The Homeless and Drug Dependency Trial

BUILDING CAPACITY

Final-year Evaluation Report of the Homeless and Drug Dependency Trial's Part A Capacity-building Activities.

Report 8

Kim Rayner

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For the Homeless and Drug Dependency Trial. A partnership between Hanover Welfare Services, The Salvation Army, St Vincent de Paul Aged Care and Community Services and the Victorian Department of Human Services.
PO Box 1016, South Melbourne, Victoria, 3205.

August 2004

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ISBN – 0 9751557 9 2

ACKNOWLEDGEMENTS

Adopting an Action Research Methodology as has occurred within the Homeless and Drug Dependency Trial required many individuals within each service to openly and consistently review the progress of key strategies and overall efforts to achieve capacity-building objectives.

In recognition of this, the author wishes to thank the following people for their contribution to this final year report:

- Staff at each of the Crisis Supported Accommodation Services for their direct input and participation in third-year focus group and journaling sessions.

- Drug and Alcohol Case Manager Coordinators – Karen Efron, Darren Schwartz and Danny Tilkeridis.

- Inter-Agency Working Party members, in particular Tony Nicholson, Jane Barnes and Tony McCosker.

- CSAS Managers – Helen Riseborough, Leanne Acreman, Micaela Cronin, Simon Lenten and Michael O'Kelly.

- CSAS Coordinators – Mary Riley, Lisa Sammut, Eloise Tregonning and Ros Kelly.

- Members of the Trial's Evaluation and Research Advisory Group for their expertise, guidance and direction in regard to the Trial's Initial Evaluation Framework, in particular Silvia Alberti, Michael Horn, Meg Montague and Amanda Jones.

- Members of the Alcohol and Other Drug Reference Group.

- Members of the Trial's Project Team – Deb Batterham, Rochelle Wiltshire, Thalia Logothetis and Bill Couche.

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GLOSSARY

ADSA	Alcohol and Other Drugs Supported Accommodation Program
ADIS	Alcohol and Drug Information System
AOD	Alcohol and Other Drugs
ARBIAS	Acquired Brain Injury Support Service
CATT	Crisis Assessment and Treatment Team
CD	Community Development
CRP	Community Reintegration Program
CSAS	Crisis Supported Accommodation Service
DACMC	Drug and Alcohol Case Manager Coordinator
DPSB	Drugs, Policy and Services Branch
DHS	Department of Human Services
DTS	Drug Treatment Services
HARP	Hospitals Admission Risk Program
HDDT	Homeless and Drug Dependency Trial
HDDP	Homeless and Drug Dependency Program
HOPS	Homeless Outreach Psychiatric Service
IAWP	Inter-Agency Working Party
IDRS	Illicit Drug Reporting System
NDCA	National Data Collection Agency
NMIT	Northern Melbourne Institute of Technical and Further Education
PCM	Primary Case Manager
HPP RDNS	Homeless Persons' Program Royal District Nursing Service
SAAP	Supported Accommodation Assistance Program
SUMITT	Substance Use in Mental Illness Treatment Team
THM	Transitional Housing Management
TNA	Training Needs Analysis
TRIAL	Refers to the Homeless and Drug Dependency Trial

FOREWORD

In November 2000, the Victorian Government announced the implementation of a three-year Trial costing $7,600,000. The allocation of funding was targeted at 'utilising major crisis accommodation services as strategic sites for engaging drug-using homeless people, with the aim of reducing their drug dependence, minimising the harm they do to themselves and building pathways out of homelessness and drug addiction toward secure accommodation and stable lifestyles' (Inter-Agency Working Party, 2000).

The funding of this initiative was in direct response to the growing number of homeless people presenting at the Crisis Supported Accommodation Services (CSAS) with drug-dependency problems. The CSAS found themselves under-resourced to address their needs and the impact of their behaviours on other residents and on staff.

The Homeless and Drug Dependency Trial incorporates a partnership between **Hanover Welfare Services'** Southbank Crisis Supported Accommodation Service, the **Salvation Army's** Flagstaff Crisis Supported Accommodation Service, the **Society of St Vincent De Paul's** Ozanam House, **Drug and Alcohol Services** and the **Department of Human Services** (Drugs, Policy and Services Branch /SAAP).

At the time of writing this report the Homeless and Drug Dependency Trial (HDDT) has been successful in securing $8.3 million dollars in recurrent funding for the next three years. This includes additional resources from the Mental Health Branch to introduce three new Homeless Outreach Psychiatric Positions (HOPS). These new HOPS positions are to be principally based at the CSAS and will be focused on collaborative work with CSAS staff to address some of the identified gaps in the area of service provision to homeless clients with a mental health disorder. In light of this new initiative, direct partnerships within the HDDP have been extended to now include mental health services and the Mental Health Branch of the Department of Human Services.

HDDT PART A FINAL REPORT - EXECUTIVE SUMMARY

The Homeless and Drug Dependency Trial (HDDT) has now operated for three years and was implemented in July 2001 as an innovative service response aimed at trialling strategies to effectively address the needs of individuals experiencing homelessness and drug-dependency problems. The establishment of the Trial was in direct response to the growing demand on the Crisis Supported Accommodation Services (CSAS) to provide crisis accommodation and support to an increasing population of drug-dependent homeless clients, without the necessary resources and expertise required to do so. Further, CSAS recognised that their facilities were well placed to strategically engage with this client group, many of whom were presenting with complex needs but had traditionally been struggling to access treatment and other ongoing support services.

The Trial has been a joint initiative of Hanover Welfare Services, the Salvation Army, the Society of St Vincent de Paul Aged Care and Community Services and the Department of Human Services. It has operated from the three crisis accommodation centres: Hanover Southbank, Flagstaff Crisis Accommodation Centre and Ozanam House, and has also involved other drug treatment and community services. The Trial is managed by an Inter-Agency Working Party and was funded initially by the Victorian Government for three years. As a consequence of the successful outcomes of the Trial as evidenced in the comprehensive levels of reporting, recurrent funding has now been secured for a further three years. New mental health funding will be directed at strengthening the CSAS responses to homeless clients with a mental health disorder.

This report is the eighth in a series of Trial evaluation reports detailing key activities attached to the HDDT's Part A: Capacity-building component during its third and final Trial year. Key strategies implemented as part of the Trial were examined in terms of what has occurred; achievements; learnings where applicable; identified areas for improvement; and the current status in addressing areas for improvement identified in the second-year evaluation report. Part A is focused on improving the capacity of the CSAS to provide a safe and effective service to their clients. This has been achieved through the implementation of policies, programs and activities designed to better assist clients with problematic drug use and to reduce the detrimental impact their behaviour has on themselves, other clients and staff.

At the end of the Trial's final year, all three CSAS have continued to strengthen their capacity to effectively engage and provide appropriate assistance to homeless clients with drug dependency and other often-complex problems, exceeding initial targets set in key activity areas. Achievements and progress established during the Trial and reported more broadly at the end of the second year have generally not only been sustained in the final year of the Trial but extended and continually improved upon, as evidenced in this report. The harms attached to drug use experienced within the CSAS prior to the Trial have been significantly reduced, while a culture of greater understanding, openness and inclusiveness towards drug-using clients now drives current staff practices. Such practices primarily aim to effectively engage drug-using clients upon entry to the CSAS, while also working with the client to resolve their current crisis

state and establish appropriate and sustainable pathways into housing, treatment and community supports.

All of the key strategies implemented through the Trial have proven to be successful measures, allowing each CSAS and the Trial to achieve its intended objectives. These include a broad and relevant professional development response for all CSAS staff; enhanced on-site health care and health promotion services; improved casework and engagement practices; a range of daily diversionary activities available to residents; policy and protocol development, both internally and with partner agencies; as well as supports provided by the Trial's project management component. All of these strategies have contributed in a unified way to the achievements of capacity-building efforts within the Homeless and Drug Dependency Trial and are to be sustained in an ongoing way beyond the three-year Trial period.

Initially, significant organisational changes were needed and these occurred by the end of the Trial's first year against varying degrees of resistance to proposed Trial activities. These activities were further consolidated in the second year. Communication with a cross-section of staff during final year-focus group and journaling sessions has further highlighted what can be achieved, even with presenting challenges when there exists shared commitment and drive to improve service delivery and individual outcomes for drug-dependent homeless clients. Of note when meeting with CSAS staff over the course of the Trial's three years has been the increasing level of knowledge, expertise and commitment to working with such a disadvantaged group; significant attitudinal changes to drug users; their ability to articulate clearly their processes of reflection and approaches when working with this target group; and their commitment to ongoing improvements and new developments in service delivery.

The reflective evaluation processes and the evidenced-based approach attached to the Trial has also allowed the CSAS to work in an environment that has promoted and supported the ongoing critical reflection of practices and services offered at the CSAS. This has been a good way of not only identifying successes but also gaps and areas for improvement. In recognition of the benefits in adopting a continuous improvement strategy, the Inter-Agency Working Party and participating services have made a commitment to sustain ongoing collaborative learning and evaluation measures beyond the Trial period. This will allow for the continual development of an evidence base to support HDDP activities and influence future policy direction in the area of service delivery to homeless clients.

Final reflections by key informants and focus group participants in regard to the past three years of the Trial further highlight the positive changes that have taken place within the CSAS. Key benefits of the Trial reported across the three CSAS include the Trial's capacity through targeted strategies and activities to challenge previously held limiting practices and beliefs, resulting in a workforce that is far more knowledgeable and skilled at working effectively and openly with drug-dependent clients. Further, key informants reported that staff are now viewed by residents as more accessible and non-judgmental towards their drug use, resulting in the improved identification of drug and alcohol problems among residents, with follow-up support to access appropriate drug treatment or support options available. Additionally, staff reported that while the Trial has given them opportunities to extend their knowledge base, it has more importantly given greater emphasis to the genuine needs of homeless clients who access the CSAS. This has occurred through the provision of a range of flexible services to address these needs, rather then simply seeing eviction from the CSAS as the only solution available to problematic drug-related behaviour. Finally, the Trial has demonstrated the benefits of

collaboration between services and of what can be achieved when different CSAS and sectors work in partnership together. However, achieving such is resource intensive, requires strong commitment and leadership throughout organizations and a willingness to change.

While the findings of this final-year report have continued to demonstrate the many successes and key learnings of the Trial, areas for improvement and challenges for the HDDP and individual CSAS still exist. While noted areas for improvement within each CSAS are discussed more fully in the body of this report the following future directions represent overall Trial areas that still need to be addressed. These areas require further action in order to support continued progress and strengthen the capacity of the CSAS and partner agencies in the provision of assistance and support to homeless persons with complex needs.

- The implementation of a strategic mental health response in partnership with mental health services that is able to meet the identified gaps currently experienced at the CSAS. Any new initiatives will need to also be monitored so that key learnings can be identified and improvements made if and when needed.
- The implementation of an ongoing evaluation framework to support the evidence-based objectives of the HDDP that is robust, manageable within the resources available, and not a significant impost on staff.
- The lack of affordable and appropriate long-term housing options remains an ongoing challenge requiring continued advocacy and the need for the HDDP to further explore ways of establishing an alternative housing program for high-support needs clients.
- The HDDP needs to build on cross-sector partnerships implemented as part of the Trial, particularly in the area of future directions identified at the HDDT's recent cross-sector partnerships conference and through the Trial's recent transition planning process.
- The need to implement a broader dissemination strategy of Trial findings and learnings across government, community and health sectors.
- The need to continue to develop broader linkages and partnerships with drug treatment services, mental health services, GPs, disability services and the criminal justice system in order to support the newly revised objectives of the HDDP.
- The need to examine further ways of offering proactive and practical opportunities to clients accessing the CSAS in the areas of further training, education and work experience.
- The need to sustain and further develop professional development responses that not only meet the needs of new and inexperienced staff but also provide experienced staff with opportunities to further extend their knowledge and practice. Any future developments will also need to incorporate a comprehensive approach to addressing current mental health training gaps within the CSAS.
- The HDDP AOD reference group now needs to establish ways of involving a wider range of workers and services in the reference group that reflects more broadly the revised terms of reference for this group.

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1. INTRODUCTION

The Homeless and Drug Dependency Trial (HDDT) has operated for the past three years in order to implement innovative service responses to help individuals experiencing homelessness and drug-dependency problems. The Trial has been a joint initiative of Hanover Welfare Services, the Salvation Army, the Society of St Vincent de Paul Aged Care and Community Services, and the Department of Human Services. It has been centred at three Crisis Supported Accommodation Services (CSAS): Hanover Southbank, Flagstaff Crisis Accommodation Centre and Ozanam House, and has involved other related drug treatment services. The Trial has been managed by an Inter-Agency Working Party and was initially funded by the Victorian Government for three years.

Given the successes of the Trial, this programmatic response has been re-funded for the next three years and will continue to deliver an enhanced drug and alcohol service to homeless individuals accessing the participating crisis supported accommodation services. It will also continue to strengthen its overall program of service delivery to homeless clients with complex needs.

This report is the eighth in a series of Trial evaluation reports and details Trial activities during its third and final year. Consistent with the HDDT's commitment to an Action Research Methodology, this report will focus on the Trial's Part A: CSAS-based Capacity-building Activities and their progress in achieving capacity-building objectives. Key strategies implemented as part of the Trial will be examined in terms of what has occurred; achievements; learnings where applicable; identified areas for improvement and the current status in addressing areas for improvement identified in the second-year evaluation report (Rayner, K. November 2003. Given the level of similarities in strategies implemented, this report encompasses the three services and has drawn on both qualitative and quantitative data collected as part of the Trial's ongoing evaluation process.

Background information on the HDDT model and its historical context is covered in Report 1 – 'Setting the Scene' (Rayner, October 2002). Additionally, more detailed information on each service model can be accessed from the participating CSAS directly. These aspects of the HDDT are therefore not covered within the current report.

Additional evaluation reports on the many program elements encompassed within the Trial overall are available on the Trial's web site, as well as the research study into the profile and needs of drug-dependent homeless clients – 'Making Change Possible – Sharpening the Focus of Homelessness and Substance Use Within Crisis Supported Accommodation Services in Inner Melbourne, Victoria' (Rayner, K 2003). The web site address is www.hddt.org.au. These reports are also available on Hanover Welfare Services' website – www.hanover.org.au.

2. TRIAL MODEL

The following section outlines the overall key model elements and then details the objectives and strategies of the Homeless and Drug Dependency Trial's Part A Capacity-building Response. An overview of the differences and similarities of the three participating agencies is included in order to briefly describe each agency model.

2.1 Trial Design

The multifaceted Trial comprises several major focuses and its structure is divided into three parts – A, B and C.

Part A is focused on increasing the capacity within the Crisis Supported Accommodation Services (CSAS) to more effectively engage with drug-dependant clients. Part A initiatives deal with structural and operational factors including service design and delivery and the ability of CSAS to respond to the often complex needs of the target group. A parallel aim is to develop the capacity of drug treatment and other services to respond to the needs of homeless clients presenting to the CSAS with drug-dependency problems.

Part B involves the development of innovative models of service delivery and the development of pathways out of homelessness and drug dependency. Part B clients are first engaged through the three participating Crisis Supported Accommodation Services (CSAS) and then allocated a primary case manager who is able to work with them long term. In addition, resources attached to this part of the Trial's response such as the Bridge Withdrawal Beds, the Community Reintegration Program and the A&D Supported Accommodation programs significantly assist with the stabilisation and reintegration of homeless clients.

Part C incorporates Project Management and the comprehensive research and evaluation component of the Trial.

2.2 Part A Objectives

The overall aim of Part A is to build the capacity of Crisis Supported Accommodation Services, in particular that of the three major participating CSAS agencies: Hanover Southbank, Flagstaff and Ozanam House. The Trial has aimed to render crisis supported accommodation services better equipped and able to respond to clients with drug-use problems more effectively. By extension, it was envisaged that the impact of drug-using clients' behaviour on non-drug using clients would be reduced. Part A initiatives have also impacted on all Crisis Supported Accommodation Service residents, irrespective of whether or not they are dependent on drugs or participating in drug treatment.

The major objectives of Part A relate to all facets of the CSAS design and delivery. They are to:

- minimise the harm of drug use among drug-using clients

- improve the services' ability to reduce and respond to drug-related harm, including overdoses
- reduce the level of staff pressure and stress in adherence with occupational health and safety (OH&S) requirements
- strengthen the capacity of services to involve/engage drug-using clients in drug treatment, mental health and other health-related services
- enhance and develop casework responses to drug-using clients
- increase the capacity of staff to respond to hard-to-reach clients
- enhance the capacity of services to engage all clients – drug using and non-drug using – in diversionary activities that are designed to promote health, self-esteem and develop work-related skills
- minimise the impact of drug-using clients on non-drug using clients
- encourage and enhance the involvement of volunteers in selected elements of the Trial.

2.3 Key Part A Strategies

Key strategies have been identified in response to the Trial's objectives. They are:

- a professional development response for all staff at the Crisis Supported Accommodation Services
- an enhanced health care response and health promotion strategies
- diversionary and group activities for residents
- policy and protocol development internally within the services and externally in conjunction with related services
- proactive casework and engagement strategies.

Each of these strategies has given rise to different activities in the three agencies, although there are common strategies.

2.4 Differences and Similarities Between the Three Agencies

The enhanced spirit of communication and cooperation between the parties has continued to be strengthened throughout the third and final year of the Trial. The Trial has increased the collaboration and interaction between the three Crisis Supported Accommodation Services as well as related services (including drug treatment and mental health services), resulting in improved client outcomes.

As has been previously reported (Couche & Kelsall, January 2003), the service providers wanted to ensure that the Trial did not dilute the diversity and richness in service delivery that reflects each service's traditions and philosophy of care. In addition, services recognised the importance of collaborating on Trial activities in order to develop an effective and integrated service response for homeless individuals experiencing problematic drug and alcohol problems. Consequently, when discussing the Trial it is important to take into account the differences between the three services as well as the commonality that exists.

Hanover Southbank is the only CSAS that accommodates women, men and families and, as a specialist provider of assistance to these groups, its model included specifically tailored responses and activities for the target group. Hanover integrated its primary case management of clients involved in Part B of the Trial with the case management and support of all clients at Hanover Southbank as well as transitional clients so that each case manager has a mixture of trial and non-trial clients. Hanover directly employs its own nurses and in the early stages of the Trial focused its diversionary activities program on the provision of individual support to residents by the community support worker as well as the facilitation of community development activities. However, these activities have not operated at full capacity due to the absence of the community support worker position during a significant part of the third year.

Flagstaff Crisis Accommodation Centre accommodates men only. At the commencement of the Trial Flagstaff created a stand-alone primary case management team for Part B Trial clients that also incorporated the service's Alcohol and Other Drug Supported Accommodation Program. The role-combining approach produced a service that was able to provide a seamless response to Trial clients. The agency has always seen the value of recreational activities that enables staff to interact with clients within a dynamic activities program, and the Trial extended this approach through the variety of activities taking place on a daily basis and over the weekend. Flagstaff's capacity building program has also been strengthened by the health promotion component of their Trial model and the extension of the RDNS nursing service to the weekends.

Ozanam House's model of primary case management was developed in order to promote service integration and clear pathways for clients within the Ozanam Community. This resulted in primary case management functions being spread across teams, though a focus on Ozanam house residents was maintained. Ozanam has also maintained a strong focus on running a range of community development activities with residents and developing linkages into the community to improve positive outcomes for clients. Additional RDNS nursing capacity further strengthened the clinical and health promotion service to residents. The broader Ozanam Community took advantage of the Trial as an opportunity to review its staffing models and casework practices, and changes were implemented in the early stages of the Trial as a consequence of this review.

