EXECUTIVE SUMMARY

This final year report presents the evaluation findings on the Homeless and Drug Dependency Trial's (HDDT) continuous primary case management and pathways response, commonly referred to within the Trial as Part B. While there has been a close link between CSAS based capacity building activities (Part A) and the HDDT continuous primary case management response, final year evaluation findings on capacity building activities have been reported separately. These simultaneous approaches in the Trial's model have delivered significant benefits to homeless clients accessing one of the three participating Crisis Supported Accommodation Services (CSAS); staff working within these facilities and participants who engaged in the Trial's longer term primary case management and pathways response.

The HDDT 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 drug treatment and other ongoing support services.

In order to monitor and inform the primary case management and pathways model, processes, impact and outcomes, as well as the use of the practice/evaluation tools, an evidence-based approach to Trial activities has exited. A methodology based on action research has been operational from the beginning of the Trial. This approach was then supplemented with extensive quantitative and qualitative data collected on the participants' profile, progress while in the Trial and exit/outcome data. The process of interpreting findings throughout the Trial was collaborative between the researchers and key stakeholders from across participating services, directly influencing service providers in their actions during the course of the Trial, while also enhancing the overall findings and recommendations of this report.

Between the 1 July 2001 and 30 May 2004, 213 participants entered the Trial, with 161 of these participants consenting to be involved in the Trial's evaluation process and forming the basis of this report. Specifically, this final Part B report firstly details the profile of participants as recorded in the initial assessment tool (IRF) and includes more in depth analysis of differences based on gender, mental health status and the legal status of participants. This report also examines participant's progress while in the Trial, which has been modified from previous reports due to the greater volume of information across a longer period of time. Included now is a more in-depth within-subjects-analysis of change over time for those involved in the Trial for two years. Other participant sub-groups have also been singled out for additional analysis on the basis of important characteristics of interest such as mental health status, legal history and gender and the impact of these characteristics on progress within the Trial. Key areas of examination include changes in accommodation, drug-use patterns, occurrence of significant life events, service utilisation and treatment goal obtainment. Finally an examination of participants' status at exit from the Trial and the results of the three-month exit follow-up interviews are also included.

Profile of Part B Trial Participants

The profile of Trial participants is one of significant social, health and economic disadvantage. Profile patterns remain consistent with previous reports, however more in-depth analysis for this final report has identified that those with a co-occurring mental illness have the highest needs. These findings also support the Trial's approach to tackling long-standing and often entrenched problems among this homeless population.

- Participants of the Trial were mostly young males with an average age of 33 years. The greatest age bracket for those entering the Trial was between 25-29 years of age and the majority of participants were Australian-born. Seventy percent of participants (n= 147) had low levels of educational attainment, having only completed year 10/11 or below.
- At entry to the Trial, participants were overwhelmingly unemployed (97%, n=154) and dependent on government benefits for their income. The two main income supports accessed were Newstart (55%, n=158) and the Disability Support Pension (36%, n=154), with a higher proportion of participants with a diagnosed mental illness accessing DSP (48%, n=87) compared to those without a diagnosed mental illness (18%, n=33).
- The accommodation history of Trial participants suggests substantial levels of transience and chronic homelessness prior to Trial entry. Participants typically moved five times in the twelve months prior to assessment, with 69% of participants moving between three and nine times. Close to half of participants (49%) felt they had not had a home for longer than a year, while 23% of participants could not remember having a home or felt that they had never had a home.
- Almost all participants (94%, n=161) had stayed in crisis accommodation in the two years prior to assessment and close to half (44%, n=161) had slept rough.
- Participants reported high lifetime use of both licit and illicit substances. Consistent with previous findings alcohol was the most commonly used substance (94%, n=156), followed by cannabis (86%, n=156), heroin (76%, n=155), amphetamines (73%, n=155) and benzodiazepines (69%, n=156).
- Those with a diagnosed mental illness were more likely to have used heroin, benzodiazepines, anti-depressants and cannabis compared to those without a mental illness.
- The two most-commonly reported reasons for the participants' current drug use was in order to stay calm and cope with current stressors; and to meet their drug addiction.
- The majority of participants (63%, n=131) met the criteria for poly-drug use in the four weeks prior to assessment, with men and those with a diagnosed mental illness using more substances at the time of doing so.
- Rates of risk-taking when using drugs were high among Trial participants, highlighting the risks of blood-borne virus transmission as well as physical and psychological harms.
- High rates of mental illness among participants exist, the majority (72%, n=120) having been previously diagnosed with a mental illness prior to assessment. Further, prevalence rates were much higher among female participants. Depression was the

most common diagnosis, followed by anxiety disorder and psychosis.

