

# Part 1

## 1.1 INTRODUCTION

The Homeless and Drug Dependency Trial (HDDT) commenced in July 2001 for three years and has utilised “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). This collaborative response has to date incorporated a partnership between Hanover Welfare Services, The Salvation Army, The Society of St Vincent de Paul, Victorian Drug and Alcohol Services, Housing and Health Services. The Department of Human Services, Drugs Policy and Services Branch and the Office of Housing (SAAP) have also been partners in this joined-up government initiative, which as a result of its successes has received a further three years of funding with an additional focus on responding to the mental health concerns of the Trial’s target group.

The HDDT has operated and will continue to do so from three major crisis supported accommodation services (CSAS) in inner Melbourne, namely Hanover Southbank (Hanover Welfare Services), Flagstaff (Salvation Army) and Ozanam House (Society of St Vincent DePaul). Within the overall agreed Trial model and objectives, each of the three CSAS developed their own model of implementation that was reflective of the individual agency’s philosophy and specific agency needs, issues and organisational structure. The differences in these models are summarised in Section 3 of this report.

The Overall Trial Model has three components, commonly referred to as: Parts A, B, and C. Part A of the Trial has focused on **Building Capacity** within the three participating CSAS in order to effectively assist residents who are drug and alcohol-dependent. Capacity-building within the three partner CSAS has involved the key strategies of targeted professional staff development, an enhanced health care/health promotion response for CSAS residents, diversionary activities for residents, policy and protocol development and focused resident engagement strategies.

Part B of the Trial has provided **Continuous Primary Case Management** to Trial participants during their stay at the CSAS and then throughout their involvement with various drug treatment and other support services. It has also facilitated and supported clients to access different forms of treatment and housing by developing **Pathway Models** that provide clear links between the CSAS and different forms of treatment and community support services. Its focus on providing a holistic response that not only addresses the homeless clients’ housing and substance-use problems, but also the interconnected issues that both contribute to and are a consequence of homelessness and drug addiction have been central to the Trial’s service delivery model. Part C of the HDDT has involved **Project Development, Management, Evaluation** and targeted **Research** during the three years of the Trial.

Crucial to the early stages of the HDDT were findings and feedback from within the CSAS in the years just prior to the Trial’s commencement (discussed in more detail in *Report 1: Setting the Scene*: Rayner, 2002). During this time CSAS staff were reporting “a significant shift in the profile and behaviours of residents. Increasing reports of overdose, increased levels of

injecting drug use, drug dealing, increased violence and intimidation, unsafe drug use, poly-drug use and the introduction of drug taking among non-using residents were just a few of the issues facing staff on a daily basis” (Rayner, 2002). In general, staff and services were feeling under-resourced to deal with the rising incidence of drug and alcohol-related problems. There were concerns about staff safety, the health and welfare of all residents and the ability of these services to effectively meet the needs of this client group.

According to Rayner (2003) “the prevalence of drug and alcohol use amongst homeless persons in Australia is not exactly known due to inadequate recording and the lack of homeless identifying questions in state and national drug and alcohol studies”. However, the literature review undertaken in the early stages of the Trial on homelessness and substance use corroborated staff feedback that substance use among the homeless population was a serious issue and one that was increasingly present within crisis accommodation services (for a detailed discussion of this literature review refer to the study titled, *Making Change Possible: Sharpening the Focus on Homelessness and Substance Use within Crisis Supported Accommodation Services in Inner Melbourne, Victoria*(Rayner, 2003).

For example, Horn (1996, 1999) undertook a survey of clients supported through Hanover Welfare Services under the Supported Accommodation Assistance Program (SAAP) in 1996 and again in 1999. This survey focused on clients’ problematic drug and alcohol use as well as their use of drug treatment services. Findings indicated that 54% of surveyed clients in 1996 and 49% in 1999 reported drug and alcohol problems across Hanover’s crisis accommodation and outreach and support services. This study also found that 63% (n = 46) of clients residing at Hanover Southbank (an inner-Melbourne CSAS) reported drug and alcohol problems in 1999. Heroin was by far the most commonly used drug among 69% of surveyed clients, up from 49% in the 1996 survey period.

Further, a study of homeless persons in inner Sydney (Hodder et al., 1998) found that 49% of homeless men and 15% of the women surveyed had a diagnosis of an alcohol use disorder in the previous twelve months. An overview report from this study reported that 34% of people using inner-city hostels and refuges were dependent on drugs, with 19% of men and 23% of women abusing or dependent on opiates, including heroin (Hodder et al., 1998). In addition, a more recent study by Crofts and Reid (2000; cited in Rayner, 2003) reported that 37% (n = 196) of the street drug-using community in Footscray, Melbourne were homeless at the time of interview, with 89% of respondents reporting difficulty finding affordable accommodation.

Despite varying prevalence rates, international literature further demonstrates a strong association between homelessness and substance use. Hammersley and Pearl (1997, cited in Rayner, 2003) undertook a study in the United Kingdom and found that 89% of homeless respondents reported drug-dependency issues, while Flemen (1997) reported drug and alcohol use among 88% of homeless youth surveyed. In the United States (Zerger 2002a; cited in Rayner, 2003) it has been reported that 20-30% of homeless persons have substance-use problems.

Given the limited research into the needs and issues facing homeless drug users accessing crisis shelters, the Trial conducted a cross-sectional study in the early stages of the project (Rayner, 2003), administering a semi-structured survey to 95 individuals staying at one of the three participating CSAS. This research provided a detailed profile of the Trial’s target group pre-intervention, while also informing the Trial of key areas requiring a concerted response.

Rayner's (2003) findings identified significant health, economic and social disadvantage among homeless drug users accessing crisis accommodation in inner Melbourne. Respondents in Rayner's study were typically young (mean age, 29 years) Australian-born, not having completed secondary education, unemployed, with high rates of drug use, hepatitis C and poor general health. Accommodation history among the sample population illustrated homelessness, with 72% having stayed in a crisis accommodation service in the past, and the mean number of moves in the past year among this group was eleven. In addition to identified high rates of poly-drug use, non fatal overdoses, attempted suicide and self-harm, 63% reported that their current state of homelessness was due to their drug addiction, revealing a strong association between homelessness and problematic drug use.

In addition to the dimensions of social exclusion experienced by this client group, Rayner (2003) also investigated their experiences of drug treatment services. She found that while the majority had accessed a drug treatment service in their lifetime, "the most utilised service types were not funded specialist treatment services (except for CCCC) but public health services such as the general practitioner" (page viii, Rayner, 2003). She found that the most common barriers to accessing treatment were structural, predominantly long waiting lists, the need to ring everyday, and difficulty finding out about services.

Rayner (2003) also investigated personal barriers to seeking assistance, finding that these barriers were more complex than the often-held belief that the client is "not motivated" and included such factors as the positive and functional benefits derived from drug use. While 9% reported that their personal lack of motivation was the current factor preventing them from changing their current situation of homelessness and drug-dependency, the majority (52%) instead identified significant structural factors such as the lack of permanent accommodation and financial supports to secure and maintain accommodation and build stability, as the main barriers to change (Rayner, 2003).

The barriers experienced personally as well as within the service system were compounded by the lack of resources that accompany stable housing. Rayner concluded that "accessing and sustaining treatment without stable accommodation is difficult if not impossible for homeless individuals" (p176, Rayner 2003).

The literature review reinforces the practice experience that persons experiencing homelessness with problematic substance use are a significant and further disadvantaged group within the overall homeless population. These findings also highlight the multiple issues facing this group and the difficulties they encounter in accessing treatment and rebuilding their lives. The development of an integrated and holistic response, which addresses the person's interconnected issues of homelessness, drug addiction, poor physical and mental health, isolation from family and community networks and financial and societal exclusion was clearly needed.