3. EVALUATION PROCESS

The following section outlines the evaluation process attached to Part A of the Trial. As previously reported in the second-year report (Rayner, November 2003), Trial partners were committed from the outset to establishing an evaluation and research framework that allowed for the ongoing monitoring of Trial progress and outcomes. This element was built into Part C of the Trial where the primary functions of project management and evaluation exist. A great deal of work has taken place within the project team and the participating services over the course of the Trial to continuously improve the Trial's capacity to evaluate progress, implement changes where identified and then report findings within the resources available. This section details the processes attached to the Part A evaluation framework and the identified limitations in the methodology.

3.1 Methodology

An Action Research Methodology was the main design chosen during the development stages of the Trial as it was deemed the most appropriate form of evaluation to facilitate a culture of learning, direct participation and action. A key principle of the Homeless and Drug Dependency Trial was to 'trial' strategies that would achieve key objectives directed at organisational change and enhanced service delivery to homeless clients with problematic drug and alcohol issues. From the outset, services were committed to a process of ongoing reflection that would allow for the identification of successful trialed strategies or the need to implement alternative approaches to produce the intended change and outcomes required. While this report is focused on Part A: Capacity-building Activities, an Action Research Methodology has also been applied to elements of the Trial's Part B evaluation.

The following definition of Action Research by McCutcheon and Jurg (1990) aptly describes the principles and processes taking place within the Trial:

> Action Research is a 'systemic enquiry that is collective, collaborative, self reflective, critical and undertaken by participants in the enquiry'.

Given this context, an interactive form of evaluation based on the Action Research Methodology has occurred within the Crisis Supported Accommodation Services in an ongoing way since the Trial began. This process has been supplemented with additional layers of both quantitative and qualitative data to inform the regular cycles of reflective evaluation throughout the life of the Trial, and to also monitor the activity and progress of the three agencies against their program plan (model) and intended outcomes. In addition, quantitative measures have been included as a way of verifying qualitative findings and anecdotal information from other sources.

The following methods have been used throughout the Trial and specify the data that has been included in this final-year evaluation report.

The Inter-Agency Working Party also established the Evaluation and Research Advisory Group to advise the Trial on its evaluation and research plan. An ethics subcommittee was convened with representatives of each agency and the Department of Human Services to assess and approve evaluation processes and materials.

Sources of Qualitative Information

- Bimonthly project management journaling sessions between senior CSAS management staff, Drug and Alcohol Case Manager Coordinators (DACMC), and the Trial's Project Management and Evaluation Manager.
- A series of focus group discussions with a wide range of staff from each of the three CSAS during the months of April, May and June 2004.
- Key stakeholder interviews with participating external drug and alcohol and mental health services.
- DACMC quarterly reports to DHS on Part A activities against targets set.
- Participant feedback forms from the worker exchange program and progress reports.
- Hard-to-Reach Clients Study (Rayner and DiTeodoro, March 2002).
- Annual policy and protocol review documentation.
- Feedback from the Trial's AOD reference group, Community Reintegration Program Advisory Group and the Professional Development Reference Group.

Sources of Quantitative Information

- Annual staff turnover figures from each CSAS pre-Trial and during the Trial.
- Critical Incident Monitoring data pre-Trial and during the Trial. This data is collected by each agency using a standard proforma with agreed definitions for each service.
- Resident profile study conducted in early 2002 with ninety-five CSAS residents who identified as current drug and alcohol users. The title of the study is 'Making Change Possible – Sharpening the Focus on Homelessness and Substance Use Within Crisis Supported Accommodation Services in Inner Melbourne, Victoria', (Rayner, 2003).

3.2 Limitations

- Due to evaluation resource limitations within the Trial, the intended CSAS Resident Exit Survey has not been conducted. In light of this, the evaluation does not include the direct feedback of CSAS residents. While indirect resident feedback has been sourced from staff, this evaluation report cannot be seen to be representing the direct views of previous or current residents.
- The intended analysis and inclusion of SAAP NDCA data for 2003/04 has not occurred as the writing of this final report needed to be completed prior to being able to access data from the AIHW. Such data from the AIHW is not scheduled for release until October 2004.

- DACMC quarterly reports submitted by each CSAS to their DHS region and the central office of the DPSB have been utilised as one source of evaluation data for this report. This data, however, cannot be viewed as comparative material between agencies given the variation in recording practices, model elements and the deployment of resources at each CSAS.

4. PROFILE OF THE TARGET GROUP

In broad terms, the target group for the Trial's capacity-building activities includes any homeless client who stayed at one of the three participating CSAS. The residents of these crisis accommodation services may have identified at assessment as current, problematic drug and alcohol users or they may not have. Other residents of these services may not have a drug and alcohol problem but were homeless and in need of crisis accommodation and support. Established in previous Trial-related research and evaluation reports (Rayner, 2003; Rayner November, 2003), however, is that a large proportion of homeless clients presenting to the CSAS (many on repeat occasions) have significant homelessness histories, complex care needs and problematic drug-use behaviours.

4.1 2002/03 SAAP NDCA Data

An analysis of 2002/03 SAAP NDCA data provided an updated evidence base to confirm the needs of the target group while also identifying shifts over time in the profile of those accessing the CSAS. While previously reported in more detail in the second-year report (with comparisons between pre-Trial years' data to that of the first two Trial years), the following represents a brief overview of these findings to support this third and final year evaluation report. Due to inconsistency in Ozanam's data, the following discussion only includes analysis of data from Flagstaff and Hanover Southbank.

4.1.1 Demographics

Age

SAAP NDCA data analysed at the end of the Trial's second year identified that during the second year of the Trial (2002/03) the average age of homeless clients accessing Flagstaff was thirty-six years, while at Hanover the average age of clients was thirty-two years**.**

Gender

Both Ozanam House and Flagstaff accommodate men only, while Hanover Southbank accommodates men, women and families. In the second year of the Trial SAAP NDCA data (2002/03) identified that the proportion of female clients (49%) accommodated at Hanover Southbank was slightly less than the proportion of male clients (51%) accommodated that year.

4.1.2 Reasons for Seeking Assistance

While SAAP NDCA data was not available for the final year of the Trial, Table 1 shows that the need for drug and alcohol assistance was the first or second main reason why homeless clients sought assistance from Flagstaff and Hanover Southbank during the second year of Trial (2002/03). This demonstrates the need for CSAS to be able to deliver effective drug and alcohol interventions to this disadvantaged group. This is then followed by a lack of usual accommodation or eviction, and then financial difficulties. The last of the top-five reasons for seeking assistance is due to relationship/family breakdown, which is much higher for clients of Hanover Southbank than Flagstaff. This in part may reflect that Hanover Southbank accommodates homeless women and families.

Table 1: Main Five Reasons for Seeking Assistance at the CSAS (2002/03)

Main Five Reasons for Seeking Assistance	Hanover Southbank	Flagstaff
	2002/03 (n=627) %	***2002/03 (n=479) %***
Drug/Alcohol/Substance Abuse	*54*	*34*
Usual Accommodation Not Available	*49*	*55*
Financial Difficulty	*64*	*41*
Eviction/Previous Accommodation	*47*	*25*
Relationship/Family Breakdown	*53*	*21*

Psychiatric Assistance

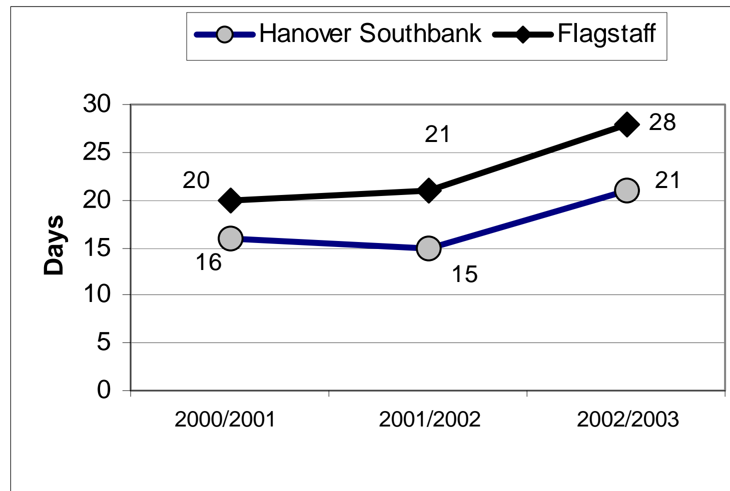
While the need for psychiatric assistance was not one of the five main reasons why homeless clients sought assistance from the CSAS in 2002/03, it emerged as an increasing reason for presentation for a proportion of homeless clients during the Trial's second-year evaluation.

4.1.3 Length of Stay (Support)

While the median length of stay (support) in the final year of the Trial is not known due to SAAP NDCA data not being available at the time of reporting, anecdotal reports from key informants in the CSAS suggest that the increase in length of stay reported in the second year (Rayner, November 2003) has remained relatively unchanged as each CSAS continues to promote and deliver an enhanced service response to drug-using clients. This enhanced service response is founded on proactive engagement strategies at the CSAS and an emphasis on the resolution of the homeless client's immediate crisis as the first step in delivering an effective drug and alcohol intervention.

As previously reported, Figure 1 on the following page documents an increase in the length of stay over the course of the Trial (2001–2003) when compared to the benchmark year (2000/01).

Figure 1: Median Length of Stay (Support) for Clients of Hanover Southbank and Flagstaff



At Hanover Southbank the median length of stay (support) increased from sixteen days pre-Trial (2000/01) to twenty-one days in the second year of the Trial (2002/03). At Flagstaff the median length of stay (support) ranged from twenty days pre-Trial (2000/01) to twenty-eight days in the second year of the Trial (2002/03). Discussions with Hanover Southbank highlighted that the differences in lengths of stay between Flagstaff and Hanover Southbank may possibly be attributable to Hanover accommodating families, who often move out of the CSAS more quickly.

While all three CSAS remain focused on meeting SAAP targets for accommodating homeless clients each year at their service, CSAS continue to report that they are committed to monitoring and balancing the demands of throughput to that of immediate crisis resolution, followed by linkage to appropriate exit pathways.

4.2 CSAS Resident Profile Study of Homeless Drug Users

The following is a direct extract summary from a prospective study conducted with ninety-five CSAS residents who identified as using drugs and/or alcohol at the time of interview. While this extract of the Resident Profile Study was reported in the second-year evaluation report, it has been included once again in this final-year report due to its continued relevance and important overview of needs among the Trial's target group. This investigation into the profile of homeless drug users staying within the Trial's three participating CSAS was undertaken in the first quarter of 2002. The full title of this report is 'Making Change Possible – Sharpening the Focus on Homelessness and Substance Use Within Crisis Supported Accommodation Services in Inner Melbourne, Victoria' (Rayner, 2003). The full report is available on the Trial's website at www.hddt.org.au or on Hanover Welfare Services' website – www.hanover.org.au.

This study revealed that a high level of social, economic and health disadvantages existed among participants. Ninety per cent of participants were unemployed and 84% had not progressed past secondary education. Accommodation history shows one of instability and long-term homelessness. Seventy-two per cent had stayed at a CSAS in the past, and the mean

number of moves in the past year was eleven. Sixty-three per cent reported their current state of homelessness was due to their drug addiction, revealing a strong association between homelessness and problematic drug use.

Other findings include:

- Participants reported that their current main drug of choice was cannabis (39%), followed by heroin (25%), amphetamines (12%) and alcohol (12%).
- Over 50% of participants had changed from a previous drug of choice with heroin being the most common drug used in the past.
- Reported reasons for first using drugs were often linked to social factors such as peer pressure or to socialise with others, while the reasons for current use were related to achieving a desired drug effect or to assist with the management of their other drug use. These self-reported reasons verify the functional role of drug use as a coping mechanism and a form of fulfilment for this socially isolated group.
- The study group had experienced a wide range of health issues and had engaged in a number of risk-taking behaviours.
- Poly-drug use was widespread, increasing the risk of overdose and associated harms.
- Seventy-nine per cent had been diagnosed in their lifetime with clinical depression while the incidence of other mental health disorders was significant.
- High rates of attempted suicide (41%) and self-harm (34%) among participants exposes an alarming picture of vulnerability and potentially high rates of mortality.
- More than half of those who had ever used heroin had experienced one or more overdoses in their lifetime. Forty per cent reported that they usually used alone, impacting on their ability to receive timely help if they did overdose.
- Drug-injecting behaviours among the study group indicate that the risk of transmission of a blood-borne virus such as hepatitis C, hepatitis B and HIV is high. Three-quarters of participants had injected drugs in the last month, with heroin (40%) and amphetamines (26%) being the most common. Almost 50% of those who had injected in the last month reported that they had shared some form of injecting equipment.
- Forty-one per cent reported that they had been diagnosed in the past with hepatitis C (HCV).
- While the majority of participants had accessed a service for drug treatment in their lifetime, the low levels of participation within the past twelve months reflects a somewhat different picture of limited access to a range of treatment options and possible opportunities for recovery.

5. MINIMISING THE HARM OF DRUG USE WITHIN CRISIS SUPPORTED ACCOMMODATION SERVICES

Chapter 5 details the Trial's progress in achieving the overall objective of minimising the harm of drug use within the three CSAS during the Trial's third and final year, as well as the CSAS current status in addressing areas for improvement or future directions noted in the second-year report. The progress and impact of implemented strategies as articulated in each agency model is examined in order to identify the impact of these strategies on the CSAS environment, residents and staff. Where identified, key learnings and areas for improvement have also been documented. The following represents the related objectives of the Trial that have directly impacted on minimising the harm of drug use within the CSAS.

Related Objectives:

- Minimise the harm of drug use among drug-using clients.
- Improve the services' ability to reduce and respond to drug-related harm, including overdoses.
- Enhance and develop case work responses to drug-using clients.
- Increase the capacity of staff to respond to hard-to-reach clients.
- Enhance the capacity of services to engage all clients – drug-using and non-drug using – in diversionary activities that are designed to promote health and self-esteem and develop work-related skills.
- Minimise the impact of drug-using clients on non-drug using clients.

5.1 Professional Development

In the early stages of program planning for the Trial, a key strategy identified as critical to building capacity within the CSAS was a targeted professional development response. Each CSAS embedded within their model a comprehensive professional development framework with the clear intention of building staff capacity to better respond to homeless clients with problematic drug-use issues and other complex needs.

5.1.1 What Has Occurred?

A first step in building staff capacity was to assess the level of staff skills and training needs across the three CSAS. This then allowed for the identification of the most important competencies that staff who work within the Trial need to be proficient at in order to meet the intended capacity-building objectives. The benchmarking of each competency against the appropriate level of skills required for three tiers of seniority (team leader/coordinator, case manager and other support workers) occurred. As previously reported (Couche & Kelsall, January 2003), Table 2 represents the most important competencies that staff working within the Trial needed to be proficient at in order to meet the intended capacity-building objectives. Through this process, gaps, training needs and strengths among staff were identified early on in

the Trial, and a full calendar of professional development activities, inclusive of existing agency programs, was implemented.

As the Trial now moves towards becoming an ongoing program attached to the CSAS, the ongoing achievement of these competencies by staff will remain critical to the services' sustained capacity to operate at a level of best practice, now recognised as critical to effectively meeting the complex needs of homeless clients. Given the reported levels of staff turnover that occurs within these services, listing the following key competencies required by staff is an important reminder, as will be the need for each CSAS to sustain and extend professional development activities in an ongoing way in order to meet continual staff training requirements. At the time of writing this report, the Inter-Agency Working Party has agreed that professional development activities need to be maintained with a level of direct support from the project coordinator to facilitate key collaborative and soon-to-be-developed mental health training initiatives.

Table 2: List of the Most Important Competencies Required by Staff in order to Work Within the CSAS and Meet Trial Expectations

Human Services Work:
• Ensuring duty of care (particularly assessing risk) • Managing complex behaviour (particularly identifying and assessing the situation)
Common Competencies:
• Assessing and delivering services to clients with complex needs (particularly assessing and analysing client need) • Delivering and monitoring services to clients (particularly identifying client need and reviewing client services) • Communicating appropriately with clients and colleagues (particularly completing records and recording information) • Following the organisation's OH&S policies (particularly utilising strategies to prevent stress overload) • Participating in networks (particularly identifying and selecting appropriate networks)
Alcohol and Other Drug Issues:
• Ensuring duty of care (particularly developing a knowledge of the A&OD sector) • Providing A&OD services (particularly assessing the needs and status of clients, assisting clients with harm minimisation and providing education on safer drug use)
Community Housing Work:
• Orientation to the sector (particularly developing knowledge of the sector)
Mental Health Work:
• Orientation to the sector (particularly judging priority of need and working within the context of the sector)

The following list of strategies continued to be available to staff in the final year of the Trial.

These responses included:

- on-site secondary consultation
- enhanced supervision practices
- internal CSAS training that included both compulsory and elective training options across a range of areas
- NMIT – Diploma of Community Services (AOD) that encompasses a course design specifically geared to the work environment and issues presenting for practitioners working with homeless drug users
- a Worker Exchange Program that facilitated the placement of CSAS staff into drug treatment, mental health and other health services. This program also facilitated the placement of staff in CSAS from other sectors
- a training bank list, which was posted to the Trial's web site. This training bank list was updated bimonthly and provided the CSAS with a list of training that has been held for staff in one of the other CSAS. Attached to the list was feedback on the training offered, the trainer who provided it, their contact details and any overall comments on the program.

5.1.2 What Has Been Achieved?

Staff focus group discussions and feedback from key informants have consistently reported the ongoing gains that have been achieved as a consequence of the diverse professional development activities available to staff. These activities are directed at building staff capacity and ultimately the service response delivered to homeless clients.

Secondary Consultation

Secondary consultation and support offered by key personnel such as the Drug and Alcohol Case Management Coordinators (DACMCs), other Trial Primary Case Managers and the nurses (Hanover Southbank), has been one of the Trial's most immediate and effective responses to building capacity.

The level of secondary consultation taking place within the CSAS has continued to extensively exceed the targets set for Hanover Southbank and Flagstaff (Table 3, page 39).

Ozanam House has also reached or exceeded their targets during the final year, although at lower levels due to the difference in how the DACMC position has been principally deployed.

The CSAS continue to report that secondary consultation plays a major role in strengthening relationships between teams, while at the same time having a direct impact on building staff confidence and competence in catering for the needs of drug-using clients.

> *'The level of secondary consultation provided as a consequence of the Trial continues to be instrumental in supporting staff and*

driving best practice.' – CSAS Manager

In the final year of the Trial, Hanover Southbank have extended their secondary consultation to staff by utilising the two nursing positions in unison with the DACMC to provide both informal and designated meeting times each week to meet with staff around a number of casework issues. In addition the DACMC and the nurses have provided opportunities to co-casework with staff, further strengthening casework responses. Further supporting this process has been the DACMC's capacity to mentor and debrief staff in relation to complex client work.

Flagstaff continues to report that the Trial's primary case management team all provide a degree of secondary consultation to CSAS-based staff such as caseworkers, facility staff or to support teams. This usually consists of direct advice on a case-by-case basis, assistance with assessment (particularly drug and alcohol), provision of information and mentoring. The range of support offered has enhanced the workers' ability to deal with the drug and alcohol issues experienced by clients.

While each CSAS has responded to the need for staff to be skilled and confident in the area of mental health work, efforts in the final year of the Trial appear to have only partly met this gap. While staff focus group discussions at Flagstaff and Ozanam identified that the secondary consultation they receive from HOPS or SUMMIT has been of assistance, it has also been limited due to the mental health services' primary focus on major psychiatric disorders and short-term client involvement. Hanover Southbank viewed the formal secondary consultation provided by the Inner South HOPS team in the past year as invaluable and grounded in the current issues facing staff in their work with clients at the time.