- Forty percent of participants (n=144) had previously attempted suicide, while 20% were experiencing suicidal ideation at the time of assessment. As expected, those with a diagnosed mental illness had much higher incidences of suicidal ideation and were far more likely to have attempted suicide in the past.
- Many participants were experiencing physical health issues at the time of assessment. The most frequently reported physical health problems were dental (37%, n=153), liver disease related to hepatitis (30%, n=152) and head injuries (24%, n=152).
- The majority of participants (70%, n=115) had been admitted to hospital in the past and those with a diagnosed mental illness having done so more often. This is consistent with a higher incidence of a range of physical health problems among those with a diagnosed mental illness.
- More than half of Trial participants (56%, n=156) had overdosed in their lifetime, while 23% (n=152) had overdosed in the twelve months prior to assessment.
- Significant levels of criminal behaviour were recorded. Sixty-eight per cent of participants (n=121) had previous convictions, with two-thirds (67%, n=76) of these a consequence of drug-related crime, suggesting a close association between crime and drug use among this homeless group.
- A significant proportion of all participants (42%, n=137) had been previously imprisoned, while 27% (n=154) of participants had charges pending at the time of assessment. Men were more likely to have been imprisoned than women.
- A majority of participants (89%, n=160) were in contact with at least one support service at the time of assessment, many of these a result of early Trial involvement. The most common support services being accessed included GPs, a case manager and a housing worker.
- A majority of participants (86%, n=156) had previous contact with Drug Treatment Services. The most commonly accessed DTS prior to entry into the Trial was residential withdrawal. It is unknown whether participants completed these forms of treatment.
- While many participants had previous partners, children and connections with family of origin, most had seen these relationships breakdown. For example, 50% of the 88 participants with children had no contact with them at the time of assessment. Men were much more likely to have no contact with their children (55%, n=76) than women (17%, n=12).

Findings of the Primary Case Management and Pathways Response

Evaluation findings of the Trial demonstrate the positive impacts this response has had in rebuilding the lives of such a complex and disadvantaged group of people. While these positive shifts start to appear in the early stages of involvement, significant improvements and greater levels of stability progressively occur with longer periods of time in the Trial.

Engagement and Participation

Engagement and participation figures have continued to demonstrate the Trial’s capacity to not only engage homeless clients with significant support needs and complex histories effectively,

but to also retain them in a targeted ongoing treatment and support program, with linkages to needed services. While differences in the length of stay differ between CSAS, at the end of the Trial's third year, the median duration of treatment overall was 403 days (mean 436, range 2-1034 days), which is approximately 13 months. While differences in approach exist, the duration of treatment achieved in the Trial is in contrast to the previously characteristically short periods of duration for homeless clients in conventional drug treatment services, where for a third it was less than seven days and for two-thirds, less than 35 days (Kelly, 2003). While this highlights the importance of using the CSAS as strategic sites for the engagement of homeless drug users, it also highlights the capabilities of homeless services, with added resources, to effectively engage this population and work with them on a range of problems. Further, it demonstrates that homeless clients with significant drug and alcohol, health and social problems do want to address their problems and on the whole can remain engaged in treatment when specifically targeted and supported appropriately. Findings also identified, not surprisingly, that homeless clients with a mental illness consistently required longer periods of support.

Accommodation Status

The Trial has substantially improved housing stability and outcomes for participants. It has made existing housing pathways more accessible such as transitional housing and public housing, utilised residential drug treatment in the pathway towards achieving housing and personal stability and decreased the use of less desirable forms of accommodation. Compared to the 12 months prior to entering the Trial, participants overall were accessing and sustaining less temporary forms of accommodation and moving less frequently while in the Trial. Analysis of accommodation movement in the change over time group showed a steady decrease in the number of moves with continued involvement in the Trial, down from two moves to .5 of a move after two years. Further, there was a decrease in the proportion of this group experiencing evictions.

As a consequence of the ongoing support provided through the Trial, participants were more likely to access as well as sustain more desirable and less temporary forms of accommodation, such as public housing and transitional/supported accommodation. After entering the Trial, participants were significantly less likely to sleep rough, stay in crisis accommodation or go to prison. For example, 40% (n=161) of participants had slept rough in the 12 months prior to Trial entry, with only 11% doing so during the Trial period.

Analysis of differing participant features showed having a diagnosed mental illness, being a woman, (many of whom had a mental illness) and having a criminal history, made it more difficult to find and maintain housing. However, despite the complexity added by these factors, findings show that the Trial has been successful in bringing these participants closer to sustained housing, even when very limited supportive housing options, exist, which are often required by a proportion of this higher needs group.