While a number of sources have suggested such a response is likely to maximise outcomes (see for example: Culhane et al., 2001; and Social Exclusion Unit, 1998; both cited in Rayner, 2003), this Trial has been the first of its kind within Australia to implement an integrated primary case management response with accompanying treatment and housing pathways to tackle homelessness and drug addiction, with an overlaid evaluation framework.

This is the Final Report on Part B of the Homeless and Drug Dependency Trial, and the ninth in a series of reports documenting the progress and findings of the Trial over its three-year

lifespan. This report documents findings on the profile, progress and outcomes of Trial participants who have been involved in the primary case management response up until May 30, 2004 and who have completed the necessary case management documentation required for evaluation purposes.

The reporting of information varies somewhat from first and second-year reports owing to the greater volume of information spanning a longer period of time. The reporting of the profile of participants entering the Trial has expanded to include a more in-depth analysis of gender differences and differences based on mental health status. The reporting of participants' progress within the Trial has also been modified in some important ways. 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 been singled out for additional analysis on the basis of important characteristics of interest such as mental health status, legal history and gender. Analysis of three-monthly ITP data for these groups has allowed for an exploration of various characteristics among Trial Participants and their impact on progress within this treatment response.

Part 1 of this report details the differences between CSAS Trial models, followed by a discussion on the evaluation processes underpinning the Trial and an examination of rates of engagement and participation within the Trial. Part 2 of the report provides a detailed profile of participants, while Part 3 provides an updated and more in-depth examination of the progress and outcomes of all Trial participants. Finally, Part 4 of this report explores participants' status at exit from the Trial and the results of a three-month post follow-up exit interview with a small number of previous participants.

In keeping with the spirit of the Trial, the progress and outcomes of participants in each of the three participating services have been analysed together. This report does not go into detail on the specific Trial elements of Part B such as the A&D Supported Accommodation Services, the Trial's Community Reintegration Program, The Bridge Withdrawal Service and the Residential Rehabilitation components of the Trial. While this report examines the utilisation of these services, the review specific to each of these components has occurred separately and can be found on the Trial's website – [www.hddt.org.au](http://www.hddt.org.au). A full list of Trial reports is given on page 27. Additionally, more detailed information on each service model can be accessed from the participating CSAS directly.

## 1.2 THE TRIAL MODEL

The following section outlines the key model elements, objectives and strategies of Part B of the HDDT.

### 1.2.1 Trial Design – Part B

Part B of the HDDT set out to provide an enhanced service response to homeless persons experiencing problematic drug use and who make use of the three participating CSAS. This enhanced service response involves two sets of interventions. The first is a **continuous primary case management approach** for all clients accessing Part B of the Trial; the second is **priority or supported access to the following drug treatment and community supports:**

- The Bridge Residential Withdrawal Service
- Trial Alcohol and Drug Supported Accommodation Program (auspiced by Windana, Ozanam House and Flagstaff)
- Residential Rehabilitation Programs (Windana and Odyssey)
- Established community drug and alcohol programs (other existing programs not mentioned above)
- Funding pool that is flexibly deployed to meet other participant needs
- Community Reintegration Program that builds alternative lifestyles through:
  - Therapeutic drug and alcohol interventions
  - Health and social pathways
  - Educational programs
  - Employment/training pathways.

Participation is entirely voluntary. Not all eligible residents from the CSAS were able to participate in Part B due to caseload capacity. Further, not all participants of Part B engaged in all or any of the above listed elements outside of support from their primary case manager due to a variety of factors.

### 1.2.2 Part B Key Objectives

Part B of the Trial is guided by the following key objectives:

- To provide continuous primary case management to individuals throughout their involvement with drug treatment services and other support services.
- To provide clear and direct links between CSAS and different forms of treatment and support appropriate to homeless clients.
- To establish secure housing arrangements that facilitate stable lifestyles.
- To provide a response that builds self-esteem and improves quality of social and family relationships.

- To build pathways that will assist Trial participants to reintegrate into community networks, employment and training.

### 1.2.3 Part B Key Strategies

In broad terms the following activities represent key strategies of Part B during the three Trial years.

- Provision of primary case management responses to approximately 100–120 individuals accessing the Trial across the three CSAS at any one time.
- Implementation of a targeted drug and alcohol/homelessness primary case management model and interventions with supporting practice tools for PCMs.
- Integration of the Trial case management response within existing case worker practices and staff teams at Hanover Southbank and Ozanam House.
- Integration of a specific new Trial team into Flagstaff CSAS.
- Professional development response for PCMs targeted towards building expertise and confidence within areas of D&A practice, mental health and complex care.
- Direct collaboration, facilitated by clear IAWP protocols and strong partnerships with:
  - The Bridge Residential Withdrawal Unit
  - Odyssey House & Odyssey Community Services
  - Windana Residential Rehabilitation Service
  - Windana Alcohol & Drug Supported Accommodation Program
  - Trial CRP (Employment, Training and Personal Support Program)
  - De Paul House Residential Withdrawal Service
  - RDNS Homeless Persons Program
  - Summit/HOPS Teams (Mental Health Services)
  - Other D&A Services

## 1.3 DIFFERENCES BETWEEN THE THREE CSAS MODELS

During the development phase of the Trial, each of the three participating CSASs were asked to design their own individual model of service delivery that would meet agreed Trial objectives. The Inter-Agency Working Party was keen for services to develop a variety of different strategies, consistent with agency philosophies of care and the presenting needs of homeless clients.

The final presentation of models to the Inter-Agency Working Party for ratification in July 2001 highlighted a great deal of similarity between CSASs regarding the strategies to be implemented. There were, however, some differences in approach as highlighted in the following section. The outline on the following page has been updated from that presented in first year and second-year reports to include current model operations within each participating CSAS.

### 1.3.1 Part B Pathways – Continuous Primary Case Management Response

The key differences in each of the CSAS Trial models of continuing primary case management are:

#### Hanover Southbank

- Hanover Southbank was the only participating CSAS that accommodates women, men and families. As such, the majority of women who entered the Trial entered through this service.
- The Trial primary case management response was integrated with the existing CSAS case work team. Two new case workers were employed in addition to the DACMC. Case workers managed a mixed caseload incorporating Crisis, THM, and Trial clients while the DACMC primary case managed a Trial caseload only.
- The two Community Health Nurses also primary case managed some Trial participants, particularly those who presented with significant health issues
- As a function of the approach adopted by the Trial, case workers were able to work with clients long term after supporting them initially in the CSAS, allowing for continuity of care.
- DACMC oversighted Part B activities and case management practices. The DACMC also acted as a secondary consultant to staff and managed the Community Health Nurses and the Community Support Worker.
- Day-to-day direct supervision and management of case work staff remained the responsibility of the HSB Case Management Coordinator.

- Hanover explored the possibilities of inclusion of Hanover Inner North Outreach Team, Hanover Women’s Services and Hanover Young Adults and Young Women’s services during the Trial. To date, Hanover Southbank has expanded its PCM response to the Women’s Service in a small way.
- During the Trial period, Windana Drug and Alcohol Service directly managed Hanover’s Trial-specific Alcohol and Drug Supported Accommodation.