As has been identified throughout the Trial's three-year evaluation process, the impact of secondary consultation provided by staff based within the CSAS has been critical to ensuring that practice standards are maintained and that practice wisdom is continually shared among staff. This activity has continued to shift agency cultures towards a more open and reflective position on drug use and the level of assistance that now needs to be provided. This shift has since moved to a position where a greater level of discussion appears to be around understanding more fully the context and meaning of a homeless person's drug use and the impact this has had on their life. From the evaluators' observational perspective, there now exists a greater level of understanding and empathy towards clients who use drugs. This is reflected in a style of working that is focused on positive engagement and a commitment to look at differing ways of providing assistance to clients that extends beyond emergency accommodation and referral.

Formal Staff Training Programs

A wide range of formal staff training programs have been offered across the services during the final year of the Trial. The focus of training has continued to involve the development of knowledge and skills among staff in two domains: *direct client work* and *management/staff support skills.*

Direct client work: Examples of formal training that has been delivered in the domain of direct client work during the final year of the Trial includes: managing challenging behaviour; critical incident management; Level 2 first aid; cardio pulmonary resuscitation refresher; VCAT guardianship and administration orders; suicide risk prevention; writing court reports and the legal system; hepatitis C education and training; strategies for effectively engaging

drug using clients; mental health assessment; personality disorder training; managing aggressive clients; motivational interviewing; clients' rights and mental health and cannabis.

Management and staff support skills: At Ozanam, team leaders have undertaken formal training in the area of staff supervision and debriefing. Both team leaders and managers are currently undertaking the Diploma of Frontline Management. The Hanover Southbank Casework Manager is currently undertaking the Diploma in Management offered through DHS. In addition, staff have undertaken training in Critical Reflective Practice, which managers report is being incorporated into the formal staff supervision that they provide.

The Diploma of Community Services (AOD)

The Diploma of Community Services (AOD) offered through a special arrangement with NMIT has continued in 2004 as was counted as formal staff training. This course has provided the opportunity for staff to achieve accredited training through a combination of group training and recognition of current competencies. Recognition of current competencies has continued to be viewed by staff as positive as it valued previous work experience and qualifications while also acknowledging current workplaces.

By the end of 2004, approximately sixty-three staff from across the three CSAS will have completed this Trial-initiated Diploma of Community Services (AOD). In general, staff focus group feedback and key informant reports have been positive, however some staff, particularly at Hanover Southbank, have reported dissatisfaction with the course in 2004, stating that content material within modules is pitched too low and not adequately matched to their current level of experience and tertiary qualifications. However, staff from Ozanam and Flagstaff reported that they found the course had been positive and beneficial.

> *'The course has provided me with the opportunity to study drug and alcohol work, and to be supported by your workplace to do this is positive and places value in my work.' – CSAS Case Worker*

Key informants at Ozanam and Flagstaff also reported that the Diploma has provided the majority of staff from across their organisations with the opportunity to develop their knowledge and enhance their casework practice in the area of drug and alcohol work. This in turn has supported an organisation-wide approach to universal staff knowledge and consistent approaches to clients with drug and alcohol problems.

Supervision, Support and Mentoring

Staff supervision, support and mentoring has been identified in previous evaluations as critical to supporting staff development, while also providing staff with the opportunity to process events and feel supported when dealing with clients who have challenging problems.

In addition to the supervision offered at Hanover Southbank by the casework manager, the DACMC recently commenced group staff supervision with an emphasis on examining long-term work with clients who have an addiction.

> *'The provision of this group supervision has placed value in the group process, particularly in terms of promoting philosophies attached to the Trial's long-term holistic primary case management response.' – DACMC*

Key informants at Ozanam report that the practice of staff supervision is much more consistent across the organisation, with all team leaders now having undertaken specific training. All staff at Ozanam receive fortnightly supervision and new staff are automatically linked into a mentoring program when they first start. Supporting this process and the work of staff has been the development and introduction of a practice manual, as well as the ongoing overview of this work by an internal working group.

Feedback and observations in terms of organisation change in the final year of the Trial demonstrates that the practice of supervision has been consolidated and extended within the three CSAS in way that now allows services to meet individual staff support needs in a number of ways. As a consequence, staff reported that they felt more supported and confident in their work with homeless clients and perceived their organisation to be responsive and committed to their support needs.

5.1.3 Response to Identified Areas for Improvement/Future Direction

The following discussion represents the current status of identified areas for improvement documented in the second-year capacity building evaluation report in regards to professional development. During final-year focus group discussions and key stakeholder journaling sessions the evaluator reflected on these areas with each service in order to identify actions taken to address previously noted areas for improvement.

NMIT Course

It is important to note that while the NMIT course continues to be viewed positively by staff and has been well attended, the ability of this course to meet the varying levels of staff experience within each course intake remains a challenge. This is largely due to the student intake being drawn from across three services and differing staffing positions.

In the second-year evaluation report it was recommend that two streams of the NMIT Diploma Course be introduced in 2004 as a way of responding to varying levels of staff experience. This did not occur, however, as it would have required additional resources and higher levels of worker releases that would not have been sustainable to the CSAS' ability to meet their day-to-day staffing needs.

An additional recommendation was for NMIT to meet with CSAS Coordinators and team leaders prior to the course commencing as a way of influencing the level and workplace relevance of content material to be delivered in the 2004. While NMIT held meetings in late 2003 to map this process, it would appear that an ongoing process of meetings might need to occur in order to address areas of concerns that arise, and to support the course's ability to challenge workers and extend their knowledge base. Further, it appears important that Hanover Southbank review with staff that have attended the course in 2004 their experience of being involved in order to more fully inform any future decisions regarding Hanover's involvement in the course.

In addition, there is a need for consideration of how to embed mental health curricula into the NMIT course program with a focus on the dually diagnosed client.

Table 3: Number of Formal Professional Development and Staff Training Sessions Against Targets Set

	Flagstaff					Ozanam House					Hanover Southbank				
Activity	**Quarterly Target**	July/Sept 003	Oct/Dec 2003	Jan/Mar 2003	Apr/Jun 2004	**Quarterly Target**	July/Sept 003	Oct/Dec 2003	Jan/Mar 2003	Apr/Jun 2004	**Quarterly Target**	July/Sept 003	Oct/Dec 2003	Jan/Mar 2003	Apr/Jun 2004
Formal Staff training sessions	4	16	6	12	12	3	3	4	5	10	5	3	9	7	15
Secondary consultations provided by DACMC, nurses and primary case managers (Hanover includes both informal and formal meeting times and co-casework episodes in their count)	96	100	130	140	110	48	55	55	50	40	48	125	460	490	570
Totals	100	116	136	152	122	51	58	59	55	50	53	128	469	497	585

Source: DACMC quarterly report to DPSB (DHS)

**Variations between services in the actual targets achieved reflect differences in each model and the deployment of staff*

Broadening the Scope of Training Offered

The second-year evaluation report identified that significant staff capacity and expertise had been developed within the areas of drug and alcohol practice as a consequence of Trial activities. However, it was also reported that the need to provide a broader scope of training opportunities to meet the needs of both experienced and new staff was needed. While CSAS report that supervision has provided a mechanism for addressing individual staff needs, a gap remains in terms of formal training experiences. As the Trial moves forward into an ongoing program, both the project team and the services need to develop different levels of training opportunities for staff.

Mental Health

Staff training in the area of mental health disorders (in particular, managing clients with psychosis, personality disorders as well as those with a dual diagnosis) continues to be reported in the final year of the Trial as an area requiring the coordination and development of a training plan. While staff focus group discussions identified that some staff were confident in this area, others reported that mental health remained an area that they would like to receive a greater level of training in.

In response to this gap the HDDT Executive and the Trial Project Manager undertook a situation analysis during the final year of the Trial to examine gaps affecting both clients and staff in the area of mental health and homelessness. This was a way of supporting negotiations for additional funding from the mental health department to assist in addressing gaps. As a consequence of these efforts, three newly funded HOPS positions will commence in the second half of 2004, with a focus of their work directed at building staff capacity in the area of mental health practice.

Dissemination of National and International Literature

Dissemination of relevant national and international research and literature to staff was identified as an activity that to date has been limited. During final-year staff focus groups, staff reported that providing such information on a regular basis was an area that could be improved, as it would keep them up to date with practices and issues within the addiction, homelessness and mental health fields. While resources for collecting and disseminating this information appear limited, ways of achieving such need to be explored further.

Strengthening Secondary Consultation Provision across the Ozanam Community

In response to previously identified gaps and a desire to extend the benefits of Trial activities more broadly across the Ozanam Community, primary case managers will be out-posted to a designated team on a weekly basis to attend staff meetings, offer secondary consultations and assist other clients with D&A issues. It is intended that each PCM will need to respond flexibly to the needs of each individual service, and act as a significant D&A resource to these teams.

5.1.4 Ongoing Challenges

Challenges identified by the evaluator in the second-year evaluation report still remain. The ability of each CSAS to respond to the compulsory training needs as well as emerging staff training needs will to a degree be determined by the level of resources available. While the Trial has allowed for the allocation of training dollars in recurrent funding, there has been no increase in this area, necessitating the need to attract additional resources to meet training

objectives where possible in the future. It will also remain advantageous if the three CSAS continue to be involved in collaborative training activities as a way of pooling resources to meet similar training needs. An additional challenge presenting is that as staff become more experienced and qualified as a consequence of their work at the CSAS and within the Trial, they are leaving the organisations in some instances to take up higher-paying positions within the drug/ alcohol and health sectors. As a result, CSAS's will need to monitor this trend and allow for the continual staff development implications this poses.

5.2 Enhanced Health Care Response

5.2.1 What Has Occurred?

In general terms, each service enhanced their existing health care services by employing an additional nurse or, in the case of Hanover Southbank, two nurses at the beginning of the Trial. This occurred in order to extend the availability of clinical nursing services as well as to provide integrated health promotion/harm reduction activities at the CSAS's.

Flagstaff employed an extra RDNS Homeless Persons' Program (HPP) nurse in order to provide 7 days a week coverage of clinical services to residents and secondary consultation for staff. In addition, this extra resource has allowed for the extension of health promotion activities on site.

Initially **Ozanam** employed an additional part-time RDNS Homeless Persons' Program (HPP) nurse in order for that position to primary case manage a small Part B caseload and to facilitate ongoing health promotion activities for residents from Monday to Friday. This position has continued to manage 1–2 Part B clients in the final year of the Trial and has also been involved in health promotion activities.

At the commencement of the Trial **Hanover Southbank** chose to employ its own nurses in order to strengthen its multi-disciplinary team approach and to simplify collaborative planning and the sharing of files. During the final year of the Trial, the two nursing positions at Hanover Southbank have predominantly facilitated on-site clinics with weekend cover; provided secondary consultation to staff; and also primary-case managed a small Part B caseload. To a lesser degree, these positions have delivered some health promotion activities to residents.

5.2.2 What Has Been Achieved?

Nursing Clinics and the Role of the Community Health Nurse

The role of the community health nurses continues to remain an essential and critical element to CSAS-based Trial activities and the achievement of key objectives. Staff and key informants continue to view these positions positively, seeing them as an important adjunct to casework, and essential to meeting the individual and often poor health needs of homeless clients who access the CSAS.

As indicated in Table 4 (page 43), the number of nursing clinics (Trial-funded only) delivered across the three services reached or exceeded targets set in the final year of the Trial, except in the July–Sept 2003 quarter at Hanover Southbank due to staff turnover.

Health promotion and health and wellbeing groups were delivered by all three services with targets being reached or exceeded during the final year of the Trial. While no target was set, Flagstaff has continued to supplement their group-based health promotion activities with one-on-one health promotion discussions with residents, conducted primarily by the RDNS nurse. This two-pronged approach to health promotion at Flagstaff continues to provide an extensive and integrated health promotion response that is able to reach a wide cross-section of residents and individual health information needs. Staff have continued to report that the nurses' ability to deliver a wide range of health information to residents, whether that be specifically about safer drug-use practices, diet and nutrition or the use of medication, has been integral to achieving the objectives of the Trial.

> *'The nurses are great. They provide vital health care to such a disadvantaged group. They also assist us with many queries or concerns we may have about a client's health, offering practical solutions.' – CSAS Caseworker*

As of September 2003, Hanover Southbank had two new Community Health Nurses on board that saw an increase in the number of nursing clinics delivered and the provision of weekend clinics. Within Hanover's model the two nurses have played a key role in providing secondary consultation to staff in conjunction with the DACMC, reflecting the higher number of secondary consults recorded (see Table 4 on the following page). This high number of secondary consults also reflects Hanover's recording method, where any advice sought by staff, both formal and informal, is counted as well as co-casework activities between Trial staff and CSAS staff. Key informants also reported on the positive aspects to the mix in expertise provided between the two nurses and the level of support available to staff.

> *'The availability of the two nurses has provided staff with the security and the support they need around often complicated health issues present among residents.' – Casework Manager*

Both the HPP RDNS nurses contribute to Ozanam House's enhanced health care response. While Table 4 only represents clinics and health promotion activities of the funded part-time position, a higher number of clinics have been held each week.

Health Promotion Activities and Alternative Health Therapies Offered Within Each Service

Ozanam: In the final year of the Trial, Ozanam have continued to deliver or facilitate the delivery of a wide range of health and wellbeing activities for residents. The Community Development Worker jointly coordinates this program with the RDNS nurse.

Examples of health and wellbeing groups/sessions that have been held according to the DACMC quarterly reports include weekly 'Feet Up' foot clinics; acupuncture; a weekly walking group called 'Park Ramble'; 'Lovin Ya Liver' hepatis C and BBV education group facilitated by Inner West Needle and Syringe Exchange Program; and overdose/harm reduction education by DASWEST.

A common theme reported in terms of the benefits of the above activities is that they provide not only important health information and treatment, but also often led to the follow-up of other health problems experienced by the resident.

Table 4: Number of Services Delivered Against Set DHS Targets Within Each CSAS-Enhanced Health Care Response

	*Flagstaff					Ozanam House					**Hanover				
Activity	**Quarterly Target**	**July/Sept 2003**	**Oct/Dec 2003**	**Jan/Mar 2004**	**Apr/Jun 2004**	**Quarterly Target**	**July/Sept 2003**	**Oct/Dec 2003**	**Jan/Mar 2004**	**Apr/Jun 2004**	**Quarterly Target**	**July/Sept 2003**	**Oct/Dec 2003**	**Jan/Mar 2004**	**Apr/Jun 2004**
Nurses' clinics (Trial-funded only)	**24**	36	36	36	36	**24**	26	24	27	32	**48**	30	120	116	120
Health promotion and health and wellbeing groups	**36**	36	36	36	36	**24**	36	10	35	25	**48**	42	57	59	54
Informal one-on-one health promotion sessions	**No target set**	195	235	235	235	**na**	-	-	-	-	**na**	-	-	-	-
Totals	**60**	267	307	307	307	**48**	62	34	62	57	**96**	72	177	175	174

Source: DACMC quarterly report to DPSB

*Flagstaff totals are much higher due to the level of individual one-on-one health promotion.

** Hanover Southbank funded two nurses for Trial activities, hence the higher level of Trial-funded nursing clinics recorded.

Please note that informal one on one health promotion session occurred at Ozanam and Hanover, however no exact targets were set and this information was not included in the initial reporting requirements.

Flagstaff: In the final year of Trial, Flagstaff has continued to deliver both formal and informal health promotion and health and wellbeing activities to residents. According to DACMC quarterly reports, a wide range of activities has been offered consistently across the year and have been provided by either the RDNS nurses, Trial PCMs or from external agencies attending the service to run a session. Examples of such activities include hepatitis C education; safer using practices; foot care clinics; massage; yoga; acupuncture and stress management. Key informants report that most of these groups/sessions are held weekly or fortnightly with reports that all of the natural therapies offered are consistently well attended.

Hanover Southbank: Hanover Southbank has continued to offer health and wellbeing groups or sessions, with the majority of these being delivered by external providers. Such activities include Reiki; acupuncture; shiatsu; and health education sessions provided by RHED to sex workers residing at Hanover Southbank.

While targets for this activity have been met, there have not been as many groups due to the part-time community support worker position being vacant for part of the third year. While the nurses provide individual health information to residents when needed, the focus of their work is not directed towards the development and delivery of health and wellbeing groups. An exercise session on Saturday provided by an after-hours staff member has been offered in the past year with positive feedback from staff and clients.

5.2.3 What Have Been the Challenges?

GPs – The Difficult Link

The Trial's second-year evaluation report (Rayner, November 2003) stated that the direct involvement of GPs within the CSAS had continued to remain difficult to achieve. Reasons given included finding the right GP who is willing and skilled in working with homeless clients with complex health problems and GPs who are prepared to bulk bill and not receive a retainer for their service.

While there had been early efforts in the Trial to involve GPs in the delivery of medical services to homeless clients at the CSAS, very little further work has taken place due to resource limitations. Having said this, Hanover Southbank during the final year of the Trial has seen the trial of several health clinics delivered by an Alfred Hospital Medical Officer to residents. While staff reported that these were well attended by residents, the ongoing formal delivery of these clinics has not continued. At the time of reporting the DACMC was in the process of identifying whether this service from the Alfred Hospital would commence again.

Nurses and caseworkers at Hanover Southbank have continued to link residents to understanding GPs within the community so that residents have an established relationship with a GP once they leave the CSAS. While every effort is made to achieve this, it is made difficult at times by the scarcity of GPs who are willing to care for homeless drug users in an ongoing capacity.

While there has been no formalisation of GPs delivering a service to residents at the CSAS, Ozanam reports that it has continued to maintain links to GPs through its Ozanam Community Centre, and is now in the process of further enhancing these links rather than aiming to have a GP on site at Ozanam House. The RDNS nurses also have very good links with GPs in the local area and this has significantly assisted with the linkage of residents to supportive GPs.

Flagstaff noted during second-year evaluations that it was hoping to commence discussions with Doutta Galla Community Health Centre to see if it could secure the services of a GP. While key informants report that the links with supportive GPs in the community is good, to date they have not pursued discussions with Doutta Galla CHC. They do, however, still see the benefits in having GP access for residents at Flagstaff and hope to follow this up in the future.

5.2.4 Response to Identified Areas for Improvement/Future Directions

While the linkage to GPs continues to remain an area for improved service development, the second-year evaluation report also noted other areas within the services that required improvement. One area was for 'staff in all services to receive regular training and support around practical ways of identifying and then educating residents about drug-related harms and health risks' (Rayner, November 2003). While significant efforts had been achieved at the end of the second year in the building of staff knowledge in this area, there was a proportion of staff who appeared to not possess the level of knowledge required of them. Focus group discussions, key informant journaling and observation all appear to support that significant gains have since been made in the level of drug and alcohol knowledge possessed by a wide range of staff, whether they be after-hours facility staff, caseworkers, CD workers or support team members. Key factors that appear to have contributed to this improvement is the extension of the Diploma in Community Services (AOD) to a cross-section of staff in 2004; continued secondary consultation provided by experienced and readily available primary case managers and nurses, and the delivery of targeted training to staff in this area.

Hanover Southbank: During the Trial's second-year evaluation process, staff reported that while health promotion forums for residents had been held, staff felt that the level and availability of these could be broadened. In the final year of the Trial, health promotion activities for residents have occurred, but the program itself has not been broadened, nor have the nurses been designated this activity as a key area of responsibility. A factor impacting on this occurring is the two nurses' responsibilities are being directed towards clinical client work and secondary consultation as opposed to facilitating health-promotion work. While the issue of well-coordinated health promotion activities needs to be further considered, the employment of two new nurses has led to the delivery of regular nursing clinics six days per week, with staff reporting that this has resulted in improvements in the delivery and promotion of health services for residents.

