group:

0-4 yrs ☐ 1 5-11 yrs ☐ 2
12-15yrs ☐ 3 16 yrs & over ☐ 4

S2_6. Country of birth

Australia ☐ 1
Other ☐ 2

Other please specify……..

S2_7. Cultural identity

Aboriginal or Torres Strait Islander Background. ☐1

Other, please specify.....…… ☐2

S2_8. Main language spoken

English…… …… … ☐ 1

Other, please specify…… …… ☐ 2

Interpreter required Y ☐ 1 N ☐ 2

S2_9. Main income source:

Please tick one box only

No income ☐ 1

Registered/awaiting benefit ☐ 2

Newstart ☐ 3

Parenting Payment ☐ 4

Disability Support Pension ☐ 5

Sickness Allowance ☐ 6

Youth Allowance – Jobsearch ☐ 7

Youth Allowance – Studying ☐ 8

Austudy 25 years + ☐ 9

Abstudy ☐ 10

Age Pension ☐ 11

Special Benefit ☐ 12

Other benefit/pension ☐ 13

Wages/salary/own business ☐ 14

Part-time wage/casual work ☐ 15

Other income…… ☐ 16

Other, please state……..... ☐ 17

No information ☐ 18

SECTION 3: CURRENT AND PAST HOUSING HISTORY

S3_1. What type of accommodation was the client living in *immediately* before service contact? ***Please tick one box only***

- Renting - private rental market ☐ 1
- Renting - public housing ☐ 2
- Renting - caravan park ☐ 3
- Renting - community housing ☐ 4
- Staying with friend(s) ☐ 5
- Parent(s) home ☐ 6
- Sleeping out/car/tent/park/street ☐ 7
- Hotel/Motel ☐ 8
- Squat ☐ 9
- Boarding at rooming house/hostel ☐ 10
- Purchasing or living in own home ☐ 11
- Refuge/crisis/emerg'y accommodation ☐ 12
- Other SAAP ☐ 13
- Supported group home (non-SAAP) ☐ 14
- Institutional setting ☐ 15
- Hospital/psychiatric institution ☐ 16
- Prison/detention/YTC ☐ 17
- Detox/rehab centre ☐ 18
- Other…… ☐ 19

Has the client previously been?
(Please tick all relevant boxes)

S3_2. public housing tenant Y ☐1 N ☐ 2 not known☐ 3

S3_3. in DHS protective services accommodation Y ☐1 N ☐2 not known ☐ 3

S3_4. hospitalised within psychiatric institution Y ☐1 N ☐2 not known ☐ 3

S3_5. imprisoned for prior conviction Y ☐1 N ☐2 not known ☐ 3

S3_6. Did the client have a segment one? application for public housing whilst receiving support? Y ☐1 N ☐ 2 not known ☐3

S3_7. Did the client have public housing rent? arrears that may prevent them re entering public housing? Y ☐1 N ☐ 2 not known ☐ 3

S3_8. To your knowledge, when was the client last living in housing that had security of tenure (i.e. leasing private rental property, public housing, owner occupied or living permanently with family/carer)?

……

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S3_9. Based on your knowledge, please describe the client's housing history/story. (i.e. What is your understanding of the client's housing pathway to the service? When did they first become homeless and why? What type of accommodation have they lived in prior to service contact? Have they been moving in and out temporary forms of housing for extended periods?)

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SECTION 4: CLIENT STRENGTHS AND CAPACITIES

S4_1. What individual strengths has the client displayed throughout the duration of service? provision *(i.e. capacity to plan for the future, ability to problem solve, seek help when needed)?*

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S4_2. What specific skills does the client have that you are aware of? *(i.e. previous work skills,* recreational and creative abilities)?

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S4_3. Has the client referred to any significant family member/s that they can draw on for? support? *Please describe the relationship and how they are a support to the client.*

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S4_4. Has the client referred to any significant others that they can draw on for support? *Please describe the relationship and how they are a support to the client.*

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S4_5. Does the client have any connection to other community supports in addition to the current service provided by your organisation that you are aware of? *Please describe i.e. support* groups.

……
……
……

SECTION 5: CURRENT PRESENTING SUPPORT NEEDS

Mental Health

Whilst accessing the service did the client require services to assist with: *(Please tick all relevant boxes?)*

S5_1. Diagnosed mental health issue Y☐1 N ☐2

Describe issue……

……

S5_2. Undiagnosed mental health issue Y☐1 N☐2

Describe issue……..

……..

S5_3. Intellectual disability Y☐1 N ☐2

Describe issue……..

……..