#### Ozanam House

- From the outset the Trial’s case management response was mainly integrated into existing case work teams, these being the Outreach Service, Intensive Youth Support Service, Quinn House, Ozanam Community Centre and RDNS HPP. Increased staff resources were allocated from the Trial into the RDNS HPP and the community centre D&A clinician roles only. Additionally new staff were recruited for the Trial’s Primary Case Management and ADSA roles. Only one specific case manager had a Trial-only caseload.
- The DACMC coordinated the allocation of clients to Primary Case Managers across the whole organisation and directly liaised with all program areas.
- The Trial’s ADSA response was set up as a separate program and was managed through Ozanam House by the DACMC.
- During the Trial period the DACMC directly managed and supervised Trial-specific Case Managers and the ADSA Workers.
- Women were able to access the Trial through the Primary Case Manager at Ozanam Community Centre, vacancies permitting

#### Flagstaff CSAS

- A stand-alone D&A team was established at the commencement of the Trial which primary case managed Part B Trial participants only. The DACMC coordinated this team and also managed a caseload.
- The Flagstaff model combined the case management responses of both the Trial primary case management and the ADSA case management programs. This allowed for the combining of roles and prevented a number of clients being referred to ‘another service’.
- The ADSA component was also managed by Flagstaff Adult Services.
- All Primary Case Managers acted as secondary consultants to case work and accommodation staff at the Flagstaff.

## 1.4 REFLECTIONS ON CURRENT MODELS AND INTENDED CHANGES POST-TRIAL

### 1.4.1 Flagstaff

From the outset Flagstaff implemented a stand-alone Trial Drug and Alcohol Team that also incorporated the ADSA program. Combining these services allowed Flagstaff to provide a seamless response to Trial participants. Service managers and staff continue to report that they are pleased by the outcomes achieved in the Trial. Both staff and clients report that the greatest strength has been the service's ability to offer continuity of care while also delivering differing levels of treatment options to homeless clients.

Given the success of Flagstaff's model, managers reported at the end of the Trial period that they would not be making any significant changes to the way they deploy staff and resources to key HDDP program areas.

### 1.4.2 Hanover Southbank

Hanover Southbank's approach to primary case management was to incorporate this function largely into the existing case work team. In addition, the DACMC and the community health nurses have managed a small caseload of Trial clients. The integration of the Trial's primary case management response into the case work team enabled case workers to manage a mixed caseload that now incorporates crisis clients, transitional housing clients and Trial clients. One of the challenges identified early in this model of approach is the difficulty case workers face in having to manage such varied and complex caseloads. Final-year focus group discussions and key informant journaling however, identified that a positive view still exists supporting the continuation of this approach.

While staff still reported that managing a mixed caseload has its challenges, all felt that the PCM model adopted by HSB had enabled them to deliver continuity of care to homeless clients, which was not only professionally rewarding but had resulted in improved client outcomes. Of note has been the success at remaining engaged and supportive of such complex clients whose drug use, health and social circumstances would have further deteriorated rather than improved without pro-active engagement and follow-up. Staff also reported that the high levels of support and supervision provided by the case work manager, DACMC and peers had assisted their approach and management of such varied and complex clients.

In response to evaluation feedback, HSB management report that no changes to their PCM model will occur after the Trial period.

### 1.4.3 Ozanam

From the outset Ozanam's model of primary case management was developed in order to promote service integration within Ozanam Community. This resulted in primary case management functions being spread across teams in order to meet caseload numbers and to create a range of pathway options.

As previously reported, second-year evaluation discussions with managers and staff identified that improvements could be made to further strengthen Ozanam's model. It was identified at this time that management and communication systems needed to be tightened in order to heighten the Trial's profile across the entire organisation and improve the model of service delivery.

During the early stages of the Trial's final year, Ozanam conducted further internal consultations and planning meetings to address identified gaps and to develop a modified Trial model that would further improve the services primary case management and pathways response. After this period of planning, Ozanam acted swiftly to implement changes in the final half of the Trial, which now constitutes Ozanam's HDDP response. For further details on these changes please refer to the final-year evaluation report on *Part A Capacity-Building Activities* (Rayner, August 2004).

#### 1.4.4 Critical Issues to Monitor and Address in an Ongoing Response

- Final-year evaluation processes have continued to identify the challenges PCMs face in effectively working with homeless clients who have a mental health disorder coupled with other complex needs. Appropriate pathway options and support services available to this group are limited. This is particularly the case when higher levels of support attached to housing are required. This area of service provision remains a significant service delivery gap and has been identified throughout the three years of the Trial as an ongoing gap.
- DACMCs continue to acknowledge the importance of continually monitoring the engagement and uptake of participants into the Trial. The point at which individuals are ready to commit and engage in such a service response has been an ongoing topic of discussion. Services generally report, however, that they do not look for a high level of commitment or engagement from clients at the beginning but see this as part of their work to build this capacity. Early findings point to the assessment and management of the intending participants' crisis in unison with CSAS case workers prior to official entry into Part B of the Trial as paramount to engaging the client in the Trial. Given the importance of this initial work with the client, the HDDP will need to regularly review this practice and ensure that this process remains a strong focus of the CSASs.
- Sustaining pro-active engagement with a disadvantaged client group requires considerable commitment by PCMs and a belief that the small steps taken forward and even sideways are important and critical to supporting the process of change. DACMCs have highlighted the importance of instilling this belief in PCMs through supervision and mentoring. While all three CSAS in final-year evaluation discussions continue to report the ongoing importance of this activity, staff feedback also highlighted that PCMs are highly motivated and conscious of remaining engaged with the homeless client. Staff were also aware that situational changes with the client would at times make this difficult and require greater input by the PCM. In addition, CSAS acknowledge that this issue requires monitoring in order to continue to sustain participants in a response and to support staff to do so.

## 1.5 PROCESS OF ENTRY INTO THE TRIAL

The following discussion outlines the processes of entry intending Trial participants went through at each CSAS, as reported by the DACMCs. It reflects differences in process and organisational structures of each CSAS. While Flagstaff and Hanover Southbank will not be changing their process of entry after the Trial, Ozanam has already implemented changes.

### 1.5.1 Flagstaff

- Step 1: Upon entry into Flagstaff CSAS homeless clients are allocated a CSAS case worker.
- Step 2: If homeless clients have D&A issues and want to speak to a D&A worker, the case worker refers them to Flagstaff's Trial D&A Service Team.
- Step 3: Upon referral to the D&A Trial team, an appointment is made with a team member. An initial assessment of the resident's housing, drugs and alcohol use and mental health is made with the aim of identifying if the CSAS resident is really interested in a D&A response.
- Step 4: After this assessment, if the CSAS resident would like to keep meeting with staff from the Trial team to discuss D&A use then the team member continues to facilitate further discussion. These clients are referred to as Part A+ clients and are at a point where they want to 'do something about their drug use'. For those who do not want to do anything about their drug use at the point of assessment by the Trial team CSAS case workers will continue to manage the client and address presenting issues.
- Step 5: A range of responses are offered to the differing client groups outlined below:

#### **Part A: Pre-contemplative Clients**

##### **PCMs continue to offer:**

- Secondary consultation to assist case work staff
- An open-door policy for clients wanting to re-engage
- Continuation of informal client contact
- The providing of linkage to nursing staff
- Clients continue to receive enhanced case work response involving:
  - Harm-minimisation interventions
  - Health promotions/information
  - Information to assist clients to move from pre-contemplative to contemplative stages
  - General crisis support and advocacy

#### **Part A+ Clients**

For clients that have been referred to the Trial but who have chosen, for whatever reason, not to enter the Trial formally, the D&A team have offered a continuing service. The following services were offered to 54 non-Trial clients who were seen three times or more up to the end of June 2003.

**These clients were offered the following services:**

- Initial assessment
- Crisis counselling
- Crisis interventions
- Referral to withdrawal and other treatment options
- Harm-minimisation information
- Service system information
- Information regarding re-linking to the Trial.

**Part B: Contemplative or Further Along the Change Cycle**

**Case management process put in place. PCMs assume overall management and responsibility for engagement and offer:**

- Relationship-building
- Crisis intervention
- Stabilisation
- Counselling
- Referral
- General support and advocacy.

Case work staff deal with facility issues and act as a conduit between the crisis facility and PCMs.