Flagstaff: Consistent with second-year evaluation findings, key informant journaling and staff focus groups at Flagstaff continue to report that they are extremely happy with the clinical services, secondary consultation and health promotion activities provided by the RDNS nurses or in collaboration with Trial staff.

Areas for improvement noted at the end of the second year were to further develop Flagstaff's health promotion calendar and to timetable activities with the Vic Health promotion calendar. While key informants report that health promotion activities where possible have coincided with the Vic Health promotion calendar, limited resources in terms of staff time have prevented the development of this activity more fully.

Key informants continue to report that the demand for nursing services at Flagstaff has remained high in the final year of the Trial, and if resources were available the extension of evening services would be further considered. While this area of improvement was noted in the second-year report, there has been no additional funding secured at this time to extend nursing

services to the evening.

Ozanam House: Staff and managers at Ozanam House continue to report that they are generally pleased with the level and range of health care services available to residents.

An area for improvement identified by key informants at the end of the second year was for an increase in the provision of alternative therapies. A range of alternative therapies, such as acupuncture and yoga, has continued to be offered regularly to residents during the final year of the Trial. Feedback from resident meetings guided the focus of these activities and residents have reported positive feedback.

The need to further develop external linkages and pathways was also identified as an area for improvement and has been an area of service development at Ozanam House by staff in the final year of the Trial. Staff focus groups and key informant journaling identified that additional work has been taking place at Ozanam House to further strengthen external linkages to health and community support services with improved pathway outcomes for residents being reported. Additional work taking place to support this area of service development has been the appointment of a research officer to examine how the Ozanam Community can make HACC services more available to homeless clients.

Finally, RDNS nurses at Ozanam House reported that an area of improvement needed is in the provision of information, testing and treatment for CSAS residents with a known or suspected blood borne virus such as hepatitis C. General BBV education is being provided to residents, and a broader health care response is being provided by linking to other health services as required.

Access to therapeutic counselling for CSAS residents was also reported as an area of service provision for further consideration at Ozanam House. Over the course of the Trial both Hanover Southbank and now Flagstaff have established an on-site counselling service for residents, meeting a significant gap and providing homeless clients with an opportunity to receive counselling, often for the first time, while a resident of the CSAS. It now appears timely for both Hanover Southbank and Flagstaff to share their experiences of setting up these programs with Ozanam.

5.3 Policies and Procedures

5.3.1 What Has Occurred?

During the development stage of the Trial, each agency identified within their models existing policies for review or development in order to support the current context of the CSAS and the direction of Trial activities. In some instances new policies were identified as needing to be developed in order to provide a framework of practice and clear lines of accountability for staff in Trial-related areas. While each agency has the overall responsibility for this procedural task, the Trial annually reviews this component with agencies against benchmark data as part of its evaluation process. In addition to this, policies are reviewed at least annually through management forums or established agency committees.

As indicated in Table 5 on page 48, the status of these policies has generally remained the same as that reported at the end of the second year. Since last reporting, Flagstaff has developed a

needle exchange program policy and additionally written and implemented a substitute pharmacotherapy client subsidy policy. This policy is directed at supporting clients living in semi-independent accommodation to meet the costs associated with substitute pharmacotherapy treatment by paying either 50–75% of the costs attached to this treatment. The subsidy provided is dependent on the level of benefits the client currently receives and is reviewed regularly with the client. Ozanam already have a harm minimisation (covers needle exchange) and substitute pharmacotherapy policy in place, while Hanover Southbank has a harm minimisation policy.

Ozanam reports that the standards policy manual is now in place and the recent appointment of a Policy and Research Officer will support this work by regularly reviewing current service needs and updating the manually accordingly.

During the final year of the Trial all three agencies have maintained their processes of regularly reviewing and monitoring policies and procedures that pre-dated the Trial but have been strengthened as a consequence of it.

5.4 Monitoring and Responding to Resident Drug-use Patterns and Associated Harms

5.4.1 What Has Occurred?

The monitoring of drug-use patterns and presenting harms remains a key focus of Trial activities and continues to be viewed by staff as an area for reflection and consideration in day-to-day work practices. Drug-use patterns and problematic drug-using behaviours among residents within each CSAS are regularly monitored and openly discussed at a number of levels, whether that be at daily handover meetings or weekly team meetings.

In addition to this, the Trial's Action Research Methodology has allowed for another layer of facilitated discussion among staff through the continuation in the final year of project management meetings, journaling sessions, staff focus groups and the monitoring and recording of critical incidents.

Final-year focus group discussions across the services identified that while a wide range of harms associated with drug use were present during the third and final year of the Trial, the most significant related to injecting drug use, poly drug use and an increase in the use and availability of heroin among residents. Of note is the continued reference by staff that suggests patterns of drug use among residents appears to be influenced not only by the illicit drug market and subsequent shifts in this, but also by the use of certain drugs by resident social networks at the CSAS.

During focus group discussions held in April/May 2004, staff were asked to recall any noted patterns or shifts in drug use among residents in the preceding six months. A consistent theme across the three CSAS was the observed increase in the number of residents using/injecting heroin. Staff also reported that they felt that 'heroin was stronger', with residents often reporting this to staff. While the Trial's second-year report also noted an increase in the use of heroin among residents (a pattern supported by the Illicit Drug Reporting System [IDRS] survey conducted between June–October 2002 [Jenkinson, Fry & Miller, 2003]), staff across

Table 5: Summary Status of Policies Relevant to Trial Objectives

Policy Area	Flagstaff		Hanover Southbank		Ozanam House	
	Opera-tional	Review Status	Operational	Review Status	Opera-tional	Review Status
Harm Minimisation	Yes	Salvation Army policy in place. In addition the service, in consultation with the Trial team, has completed the development of a specific policy on the needle exchange program	Yes	Currently reviewing Needle Syringe Program component.	Yes	Policy in place directed at reducing health risks associated with drug use-related harms
Overdose Policy	Yes	As above	Yes – incorporated in harm minimisation policy	NA	Yes	Policy in place directed at reducing health risks associated with drug use-related harms
Response to Critical Incident Policy	Yes	NA	Yes	NA	Yes	Reviewed and updated. Work practice manual in place across the entire organisation
Case Work Response Policy	Yes	–	Yes	After-hours response has been completed	Yes	As above
Staff Support Policy	Yes	Working party exists to regularly review and monitor supervision and support practice policy. This is built into the service's Employment Assistance Program	Yes – in staffing policy manual	NA	Yes	As above
Staff Supervision Policy	Yes	Working party exists to regularly review and monitor supervision and support practice policy	Yes – in staffing policy manual	NA	Yes	As above
Professional Development/Staff Training Policy	Yes – relates to mandatory training and incorporated into supervision framework and case work policies	As above	Yes – relates to mandatory training	NA	Yes	As above
Resident Feedback/Satisfaction Policy	No formal policy exists	Occurs via resident meeting and grievance procedures	No	NA	Yes	As above. Continues to occur through weekly resident meetings
Resident Grievance Policy	Yes	NA	Yes	NA	Yes	As above
New: Substitute Pharmacotherapy Client Subsidy Policy	Yes	In order to support clients and the costs attached with substitute pharma-cotherapy, Flagstaff will pay up to 75% of the costs, with clients meeting the remainder	NA	NA	Yes	The total cost of substitute pharmacotherapy is paid by Ozanam and clients are encouraged to make part payments where possible.
New: Volunteer Policy	NA	NA	Yes	Under review Hanover wide	Yes	Reviewed and updated

the three services believed that the number of residents using appeared higher than that reported at the end of the second year. However, the 2003 IDRS survey that collected data between June–October 2003 reported that trends in heroin use over the past twelve months had remained relatively stable: the 'frequency of heroin use had increased slightly (76 days in 2003, 60 days in 2002), however it had not returned to the levels seen prior to 2001 (176 days in 2000), during the peak of the street heroin market' (Jenkinson, Fry & Miller, 2004).

While all three CSAS separately reported in focus group discussions that heroin currently being used by residents was 'stronger', it is difficult to determine whether the purity of heroin used by residents had in fact increased. The 2003 IDRS survey reported that the purity of heroin in Victoria had remained relatively stable (Jenkinson, Fry & Miller, 2004).

Connected to the growing use of heroin is the noted increase in the number of overdoses and associated risk of mortality and morbidity. Key informants at Flagstaff reported that in the past six months there had been two drug-related deaths due to overdose among clients living in the community but supported by the Flagstaff support teams, as well as one resident death due to overdose at Flagstaff CSAS. Of particular concern to staff is the potential risk of overdose among clients released from prison to the CSAS, with CSAS staff now actively trying to identify and then educate and support this group immediately after their release.

Further, consistent reports among the CSAS in regards to the sharing and injection of buprenorphine among residents and the action of poly drug continues to be present among a significant proportion of residents within the CSAS. Staff continued to report in the third year that poly drug-using behaviours were not always viewed as problematic by residents but seen as normal and beneficial to alleviating their feelings and achieving their desired drug effect.

> *'There is always a core group of residents who use whatever is easily available to them at the time.' – CSAS Primary Case Manager*
>
> *'Cocktails of drugs continue to be used, with more combinations of drugs being explored by residents.' – CSAS Caseworker*

Methamphetamines, particularly 'ice' and 'speed', continue to be injected by a proportion of residents staying at the CSAS, but not to the same degree previously reported in the first two years of the Trial. As a consequence, staff report that the level of aggression and violence experienced in the past has not been present during the final year of the Trial.

Alcohol and/or cannabis continue to be the most widely and regularly used drugs among residents, with cannabis remaining easily accessible across the CSAS.
Staff focus groups and Key informant feedback highlighted that the past year has seen an increase in the number of older male alcoholics at Ozanam House. This is a direct consequence of a strategy to target this population through the implementation of a 'sobering up bed'. Please see section 7.5. for more information.

Consistent with previous Trial evaluation reports, staff within the CSAS continue to undertake a variety of activities in order to monitor and prevent drug-related harms presenting on a daily basis within the services. Additional Trial resources and the integration of these positions into day-to-day operations has raised the awareness of these issues and kept the focus on the identification and reduction of harms. In each service, staff continue to perform regular walk-

throughs, and if concerned about residents, conduct room checks/door knocks in order to reduce the risk of overdose. Daily morning meetings within each service are held where concerns related to resident drug use are discussed and the need for resident education or health and safety checks among residents is determined. With this has come a greater awareness and response to medical emergencies.

The distribution of clean needles and syringes and safer using information has continued and is available to residents through the nurse at Ozanam and Flagstaff, while both accommodation and nursing staff at Hanover Southbank implement the needle exchange program. Regular health education sessions such as hepatitis C awareness classes are conducted within each service either by staff on site or by organisations such as VIVAIDS or Foot Patrol.

Finally, compulsory first aid training and the regular upgrading of these qualifications is readily available to all staff. Such responses have had an impact on improving staff confidence and skills in dealing with emergencies and liaising with health care professionals from emergency and primary health care services.

Monitoring of Critical Incidents

The monitoring of critical incidents was implemented at the commencement of the Trial as a quantifiable measure of observing change and events within the CSAS. While there have been some differences in how each CSAS records critical incidents, making definitive comparison between services difficult, shifts within services can be monitored and emerging patterns examined. Each CSAS has been recording the frequency of and their response to a range of critical incidents within their services, however only key critical incidents, as listed in Table 6, have been examined. These were considered by the CSAS to be the most relevant to the Trial, while also having consistent definitions applied across all three services.

Of note in the final year of the Trial has been the increase in the incident of overdoses at Flagstaff and Hanover Southbank when compared to numbers recorded in the second year of the Trial (2002/2003). Key informants state that this increase appears to correspond with the reported and observed increased availability and use of heroin by residents noted across all three CSAS, and the continued reporting of poly drug use by many residents. While the incident of overdose is much lower for Hanover Southbank and Flagstaff compared to the benchmark years prior to the Trial (1999–2001), overdoses are still occurring and appear to be increasing. While all three CSAS have remained active in sustaining daily intervention measures to reduce overdose in the past year, the need to remain vigilant in order to identify and prevent further rises remains critical.

Corresponding with the increased level of overdoses has been the incidence of client deaths at Flagstaff (three deaths), and Ozanam (one death) in the final year of the Trial. Key informants report at Flagstaff that the three deaths were a result of drug overdoses. For Ozanam the death in the final year of the Trial occurred off site, as a consequence of a drug overdose. While no other client deaths had occurred in the first two Trial years, the occurrence of such in the final year sadly highlights the associated risks attached to a homeless drug user’s life and the necessity for services to intervene where possible to reduce the risk of death or serious injury which can occur as a result of a drug overdose.

As indicated in Table 6 (page 52), the incidence of needle stick injuries at the CSAS has remained low across all three services, with one incident at Flagstaff and Ozanam occurring in the final year of the Trial. Staff reported that the safe disposal of used needles generally occurs,

however in the final year there have been times when the promotion of such has needed to be stepped up in order to address episodes of unsafe disposal.

The increased incidence of physical assaults across the CSAS in the first two years of the Trial (2001/2003) was one of the most noted changes, largely as a result of increased methamphetamine use by residents that resulted in aggressive and erratic behaviour. The increased use of methamphetamines at this time also coincided with the reduction in the availability and use of heroin by residents, particularly during the first year of the Trial. However, of note in the final year of the Trial is the reduction in the incidence of physical assaults across the three CSAS. While staff across the services still report that some residents continue to use methamphetamines, the prevalence of use appears to be lower, with fewer episodes of erratic and aggressive behaviour needing to be managed compared to those experienced in the first two Trial years.

Mental health incidents (calls to HOPS, CATT or other emergency services in the event of a mental health crisis) have remained high at Flagstaff during the final year of the Trial, with a noted increase from levels reported in the second year. However, there has been a significant reduction in the occurrence of these incidents at both Ozanam House and Hanover Southbank**.**

Both Ozanam and Hanover described similar processes at work in this decrease**.**
Over the course of the Trial staff have improved the response to the early signs of residents' experiencing mental health problems. Staff are becoming more skilled and confident in responding to clients exhibiting signs that they may be becoming unwell. Calls to emergency services such as HOPS/CATT are now more pre-emptive than in the past, and such calls are viewed as a management strategy for residents' mental health problems. As such, staff are not treating these incidents as 'critical' and are not recording them as such. The various strategies funded as "Part A" of this Trial and an enhanced working relationships with mental health services have also contributed to this improved response.

Flagstaff attributed their increase to a number of factors. First, there is a greater awareness and greater focus on clients mental health needs than there was previously. This is in part due to ongoing reflection around client needs and in part due to the new onsite mental health team. This growing awareness has led to better links with other mental health services and the targeting of complex care clients exiting psychiatric hospital. As a result of an increased awareness and an increase in complex clients, specific care was taken to record all mental health incidents as critical incidents.

5.4.2 What Has Been Achieved?

The variety of different measures put in place as a result of the Trial have allowed the CSAS to develop significant capacity in their ability to respond confidently to harms associated with drug use and critical incidents, regardless of the changes to the supply and use of drugs.

An openness by staff to reflect on drug-using behaviours with a view of then considering their response as well as that of their organisation has continued during the final year of the Trial. Staff have also continued to report that residents appear more comfortable talking with staff about their drug use, whether it is with the nurse, accommodation facility staff or their case worker.

Table 6: Number of Critical Incidents Within the Crisis Supported Accommodation Services

Critical Incidents	Flagstaff					Hanover Southbank					Ozanam House				
	99/00	00/01	01/02	02/03	03/04	99/00	00/01	01/02	02/03	03/04	99/00	00/01	01/02	02/03	03/04
Client death	No record	2	0	0	3	2	0	0	0	0	2	2	0	0	1
Staff death	No record	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overdose	No record	29	9	2	17	88	67	27	4	15	8	8	3	7	6
Needle stick injury	No record	0	0	0	1	1	1	4	1	0	1	0	0	1	1
Physical assault	No record	47	89	64	37	19	17	65	71	10	8	16	30	19	7
Sexual assault	No record	-	-	-	-	0	0	11	0	0	0	0	1	0	4
Property damage	No record	No record	34	22	31	6	1	55	22	4	7	13	300	9	7
Major fire	No record	0	0	0	0	0	1	0	0	0	0	0	0	0	0
Mental health incident – calls to CAT/HOPS/other emergency services	No record	No record	74	76	104	32	16	89	59	9	No record	4	62	81	41

*While consistent definitions apply, reporting of critical incidents is influenced by the consistency across and within services in the recording of these events.

6. STRENGTHENED CAPACITY TO INVOLVE DRUG-USING CLIENTS IN DRUG TREATMENT SERVICES, MENTAL HEALTH SERVICES AND OTHER HEALTH-RELATED SERVICES

Chapter 6 details the Trial's response to strengthening its capacity to involve drug-using clients in drug treatment services, mental health services and other health related services during the third and final year of the Trial.

The progress and impact of implemented strategies as articulated in CSAS Trial models have been examined in order to identify the current effects of these strategies, further developments, as well as the services' response to noted areas for improvement identified in the second-year evaluation report. In addition, achievements, challenges, learnings and areas for improvements, if relevant at this stage of the Trial, have also been examined.

Related Objectives:

- Strengthen the capacity of services to involve/engage drug-using clients in drug treatment, mental health and other health-related services.
- Minimise the harm of drug use among drug-using clients.
- Enhance and develop casework responses to drug-using clients.

6.1 Enhanced Case Work Practice

6.1.1 What Has Occurred?

Additional staff resources implemented as a result of the Trial have continued to positively impact on the services' ability to effectively engage homeless clients with regard to their problematic drug use and other associated problems. Key factors that have influenced this shift include the current enhanced capacity of staff to work with clients who have drug dependency and complex needs problems, and the cultural shift within the CSAS that now support and actively influence the proactive and effective engagement of this target group.

As previously reported, key Trial strategies that have had the greatest impact on enhanced casework practice in the final year of the Trial continue to be the DACMC positions and primary case managers who provide secondary consultation to CSAS staff, the broad professional development program on offer, enhanced health care services and Flagstaff's Part A+ response.

While not having a direct impact on enhancing casework practice to clients with a mental health disorder in the third year but being able to do so in the future is the Trial's receipt of specific mental health funding to partly address identified gaps in the area of mental health practice and service delivery to homeless clients.

DACMC Positions and the Role of the Trial's Primary Case Managers

The Drug and Alcohol Case Manager Coordinator Positions (DACMCs) across the three services have focused a large amount of their efforts towards enhancing the quality of case work interventions through the provision of secondary consultation around drug and alcohol issues, supervision of staff and the coordination of broader Trial activities. These key tasks have continued across the three CSAS in the final year, with some variations between services in how this position is deployed on a day-to-day basis. Emerging more strongly in the final year is the important role that Trial primary case managers play, particularly those who have gained significant experience and expertise over the past three years of the Trial and are now called upon by general staff at the CSAS for advice and support in the area of drug and alcohol practice. This additional layer of expertise has further contributed to the level of staff supports available and also significantly impacted on the organisational culture of these services where the majority of staff now positively work within a framework that is inclusive and proactive to the need of drug-using homeless clients.

Key informants from across the three CSAS noted that the process of introducing the role of the DACMC into the CSAS has been tested and proven successful.

> *'The role and functions attached to the DACMC role have been right. What we identified at the beginning as needed has now been tested and proven.' – CSAS Manager*

Enhanced Health Care Response

The additional nursing capacity now available continues to be viewed by CSAS staff as a further critical element contributing to enhance casework practices. The increased levels of nursing advice and support now available through the Trial and retained in recurrent funding for the program also assist case workers in the management of their homeless clients' drug, alcohol and other health problems. The extension of on-site nursing clinics and health promotion activities has also supported case workers by providing an accessible referral point for residents to address health problems.