S5_4. Acquired brain injury Y☐1 N ☐2

Describe issue……..

……..

If yes, to any above mental health issues please describe services required ……..……..

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S5_5. Has the client experienced psychosis requiring mental health support whilst accessing the service? Y☐1 N ☐2

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Known Risks to Personal Safety of Client

S5_6. Has the client talked about wanting to commit suicide whilst accessing the service? Y☐1 N ☐2

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S5_7. Has there been any suicide attempts made by the client whilst accessing the service? Y☐1 N ☐2

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……

S5_8. Has the client made any suicide attempts in the past that you are aware of? Y☐1 N ☐2 not known☐ 3

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S5_9. Has the client engaged in any self-harming/ and or risk taking behaviour whilst accessing the service? Y☐1 N ☐2

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Support with Living Skills

S5_10. Has the client required any assistance with daily living skills whilst accessing the service? Y ☐1 N ☐2

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S5_11. Has the client experienced difficulty living with others whilst receiving support? Y ☐1 N ☐2

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S5_12. Does the client require permanent/ ongoing support with living skills in order to maintain accommodation? Y ☐1 N ☐2

If yes, what living skills support is required to assist the client in maintaining accommodation?

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Substance Use

Was the client regularly** (once a week or more) **using any of the following substances at the time of support?

S5_13. Illicit Drugs Y ☐1 N ☐2

If yes, please list the main drugs or combinations

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……

……

S5_14. Prescription drugs Y ☐1 N ☐2

If yes, please list all known medication

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S5_15. Alcohol Y ☐1 N ☐2

S5_16. Other substances Y ☐1 N ☐2

Please describe……

……

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……

S5_17. Did the client require treatment for a substance use problem at the time of support Y ☐1 N ☐2

If yes, please specify substance/s that the client required treatment for:……

……

……

If yes, please specify the treatment and support required (please tick all relevant boxes in the table below)

Table 1. Types of Substance Treatment and Support

Withdrawal	☐ 1	Counselling	☐ 2
Rehabilitation	☐ 3	Peer support/ NA/ AA	☐ 4
Specialist Methadone Program/ Naltrexone/ Buprenorphine	☐ 5	Other …… …… …… ……	☐ 6

S5_18. To your knowledge has the client accessed treatment for their substance use within the last 12 months?

Y☐1 N ☐2 not known ☐ 3

Please describe service type……

……

……

Past and Current Experiences of Violence, Abuse and Trauma

S5_19. Please indicate in the table below whether the client required counselling or support for sexual, physical and/or emotional violence/abuse whilst accessing your service. Please complete each column for both childhood and adult experiences of violence and record the perpetrator/s in the column beside.

Table 2. Past and Current Types of Abuse/Violence Requiring Counselling and Support

	Childhood		**Adult**	
Type of Abuse/ Violence	Please tick boxes below	Please record perpetrator/s (i.e. unrelated person, family member)	Please tick boxes below	Please record perpetrator/s (i.e. spouse, family member, unrelated person)
Sexual	Y ☐1 N ☐2		Y ☐1 N ☐2	
Physical	Y ☐1 N ☐2		Y ☐1 N ☐2	
Emotional	Y ☐1 N ☐2		Y ☐1 N ☐2	

S5_20. If client, was a refugee or recent arrival to Australia did they require counselling or support for torture or trauma in their country of origin? Y ☐1 N ☐2

……..

……..

Past and Current Experiences of Violence, Abuse and Trauma Continued

S5_21. Has the client been a victim of physical violence whilst experiencing homelessness or living in temporary and emergency accommodation? Y ☐1 N ☐2

If yes, please describe ……

……

S5_22. Has the client been a perpetrator of physical violence whilst receiving support within your service? Y ☐1 N ☐2

If yes, please describe……..

S5_23. Has the client made threats of violence/harm to staff or other clients of the service? Y ☐1 N ☐ 2

If yes, please describe ……..

Financial Support Needs

Whilst accessing your service:

S5_24. Did the client require assistance with a gambling problem? Y☐1 N ☐2

Please describe ……..

……

……

S5_25. Did the client have a Centrelink debt? Y☐1 N ☐2

Please describe ……..

……

S5_26. Did client have any current reductions in Centrelink payments as a result of breach? Y☐1 N ☐2

Please describe ……

……

S5_27. Were there any other financial issues impacting on the client? Y ☐1 N ☐2

Please describe……..