**Formal Entry into Part B of the Trial Occurs When:**

- Initial crisis is managed and some degree of stabilisation is achieved
- The client has received information about the Trial's purpose and nature
- The client voluntarily chooses to continue to participate and work with the PCM on the Trial.

### 1.5.2 Hanover Southbank

- Upon entry to Hanover Southbank, all residents are allocated a case worker. At this point staff will prioritise to actively seek out residents who have significant histories of problematic drug use, homelessness, high-risk behaviours and difficulties engaging.
- This 'assertive approach to engagement' is seen as necessary as it is assumed that most residents will have difficulty engaging in and/or contemplating sustaining a process of change.
- The DACMC meets with any potential Trial clients to inform and promote access, offering a process of case management/support that is not bound by time or DHS region.
- Allocation is managed collaboratively between the DACMC and the case management coordinator of the PCMs.

Trial participants are signed up to the Trial when the client states they are interested. PCMs then commence their work with Trial participants as soon as possible within the CSAS.

Priority of entry into the Trial is given to those who have either not accessed and/or completed their negotiated residency in either drug treatment services or accommodation options in the past. As a result of this process of entry, the majority of participants will be in crisis upon entry into the Trial, therefore relationship-building and stabilisation are the initial priorities.

### 1.5.3 Ozanam House

During the first two and half years of the Trial, the following processes existed. However, changes to improve and simplify access have since been initiated.

- Homeless person was admitted to Ozanam House after a screening process with HIR – Housing Information and Referral worker.
- Referral was then made to an Ozanam House case manager/support worker where an initial assessment occurred and a care plan was discussed.
- If vacancies existed in the HDDT a referral was made to the HDDT DACMC or senior HDDT PCM. Support team staff were regularly informed of the status of vacancies and progress of the HDDT program.
- Ozanam’s internal ‘service gateway’ provided options that were discussed in consultation with support services, the case manager, and the client. The HDDT was one of the gateway options available to clients.
- All new referrals to the Trial were discussed between the DACMC and the Trial’s senior primary case manager and consideration was given to multiple ‘gateways’ within the organisation that may or may not include entry to the Trial. If a vacancy existed and the Trial was deemed the best pathway, the homeless client would then undertake the Trial’s assessment with the senior PCM. At this point the handover of the client occurs between Support Services and the HDDT senior clinician.
- Once a client has undergone the IRF assessment, the client was referred in a timely fashion to available and appropriately matched Trial PCMs located within a variety of Ozanam program areas. This includes the Trial’s ADSA, Outreach, IYSS, Quin House and the Community Centre.
- A handover process was organised between PCM to ADSA case management if the client enters the ADSA program.
- Ongoing, regular three-month contact was activated by the PCM if the client is referred to the ADSA service. All other clients were regularly supported by their allocated PCM.

## 1.6 RESEARCH PROCESS

### 1.6.1 Introduction

The following section outlines the evaluation and research processes attached to Part B of the Trial. From the outset, Trial partners were committed to establishing an evaluation and research framework that would allow for the ongoing monitoring of Trial progress and outcomes over the three-year Trial period. This element was built into Part C of the Trial where the primary functions of project management and evaluation existed. A great deal of work has taken place within the project team and the participating services to implement and also improve the Trial's capacity to evaluate progress and report findings with the resources available.

This section details the processes attached to the Part B evaluation; the population under study for this report who represent only those who have consented to be a part of the evaluation; ethics; and limitations in the methodology. Given that this is the third in a series of Part B reports, much of the information presented in this section (excluding the data analysis and limitations section) remains the same as that reported in the previous Part B reports.

### 1.6.2 Methodology

**The aims of the evaluation for Part B of the HDDT and the focus of this report were to:**

- Map the progress and outcomes of clients participating within the primary case management response and other drug treatment and support interventions while involved in the Trial.
- Provide a final-year report directly informs participating Trial services and other community-based services on the learning's and outcomes of implementing a primary case management and pathways response for homeless clients with substance-use problems.
- Gain a greater understanding of the relationship between homelessness and substance use and the impact of such on the homeless person's ability to make changes and create a stable lifestyle.

**Two parallel processes** have been utilised to address the aims of the evaluation. These include cyclic key stakeholder participation, observation and reflections as well as both quantitative and qualitative client progress and outcome data.

#### **PROCESS 1: Cyclical Key Stakeholder Participation, Reflections and Action**

In order to monitor processes, impacts and outcomes of the Trial's primary case management and pathways model as well as the use of the practice/evaluation tools, a methodology based on action research was operational from the beginning of the Trial. An approach of self-reflective cycles of planning, acting, observing and reflecting on the various elements of Part B has occurred. The focus of these discussions has been recorded in journal entries by the research team, which occurred at regular intervals via:

- Monthly individual CSAS project management meetings
- Combined Drug and Alcohol Case Management Coordinator meetings between the three services
- Internal meetings with PCMs and discussions within services
- The Trial's Alcohol and Other Drugs Reference Group
- The Trial's Evaluation and Research Advisory Group, and;
- The Inter-Agency Working Party.

## **PROCESS 2: Collection of Client Profile, Progress and Outcome Data**

### ***Data Collected by Primary Case Managers***

Primary Case Managers have continually collected quantitative and qualitative information from Part B participants throughout the clients' involvement in the Trial. This information was collected using the following Tools:

- Initial Recording Form (Trial Assessment Tool) – providing profile information and benchmark data (*Appendix 1*)
- Individual Treatment Plan (ITP) which is reviewed and updated by the PCM in conjunction with the participant at three-monthly intervals (*Appendix 2*)
- Resident Self-Report Survey (RSRS), which may be completed by participants in residential rehabilitation in place of their three-monthly ITP (*Appendix 3*). Very few primary case managers collected information using this tool, hence the decision to not include this data for analysis in this final report.

The ITP enabled progress to be tracked every three months in the following domains:

- Accommodation history
- Substance use – levels of use and changing patterns
- Significant life events experienced
- Service system utilisation
- Monitoring of treatment goal progress
- Level of PCM contact for each ITP period
- The ITP also included a client exit summary sheet, which was completed by the PCM at the time of the participants exit and forwarded to researchers.

### ***Data Collected by Researchers*** – three-month exit follow-up interviews.

Additionally, a researcher from the project team followed-up clients who exited the Trial between the 1 October 2003 and the 30 May 2004. Those clients who it was possible to contact were asked to participate in an interview approximately three months after their exit from the Trial. The post-exit questionnaire collected information over the same domains as the ITP and also asked for general feedback about the Trial (*Appendix 6*). Further methodological details are discussed along with key findings and case studies in Part 4 of this report.

### 1.6.3 Population under Study

Participants who submitted an IRF and ITPs between 1 July 2001 and 30 May 2004 and gave written informed consent to participate in the evaluation form the basis of this report. This sample population consisted of 161 of the 213 people who entered Part B of the Trial up until the 30 May 2004.

Given the above defining elements, the analysis has been based on:

- 161 participants who completed an IRF
- 138 participants who completed ITP 1
- 107 participants who completed ITP 2
- 87 participants who completed ITP 3
- 78 participants who completed ITP 4
- 66 participants who completed ITP 5
- 58 participants who completed ITP 6
- 45 participants who completed ITP 7
- 34 participants who completed ITP 8
- 24 participants who completed ITP 9
- 12 participants who completed ITP 10
- 7 participants who completed ITP 11

Please note that there were no fixed entry or exit points for the Trial. Participants were able to enter the Trial at any time, resources permitting, as well as exit the Trial. As such, participants continued to enter and exit the Trial throughout its three-year period. This explains the reducing numbers over time. This is examined in more detail in the engagement and participation section.

Recruitment of participants occurred via referral from the CSAS residents case worker in each of the services or after direct contact with a Trial primary case manager in any of the CSAS.