> *'Being able to talk to the nurses about a client's health problems has been of great benefit, not only for the resident but also in my ability to assess for health problems and access the information I need to assist the resident.' – CSAS Caseworker*
>
> *'Having nurses on site after hours and over the weekends means that clients who need a response at this time are able to receive one rather than having to wait until Monday. This has allowed us to be more responsive to client needs.' – DACMC*

Additional Professional Development Opportunities

The range of professional development opportunities now available to staff such as the NMIT Diploma course and case reviews with HOPS along with secondary consultation provided by the DACMC and primary case managers, have allowed many staff to become more experienced and confident in the area of drug and/or alcohol practice and in linkage to external drug treatment and other health services.

Flagstaff's Part A+ Clients

Flagstaff's Part A+ Client response is a further example of current enhanced casework efforts and of the strengthened capacity at Flagstaff to engage CSAS residents in drug treatment. Part A+ was a term applied to support clients who are waiting to access the Trial's long-term primary case management response (Part B) due to full caseloads or if they are ambivalent about joining the Trial but still request support from the Trial team. These clients are often living at the CSAS or they may have moved on to another supported accommodation facility such as Open Door or to a boarding house. The need to establish such a response emerged during the Trial's first year and was formally introduced in January 2002 in response to the increasing level of referrals to the Trial's D&A team and the staff wanting to support clients where possible to access other forms of drug treatment as well as offering relapse prevention counselling. During the third and final year of the Trial twenty-three residents have engaged in this support service. To be counted as receiving this service, the client needs to have been seen by a Trial Primary Case Manager three or more times.

While not counted to date through ADIS, the work undertaken by Primary Case Managers at Flagstaff in supporting Part A+ clients continues to be a service that staff refer residents to. Staff reported during journaling sessions that positive results have been noted from the brief intervention or referral support to other drug and alcohol services offered by the Flagstaff D&A team to these residents.

> *'The Part A+ drug and alcohol service allows us to utilise Trial resources more broadly to assist a wide range of clients with linkage and support to access the drug treatment system. It also allows us to be client-focused and responsive to varying levels of individual need and readiness for treatment.' – Flagstaff DACMC*

Introduction of Additional Primary Case Management Functions across the Ozanam Community

In line with Ozanam's plans to modify their current primary case management staffing model as of July 2004 in order to address identified gaps and further improve their capacity to respond to unmet client demands, Trial primary case managers will be out-posted to Ozanam support teams on a weekly basis, such as Outreach or the Youth Support Service. The primary functions of PCMs when at other service sites is to assist clients with drug and alcohol needs via supportive referral or brief intervention work and to support staff via secondary consultation so that they can more effectively engage drug-dependent clients.

6.1.2 What Has Been Achieved?

Over the past three years a series of staff focus groups as well as key informant journaling sessions have routinely taken place during the life of the Trial. These methods of evaluation have not only supported the Trial's Action Research and collaborative learning commitments, but also allowed the evaluator to observe first-hand shifts and changes within participating organisations, with staff and the Trial as a whole. Observation of and communication with a broad cross-section of staff in this final year has further highlighted what can be achieved when there exists shared commitment and drive to improve service delivery and outcomes for homeless clients. Of note when speaking with staff across the services is their ever-increasing level of knowledge, expertise and commitment in working with drug-dependent homeless clients; their ability to articulate clearly their processes of reflection and approach when

working with this target group; and their commitment to ongoing improvement and new developments in service delivery. While the following key themes were noted in the second-year evaluation report, they have remained as important ongoing areas of achievement in the final year.

Culture of Openness and Inclusiveness – Removing the Stigma

The first step towards effective casework is the perceived openness within a service to discuss a range of issues with the client, one of those being the client's drug and alcohol use and associated behaviours/risks. Prior to the Trial there existed to varying degrees a perception among residents and staff that if residents openly identified they were using drugs or needed help that they would possibly be evicted from the CSAS. In some instances this did occur. In addition to this, some staff were fearful or not as confident in identifying and discussing client drug use. This resulted in a proportion of clients' problematic drug use not being assertively or openly followed up. As recognised by the three services, this had a limiting effect on their ability to effectively support and assist the growing number of presenting clients with problematic drug-use problems. Residents were also concerned about how they would be perceived and treated by staff at the CSAS, the stigma of their drug use often inhibiting their ability to receive the care and support they critically need.

> *'There are a lot more residents in the CSAS with drug and alcohol problems. These clients, however, are not being evicted for their drug use but supported in a variety of ways to assist them with this problem.' – CSAS Coordinator*
>
> *'Our service is not as punitive. Direct leadership exists to encourage staff to consider alternative ways of assisting drug-dependent clients.' – CSAS Manager*

As previously identified, CSAS staff have continued to openly and willingly discuss problems related to a client's drug and alcohol use, presenting drug-using behaviours within the facility, and associated harms. These discussions continue to be embedded into the services' daily operations and occur through daily case work team meetings or weekly integrated staff team meetings, as is the case at Ozanam House. Two new team leaders now attached to the Support and Facility Teams at Ozanam House have further strengthened the service's overall approach to drug-dependent clients and consistency in those approaches.

Further supporting this process is the CSAS use of communication books; expectations set by CSAS managers and team leaders; regular cross CSAS training and communication forums; Trial-specific management meetings; secondary consultation from DACMCs/nurses/primary case managers; the extensive training and professional development activities on offer; and the daily resident activity programs within the CSAS. Additionally, Hanover Southbank has noted the benefits to staff of introducing in the final year group supervision that is focused on reflective practice regarding drug and alcohol and mental health casework issues.

Greater Understanding of the Complexity of Issues Attached to a Homeless Person's Problematic Drug and Alcohol Use

Key informants continue to report that an element of third-year professional development and secondary consultation activities has been to retain its focus on educating staff around the complexity of issues attached to why an individual is using drugs, and that effective drug and alcohol practice is about establishing a relationship based on understanding and working with a

client over a period of time on those issues.

> *'Staff more broadly understand that for any one problem there are many associated issues. That's why we need to deliver a holistic response where possible.' – DACMC*

Key informants and staff focus group feedback continue to support that staff remain far more aware of treatment options and the importance of assisting clients to access the most appropriate drug treatment service for them, compared to what existed prior to the Trial.

Proactive Engagement and Enhanced Assessment Skills

Supporting this inclusive response has been the focus within the CSAS to proactively engage residents around a range of issues impacting on their lives. This now requires staff to undertake a broad assessment with the client that is not just centred on the client's housing needs but rather focused also on the factors contributing to the resident's current state of homelessness and problematic drug use. Following this assessment, staff offer practical and focused assistance to address these issues within the limitations of what a CSAS facility can offer. Supportive referrals to community and health services actively takes place and, where possible, residents are linked to longer-term support options offered through the CSAS, such as the Trial's long-term primary case management response.

Knowledge and Increased Linkage to External Services

While the capacity within each of the three participating CSAS to deliver long-term primary case management drug and alcohol assistance will increase post July 2004, there will still exist case load limitations to this service. In addition, it is acknowledged within services that not all homeless clients with drug and alcohol problems are going to want to participate in this response, while for others there may be other more appropriate treatment options that they may be wanting to access. Therefore the CSAS knowledge of and linkage to external specialist services is important. As evidenced in the following NDCA data (Figure 2 on page 61) analysed at the end of the Trial's second year, there has been an overall improvement in the level of referral to external services. While it is difficult to conclude that these improvements have further increased in the third year, given the absence of SAAP NDCA data for this report, staff focus group discussions and key informant journaling support that staff have continued to increase their knowledge of and linkage to external services. A far greater number of staff from across the three services positively report that efforts in this area have further improved, compared to that reported at the end of the second year.

> *'Our linkage to external services is good. There are a lot more services coming to the CSAS on a regular basis that benefit the client and improve our knowledge and understanding of this service and what it can offer clients.' – CSAS Support Worker*
>
> *'While the system is not set up in a way that automatically treats the whole client, our ability as workers and as an organisation to make the necessary links and referral for clients is pretty good.' – DACMC*
>
> *'Our links to and use of external services for clients is much improved compared to two years ago.' – CSAS Caseworker*

> *'Staff at times used to work in a vacuum. We now share information and utilise network meetings as a way of fostering external linkages.' – CSAS Coordinator*

Additionally, the services have continued to build their capacity for direct client access to external services through partnerships with other organisations. An example of this includes Hanover Southbank's partnership with the Cairnmillar Institute that has recently increased their provision from one to two counsellors on a weekly basis to give specialist counselling to residents, with some residents continuing with this after they have left the CSAS.

Two other services that have continued to regularly attend the CSAS are the Homeless Outreach Psychiatric Service (HOPS) and Substance Use Mental Illness Treatment Team (SUMITT), either to see individual clients or to offer secondary consultation to staff. CSAS staff report that these services have continued to provide an invaluable and much-needed service to homeless clients and staff but look forward to the extension of the HOPS response at the CSAS.

Mental Health: Strategic developments to address identified gaps

The Trial's first-year reports identified an alarming level of mental health disorders among homeless clients accessing the CSAS with the second-year evaluation report continuing to note that the Trial was at a point where it needed to make a concerted effort to consider more fully the mental health needs of homeless clients accessing the CSAS, and to identify ways forward.

Since the second-year report, the Trial Executive and the three CSAS have proactively worked at addressing this area of need by undertaking a further level of analysis during the months of December 2003 and January 2004 to further support evidence gained. Part of the Trial's strategic plan has also involved lobbying the health minister and senior government officers regarding this matter and collaborating with both the Mental Health Branch and the Drugs Policy and Services Branch in identifying ways forward. An outcome of these efforts was the Trial's submission of a proposal to the Mental Health Branch, Drugs Policy and Services Branch and the Office of Housing of the Department of Human Services outlining the extent of presenting mental health problems within the CSAS; analysis of the interface between clinical mental health services and the CSAS; and priority areas of recommendations to address identified gaps.

While the Trial put forward a range of recommendations to address these gaps, not all of which have been funded, they were successful in securing three additional mental health positions that are to be managed by the Homeless Outreach Psychiatric Services but principally based at the CSAS. Discussions are currently underway between the CSAS and the HOPS teams to collectively agree upon the best ways of deploying these additional resources to address critical gaps identified.

While all agree that the three additional HOPS positions cannot be expected to address all of the reported gaps, it is a significant step forward in that targeted resources can be directed at improving collaborative efforts between the CSAS and mental health services, with a focus on building capacity within the CSAS and improving client pathways and access to mental health supports.

6.1.3 What Have Been the Challenges?

The lack of affordable and appropriate long-term housing options available to residents exiting the CSAS has continued to impact on homeless persons' movement out of the homeless service system and their ability to gain the stability they need to address other debilitating issues in their lives. While this issue is a complex social and economic problem facing people living in poverty, it is of vital importance that the Trial and participating agencies continue to advocate for appropriate and affordable housing options for residents exiting crisis accommodation. Further, alternative housing options that are able to provide a higher level of support and assistance to higher support needs clients, with a focus on assisting the individual to connect to the community, is of high importance. While the Trial and its partner agencies have developed an alternative model to do just this, the Executive of the Trial needs to consider this model more fully and to develop a plan of action to establish such a service.

> *'The lack of available and affordable housing exits for CSAS residents and Trial clients has created significant blockages in our system and limited our ability to resolve a person's homeless status.' – CSAS Coordinator*

While all three CSAS have improved their knowledge of and linkage with external services, staff across the three services consistently reported in focus group discussions that at times it is still difficult to get clients into external services as staff believe that many services are not designed to meet the specific needs of homeless clients or open to making the changes necessary to accommodate this group. This issue therefore continues to limit options available to homeless clients, making the creation of supportive pathways into the community difficult to establish for some clients, particularly those with high-support needs.

6.1.4 Response to Identified Areas for Improvement/Future Direction

As reported under 6.1.2, the Trial has actively worked on addressing the unresolved poor mental health state of many clients accessing the CSAS, noted in the second-year evaluation report. Further discussion on the work undertaken by the Trial in the final year to address this issue is discussed in more detail in Section 6.7.

6.1.5 Areas for Improvement

While challenges identified under 6.1.3 also represent areas for improvement and further consideration such as improved access to appropriate and affordable housing, additional areas have also been identified during the final-year evaluation processes.

Upon reflecting on capacity-building activities and the Trial's long-term primary case management response, an emerging theme from both areas of discussion is the need to establish opportunities where clients can access educational and training options that are specifically tailored to the needs of such a disadvantaged group. In addition, opportunities that support a client's access to employment or meaningful involvement in community activities is critical. While the Trial's Community Reintegration Program (CRP), attached to the long-term primary case management response, has significantly contributed to the Trial's ability to meet such needs and aspirations of clients, it is limited in terms of resources and was not designed to

meet the needs of all CSAS clients. Addressing boredom and providing opportunities for homeless clients that have the potential to support their aspirations needs to be considered more broadly by the Trial and the three CSAS.

Of note in the third-year evaluation process at Flagstaff is the need to introduce a common assessment tool across the organisation that begins the moment the client enters the service. Current challenges lie in encouraging all staff to see the importance of collecting assessment information that is easily transferable as the client moves through the organisation. Discussions are currently underway on how best to achieve this objective.

Journaling sessions with key informants at Hanover Southbank identified that one area of improvement now needed is the direct implementation of specific training that is able to educate staff more fully on how addiction impacts on a person's life beyond the physical implications. While such discussions and some training in this area have taken place, Hanover is keen to extend this program with staff.

> *'We now need to generate a greater depth of understanding among staff that asks such questions as – "What has the person missed out on in their life while using drugs?"' – HSB DACMC*

Finally, a further area for improvement would be the services' ability to improve their linkages with and use of disability services as well as their linkages with the criminal justice system. Focus group discussions across the three services noted this area of linkage as a gap as well as the CSAS connections with the criminal justice system. These areas have been picked by the Trial's project manager and noted as areas for consideration by the Inter-Agency Working Party, in the Trial's transition plan.

6.2 Second-year SAAP NDCA Data – Improved Service Delivery

SAAP NDCA data was accessed at the end of the Trial's second year from the Australian Institute of Health and Welfare (AIHW), as a way of quantitatively measuring client support needs and the degrees to which these are addressed within the CSAS. The SAAP NDCA data was examined for the second-year report in order to support qualitative findings that capacity-building activities have strengthened the services' ability to effectively engage clients around drug and alcohol, mental health, and other health-related issues. While SAAP NDCA data was not available for analysis at the time of writing this report, the following discussion has been extracted from the second-year report (Rayner, November 2003) in regards to the Provision and Linkage to Drug and Alcohol Services for inclusion in this final report.

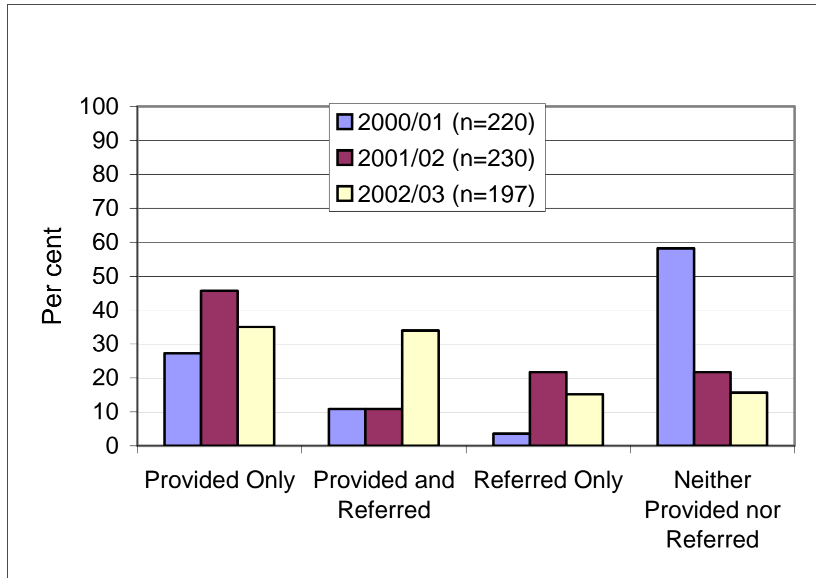
Due to the inconsistency in Ozanam's data, the following discussion only includes shifts in patterns of service delivery for Flagstaff and Hanover Southbank.

Provision of and Linkage to Drug and Alcohol Services Reported at the End of the Second Year

Flagstaff: NDCA data related to the provision of drug and alcohol services at Flagstaff clearly demonstrates that there has been a marked increase/improvement in the provision of drug and

alcohol services to residents who needed such support during the first two years of the Trial, against the benchmark year (2000/01).

Figure 2: Flagstaff – Provision of Drug/Alcohol Support Needed by Clients, 2000/01 to 2002/03



In the year prior to the Trial (2000–2001), as demonstrated in Figure 2, there was a significant gap in the provision of drug and alcohol services to Flagstaff residents who identified the need for such support. Just over half (58%) the residents who were accommodated and identified as needing support did not receive this from Flagstaff, nor were they referred. This supports pre-Trial observations that the demand for drug and alcohol assistance was far greater than the current service's capacity to meet this demand.

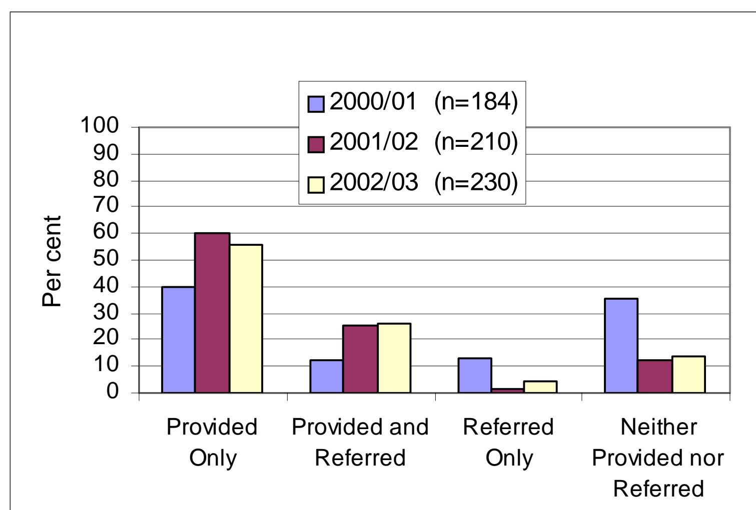
With the implementation of the Trial and the associated enhanced capacity, there has been a significant increase from 27% to 46% in the first year of the Trial, followed by 35% in the second year in the direct provision of drug and alcohol assistance to homeless clients requiring such support. With an increased focus on proactively engaging residents around a range of presenting and often complex issues, there has also been an increase in external referrals only to drug and alcohol services from 4% in 2000/01 to 22 % in 2001/02, with a drop in 2002/03 to 15%.

Accompanying this drop in referrals has been the threefold increase during the second year of the Trial in the level of drug and alcohol assistance that involved both the provision of assistance while clients were residents, as well as a supported referral to community-based drug and alcohol services that were able to support the client after they left the CSAS.

While there has been a significant decrease in the proportion of residents either being referred or being provided a service for their drug and alcohol use, there still remain a number of residents who receive no assistance with this problem. One factor that may be contributing to this is the impact of the client's length of stay on the service's ability to effectively deliver a drug and alcohol service response, particularly for those who stayed a short period of time. For instance, during the first year of the Trial (2001/02), approximately 21% of clients stayed only between 1–7 days.

Hanover Southbank: At Hanover Southbank there has been an overall increase in the provision of drug and alcohol services to residents needing this support. In the year prior to the Trial (2000/01) 40% of residents who requested assistance with their drug and alcohol use received a service response directly while staying within Hanover Southbank. In the following first two years of the Trial this increased by 20% to approximately 60% during 2001/2002 and 2002/03. Consistent with the increase in services provided there has been a decrease of 22% in the proportion of residents who were neither provided nor referred for their drug and alcohol issues. This pattern appears consistent with Hanover Southbank's Trial model where case workers manage a mixed case load of Crisis, Part B Trial and THM clients and are therefore able, depending on capacity, to begin the process of assessing and working with residents on drug and alcohol issues and to follow this through with a continued case management response.