While there has been an increase in the number of participants accessing public housing, the demand for this housing and the shortage of other appropriate and affordable exit options continues to limit movement into housing overall. In addition, the low level of access, affordability and reluctance by some staff to link participants into the private rental market out of concerns that the participant will not be able to manage this accommodation has further exacerbated this situation.

Changes in Substance Use

Cannabis and alcohol remained the most commonly used substances by Trial participants. Overall rates of use of the five most commonly used drug classes were between 21–58% in a given seven-day period. This suggests that some Trial participants did not use these substances at all or remained abstinent from use; only used one substance more often rather than multiple drugs or used these substances irregularly. While exit summary data, progress data and feedback from primary case managers (PCMs) support these patterns of use and positive shifts, analysis has also identified the typically chaotic and opportunistic nature of drug use among some Trial participants. Given these circumstances however, PCMs and DACMCs have continued to report the increased levels of awareness and insight of drug use by participants as well as an increase in safer drug using behaviours.

'Change over time' analysis of substance-use patterns among the longer-term group (two years' involvement in the Trial) showed a marked decrease in the proportion of these participants using cannabis, as well as decreases also in the use of alcohol and amphetamines after two years' involvement in the Trial. Given the identified higher rates of drug use and longer-term support needs within this group, these results are positive, however, there was also an increase in heroin use among this group. This shift appears to coincide with the increase in supply of heroin after a period of significant heroin reduction, while also highlighting the difficulties some participants face in trying to address their heroin dependency.

In addition, around three-quarters of participants engaged in poly-drug use at some point during their involvement in the Trial, highlighting the high prevalence of this behaviour among participants and the many risks that this group is therefore exposed to. Rates of poly-drug use, did, however, decrease by 10% over time among the longer-term support group after two years' involvement in the Trial. Those with a legal history and diagnosed mental illness were also more likely to engage in poly-drug use and use a higher number of drugs when doing so compared to those without these histories.

Significant Life Events

Most participants experienced significant life events throughout their involvement in the Trial which were deemed both positive and negative, highlighting the complexity of clients' lives and the breadth of issues PCMs face when working with this client group. Continued involvement with the Trial significantly reduced arrests, evictions, physical health episodes and suicide attempts. Involvement in the Trial also led to a slight decrease in mental health issues and suicidal ideation among the longer-term support group. However, participants with a diagnosed mental illness were more likely to experience almost all significant life events than those without a mental illness, in particular suicidal ideation, self-harm, and attempted suicide. Women were also more likely to experience non-fatal overdose, be involved in violent episodes and be evicted from accommodation compared to men. Feedback from services indicated that these events commonly co-occurred, indicating higher levels of instability among the Trials female population, the majority of whom had a diagnosed mental illness. Finally, participants who had previously been involved with the criminal justice system were more likely to experience most significant life events than those without a legal history.

Utilisation of Services

Consistent with the complex histories of participants, findings indicate that Trial participants require and use a wide range of services including drug treatment services, accommodation services, mental health services and general health services. However, the most commonly required services continued to be those funded directly through the Trial. Patterns of use, as well as key stakeholder feedback suggest that it is the continuos supportive relationship of the primary case manager coupled with an individuals involvement in ADSA or other forms of supportive and secure accommodation and the Trial's Community Reintegration Program (CRP) that deliver the most effective package of support.

The allocation of targeted Trial resources and partnerships with other services, specifically drug and alcohol services influenced levels of access and degrees of flexibility in approach to working with homeless clients with complex needs. While the Trial experienced an improved response in how some services engaged and subsequently supported Trial participants, many still experienced difficulties accessing services. Structural problems with services, such as lengthy waiting lists and their approach, as well as personal participant factors largely to do with readiness and motivation impacted on participant access and the use of much-needed services. Key stakeholder feedback and these findings highlight the need for supported access and clear established pathways and partnerships with a range of service providers. Participating services however, need to also be willing and able to work with homeless clients with high support needs and to do things differently if needed.

Goal-setting and Achievements

Consistent with previous reports, the emphasis of primary case management work continues to remain spread across a number of goal domains with a slightly higher focus on improved social-functioning goals followed by reduced substance-use goals. The majority of goals (86%, n = 4897) were achieved to some degree by participants during their time in the Trial, indicating the Trial's success at establishing individual treatment plans with participants and working towards achieving change. A participant's mental health status did, however, impact on the degree to which goals were achieved.