### 1.6.4 Eligibility

To be eligible for Part B of the HDDT:

- Intending participants were either residents of **Flagstaff, Hanover Southbank or Ozanam House** at the time of entry into the Trial or were former residents but current clients of the facilities and/or services associated with the participating CSAS at the time of entry.
- Intending participants had to be between the ages of 18–75 years of age.
- Intending participants had an identified problematic drug and alcohol issue with either illicit or licit substances.
- Participants were fully informed about the purpose of the Trial and the pathway options available.
- Informed consent regarding the nature of the Trial and the evaluation processes were obtained prior to entry into the Trial.

- Participants could elect to not be involved in the evaluation process. This did not affect their access to the Trial and associated resources.
- People who had been past residents and had discussed the Trial with the Drug and Alcohol Case Manger Coordinator or case worker/support worker, but at that time chosen not to participate or found there was no availability within the Trial, could reapply to enter the Trial at a later date. They did not necessarily have to be in the CSAS when they chose to do this.
- Trial participants who exited the Trial were able to re-enter the program at any time. The timing of access, however, was dependent on caseload availability.
- Further provisions were made to allow women who were partners of Trial clients to also enter the Trial.

### 1.6.5 Ethics

Ethical considerations were central to the development and implementation of the Trial and in particular the research and evaluation dimensions of this project. Ethics approval was granted by the Trial's Ethics Committee prior to the implementation of the Part B evaluation.

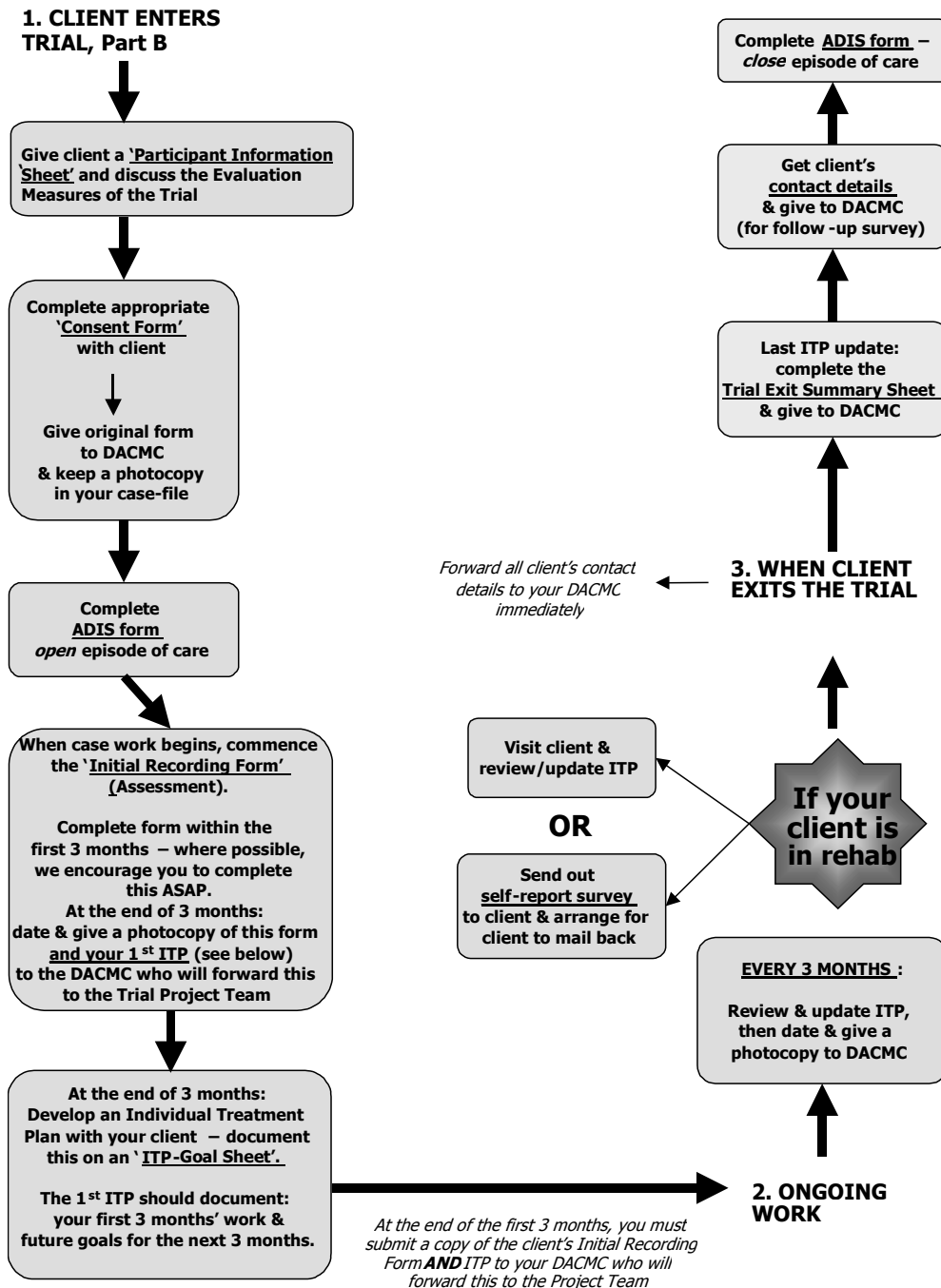
Ethical dimensions and processes were fully considered and adhered to over the course of the Trial period. In brief, some of the key processes followed included:

- Provision of information (Participant Information Sheet) pertaining to the Trial and the evaluation measures were given to the client in both a verbal and written format by the PCM (*Appendix 4*) upon entry into the Trial. At this time the participant was informed that their participation in the evaluation component of the Trial was entirely voluntary and their decision to not participate in the evaluation would not impact on their access to the Trial and the services they received.
- Written informed consent (*Appendix 5*) was obtained from each participant prior to his or her participation in the evaluation component of the Trial.
- Researchers only stored and reported on non-identifiable information from consenting clients.
- Confidentiality of all data collected was guaranteed and these issues were discussed with participants prior to the interview.
- PCMs adhered to their agency's policies and guidelines related to work practices and duty of care when working with Trial participants.

### 1.6.6 Data Collection Process

Data has been continually collected by PCMs in the course of their work with Trial participants and recorded as part of their casework practices. This involved the use of specifically designed tools that were adapted from generic Victorian Drug and Alcohol practice tools such as the assessment form and Individual Treatment Plan (ITP). The data collection flowchart on the following page illustrates the process of data collection that occurred within the Trial. It also reflects the level of primary case management review over the course of the Trial.

# Primary Case Manager HDDT Flowchart



## 1.6.7 Data Analysis

Data analysis for this report consisted of three stages:

### **Stage 1: Data Collection, Entry and Analysis**

Data collected on the Initial Recording Form (IRF) as part of assessment was entered into the software package SPSS Version 11 for Windows, as was data from the Individual Treatment Plan (ITP). Data from the exit notes was entered into Excel Office 2000 version and, where necessary, data from Excel was transported in SPSS for analysis. A separate database was developed for the exit summary sheet. Additional data reduction and identification of themes in the goal section of the ITP and some sections of the IRF occurred using manual categorisation in both Excel and SPSS. The pre-existing Excel 'Indicators' database was also used which contained information on the number of records received by participant alpha code, the date they were completed, and participants' date of entry and exit.

Once all the data had been entered into the databases, it was screened for any errors that may have occurred during data entry. These errors were then checked against the hard copy of the tool and corrected by the research officer or research assistant prior to commencing analysis.

Analysis was then undertaken on the data. A series of tables were created from these databases. Tables were generated overall for the IRF for each variable while tables were generated overall for each ITP period for each variable in the ITP. A series of tables was also generated for the Indicators database and the exit summary database. Patterns emerging from these tables were then drawn out and the meanings of these patterns were discussed and explanations offered.