Figure 3: Hanover – Provision of Drug/Alcohol Support Needed by Clients, 2000/01 to 2002/03



In addition, during the previous two years of the Trial very few residents requiring support for their drug and alcohol use were referred externally only, the majority receiving support from either Hanover Southbank or, as indicated in Figure 3, they were provided with support while staying at Hanover Southbank and referred to an external service. This pattern in service delivery has doubled in the previous two years of the Trial from 12% prior to the Trial (2000/01) to 26% (2001/02; 2002/03) during the Trial.

While there has been a significant decrease in the proportion of residents being referred or provided a service for their drug and alcohol use, there still remain a number of residents who receive no assistance with this problem. One factor that may be contributing to this is the client's length of stay on the service's ability to effectively deliver support. During 2001–2003, 24–28% of clients stayed between 1–7 days only. Key informants also report that often some women and families in particular do not stay for long periods of time in the CSAS, which can then impact on the caseworkers' ability to address drug and alcohol problems with the client if present.

6.3 Inter-agency Protocols

Inter-agency protocols have remained in operation between the CSAS and partner agencies and were first developed in the early stages of the Trial. During the final quarter of the Trial's second year, protocols had been reviewed and, where needed, modifications made in order to improve communications or further clarify collaborative processes. These include the protocols between the three CSAS and:

- Bridge Withdrawal Service
- Windana Therapeutic Community
- Odyssey House Services
- De Paul House.

Other inter-agency protocols that CSAS report are in place are with:

- RDNS
- SUMITT
- Homeless Outreach Psychiatric Service (HOPS)
- ARBIAS
- St Vincent's Hospital Drug and Alcohol Unit.

6.3.1 What Have Been the Learnings?

As previously reported protocols are important working documents that clearly articulate processes and expectations between involved parties. However, their effectiveness will be largely dependent on the extent of protocol dissemination and understanding of such processes within agencies. Further, it is the quality of the relationships that exist between services and the spirit of cooperation that will drive and support partnerships and in turn generate effective service delivery outcomes for homeless clients.

While key stakeholders have taken on the responsibility of disseminating these protocols to staff within their agencies (and, as a result, there has been a reported increase in staff awareness and the application of protocol procedures), there still remain areas for improvement. It would appear that at times not all staff have read the protocols, therefore they are not clear on how certain services operate or the processes for effective referrals and client access to these services. Processes outlined in the protocols appear to work well when there has been an opportunity for staff from the three services to meet formally or informally and exchange experiences or discuss each other's services.

6.3.2 Areas for Improvement

Areas for improvement noted in the second-year evaluation report, as articulated below still exist at the end of the final year, and by their very nature will always remain as areas for ongoing monitoring and Trial project management oversight if cross-sector partnerships are to be sustained.

As noted under key learnings, inter-agency protocols need to be relevant to staff and reflect the experiences and challenges they face in their day-to-day work with homeless clients. They also need to be supported by a range of communication forums. In light of this there needs to be a

greater opportunity for staff within all positions, not just those in management, to meet with staff from other sectors where there can be a sharing of ideas, experiences and the possibility to work on projects together. While there are various network forums on offer within DHS regions, they do not appear to involve all sectors at the one forum. In addition, those that attend these forums are usually managers or coordinators, and while it is important to have this representation, it does not allow for broader participation by other staff. This thereby limits the degree to which services can fully integrate and understand each other.

Finally, in light of Trial funding being reallocated away from the provision of the five residential rehabilitation beds and with a cut to Bridge residential withdrawal beds attached to the primary case management response, Trial management and partner agencies need to now review existing protocols and agree on what flexible arrangements can be sustained in the future. At the time of writing this report, the Project Manager had already conducted discussions with partner agencies regarding this matter, with services making an in-principle commitment to keep working collaboratively with the CSAS.

6.4 Alcohol and Other Drugs Reference Group

6.4.1 What Has Occurred?

The Alcohol and Other Drug Reference Group was established at the beginning of the Trial and has continued to meet every six weeks: first, to act as an information exchange between participating services within the Trial; second, to develop and continually review inter-agency protocols between the CSAS and participating services; and third, to identify gaps within the Trial, make recommendations to the IAWP and review Trial pathway options with the intention of improving the care and treatment options provided to Trial participants and CSAS residents where applicable.

6.4.2 What Has Been Achieved?

The intended activities of the reference group have largely been achieved at the end of the second year, leading to an increased understanding of other service systems that Trial clients and CSAS residents have needed to gain access to. The reference group has enabled relationships to be formed between staff working in a range of services and, most importantly, improved the access for Trial participants and CSAS residents to D&A services in a more flexible and responsive way.

Members of the AOD reference group continue to report that discussions within this forum have challenged workers to consider new approaches or examine established practices and beliefs, leading to improved responses for homeless clients. In addition, perceptions or assumptions held by workers about each other's service systems have been discussed or challenged as participants shared experiences or explained the reasoning behind, for example, certain approaches to drug treatment. All of these shifts were noted by parties as having improved communication and understanding between the CSAS and partner agencies.

The terms of reference for the group were reviewed in November 2003 in direct response to the second-year evaluation report, identifying that it was now timely for the group to modify the terms of reference in order to make meetings and discussions more relevant to the current stage

of the HDDT and partner relationships. Membership of the group has not broadly been extended as yet, even though this was noted as an area for improvement in the second-year report.

Alternative Housing Model

An additional achievement of the AOD reference group has been the development and documentation of an alternative housing model in direct response to an emerging need being identified by the group. This work has taken approximately six months to complete, with Odyssey being commissioned to work closely with the reference group
in the write-up of an alternative housing model for Trial clients with higher levels of complex support needs. At the time of writing this report, the model document had been circulated for discussion and consideration by the Inter-Agency Working Party.

6.4.3 Areas for Improvement/Response to Identified Areas in the Second-year Report

The importance of continuing to support and resource the facilitation of cross-sector partnerships is critical to sustaining current developments and achievements of the Trial. The AOD reference group is one forum attached to the Trial that will remain critical to this process. While the terms of reference were reviewed in November 2003, this occurred prior to the successful obtainment of mental health funding and of the recent review of ongoing HDDT objectives. It is therefore important that the reference group review the terms of reference and modify such where necessary to support the new HDDP objectives and the move towards the inclusion of mental health issues. In light of this, it also appears timely to review the name of the reference group so it is more representative of current and future HDDP directions.

As previously reported, there still exits a need to establish ways of involving a broader range of workers in the reference group, particularly those who are assessing and working with homeless clients with D&A issues, whether that be in the CSAS or a DTS. This is so that there is a greater level of understanding among staff of all participating service systems and structures, rather than that knowledge being held by just a few. While stakeholders acknowledged at the end of the second year that this could be difficult to achieve due to staffing constraints and service delivery commitments, all felt that it was worthy of exploring further. However, as yet this has not occurred and needs to be on the agenda for discussion at a forthcoming reference group meeting.

6.5 Worker Exchange Program

6.5.1 What Has Occurred?

The Worker Exchange Program was introduced in January 2003 and was a cross-sector training initiative implemented within the Trial and funded from a one-off SAAP grant. It aimed to strengthen the capacity of staff within the CSAS, drug treatment services and mental health services to more effectively respond to homeless clients by undertaking placements within other service systems that will lead to an increased understanding of different treatment/service approaches. It has also aimed to enhance the services' ability to engage drug-using homeless clients from the CSAS into other forms of treatment and support. The intended outcomes of this response were to:

- improve worker knowledge and understanding of participating service systems and specific agency models
- improve worker knowledge of issues affecting homeless clients with drug and alcohol problems
- enhance cross-sector communication and relationships
- improve knowledge of participating agency referral processes
- improve shared care management arrangements of clients across sectors.

The design of the program has allowed for one, two and four-day placements at either a CSAS or a range of DTS and mental health services. Staff were also encouraged to contact the project worker with other areas/services of interest to them so that placements could be arranged. Built into the design of this project has been the ability to reimburse placement providers and the service that undertakes a placement. The receipt of these funds can be used towards backfill, internal staff development or extra staff support activities.

6.5.2 What Has Been Achieved?

The Worker Exchange Program continued in the third and final year of the Trial, however low levels of participation since the program's introduction in January 2003 have impacted on the Trial's ability to reach its target of forty placements by the end of September 2003.

At the end of April 2004,thirty-four placements had occurred over the previous fourteen months of operation. While efforts were made by the Trial project team to actively promote the program in the third year, key factors have continued to impede higher levels of participation.

To date, participating workers have undertaken placements at SUMITT, De Paul House, HOPS, Bridge Withdrawal Service, Bridgehaven, Ozanam House, Hanover Southbank, Community Reintegration Program, Odyssey House, Bendigo Community Health Day Program, DASWEST, Flagstaff and Windana TC.

Feedback from participant evaluation forms indicate that the majority were satisfied with their placement, noting that they felt more informed about the service referral process and what the services had to offer. In addition, participants reported that they had gained valuable knowledge in relation to the drug treatment system and differing approaches and philosophies between services. The placements had also provided opportunities for staff to reflect on their own practices and to network with staff from other sectors and agencies. This proved a valuable opportunity to build and enhance communications and relationships between staff of differing organisations and sectors.

6.5.3 What Have Been the Learnings?

Any type of worker exchange program needs to be flexible in order to meet a range of requests from staff that are dependent on the worker's interest level, knowledge and skills. The program's ability to achieve this requires adequate resources being attached to promoting and coordinating such a program.

The following list of key factors has impacted on the success of this project, as identified through the Trial's evaluation process.

- The WEP places demands on managers to appropriately coordinate the backfilling of positions.
- Contrary to earlier thoughts, financial reimbursement is not such a strong incentive. Locating experienced staff to backfill is the most significant issue, rather than just having the resources to do so.
- Adequate resources needed to be dedicated towards the coordination and ongoing promotion of the program.
- Services need to see the program as valuable, and support staff to undertake placements.
- A broad range of placements needs to be made available in order to meet the interests of the majority of staff.

These factors will need to be considered more fully by any future worker exchange program if it is going be successful.

6.5.4 Future Direction

In light of feedback and regular progress reports, the Inter-Agency Working Party made a decision as part of its transition planning process to not continue with the Worker Exchange Program. Limited resources to continue with its coordination and agency reluctance to embrace the program more broadly due largely to resource constraints were the key factors influencing this decision. While all acknowledge that the worker exchange program has provided staff with an invaluable learning opportunity, it is an activity that requires a higher level of resources and coordination than first envisaged.

6.6 Community Forums and Broader Networking

6.6.1 What Has Occurred?

Continuing in the final year of the Trial as part of its overall communication strategy has been the participation by the Trial's project team, DACMCs and other key staff from each of the three CSAS in various forums to advocate for the needs of homeless drug users and to promote the activities, achievements and learnings of the Trial.

In the third year, Trial staff report that these forums have been held with a variety of community groups, government departments and services. Reported benefits have been a greater awareness and understanding among other services and the community about the needs of homeless clients who have problematic drug-use issues and other complex needs.

Cross-sector Partnerships Conference:

On 14 May 2004 the Homeless and Drug Dependency Trial, in collaboration with a range of drug treatment, housing and mental health services as well as government departments, held a one-day conference titled: *Cross-Sector Partnerships Conference; Enhancing Service Delivery to Homeless Clients Who Require a Complex Service Response*. This one-day conference was targeted at both managers and practitioners of mental health, drug treatment, housing and homeless services with the intended purpose of facilitating collaborative practice among

practitioners from these sectors by encouraging constructive discussion and reflection on current practice.

The conference was a success with 360 delegates attending and a further 110 people unable to be allocated a place. The broad aim of the day was to bring together a diverse group of services from across a range of sectors to generate broader discussion on cross-sector partnerships and improve service delivery to homeless clients. The HDDT reported that they were pleased with the day's outcomes and look forward to continued discussion and action in this area. A report of the day is to be completed by the end of August 2004 for dissemination to the conference organising committee for consideration that will include suggested areas for action against key issues identified on the day.

6.7 Enhancing the CSAS Mental Health Response

Emerging at the end of the second year was the need for the HDDT to focus a greater level of attention towards the development of an enhanced mental health response so that current demands and service gaps experienced could be effectively addressed. Second-year evaluation reports provided an evidence base from which the IAWP actively lobbied the Health Minister's Office, the Mental Health Department, Drugs Policy and Services Branch and the Office of Housing in order to further highlight this significant problem during the period of October 2003 through to April 2004. Part of this process involved the HDDT Project Manager in collaboration with Mental Health Department representatives undertaking an additional level of analysis to that provided in the second-year evaluation report, with a focus on the interface between the CSAS and clinical mental health services. This situation analysis involved key informant discussions with the Inner South and North/Western HOPS team managers and further discussions with CSAS managers and coordinators. The following discussion represents a summary of these findings from the final proposal submitted to the Mental Health Branch, Drugs Policy and Services Branch and the Office of Housing, titled *Mental Health, Homelessness and Problematic Drug Use – Strengthening Our Response* (prepared by Kim Rayner on behalf of the Executive of the HDDT, February 2004).

6.7.1 Challenges and Gaps

The following extract from the situation analysis report details the challenges and gaps identified during this process.

Gaps and Challenges Experienced Within the Three CSAS:

- While managers and team leaders participating in recent discussions spoke positively of the service provided by the HOPS clinicians, restrictions with their eligibility criteria, however, made it difficult for staff to link clients into this mental health service. In particular, this involves clients with a personality disorder or behavioural issues as well as those with depression and anxiety disorders.

- Geographical catchment restrictions within mental health services created difficulties in a number of ways. Firstly, staff spoke about the lack of coordination between regions and the inadequacy of discharge planning and handover from one service to the next. Further, when Triage is contacted by the CSAS to seek assistance with a client they want to know which region the client is from. Given that the person in the CSAS is

homeless and has no fixed address the follow-up of this client often results in the client not receiving a mental health service for four to five days, whether this be from HOPS or another service. Finally, mental health services such as HOPS are unable to work with clients outside of their catchment area, which limits continuity in care and possibly increases presentations to the CSAS or acute services.

- All three CSAS spoke of the ongoing difficulties they experience when they try to communicate or work with the CAT team. Many felt that the CAT team did not listen to what CSAS staff had to say about the client, even though they knew more about them. The inconsistency in approach by CAT to involve or not involve the police often led to poorly timed interventions and an escalation in the situation, resulting in clients becoming more distressed and at risk of self-harm. Finally, staff spoke of the regular turnover of staff within CAT that had resulted in there being no solid working relationship formed between the CSAS and CAT.

- As has been consistently reported, staff at Ozanam spoke of the lack of discharge information and poor communication with hospitals, in particular RMH, prior to a client being released from hospital to the CSAS.

- The lack of after-hours or weekend cover from mental health services placed significant pressures on the CSAS to manage unstable clients with limited supports.

- While staff reported that SUMITT is very accessible and does engage with the client, there still exists a period when no one is able to confirm whether the client's behaviour is due to their drug use or a mental health disorder, often resulting in limited provision of support. Staff reported that the service only works with the client short term, possibly two to three times, before making recommendations or linking the client to a psychiatrist. Long-term support was not available.

- On any one night, staff at Ozanam reported that close to 50% of residents are on some form of psychiatric medication. An audit of the sixty residents staying at Ozanam House on one night in January identified that 36% of residents were on some form of psychiatric medication, requiring staff to oversight the client's compliance, with a further 8% of clients awaiting follow-up from HOPS at that time. Staff reported that at times the facility felt like a psych ward and posed many management challenges, especially during the night when there are only two staff to sixty residents. The RDNS nurse at Flagstaff also reported that at least 50% of residents were on psychiatric medication on any one night. Finally, Hanover Southbank does not hold a person's medication, unless a specific request has been received.

- Limited specialist exit options exist for homeless clients with a mental health disorder or a dual diagnosis, often resulting in clients relapsing as they cannot manage their needs after leaving the CSAS. Staff also reported that the homeless persons often end up back in hospital or at the CSAS in a worse health state then when they left.

- The need for ongoing and specialist training in the area of dual diagnosis and mental health was reported by all three services as a gap. The introduction of any future training needs to also allow for the provision of more advanced training for some CSAS staff.

- All three CSAS spoke of the need for additional services that can provide ongoing and continuous care to homeless clients with a range of mental health disorders and/or dual disorders.

- Staff once again reported that the lack of specialist counselling available to CSAS clients experiencing depression, previous trauma as well as grief and loss issues appears to be further compounding the homeless clients' mental health state.

- While staff reported that they were closely linked to the HOPS teams and SUMITT, the interface between the CSAS and other providers of mental health services needed to be strengthened through collaborative efforts that generate a greater level of shared understanding.

Based on these findings and others included in the final submission, the following summary with supporting recommendations was arrived at:

That services delivered by both HOPS and SUMITT are highly valued but limited by:

- their primary focus on working with homeless clients who have a major psychiatric disorder
- geographical restrictions that affect continuity of client care
- level of capacity within their existing resources
- SUMITT's short-term involvement (two–three times) with clients.

The summary has also identified significant gaps in the service capacity of CSAS to deliver an effective service response to the target group. These include:

- less than optimum knowledge and skills in the area of mental health
- lack of additional services available to homeless clients that are able to provide continuity of care to individuals with a range of mental health disorders/dual diagnosis
- limited integration with a broad range of community-based mental health services such as GPs, hospitals and continuing care teams.

The situation analysis report also noted that the HDDT has demonstrated the services' unique capacity to engage and sustain clients with A&D and mental health problems in a purposeful relationship, as a basis for ongoing case management. However, the lack of capacity to deliver longer-term case management around mental health problems is seen as a significant gap to the service delivery needs of the target group.

Consequently, six priority recommendations were made **with the highest priority attached to the introduction of mental health specialist positions within each of the three services, focused on increasing the services' capacity in long-term case management for homeless clients with a mental health disorder/dual diagnosis, as well as strengthening linkages with existing mental health services**. This also includes the extension of the services' ongoing professional development response, with additional resources allocated to providing ongoing training and education opportunities for all staff in the area of mental health and dual diagnosis practice.

Other recommendations included:

- the development of specific dual diagnosis modules

- enhancing cross-sector integration

- extending the focus of current HOPS teams attached to the CSAS
- provision of on-site therapeutic counselling
- the development of an alternative housing model.

6.7.2 Future Directions

The HDDT was successful in securing funding for three new Homeless Outreach Psychiatric Service (HOPS) positions. These are to be principally based at the CSAS from July 2004 and targeted towards addressing identified gaps. While the gains made thus far represent a positive step forward, the HDDT must endeavor to further strengthen its response in close collaboration with both clinical and community-based mental health services if it is to address in real terms the range of gaps and difficulties now facing the CSAS. These difficulties have continued to limit improved health and wellbeing outcomes for homeless clients with a mental health disorder who access the CSAS, many on repeat occasions.

7. ENHANCED CAPACITY FOR ENGAGEMENT

Chapter 7 details the Trial's third- and final-year efforts at enhancing the CSAS capacity for engaging with homeless clients experiencing problematic drug and alcohol issues as well as with other residents, many of whom were termed prior to the Trial as 'hard to reach'. While all of the Trial's key strategies were aimed at enhancing the services' ability to engage residents with complex and varied needs, the following chapter will only report on the most significant strategies exclusive of the professional development response reported in greater detail in Chapter 5.