Summary Exit Data

Of the 118 exits during the three years of the Trial, 82 exit summaries were received. Forty of these were planned exits while 42 were unplanned. When compared against the profile of participants at Trial entry, both planned and unplanned, many participants were in a position at exit of improved health, greater housing stability, had reduced or were abstinent from problematic substance use, employed or involved in educational pursuits and connected to family and friends that they were once estranged from. For example, 63% (n=65) had achieved significant improvements to their previous problematic drug use by the time they exited the Trial, while the majority (80%, n=64) were residing in stable housing at this time. While these results are encouraging, there still remained a proportion of participants, most of whom made unplanned exits whose life was unstable at exit, necessitating the continued focus by the Trial on maintaining engagement with this group and reducing the number unplanned exits from the program.

Three-month Post-exit Follow-up Interviews

Nine participants were successfully contacted and interviewed out of a group of 14 exited participants who had available contact details between October 2003 and May 2004.While a limited number of interviews occurred with 'unplanned' exited participants, these case studies further illustrate the complexity of clients and realistically portray the various participant experiences during the Trial and three months after leaving. Similarities in the histories of these nine case studies exist. Eight out of the nine participants interviewed had been previously diagnosed with a mental illness, which was unstable when they entered the Trial. All except for one had been homeless for extended periods of time prior to being in the Trial; were unemployed; using one or many forms of substances that they believed was problematic, was in poor or marginal health; and disconnected from family and the community.

Three months after leaving the Trial, all nine participants remain in more stable and secure forms of housing, with six participants in public housing, one participant in private rental, one participant was in the process of moving into a THM property and one was about to move into supported accommodation upon exiting residential rehabilitation. Except for one case, the remaining cases had made significant changes to address their problematic drug use, with four participants remaining abstinent from all drug use, while the other four participants reported that they had maintained control over their problematic drug use, and had either reduced their levels of use or the number of drugs used regularly (three cases) or were only using socially (two cases). Four participants remained in full-time work after leaving the Trial, while those not working reported that they were either looking for work, completing treatment, undertaking a TAFE course or in one case had no employment or educational plans. Further, eight participants recorded improvements to their physical and mental health and the level of family reunification achieved was positive with four out of the nine case studies reconnecting and feeling supported by family and loved ones. However, the remaining case studies reported that they still felt isolated and lonely and had not been able to connect with estranged families.

In all but one case, feedback from participants on their time in the Trial was positive with all participants recalling the support and continuity of care offered by primary case managers as invaluable. Timely access to resources from housing to treatment and educational supports such as the CRP was also highly valued. Two participants did, however, report that their primary case managers could have assisted them more with their drug and alcohol problems. They did not specify how this could occur but it highlights a level of dissatisfaction in this area requiring further investigation. It also emphasises the need for the HDDP to explore ways of receiving ongoing client feedback in the future.

Conclusion

Pro-active engagement at the point where homeless drug users are in crisis, necessitating their entry into a crisis accommodation facility; provision of continuity of care from that point onwards; a relationship-based approach to case management; adopting a holistic framework; flexible and timely access to drug treatment; stable housing; educational links and the Trial's Community Reintegration Program among others, have all contributed to the improved circumstances of Trial participants. While many would suggest that these are not new ideas, the Trial provided the opportunity to test this combined approach and evaluate both the Trial's capacity-building endeavours and its primary case management and pathways response. Key learning's and the positive results recorded extensively throughout the three years of the Trial

and in this final-year report, attest to what is possible when agencies and government departments collaborate to deliver a service to a significantly disadvantaged group who require flexibility in approach and a range of services and supports in order to rebuild their lives.

Findings also suggest that there is a group within the Trial, many of whom have a diagnosed mental illness, who require and possibly indefinite support in order to remain stable and prevent a deterioration in their health and wellbeing. Most participants, however, move on after 13 months involvement once they have achieved their goals and sustained the changes made while in the Trial. This finding supports the Trial's flexible approach, while also defining a minimum time period of required program involvement. Any ongoing program however, will also need to be able to provide longer periods of support when required by the target group.

Finally, the Trial's committed but pragmatic approach to participant drug use was always tackled together with the many other interconnected problems experienced by homeless participants. While there are always political and public pressures for any service with a treatment focus to achieve abstinence in clients as the key marker of success, experience and research in the drug and alcohol and homeless sectors acknowledged that adopting this narrow approach only would have failed this client group and not allowed for the incremental steps to be taken towards stability. Tackling the individual crisis situation first and then assisting individuals to acquire greater stability in terms of their housing and health have allowed participants to address their problematic drug use, reduce the harms attached to use and make significant changes as evidenced in the findings. Addressing the participant's drug and alcohol use as a single issue or, for that matter, homelessness in isolation from the other complex set of problems would never have worked. Inter-agency collaboration, commitment to the target group and the flexibility to do things differently has been critical to delivering such a response. While this approach has posed challenges at times, the Trial has shown what is possible and findings support future endeavours to extend these activities and key principles to the broader homeless drug-using population.