### **Stage 2: Feedback from Primary Case Managers**

Focus group discussions were held with PCMs across the three CSAS in order to reflect on their experiences and that of their clients, as well as to record noted changes and gaps annually during the life of the Trial. Individual CSAS models of primary case management were examined in order to review the effectiveness of the originally proposed models during and at the end of the Trial's three years of operation.

### **Stage 3: Feedback from DACMCs**

In keeping with the HDDT collaborative processes, Stage 3 of this process involved the direct input of the Drug and Alcohol Case Managers from each service. A series of joint meetings were held with all three DACMCs and the evaluators to firstly analyse quantitative data emerging for each reporting period and its meaning in terms of service experiences and contextual issues impacting on the Trial. In addition, several project management meetings with managers and the DACMC were held in each service to discuss and actively reflect on early findings and to gather further insight into specific service issues and experiences and their relationship to the data.

## 1.6.8 Changes to Analysis and Reporting in the Final Report

The reporting of information in this final report varies somewhat from the previous two Part B reports owing to the greater volume of information spanning a longer period of time. This has allowed for a more detailed analysis of the data.

## Participant Profile – IRF data

A brief exploration of gender differences in participant profile and differences in progress in the Trial according to mental health status were undertaken at the end of the second year of the Trial (Report 5) after feedback by services. However, given the constraints of time and resources, the analyses undertaken at this time were only brief. As such, more time has been spent in this final reporting period exploring the impact of a participant's gender and mental health status on both their profile and progress in the Trial. To do this, we split the IRF file by gender comparing men and women on almost all variables. A split was also undertaken by participants' mental health status. This involved comparing those with and those without a diagnosed mental illness on almost all IRF variables.

Given the differences in the number of women and men in the Trial and the high rate of diagnosed mental illness in the Trial population, the differences noted throughout can only be considered exploratory at this stage. A study specifically investigating women with complex needs has been undertaken by Hanover Welfare Services that will shed more light on this population (*'Getting My Life Back Together': Women, Housing and Multiple Needs*, Parkinson S, 2004).

## Progress in the Trial – ITP Data

In the first and second year Part B reports analysis of the ITP data was undertaken using all the information collected within the reporting period for every participant. While this gave us an overall picture of each Trial participant's progress, a more in-depth analysis of changes over time was problematic due to low numbers of ITPs in later ITP periods. However, in this third and final-year report a greater volume of ITPs across longer time periods was available, allowing for more detailed analysis.

## Analysis of ITP Data in the Final Report Consists of Three Levels

- Firstly, there is an overall analysis of some variables using all the information collected on participants throughout their involvement in the Trial. It is the same style of analysis adopted in the previous two Part B reports, though it has only been conducted on a small number of variables.
- Secondly, there is an analysis of ITP data by IRF characteristics such as gender, mental health status and legal history. Participants exit status was also examined in the engagement and participation section. This analysis is designed to explore the impact of key differences in participants' profiles on progress in the Trial. Given that these analyses do not explore change over time, instead examining change while in the Trial as a whole, for simplicity these 'groups' of participants have been referred to as participant sub-groups.
- Thirdly, a within-subjects-analysis of change over time has been conducted on those participants who have been in the Trial for eight ITP periods (two years). From hereon this group will be referred to as the 'change over time' group.

## Participant Sub-groups

The following details the snapshot groups and the number of participants in each snapshot group.

- Of the 157 people who completed at least one ITP, 23 were women (15%) and 134 were men (85%).
- Of the 116 people responding to questions on diagnosed mental illness and having completed at least one ITP, 85 (73.3%) had a diagnosed mental illness at the time of assessment while 31 (26.7%) did not.
- Those with a legal history had either a previous conviction or had charges pending at the time of assessment. Of the 132 participants responding to questions about their legal history and having completed at least one ITP, 96 (73%) had a legal history while 36 (27%) did not.
- Of the 157 participants who had completed at least one ITP, 86 had exited the Trial as of 30 May 2004. Of those 86, we received 75 exit summaries and using these identified that 38 (51%) had made planned exits from the Trial while 37 (49%) had made unplanned exits (for further clarification on this distinction please refer to Part 4 of this report).

A significance test was applied to all snapshot findings in order to determine the reliability of these differences. Given the differences in group sizes the confidence level was set to 90%. All comparisons between groups reported were statistically significant unless otherwise specified.

#### Change Over Time in the Longer-term Group

As already discussed, those participants having stayed for at least eight ITP periods (n = 36) were singled out for a within-subjects-analysis. Of these 36 participants, seven had exited the Trial; six had made planned exits while one had made an unplanned exit. The median length of stay for this group was 850.5 days (mean 856 days, or 28 months, range 709–1004 days), significantly longer than the overall average of 13 months. Nine (26.5%) of these participants were primary case managed through Flagstaff, 11 (32.4%) through Hanover and 14 (41.2%) through Ozanam. The majority of this group were men (79%).

Some of the IRF profile variables were run on this group to determine if they were representative of the overall Trial group. These were:

- Demographics
- The number of moves made in the 12 months prior to assessment
- The frequencies of stays in each accommodation type
- Access to public housing
- Lifetime use of drugs
- Proportion of participants using heroin, alcohol, benzodiazepines, cannabis and amphetamines in the 28 and 7 days prior to assessment
- Poly-drug use rates
- Rates of diagnosed mental illness

The only difference detected at this time was a slightly higher incidence of diagnosed mental illness in the ‘change over time group’, which is consistent with the longer length of stay by those with a diagnosed mental illness. As no other differences were detected, including those associated with participants’ mental health status reported on and discussed in Part 2, this

group was deemed to be representative of the overall Trial population. Later analysis of ITP data did, however, reveal that this group was more likely to use almost all drug classes than the overall group, required much longer periods of support and experienced a higher number of significant life events.

## 1.6.9 Limitations

### 1.6.9.1 Limitations Specific to this Report

- In some cases it was impossible for PCMs to review a client's progress at the planned three-month review date. This occurred for a number of reasons including: client unwillingness, difficulty contacting the client and staff turnover at CSAS. This meant that in some instances there was a gap of longer than four months between ITP reviews. In some cases, PCMs were able to retrospectively undertake an ITP review for this period, completing most fields. However, in cases where PCMs had left or clients had exited, a different strategy was required. In keeping with the longitudinal focus of this study, in these cases ITPs were reallocated as closely as possible to a three-month review date. This means that in some cases participants are missing an ITP. This process has strengthened our ability to draw conclusions about effective time frames for engagement; however it does mean that there is a small but significant amount of missing information. As such, and consistent with previous reports, only valid percents have been reported.
- Two participants were removed from the Trial evaluation (though they received ongoing support through the Trial) because their paperwork was largely incomplete and inconsistent. These participants have only been included in this report in the entry numbers along with non-consenting clients.
- While significance testing was undertaken on the participant sub-group findings, the relative unevenness of group sizes (for example the number of men versus the number of women) meant that assumptions of the difference of proportions test were sometimes violated (specifically the standard binomial requirement that  $n \cdot p$  and  $n(1-p)$  must both be equal to or greater than five, where  $n$  = samples size and  $p$  = percentage. This assumption is compromised when sample sizes are quite small. In cases where this occurred, results were not reported unless DACMCs felt they reflected a significant trend they had observed.

### 1.6.9.2 General Limitations Relevant to the Trial's Evaluation Approach

- Implementing a multi-agency project the size of the Homeless and Drug Dependency Trial, which had to commence a service response within short timelines; to drive significant cultural change within participating organisations in order to meet Trial objectives; and overlay this with an ongoing evaluation framework has, understandably, had an impact on the quality and detail of the information collected in the early stages. However, the quality and reliability of subsequent batches of data collected greatly improved from first-year standards, largely as a result of ongoing monitoring and support to case managers in the collection of this data.
- Over 30 PCMS have been included in data collection for both practice and evaluation purposes. As a consequence, the data may contain some bias reflecting this approach.