Related Objectives:

- Minimise the harm of drug use among drug-using clients.
- Improve the services' ability to reduce and respond to drug-related harm, including overdoses.
- Reduce the level of staff pressure and stress in adherence with occupational health and safety (OH&S) requirements.
- Strengthen the capacity of services to involve/engage drug-using clients in drug treatment, mental health and other health-related services.
- Enhance and develop case work responses to drug-using clients.
- Increase the capacity of staff to respond to hard-to-reach clients.
- Enhance the capacity of services to engage all clients – drug-using and non-drug using – in diversionary activities that are designed to promote health and self-esteem and develop work-related skills.
- Minimise the impact of drug-using clients on the non-drug using.
- Encourage and enhance the involvement of volunteers in selected elements of the Trial.

7.1 Diversionary Activities Program

7.1.1 What Has Occurred?

The Diversionary Activities program within each of the CSAS has continued to be an integral Trial component in the third year, delivering many benefits to residents and the services as a whole. Consistent with previous evaluation reports, a range of activities continue to take place on a day-to-day basis within the CSAS.

At the commencement of the Trial, both Ozanam and Hanover Southbank employed a community development worker who had the key responsibility of developing and delivering a variety of activities on site as well as facilitating the involvement of community groups coming to the service to deliver arts and music activities, health education forums, peer support forums and a range of alternative health therapies such as Reiki and massage. During the third year of the Trial, however, Hanover Southbank has only had a part-time community development worker for three months in the final year, with coordination of diversionary activities falling to the DACMC.

During the third year of the Trial the diversionary activities program at Ozanam House has retained its strong emphasis on community development activities and approaches, rather than just being recreation-focused. A wide range of activities have been facilitated and coordinated by the CD worker. In addition, the CD worker has been active in creating community links for residents, as well as providing support and mentoring opportunities for residents. The volunteer coordinator and activities offered by volunteers have also added to the program on offer at Ozanam House.

Prior to the Trial, Flagstaff was already running a recreation program that has, as a consequence of the Trial, been increased and extended to seven days a week and is integrated with the broader health-enhancing activities of the Trial such as naturopathy, relaxation classes, ear acupuncture as well as the delivery of health education forums and a needle exchange. At Flagstaff joint responsibility for the coordination and promotions of these services continues to lie with the DACMC and recreation worker.

7.1.2 What Has Been Achieved?

Against targets set with the DPSB, all three services have meet or exceeded the targets as outlined in Table 7 (on page 77) except during the middle quarters of third year when Ozanam's delivery of activities fell short of targets in some areas. However there were activities offered based on the expressed needs of clients against which targets were not set. For example CD workers worked with residents on the production of a music CD called the 'Ozanam's', and the delivery of the intensive one-month 'Start Here' program during Nov/Dec 2003. Both of these projects were reported to be highly successful and represent the level of community development work taking place at Ozanam House. As such, the current proforma for recording quarterly targets does not appear to adequately represent the level of work attached to developing and implementing such CD projects.

As indicated in Table 7 and in the following discussion, the volume and scope of activities is varied within and across each service, allowing each to meet where possible the interests of a wide range of residents, while at the same time also allowing for a greater level of resident engagement.

Third-year key informant journaling sessions as well as staff focus group discussions continue to support the importance of this program within the CSAS, particularly in terms of its ability to create a positive environment at the CSAS.

Staff report that residents have been able to learn new abilities and to acquire knowledge in a wide range of life skill areas such as computers, literacy, problem solving, budgeting, shopping, cooking, employment preparation, music, arts and anger management. In addition, the provision of recreation activities on a weekly basis such as Ozanam's Royal Park Ramble, Hanover Southbank's weekend exercise classes and Flagstaff's daily recreation activities have further enhanced the diversionary program and allowed residents to participate in enjoyable activities.

Of note is Ozanam House's 'Work Related' program, which included:

- a one-month intensive 'Start HERE' course, conducted during November/December 2003. This course covered personal development and information provision on courses and employment support services available Session topics included motivation and self-confidence, stress management, writing a resume, using the Internet and where to find low-cost and interesting courses
- computer lab and library assistance throughout the week
- 'Big Issue' recruitment. At the time of reporting, this activity had recently ceased.

Additionally, a variety of community groups and health services have continued to regularly attend Ozanam House. For example, Foot Patrol, DASWEST, PILCH, Alcoholic Anonymous, Centrelink, VIVAIDS and Inner West Outreach Service (IWOS) provided a range of information and education services for residents.

> *'Residents enjoy the peer education format provided by VIVAIDS. This service has allowed residents to learn from peers who know from experience and do not judge the residents' drug use.' – CD Worker*

As previously reported, the impact of the activities program on the day-to-day environment within the CSAS has been significant. Since the introduction of this Trial activity there has been a dramatic reduction in resident boredom and this has brought a decrease in problematic drug-using behaviours. These reports continue in the third year, with staff recalling the positive shifts away from aggressive, hostile and erratic behaviour that at times dominated the CSAS environment prior to the Trial.

This noted shift was an intended outcome for the Trial and consistent reports once again in the third year from all three CSAS support the achievement of this environmental change.

> *'The energy on the weekend is different, more uplifted.' – After-hours Worker*
>
> *'The environment is not as aggressive and residents report that they are more comfortable coming to the service.' – CSAS Caseworker*
>
> *'Activities break that cycle of boredom experienced by so many residents – they feel involved and seem happier after doing something.' – CSAS Accommodation Worker*
>
> *'Instead of having to ask residents to hand in their weapon, they are asking for a ping pong bat.' – CSAS Caseworker*
>
> *'The creative arts activities reveal a wealth of arts skills and talents. Residents report overcoming or managing their fears in relation to these activities and express a pride in what they have achieved.' – CD Worker*

The diversionary activities program continues to provide additional opportunities for engagement with staff and other residents that is beyond watching TV together or sharing drugs. For some residents it remains an alternative to staying in their rooms and possibly using drugs to a higher degree.

Staff from across a range of program areas within the CSAS are also encouraged to engage residents outside of formal casework activities. Examples of such include Flagstaff's fortnightly resident and staff barbeques that include a game of footy or cricket. Key informants report that this event is well attended and provides an invaluable opportunity that is non-threatening for staff and residents to get to know each other. Staff also report that it is a great icebreaker that has an immediate impact on the environment.

Further, Ozanam House has continued to run weekly resident meetings, with staff also attending this forum. These meetings continue to provide the service with a direct mechanism for receiving feedback from residents. In addition, key informant feedback on third-year activities has noted that these meetings continue to be well attended, allowing residents to have some ownership over their stay at the service and direct involvement in the types of activities that take place.

7.1.3 What Have Been the Challenges?

All three CSAS reported that budget limitations attached to the activities program has continued to restrict the development of new program areas. As reported by Ozanam House, any new activities not funded through core activities has required the community development worker to seek funding through external bodies. In addition, services also reported that identified program gaps have not been able to be fully addressed due to these restrictions.

7.1.4 Areas for Improvement/Response to Identified Gaps

While Ozanam House has continued to provide assistance with pre-employment needs that has been further extended in the final year to address gaps identified in the second-year evaluation report, Hanover Southbank and Flagstaff have been unable to offer a pre-employment and linkage program. While both services report that they still remain committed to this activity, with Hanover Southbank recently locating a PSP worker on site, further consideration on how best to address this gap within the CSAS context needs to take place.

Hanover Southbank:

After recent review, the areas for improvement identified at the end of the second year remain. The second-year evaluation report identified that Hanover Southbank needed to improve efforts in regard to promoting diversionary activities on a daily basis to residents as a way of increasing participation levels and staff awareness. While there was a period in the third year when this had improved due to the employment of a Community Support Worker, the position becoming vacant once again in the third year, reducing the service's ability to attach a focused resource to this activity.

Table 7: Number of Diversionary Activities Conducted Within the Three CSAS Against Targets Set for this Capacity-building Activity

	Flagstaff					Ozanam House					Hanover Southbank				
Activity	Quarterly Target	Jul/Sept 2003	Oct/Dec 2003	Jan/Mar 2004	Apr/Jun 2004	Quarterly Target	Jul/Sept 2003	Oct/Dec 2003	Jan/Mar 2004	Apr/Jun 2004	Quarterly Target	Jul/Sept 2003	Oct/Dec 2003	Jan/Mar 2004	Apr/Jun 2004
Community development activities (arts, music, cooking, shopping, education) **Includes recreation activities for Ozanam*									32					32	7
Recreation activities (CSAS and community-based)			27	20	20				-					-	-
Facilitation of community groups within the CSAS – involves group work activities. **Includes music activities at Flagstaff*			36		60				16					49	88
Employment (pre-vocational computer training)						No set target			20					-	-
Total									68					81	95

* Source: DACMC quarterly report to DPSB

**** Variations between services in actual targets achieved reflect differences between models and the deployment of staff**

According to the DACMC quarterly reports, activities have been delivered well above targets set, even with a reduction in staffing. However, the following areas for improvement remain and were once again noted by staff. These include:

- the need for more recreation-type activities that normalise the lives of clients by taking them out into the community on a regular basis, rather than conducting the majority of activities on site
- the facilitation of greater resident access to the Trial's Community Reintegration Program by promoting this service more broadly to residents, offering to transport residents to the service and to support clients with their transition into the program.

Ozanam House:

An area for improvement reported in the second-year evaluation report was for there to be a greater level of recreation activities on offer to residents. Achieving this, however, was dependent on securing additional funding, and this has remained a challenge. While recreation activities are offered, Ozanam's activities program has retained its focus on providing a range of community development-type activities, with staff reporting during focus group discussions that these had been positively received by residents and well attended. Adding to the Community Development.

Program on offer has been the service's focus on creating community linkages and partnerships with agencies in the community. These efforts have allowed residents to participate in a wide range of creative arts projects and has fostered resident links with the community. Ozanam reports that they would like to extend current efforts at establishing community links that support a client's reintegration into the community.

Moreover, key informants report that they would like to further develop training and educational opportunities for residents by drawing on the experience and expertise of volunteers. Ozanam is currently considering how it can set up a traineeship program for ex-residents.

Flagstaff:

Areas for improvement identified in the second-year evaluation report remain relevant and have not been addressed due to resource limitations. Key informants reported that the following areas are currently being discussed within the service.

- The need to extend activities into the evening, particularly after dinner when the majority of residents are on site with very little to do.
- Resources are needed to increase the number of computers available to residents. A worker is also needed to facilitate and educate residents on their use, which remains a growing resident need.

7.2 Health-promoting One-on-One Engagement

Flagstaff has continued with its one-on-one health promotion strategy in the final year of the Trial. The RDNS nurses utilising this strategy play a key role in engaging residents around a range of health issues, outside of or in addition to group forums and clinics. The impetus for this response was in order to provide a range of enhanced engagement strategies that would allow for improved communication with residents around a range of issues and in a non-threatening manner.

This informal response to health promotion continues to be reported as highly successful at Flagstaff where this practice of opportunistic engagement around presenting health issues such as safer drug-using practices occurs on a regular basis. Staff at Flagstaff report that the shift in the later part of the Trial's first year to more one-on-one engagement was in direct response to the low attendance at groups and the men's reluctance to attend or talk about issues in a group forum. Quarterly DACMC reports to DHS from Flagstaff state that approximately 900 one-on-one health promotion contacts occurred during the third and final year of the Trial. A proportion of these sessions involved multiple discussions or follow-up with the same resident.

7.3 Hard-to-reach Client Response

At this time, staff identified a number of different types of clients who were hard to reach. These characteristics fell into the following categories:

- Residents with a mental illness who were also drug-dependent or engaging in chaotic drug-use patterns.
- Those with a mental illness who had been discharged from hospital prematurely and were not capable of engaging with the service.
- Residents who constantly used drugs or engaged in poly drug-using behaviours on a day-to-day basis.
- Pre-contemplative residents who did not acknowledge that they had a problematic lifestyle or that they required assistance.
- Institutionalised or mistrustful residents, including those who have been in prison, involved in the criminal justice or child protection systems as well as those who had been in and out of supported accommodation facilities.
- Aggressive clients who were intimidating and hostile towards staff and other residents.
- Manipulative clients who 'played games' and were resistant to any assistance.
- Some clients for whom English is a second language and came from different cultural traditions.

It is evident that these characteristics are not mutually exclusive, with staff reporting at this time that a proportion of hard-to-reach clients presented with more than one of the above characteristics.

During these early focus group discussions, staff were also asked to identify what approaches

they undertook to engage with the different hard-to-reach client groups and to identify what other strategies they could implement to improve their own or their services' response.

7.3.2 What Has Been Achieved?

All of the strategies and activities listed within this third and final year report are aimed at building the services' capacity to more fully engage residents but particularly with those who are hard to reach, and who more often than not were exited from services prematurely pre-Trial. The achievements listed in this and previous reports represent what has been accomplished in this area.

The second-year evaluation report noted that services and staff had progressed over the first two years of the Trial, not only in their perceptions and attitudes to working with the most difficult of residents, but in their acceptance of continuously looking at ways to improve or enhance their responses to homeless individuals. At the end of the final year, these attitudes and approaches have continued with staff now not referring to these clients as 'hard to reach' but applying a universal approach to engaging all residents, no matter what their presenting circumstances or behaviours may be. All three services report that to a large degree responsibility lies with them to assertively follow up and support clients who fail to attend appointments prior to the situation escalating and possibly requiring the client to leave the service.

7.3.3 What Have Been the Learnings?

As previously reported, the so-called hard-to-reach clients can be reached – it is more about providing a range of opportunities for this to occur within a service that in itself represents a new or enhanced way of working for staff. Additional resources with a specialist focus and the ability to offer new initiatives such as the diversionary activities program, increased professional development opportunities, secondary consultation and enhanced health care responses have been keys to this success. All of these need to be embedded in organisational strategic plans and leadership needs to be focused on these issues. This should allow for cultural change to be achieved and sustained.

7.4 Ozanam's Volunteer Program

7.4.1 What Has Occurred?

While there was an optional Trial objective to encourage and enhance the involvement of volunteers in selected elements of the Trial, Ozanam has largely been the only CSAS to integrate volunteers more formally into their Trial activities.

At the beginning of the Trial, the Society of St Vincent De Paul had considerable experience in the areas of community volunteer involvement and was keen to extend this to Trial activities where possible and appropriate.

7.4.2 What Has Been Achieved?

During the third and final year of the Trial, community volunteers have worked in the computer lab at Ozanam House, assisting and educating clients in the use of computers, while other volunteers have assisted residents with literacy problems and supported on-site library activities.

> *'Community volunteers will teach residents and share skills. It also allows residents to communicate with others outside of their normal social group.' – CSAS Manager*

Through volunteer networks Ozanam has also been able to access funding through a trust fund that is to be directed at resident training and work-related development needs.

7.4.3 What Have Been the Learnings?

Having a designated volunteer coordinator at Ozanam House has provided the opportunity for volunteers to be appropriately recruited, trained and supported to work as mentors to homeless drug-using clients. Key informants also report that this position has supported the development and implementation of community activities, further strengthening Ozanam's community development program.

7.5 'Sobering-up Bed' Program at Ozanam House

7.5.1 What Has Occurred?

The Sobering-up Bed Program is an initiative of St Vincent's Hospital and St Vincent de Paul Aged Care and Community Services, funded through the Hospital Admissions Risk Program (HARP) and based at Ozanam House. The pilot commenced in August 2003 and the program began operation at Ozanam House in March 2004. This program has been implemented as part of a broader Sobering-up Beds Program specifically targeted at the high number of homeless patients presenting to the Emergency Department of St Vincent's Hospital with a range of complex problems, often linked to mental health and drug/alcohol related issues. This program involves the funding of a single crisis bed at Ozanam House and targets intoxicated men with significant social needs who have presented at the emergency department and require a safe place to sober up.

Aims and Objectives of the Program:

- Harm minimisation. To provide a safe and supported environment for homeless men to sober up from their alcohol use.
- To create a pathway for marginalised homeless men to link into crisis accommodation and the opportunity of engaging in case management.
- To create relationships with homeless men who may have been sleeping rough for extended periods of time and who experience chronic alcoholism.
- To provide an alternative place to sober up from the criminal justice system.
- To create and enhance pathways between SAAP services and acute

medical services to enhance client outcomes.

7.5.2 What Has Been Achieved?

Since this program commenced in March 2004, twenty-one homeless men have been referred from St Vincent's Hospital. Of the twenty-one men referred, fifteen have been accommodated at Ozanam House as part of the program, with the majority of men over thirty-five years of age.

> *'The men who have been referred to this service are extremely marginalised, not usually linked into support services and exist on the fringes. The sobering-up program has allowed us to actively engage this client group and to provide the support and case management that they need.' – CSAS Manager*

Key informants report that to date the Sobering-up Bed Program has been successful in terms of linking homeless clients into much-needed support services and case management. In one particular case this resulted in the client (who had chronic alcoholism and had slept rough for over five years), accessing and completing their first residential withdrawal program. An additional benefit of this program appears to be that clients referred from St Vincent's do not have to go through the normal channels to access crisis accommodation, which has often proved difficult for this client group to manage.

7.6 Trial of On-site Counselling Service at Flagstaff

7.6.1 What Has Occurred?

Flagstaff Crisis Accommodation Service introduced an on-site counselling service for residents in April 2004 as part of its overall Trial-related capacity-building efforts. This was in direct response to previously reported gaps in the provision of available and accessible counselling services for homeless men. The counsellor is now available on Tuesdays and Thursdays at Flagstaff, and is able to see up to four to five residents per day. The counselling service is available for residents while they are staying at Flagstaff, and is therefore time-limited. However, if a resident moves off site and is still participating in an agreed counselling schedule, they can return to Flagstaff to finish off their counselling commitments.

The service is focused on providing short-term counselling with an emphasis on brief intervention work with residents, and is viewed as a separate level of support to that offered by the support team. Those who are attending the service can receive up to twelve counselling sessions.

> *'The support team is primarily focused on housing pathways and the resolution of the immediate crisis, while the counselling service is focused on examining the psychological impediments to moving forward in the homeless men's life.' – Flagstaff Counsellor*

7.6.2 What Has Been Achieved?

At the time of reporting, the counselling service had only been in operation for three months, however key informants report that both residents and staff have received the service positively, referring many clients, in particular those who appear stuck and unable to move out of their current situation. While referral to this service is through the support team, residents who have or are currently receiving counselling have also been promoting the service to other residents, resulting in increased demand. To date, eight residents are receiving regular counselling and six have finished a block of counselling.

Key informants report that many of the residents accessing the service have not received counselling in the past and have limited experience in 'being heard and able to tell their story in a non-judgmental environment'. What appears critical to this process is the ability of the counsellor to not only be flexible in their response, but also able to communicate in a way that demonstrates unconditional positive regard for the resident.

7.6.3 Key Learnings

While the following early learnings will continue to be tested as this pilot moves forward, they are, however, worthy of noting at this time.

The counsellor reported that one of the early learnings for him in the trialing of this service and in making it work was to remain flexible in his approach, and reflective about how best to engage with each individual referred to his service.

> *'Sometimes when a client misses an appointment I will follow up with them; at other times I need to identify when it's important for the client to come to me. A key focus, however, is about keeping the connection with the person.' – Flagstaff Counsellor.*

Further, the prevalence of unresolved trauma among those attending the service is significantly high, with the majority of clients presenting with chronic neglect and abuse issues, as well as personal grief and loss issues. For some, the associated shame and guilt about the events that have taken place in their lives has significantly impacted on their ability to resolve their current state of homelessness and/or addiction. Given this context, the need to provide opportunities for homeless clients where they can begin to constructively deal with these issues is critical.

Finally, the counsellor reported that very early on he was seeing the benefits in providing single-session therapy to residents, with residents returning to report that even though they had only attended one or two sessions, they had benefited from the experience.