……

Legal Support Needs

S5_28. Did the client require any assistance in resolving legal issues whilst accessing the service? Y ☐1 N ☐2

If yes, please describe the nature of all assistance required i.e. intervention orders, assistance accessing legal representation etc……

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S5_29. Did the client require support with issues associated with post release from prison Y ☐1 N ☐2

If yes, please describe……

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Health Related Needs

Did the client require services to assist with?

S5_30. pregnancy Y ☐1 N☐2

S5_31. physical disability Y ☐1 N ☐2

5_32. physical ill health Y ☐1 ☐2

Please describe the nature of health related needs

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S5_33. In what ways do the service needs in the questions above impact on the client's capacity to maintain housing?

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SECTION 6: TYPE OF SUPPORT PROVIDED TO CLIENT

S6_1. Is the current period of support the client's first contact at this service? Y ☐1 N ☐2

If no, how many times has the client accessed the service within the past year……

S6_2. What was the *main* service response provided to the client for the current support period?

Crisis accommodation	☐1	Transitional accommodation	☐2	Outreach support	☐3
Crisis support	☐4	Transitional support	☐5	Other ……..	☐6

S6_3. Did the client have a case management plan? Y ☐1 N ☐2

If yes, what case management strategies were adopted in supporting the client?

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……..

S6_4. In your opinion what case management approaches have been *most* successful in working with the client? Why do you believe this?

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S6_5. In your opinion what case management approaches have been *least* successful in working with the client? Why do you believe this?

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S6_6. Did the client exit the service prematurely according to their support plan? Y ☐1 N ☐2

If yes, please indicate the main reasons why the client exited the service before completion of support plan

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S6_7. In what way has the client's housing circumstances changed as a result of support?

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S6_8. What other outcomes for the client have resulted from support provided?

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S6_9. Were there any barriers to achieving outcomes identified in the support plan?

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SECTION 7: ENGAGEMENT WITH OTHER SERVICE PROVIDERS

S7_1. Are there any particular service types apart from your organisation that the client accesses regularly? Y ☐1 N ☐2

If yes, please list all……

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……
……

S7_2. Has the client experienced any difficulties accessing support required from other service providers whilst receiving support within your organisation? Y ☐ 1 N ☐ 2 not known ☐ 3

If yes, what type of supports have been the most difficult to obtain or maintain for the client? Please tick all relevant service types. Please write the relevant code numbers (as shown in table 4 below) in the reasons column. You may write in more than one reason code.

Table 3. Service types the client has had difficulty accessing and the reasons why

Service Type *Please tick*		**Reasons** *Please record codes as shown below*	**Service Type** *Please tick*		**Reasons** *Please record codes as shown below*
Financial & Material Aid	☐		Disability services	☐	
Crisis/short accom	☐		Police	☐	
Medium/transitional accomm	☐		Legal services	☐	
Permanent/long term housing	☐		Medical services	☐	
Centrelink	☐		Culturally appropriate support	☐	
Drug & alcohol withdrawal	☐		Sexual assault	☐	
Drug & alcohol rehabilitation	☐		Domestic violence	☐	
Crisis Assessment & Treatment Team (CAT)	☐		Psychologist	☐	
Psychiatric assessment /support	☐		General counselling	☐	
Maternal and child health	☐		Family support	☐	
Child protection	☐		Financial counselling	☐	

Table 4. Service Reason Codes

Service Reason	Code number	Service Reason	Code Number	Service Reason	Code Number
service not matching client needs	1	no access to transport	5	out of catchment area	9
unable to provide immediate response/appointment required	2	unwillingness of client to engage with the service	6	unable to afford service fees	10
no vacancies/ waiting lists	3	client barred from using the service	7	Other = (please write reason in the column)	11
cultural barriers	4	client not eligible for the service	8		

S7_3. Any of other comments regarding access to other service providers ……

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Appendix 2. Women's Service Experience Consent Form & Interview Schedule

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Women's Service Improvement Research Project

I have read the project background and understand that the project is aiming to document the needs and stories of women who are currently using services and to identify ways of improving the services offered.

I understand that my involvement will be to participate in an interview with a Hanover researcher. In recognition of my time and involvement in the interview I understand that I will be paid $30.

I understand that my responses during the interview will be completely confidential and no identifiable information can be traced back to me. I understand that a report will be written to help assist with service planning.

I understand that my involvement in the research project is completely voluntary and will not affect the support I am currently receiving from this service in any way.

I.....freely agree to participate in this project according to the conditions in the background statement handed out to me, including the protection of my identify.

Participant's Name (printed).....

Signature Date

Researcher's Name (printed).....