- The completion of the IRF and ITPs requires participants to self-report on a number of sensitive issues, such as their drug use. Given the sensitive nature of the issues under examination and the fact that those recording this information are the participants' PCMs, responses may, in some instances, be influenced by the expectations of participants and their PCM.

## 1.7 ENGAGEMENT AND PARTICIPATION IN THE TRIAL

### 1.7.1 Introduction

The following section details the level of engagement and participation in the Trial for its full three-year period (1 July 2001–30 June 2004). Participation levels for each Trial quarter have been examined, followed by a discussion on the length of stay for all participants. Length-of-stay analyses were also conducted by CSAS, by participants' exit status, and for each participant sub-group. The level of planned versus unplanned exits was also examined for any differences.

### 1.7.2 Levels of Participation

Between the 1 July 2001 and 30 May 2004 there were 213 entries and 118 exits (11 participants re-entered the Trial with seven exiting once again). These figures include both consenting and non-consenting participants. As indicated in Table 1.1, there remain 102 participants in the program at the end of the Trial period.

Table 1.1 outlines the uptake of Trial participants and the level of movement into and out of the Trial throughout the Trial period. As previously reported the initial low levels of intake during the first three to six months of the Trial were due to services not being at capacity in terms of staffing and service development. The establishment of the Trial's evaluation procedures also impacted on the initial intake.

The most significant level of intake occurred during the second half of the Trial's first year (1 January 2002–30 June 2002) at which time the Trial had reached a total of 106 entries.

**Table 1.1: Movement into and out of the Trial<sup>1</sup>**

<b>Time Period</b>	<b>No. of Entries</b>	<b>Cumulative No. of Entries</b>	<b>No. of Exits</b>	<b>Cumulative No. of Exits</b>	<b>Caseload Levels at Any One Time</b>
1 July 01–30 Sept 01	15	15	0	0	15
1 Oct 01–31 Dec 01	19	34	2	2	32
1 Jan 02–30 March 02	38	72	6	8	64
1 April 02–30 June 02	34	106	10	18	88
1 July 02–30 Sept 02	19	125	11	29	96
1 Oct 02–31 Dec 02	11	136	13	42	94
1 Jan 03–30 March 03	10	146	8	50	96
1 April 03–30 June 03	15	161	13	63	98
1 July 03–30 Sept 03	3	164	10	73	91
1 October 03–31 Dec 03	10	174	4	77	97
1 Jan 04–30 March 04	5	179	11	88	91
1 April 04– 0 May 04	18	197	7	95	102
Missing Date	16		23		
<b>Totals</b>	<b>213</b>	<b>213</b>	<b>118</b>	<b>118</b>	<b>95</b>

<sup>1</sup> Please note that while the exact date of entry or exit is unknown for some clients, they have been able to be assigned to a quarter – this explains the discrepancy in the number of missing participants in this Table and Table 1.2

The total Trial caseload capacity has been mapped as illustrated in Table 1.1 to demonstrate actual capacity levels against the resources allocated to primary case management functions. Against the set target of 100–120 clients at any one time in the Trial, it is clear when examining the figures that capacity sits at between 95–100 participants.

### 1.7.3 Duration of Treatment

It is acknowledged within the Trial, the drug and alcohol field and within the literature that achieving change among those who are homeless and drug-dependent requires a lengthy period of supportive treatment. According to De Leon (1996), length of time in rehabilitation programs is the most important predictor of a client’s recovery. In recognition of this, no pre-set time frame of duration was stipulated at the commencement of the Trial; rather, it has been dependent on the client’s needs and the achievement of their stated goals.

At the end of the three-year Trial period, the median duration of treatment was 403 days (mean 436, range 2–1034 days), which is approximately 13 months.

Table 1.2 represents the duration of treatment for the entire 213 participants who entered the Trial up until 30 June 2004 and identifies that a large proportion of Trial participants stayed engaged in the Trial for significant periods of time. Also note that Trial participants were able to enter and exit at any point in time. Given this, participants may have entered the Trial, for example, only six months prior to the cut-off date for this report (as shown in Table 1.1). As such, these figures should be considered an underestimate of the time required by participants in this program.

**Table 1.2: Trial participants’ duration of treatment up until 30 June 2004**

<b>Months</b>	<b>Days (Inclusive)</b>	<b>% of Participants</b>	<b>No. of Participants</b>
Less than 1 month	0–29	3	6
1–3 months	30–89	7	14
3–6 months	90–179	14	28
6–9 months	180–239	7	13
9–12 months	240–364	10	19
12–15 months	365–479	12	24
15–18 months	480–559	5	9
18–21 months	560–649	7	14
21–24 months	650–729	5	9
25–28 months	730–819	7	13
29–32 months	820–909	6	12
33–36 months	910–999	4	7
36–39 months	1000–1089	3	5
	-	0	
Missing date		19	40
<b>Totals</b>	-	<b>100</b>	<b>213</b>

The Trial’s success in retaining homeless clients with histories of problematic drug use and other complex needs is having a direct impact on the Trial’s ability to stabilise lives, reduce problematic substance-use patterns and address other compounding problems experienced by the target group.

### 1.7.3.1 Duration of Treatment (Current vs. Exited Participants)

Of the 118 participants who exited the Trial, we had exact dates of entry and exit for 92 participants, which form the basis of the following analyses.

Examination of duration of treatment between current participants and those that have exited reveals differing lengths-of-stay periods. The median duration of treatment for participants who had exited the Trial was 264.5 days (approx nine months), with a range of 2–954 days and a mean of 308 days (n = 92). For those still in the Trial, the median duration of treatment for participants was 643 days (approx 21 months), with a range of 46–1034 days and a mean of 592 days (approx 19 months).

#### Length of Stay for Planned and Unplanned Exits

Exits from the Trial are classified into two categories (planned or unplanned) according to the participant's reason for exit. An exit was deemed to be planned when a client exited the Trial as a result of achieving a significant number of their treatment goals and/or decided in consultation with their PCM that they no longer required the support of the Trial program. An exit was deemed to be unplanned when a client was exited from the program because workers had lost contact with them or when a client had disengaged from support and were unable to be reengaged.

Of the 118 participants who have exited the program 82 exit summaries were received. The information collected in these exit summaries showed that around half (42 participants) had made planned exits from the Trial and half (40 participants) had made unplanned exits.

Exact dates of entry and exit were available for 37 of the participants making planned exits and 39 of those making unplanned exits. For participants who made a planned exit from the Trial their median duration of treatment was 373 days, just over 12 months (mean 407 days, range 58–954 days, n = 37). The median duration of treatment for those making unplanned exits from the Trial was much shorter at nine months (median 197 days, mean 280 days, range 22–881, n = 39).

Despite these differences in duration of treatment, the median period of treatment for exited clients, both planned and unplanned, is a significant outcome, especially given the disadvantaged circumstances of clients. When we compare this result against an analysis of official Victorian Government drug treatment data (ADIS) for 2000/2001 this result is more noticeable (Kelly, May 2003). In this study, where only 8% of courses of treatment were utilised by homeless clients, the treatment they received was characteristically short. A third was less than seven days and two-thirds were less than 35 days (Kelly, May 2003).

Further, the median duration of treatment for both current and exited participants has increased from the second year report. These results highlight several factors. Firstly, there exists a strong need to offer treatment and support services to homeless drug users; that homeless clients with significant drug and alcohol, health and social problems do want to receive help to access treatment and address their drug dependency; and that homeless clients can remain engaged in treatment when specifically targeted and supported appropriately.