8. RESPONDING TO STAFF PRESSURES

Chapter 8 details the Trial's direct response to addressing staff pressure and stress. This was a significant issue prior to the Trial's commencement, becoming a focus of key activities. Many of the strategies implemented as a consequence of the Trial have continued to directly reduce staff pressures within the CSAS. The most significant strategies to assist the Trial to address this key area will be discussed in this chapter.

An examination of staff turnover figures was built into the evaluation design as a way of mapping turnover and its impact on services and Trial initiatives. These figures have been reported on in this chapter and discussion of each CSAS has been included.

Related Objectives:

- To reduce the levels of staff pressure and stress in adherence with occupational health and safety (OH&S) requirements.
- To strengthen the capacity of services to involve/engage drug-using clients in drug treatment, mental health and other health-related services.
- To enhance and develop case work responses to drug-using clients.
- To increase the capacity of staff to respond to hard-to-reach clients.
- To enhance the capacity of services to engage all clients – drug using and non-drug using – in diversionary activities that are designed to promote health and self-esteem and develop work-related skills.

8.1 Staff Pressure

8.1.1 What Has Occurred?

Many of the areas discussed within this report have had a direct impact on reducing staff pressures while also building staff capacity in working with homeless clients in crisis who have complex needs.

There continues to exist two main groups of strategies that to date have had the greatest impact on reducing staff pressures experienced prior to the Trial's commencement.

The first area of response directly targets staff and involves the following initiatives:

- Flexible and easily accessible secondary consultation from the DACMC, Trial primary case managers and nurses.
- Hanover Southbank's advanced skills practitioner positions that provide peer support and leadership to staff.
- Extension of supervision and mentoring practices within the CSAS.
- Policies and protocols that clearly outline OH&S matters and give guidance to staff when discharging their duty of care.
- A wide range of professional development opportunities.

- Ability for staff to work with clients long term.
- On-site clinical coordinator and psychologist available to support and debrief staff at Flagstaff.

The second area involves the variety of services now available to residents on site that have reduced the constant demand on workers and changed the CSAS environment:

- The diversionary activities program.
- An enhanced health care response.

8.1.2 What Has Been Achieved?

The introduction of capacity-building activities in the first year of the Trial resulted in immediate benefits, minimising staff pressures experienced and supporting staff in their work with complex clients. The second-year evaluation report continued to report positive gains, with staff directly reporting that they felt more confident and knowledgeable working with clients who have a drug and alcohol problem and in discharging their duty of care responsibilities to the range of complex clients presenting to the CSAS.

While it still remains difficult to measure staff pressure, staff across the three services continue to report in the third year that they remain confident and supported by their organisations in the work that they do, with a series of recent focus group discussions also highlighting the knowledge base and expertise that now exists more broadly across the organisations. Key activities reported by staff to have made a significant difference to improving their practice and knowledge are: the range of consistent supervision practices now available; specialist secondary consultation from the DACMC, Trial primary case managers, nurses, line managers and external services such as HOPS and SUMMIT; and professional training opportunities such as the NMIT Diploma of Community Services (AOD) course.

> *'Our service has endeavoured to provide a range of options for staff that meets their practice supervision and support needs. Staff acknowledge the difference this has made to their skills base, work, and sense of value within the organisation.' – CSAS Manager*

The range of activities offered as a consequence of the Trial continues to provide the necessary mechanism of staff support needed, all of which appear to be assisting the delivery of high quality service provision to CSAS residents.

8.2 Staff Turnover

8.2.1 What Has Occurred?

A major objective of Part A of the Trial was to reduce the current stress and pressures on CSAS staff in a way that allowed them to adequately discharge their duties under occupational health and safety requirements. A range of strategies, as documented in this report, were implemented in order to achieve the said objective. These include reviewing OH&S guidelines and practices; managing the impact of the Trial on staff; providing specific and specialist training to supervising staff in order to enhance their ability to better manage and support staff;

provision of secondary consultation and support by the DACMC, nurses and other D&A staff; and the delivery of specialist drug and alcohol training and professional development opportunities for staff.

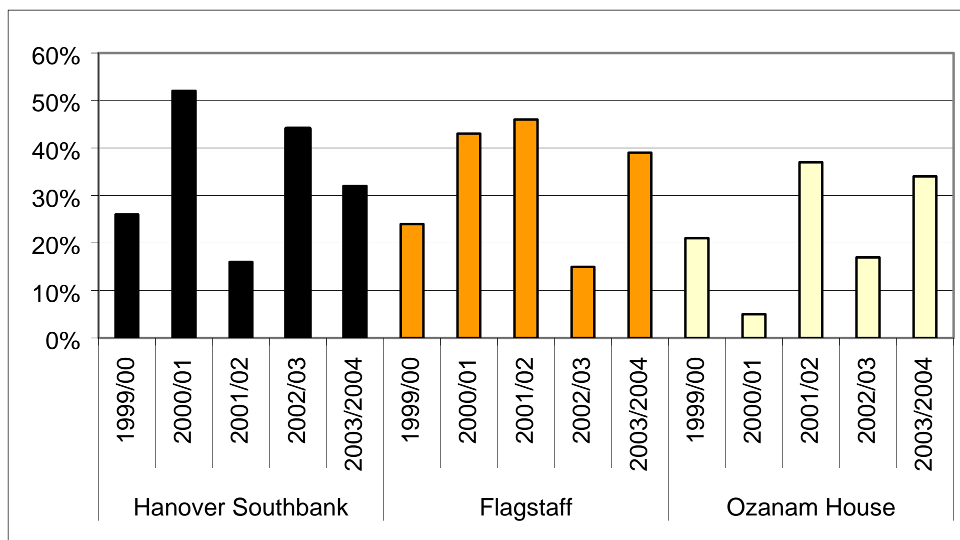
An intended outcome for the Trial as a result of these activities was to improve staff retention, which would enhance the services' ability to provide continuity of care for clients and maintain the level of service standards.

Measuring staff turnover was a quantitative measure implemented at the commencement of the Trial as a way of mapping turnover and its impact on the services and Trial initiatives.

Staff turnover is calculated from the number of people, not EFT positions. Those included in the count held either part-time or full-time positions within the CSAS and had left the service during the reporting periods. It does not include those who were casual or on short-term contracts, kitchen, cleaning and administrative staff. Figures calculated during the Trial years also represent the additional positions within the CSAS as a consequence of the Trial.

Figure 4 represents the rates of staff turnover for each of the three participating CSAS.

Figure 4: Staff Turnover Rates During the Trial (01/04) Compared to the Benchmark (99/01)



**Staff turnover is calculated from the number of people, not EFTs*
**Flagstaff staff turnover figures include promotions within the organisation as well as resignations.*

Hanover Southbank: As indicated in Figure 4 above, staff turnover rates at Hanover Southbank fluctuated from year to year.

Across all the years, including the three Trial years, the greatest level of movement is within the case work/support team where staff within these positions also primary case manage Part B Trial Clients.

The length of time that staff had been at the service prior to leaving varied, however the greatest period of employment was 2–3 years during both the benchmark years and during the three Trial years. Overall 30% of staff leaving had been with the organisation for that time. Key informants reported two major issues were at play. Firstly, they suggested that given the level of crisis work and the complexity of clients, most staff are ready to make a move or want

to change from the intensity of the case work involved after two years. Secondly, by 2001 the vast majority of Southbank staff were tertiary qualified, predominantly in social work. In the period of employment at Southbank they were well supervised and supported in their work and had benefited from professional development activities. Consequently, they were well placed to take advantage of opportunities to gain professional advancement and higher remuneration within other community service and health settings.

Most staff that left were full time (58% of all staff having left during benchmark and Trial years). This remained fairly stable from benchmark to Trial years.

While a range of reasons was reported for staff leaving, the top two responses during the benchmark period were “redundancies” and “staff burnout”. In comparison, the top three responses for those leaving during the Trial years were “to take up another job or daytime employment”, “overseas or interstate travel” and “moved interstate/to the country”. More money was also mentioned as a reason for leaving during the Trial period (4 responses).

Increased training and staff development options have been implemented to provide staff with greater skills and confidence to undertake crisis work. Feedback from key informants suggests that this has been successful in reducing staff stress and burnout. Hanover has also made efforts to increase internal career paths and address remuneration through an Advanced Skills Practitioner classification. Two positions were originally created under this classification, rewarding the attainment of nationally accredited competencies in areas relevant to the Hanover Southbank model with higher remuneration. While there is now only one position, this position has enhanced casework through support and mentoring of less experienced case workers.

Flagstaff: Staff turnover at Flagstaff includes staff who have left the service or who have moved to another position within Flagstaff Adult Services. During the benchmark years and the Trial the main reason for staff leaving positions was to take up other positions or promotion within the organisation.

During the year prior to the Trial (2000/01) and in the first year (2001/02) of the Trial, staff turnover rates were between 43–46% due to the SAAP upgrade and the organisational change that occurred within Flagstaff Crisis and Support Service. Subsequent to this change, there was marked improvement in staff retention during the second year of the Trial, with the staff turnover figure reducing to 15%. This was followed by an increase in staff turnover again in the final year of the Trial. Similar to Hanover Southbank, the greatest turnover of staff during both the benchmark years and the Trial years is within the casework team.

The most common period of time that staff had been at the service prior to leaving during the benchmark years was 12–24 months this includes both majority of staff exits and staff movement within the organisation. During the Trial years those who left the organisation and those who moved within it, more than half had been with the organisation for at least 2 years.

Reported reasons for staff turnover were due in the main to being promoted within Flagstaff Crisis and Support Services, followed by staff leaving to take up a position in a related field of work. Reasons given during the benchmark years compared to those given during the Trial years did not significantly change. However, there was increase in the number of staff leaving Flagstaff altogether to take up a related career in another organisation. During the Benchmark years 3 people left the organisation altogether whereas 16 left during the Trial years. So while

staff are more likely to stay with the organisation for a longer period of time and stay in the one position for a longer period of time, when staff do move they are more likely to leave the organisation altogether as a result of the Trial.

During the Trial's first year the service underwent an external review, which recommended greater management infrastructure. In response to this review a number of new positions were created, such as team leaders, to better support case work staff. Greater support in the case work team may be in part responsible for the longer length of stay for staff. However, while case workers are better supported in their role, the fact remains that it is difficult, complex and intense work which not everyone is suited to or able to undertake for long periods of time. Further, remuneration remains a key issue in terms of the recruitment and retainment of skilled and experienced staff.

Ozanam: In the year prior to the Trial (2000/01) staff turnover was low at 5%, however this increased significantly in the first year of the Trial to 37% due to organisational restructure and the resignation of staff. In the last two years of the Trial (2002/04), staff turnover figures fluctuated.

Turnover among Ozanam house staff team and Outreach support staff seems to be a result mainly of the restructure. However, turnover in the Intensive Youth Support Service team, the Community Centre and the Youth Outreach team happened in the later Trial years.

There has been an overall increase in staff turnover during the Trial years compared to the benchmark years. The proportion of social workers leaving remained relatively stable (53% of all turnover during the benchmark years compared to 59% during the Trial years), however, there was an increase in the turnover of community development workers, and an increase in the turnover of case workers and case managers.

Further, Staff leaving the Ozanam community during the Trial had been with the organisation longer than those leaving during the benchmark period. Twenty one percent of all staff leaving during the Trial had been with the organisation for at least 4 years. None of the staff leaving the organisation during the benchmark period had been with the organisation for this length of time. In contrast, the greatest periods of employment during the benchmark years were 7–12 months (20%) and then 19–24 months (20%). This increase in the length of stay is likely to be the result of two factors. The Ozanam community increased training options for staff in all services and implemented internal policies establishing clearer pathways between services – making it easier for staff to move within the organisation to different programs. While staff turnover figures for Ozanam were analysed and discussed only with references to staff turnover, annual report figures for the last financial year indicate that 53% of staff movement in the community services of St Vincent de Paul was due to internal labour markets.

Reported reasons for staff leaving in the years (1999/01) prior to the Trial were due to securing a full-time position or to leave the sector. This was in contrast to staff leaving Ozanam House during the Trial years reporting reasons such as resignation, staff dismissal, organisation restructure, and securing another job.
Discussion with key informants highlighted a number of issues with data collection. Changes in the Payroll information systems at Ozanam meant that staff moving from causal to permanent positions were recorded as turnover. Further, staff leaving the organisation and then returning, were not able to be distinguished as such. In light of these limitations Ozanam has proposed to modify its payroll system so as to account for instances of the above and to discuss

data collection and analysis requirements with managers now and at the outset of new projects.

8.2.2 What Have Been the Learnings?

In order for the CSAS to work in an enhanced way, significant cultural change was required. Prior to and during the Trial, significant structural and staffing changes occurred. While the impetus for these was not entirely related to the Trial but rather to broader strategic organisational shifts, they have nevertheless occurred at a time when such was required in order for staff and services to respond more effectively to current service demands.

It is important to note that examining staff turnover is not a simplistic exercise. It has in itself raised more questions for services. What appears to be emerging, however, is that each service recognises they need to enhance their capacity to retain staff, which will have a significant impact on their ability to deliver continuity in care and sustain capacity-building achievements. However, there appears to be several key factors that will continuously impact on achieving this, such as:

- Remuneration, which needs to be matched to the level of case work expertise, client work and responsibilities
- The differing organisational structures within each CSAS that allows for the promotion or transfer of staff
- Individual factors – personal factors in a staff member's life
- The intensity and complexity of work

9. FUTURE DIRECTIONS OF THE HDDT

9.1 Changes to the Trial as of July 2004

The process of reflection and evaluation attached to all elements of the Trial has provided a continual mechanism from which the Trial as a whole and each CSAS has been able to monitor progress, identify achievements, and, where necessary, make changes to model elements in light of evaluation feedback. Evaluation processes have also provided the necessary evidence base to support Trial activities, contributing to the HDDT's ability to measure its success and secure recurrent funding after its initial three-year Trial period.

While general key strategies and activities implemented through the Trial will remain, there will be some noted changes introduced as of 1 July 2004. These are:

- Additional Primary Case Management Capacity attached to each CSAS (Part B).
- Retention of Project Coordination and Evaluation Functions (Part C). These will be at a reduced capacity to that available during the Trial.
- Introduction of three newly funded Homeless Outreach Psychiatric Service Positions (HOPS) to be principally located at the CSAS and focused on high prevalence disorders and capacity-building activities in relation to Mental Health and Dual Diagnosis work.
- Funding through the HDDT of the five residential rehabilitation beds to cease.
- Six residential withdrawal beds to be reduced to three beds with priority access to primary case managed clients and general CSAS clients.

9.1.1 Main Objectives of the HDDP

As part of the Trial's recent transition planning process, the Inter-Agency Working Party has recently revised its objectives and will now work to achieve the following broad objectives that encompass both capacity building and primary case management elements.

- To maintain and further strengthen capacity-building activities of the HDDP that continues to address the needs of homeless individuals with complex problems, such as drug dependency and mental health.
- To continue to provide a primary case management and pathways response from Crisis Supported Accommodation Services (CSAS) that delivers a flexible and holistic individual response to homeless clients aimed at minimising the harms of drug use, achieving greater stability and improved social, health and welfare outcomes.
- To facilitate ongoing cross-sector partnership endeavors aimed at improving service delivery outcomes for homeless clients of the CSAS.
- To sustain ongoing collaborative learning and evaluation measures that allow for the continual development of an evidence base to support HDDP activities and influence policy direction in the area of service delivery to the homeless.

9.1.2 CSAS Model Changes

While Flagstaff will not be making any significant changes to the way they deploy staff and resources to key program areas attached to the HDDP (except with the recent Trialing of the on-site counselling service), Hanover and Ozanam are currently in the process of implementing changes to address gaps and further improve their capacity to meet the needs of homeless clients with drug-dependency problems.

Ozanam Community

Based on Trial evaluation feedback and internal monitoring processes, Ozanam aims to strengthen its approach while also addressing inconsistencies by making its primary case management team a stand-alone team, located at Ozanam House. This team will also contribute to specific ongoing capacity-building activities. Other key changes include:

- The D&A worker position that was attached to the support team has not been filled, with this staffing resource now being allocated to primary case management functions within the HDDP.
- The RDNS nurse position (twenty hours per week) funded through the Trial will no longer manage a small primary case management caseload, but will instead focus solely on clinical and health promotion activities.
- The new stand-alone primary case management team will consist of four dedicated PCMs plus a Team Leader (DACMC), combining primary case management functions and ADSA program responsibilities. Each primary case manager will also be attached to a program area within SVDP ACCS such as Quinn House, Youth Outreach, Adult Outreach, Community Centre and Ozanam House Support and Facility Team.
- Primary case managers will outpost to their designated team site each week to attend staff meetings, offer secondary consultations and assist other clients with D&A issues. It is intended that each PCM will need to respond flexibly to the needs of each individual service, acting as a significant D&A resource.
- Primary case managers will also continue with the running of specific groups at CRP and to assist with group work activities at Ozanam House and the Ozanam Community Centre.

All other activities, particularly capacity-building strategies, will remain as reported in this final evaluation report.

Hanover Southbank

Hanover Southbank reported that the only change to the their model will be that the Community Support Worker Role will not be filled. The main function of this role was to co-ordinate an activities program for residents at Southbank. The primary function for the role is undertaken by the Co-ordinator of HDDP (DACMC), while other aspects are undertaken by case management staff (PCMs) and nursing staff. The Hanover model gives priority to case management rather than community support, facilitating the involvement of clients in a variety of activities utilising the case management relationship.

10. CONCLUSION

At the end of the Trial's final year, all three CSAS have continued to strengthen their capacity to effectively engage and provide appropriate assistance to homeless clients with drug dependency and other often complex problems. Achievements and progress established during the Trial and reported more broadly at the end of the second year have generally not only been sustained in the final year of the Trial but also extended and continually improved upon, as evidenced in this report. The harms attached to drug use experienced within the CSAS prior to the Trial have been significantly reduced, while a culture of greater understanding, openness and inclusiveness towards drug-using clients dominates and now drives current staff practices. Such practices primarily aim to effectively engage drug-using clients while also working with them to resolve their current crisis state and establish appropriate and sustainable future pathways where possible.

All of the key strategies implemented through the Trial have proven to be successful measures, allowing each CSAS and the Trial to achieve its intended objectives. While during the past three years some approaches and activities have been trialled differently within each service, the key strategies, which include a broad and responsive professional development response for all CSAS staff; enhanced on-site health care and health promotion services; improved casework and engagement practices; a range of daily diversionary activities available to residents; policy and protocol development both internally and with partner agencies; as well as the resourcing provided through the Trial's project-management component have all contributed in a unified way to the achievements of the Homeless and Drug Dependency Trial. The reflective evaluation processes attached to the Trial has also allowed the CSAS to work in an environment that now promotes and supports the ongoing critical reflection of practices and services offered at the CSAS as a way of not only identifying successes but also gaps and areas for improvement, allowing each CSAS to be responsive to shifts and changes in their environment.

The advances made in the final year of the Trial to strengthen the CSAS response to homeless clients with a mental health disorder or dual diagnosis are positive, however the Inter-Agency Working Party and participating services must now include mental health as an additional key focus of the HDDP's activities for the future. Collaborative efforts need to be extended in order to implement the changes required and to address identified gaps reported that will build capacity and ultimately improve the outcomes for homeless clients who have a mental health disorder and/or dual diagnosis. Further, the HDDP must continue to sustain and, in some instances, extend linkages and partnerships with drug treatment services, while also considering the development of new partnerships with clinical and community-based mental health services, GPs, disability services and the criminal justice system. Such efforts, however, take time to build and will need to be prioritised by the IAWP, according to the new objectives and resources available within the HDDP.

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