Signature Date

Note: All parties signing the consent form must date their own signature

Women's Interview Schedule

Section One: Background Details

1. Date of Birth_____ 2. Age _____

3. Country of Birth_____ 4. Cultural Identity (i.e.ASTI)_____

5. Are you Single ❑ De facto ❑ Married ❑ Divorced/separated ❑

6. Main source of income: _____

7. What type of accommodation were you living in immediately before you came to this service? _____

8. How many times have you had to move house in the past twelve months?_____

9. What type of accommodation/housing have you lived in the last twelve months?

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10. When were you last living in housing that had security of tenure (i.e. leasing private rental property, public housing, owner occupied or living permanently with family/carer)?

Section Two: Experience within Service

11. What were the reasons for coming to this service? What is most critical for you at the moment?

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12. Have you been to this service before? How many times?

13. What types of assistance or support have you found most helpful? What has had the most impact for you? i.e counselling, practical support etc

14. Can you think of a time when the type of assistance or support was not helpful? (i.e. counselling, practical support etc). What was it about the assistance that was unhelpful?

Section Three: Experience of Other Service Providers

15. Are you currently using any other services at the moment? (i.e. counselling, other housing, drug and alcohol etc)

16. What has been the most helpful thing for you at these services? What has had the most impact for you?

17. Can you think of a time when the assistance or support at these services was not helpful? What was it about the assistance that was unhelpful?

18. What other types of services have you been to in the past? (i.e counselling, other housing services, drug and alcohol

19. What has been helpful at these services? What has had the most impact for you?

20. Can you think of a time when the assistance or support at these services was not helpful? What was it about the assistance that was unhelpful?

Section Four: Other Supports

21. We have talked about both services you are currently accessing and other services, are there other things that make a difference for you? *(helps you get through the day).*

Section Five: Suggested Improvements

22. What do you think services, including this service could be doing better to assist you?

23. What would make the most difference in assisting with your circumstances?

24. Do you have any other comments?

Other Notes

Appendix 3. Background Statement

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Women's Project Background Information for Participants

A number of services in the area providing support to women are working together on a research project to find out ways to improve the work that we do in helping women with accommodation needs also requiring support for a range of other issues. As part of planning for improved services, the research is aiming to document the needs and stories of women who are currently using services.

Hanover's Research and Development Unit is coordinating the project. The project is targeting adult women who are 18 years or older and we would like to involve as many women as possible to make sure that their experiences and perspectives are included in the research project.

We would like to interview women who are using accommodation or other support services to talk about their thoughts and experiences of services they may have used before, and offer suggestions of how they can be improved. In recognition of your time and involvement in the interview you will be paid $30.

The interview will be COMPLETELY CONFIDENTIAL, and the feedback that you provide in the interviews will be put together with other women's responses in order to identify the most important information and issues. Anonymous individual participant stories and experiences may also be written up in the report. There will be no information in the report that could identify individual participants in any way.

If you are interested in being interviewed, your support worker will arrange for a Hanover Welfare Services researcher to meet with you at a time and location of your choice. It is completely up to you whether you would like to be involved in the project. You can choose to stop participating at any stage, and your involvement in the project will have no impact on the services and support you currently receive.

At the end of the project, Hanover Research and Development unit will prepare a final report on behalf of the participating services, which will be used to help plan future services, and also be used to advocate for more funding to enable longer-term and more collaborative service responses to assist women with ongoing housing related needs.

Your participation is totally voluntary and if you have any concerns or complaints about the research please contact:

Helen Riseborough
Hanover Welfare Services
52 Haig St, SOUTH MELBOURNE, 3205
Ph 9699-6388

Appendix 4. Focus Group Questions

Women, Multiple Needs, and Housing Study

1. From your service delivery experience what are the critical issues that emerge for this particular client group? (compared with other clients)

   Service gaps

   Crisis and transitional responses

   Specific needs for women – what's different

   Experience working with other service providers

   Broader community/ environment

2. What is the service's main approach to working with the client group? What is the service aiming to achieve with the client group

   Case management

   Outreach

   Collaborative partnerships/networks

3. Does the service response differ for this client group compared to other clients – how does the service delivery vary according to different categorisation of need?

   Assessment – how are they assessed?

   Resources

4. From your service delivery experience what approaches/strategies work well? What has the most impact for the client in the short and long term? Why do you think the strategies work? What is it about them?

   Case Management

   Resources available – case loads, brokerage $, shared case planning

   Practical Assistance

   Therapeutic Approaches

5. What has the least impact – what doesn't work? and why?

6. What single change or development would lead to better outcomes for this client group?

7. How can services provide an integrated response?

   Within their service

   Across the service system