### 1.7.3.2 Duration of Client Involvement in Treatment for Each CSAS

There was a difference in the number of entries and exits at each CSAS as reported in Table 1.3.

**Table 1.3: No of exits and entries for each CSAS**

<b>CSAS</b>	<b>ENTRIES</b>	<b>%</b>	<b>EXITS</b>	<b>%</b>
Flagstaff	87	41	55	47
Hanover Southbank	70	33	40	34
Ozanam House	56	26	23	19
<b>Trial Total</b>	<b>213</b>	<b>-</b>	<b>118</b>	<b>-</b>

Differences also emerged in the overall median duration of treatment between the three CSAS. Flagstaff had a median duration of 317 days (range 0–984, mean = 399, n = 60), Hanover Southbank had a median duration of 331 days (range 5–1004, mean = 479.5, n = 47) and Ozanam had a median duration of 562 days (range 74–1034, mean = 548, n = 44). These differences were statistically significant.

The median length of treatment by CSAS for participants still in the Trial at the time of reporting varied by service. Hanover had a median of 527 days (range 46–1004), Ozanam had a median of 755 days (range 74–1034) and Flagstaff’s median length of stay was 639 days, (range 200–984).

The median duration of treatment for participants exiting the Trial varied by service also. Flagstaff recorded a median length of stay of 187 days (range 0–900), Hanover at 280 days (range 5–954) and Ozanam at 349 days (range 83–776).

A number of service delivery factors appear to have impacted on the duration of treatment at each CSAS and participation levels, and may partly explain differences between CSASs. While there have been many consistencies in the model of primary case management and pathway options between the three CSAS, differences in approach did emerge during the course of the Trial.

- Flagstaff was the first service to commence working with clients at the beginning of the Trial. From the outset they also had a dedicated HDDT drug and alcohol team providing primary case management, which appears to have led to consistency in PCM approach and management of caseload targets. Flagstaff also applied a definite model of participant responsibilities where, prior to Trial entry, participants had to demonstrate a willingness to change and show initial motivation to engage with the Trial. This approach may have possibly resulted in greater participation by a higher number of motivated clients. Further, Flagstaff was also pro-active in creating sustainable exit pathways for clients, through the utilisation of other Flagstaff and Salvation Army support and housing services in addition to dedicated Trial resources. While this broader pathways approach appears to have assisted with their throughput capacity, Flagstaff were also able to retain clients in the Trial for longer periods of time if needed, as evidenced by the data.

- Several factors appear to have influenced Ozanam’s duration of treatment and participation levels. In the early stages of the Trial, participants who moved into THM properties appear to have stayed in this accommodation for lengthy periods of time while awaiting public housing. This resulted in limited movement in the Trial at Ozanam, hindering participation rates and extending duration of treatment periods. Secondly, for the first two years of the Trial, Ozanam’s primary case management staffing model was spread between several teams within the Ozanam community. While this approach had the intended purpose of integrating Trial activities across the whole organisation as well as utilising pathway options available through the Ozanam community, difficulties were experienced in delivering a consistent primary case management approach to some Trial clients, and in facilitating movement in the program. In addition, Ozanam’s process of entry was initially much more complex for clients than through the other two CSAS, which may have also impacted on movement within the Trial. While the above issues were addressed prior to the final year of the Trial, producing a much-improved model of service delivery, rates of participation and lengths of stay reported in this report appear to have been affected by earlier difficulties.
- Participants entering the Trial through Hanover Southbank did not need to demonstrate motivation to engage with the Trial. Rather, the DACMC reports that clients who seemed the hardest to reach were pro-actively engaged by PCMs and once a relationship had been established they entered the Trial, even if they were in a severe state of crisis. This may have affected the number of clients sustained in the Trial for an extended period of time due to client readiness. Secondly, Hanover’s primary case management function was spread across two teams, the Trial team and the general case management team, and both experienced periods of staff turnover which appears to have impacted at times on the service’s ability to maintain its set caseload target.

Despite variations in entry criteria and related service delivery differences, all three services retained clients in the Trial for significant periods of time. This approach has demonstrated the need for a supportive treatment response that engages homeless clients at the CSAS and continues to work with them to secure stability in terms of housing, health, substance use and community participation.

### 1.7.3.3 Duration of Treatment by Participant Sub-groups

Participants’ duration of treatment was also examined by a number of snapshot factors: gender, mental health status at assessment and prior involvement with the criminal justice system. While there was no statistically significant difference in duration of treatment in terms of gender or prior criminal justice involvement by participants, there was a difference for those with a diagnosed mental illness compared to those without.

Participants with a diagnosed mental illness had a longer duration of treatment than those without a diagnosed mental illness. The median length of stay for those with a diagnosed mental illness was 453 days (15 months, mean 472, range 0–1004). The median length of stay for those without a diagnosed mental illness was 306 days (10 months, mean 359, range 2–802). However, a participant’s mental health status, legal history or gender did not impact on the likelihood of exit or the type of exit made (planned/unplanned). These results show that the Trial has been successful in retaining participants with more complex needs and across all higher needs categories.

## 1.7.4 Primary Case Management Contacts with Trial Participants

Primary case managers were asked to record the number of contacts they had with participants in every ITP period (three months). A contact included face-to-face contact or a phone consultation with Trial participants. A contact did not include sending a letter or unsuccessful attempts to contact the participant.

The average number of contacts participants had with PCMs for any given ITP period was 16 (median 13, range 1–103). This equates to about 1.2 contacts with clients per week. In an average ITP period, women (median 15, mean 18, range 1–54) had slightly more contacts with their PCM than did men (median 12, mean 15, range 1–103), and this was probably as a result of the higher number of women in the Trial with a diagnosed mental illness. Those with a diagnosed mental illness at assessment had slightly more contacts with their PCM for any given ITP period (diagnosed mental illness, median 15, mean: 16, range 1–103), compared to those without a diagnosed mental illness (median 13, mean 12, range 2–43).

There were no differences in the amount of contact in an average ITP period for those with a legal history compared to those without. There were also no discernable differences in the number of contacts for those who had exited the Trial compared to those who were still in or for those who had made planned or unplanned exits, demonstrating consistency in approach and support throughout the Trial.

**Table 1.4: Number and range of PCM contacts for ITPs 1–11 (all participants)**

<b>ITP Period</b>	<b>Mean</b>	<b>Median</b>	<b>Range</b>	<b>No. of Participants</b>
ITP 1	17	15	1-53	121
ITP 2	18	14	2-69	93
ITP 3	18	15	1-103	74
ITP 4	15	15	1-40	71
ITP 5	15	12	2-54	63
ITP 6	15	12	1-50	56
ITP 7	12	11	3-25	42
ITP 8	12	12	1-24	30
ITP 9	9	8	2-20	23
ITP 10	14	11	6-47	12
ITP 11	13	10	5-31	7

Table 1.4 shows a slight decrease in the amount of PCM contacts the longer participants stayed in the Trial. This is shown by a decrease in the mean, median and ranges shown in Table 1.4

## 1.7.5 Conclusion

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. While this identifies the importance of using the CSASs 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 target population and work with them on a range of problems.

Findings have also identified that a participant's mental health status; legal history or gender did not impact on the likelihood of exit or type of exit made (planned/unplanned). This further demonstrates the Trial's success at retaining a range of complex-needs clients while also highlighting the consistency in approach and support offered across the three CSASs. Findings did, however identify, not surprisingly, that homeless clients with a mental illness consistently require longer periods of support.

In addition, duration of treatment information for all participants has continued to demonstrate substantial periods of involvement in the Trial. This represents a significant achievement with this target group compared to the much shorter periods of treatment for homeless clients able to access treatment within Victoria in the past. Participation levels have, however, remained at around 95–100 participants across the three CSASs at any one time, suggesting that added resources are required to increase the HDDP's capacity to case-manage a larger number of clients.