

PART 4

STATUS OF PARTICIPANTS ON EXIT AND THREE MONTHS POST-EXIT

4.1 INTRODUCTION

Part 4 of this final report focuses on participants who have exited the Trial and incorporates an analysis of the Trial's exit summary sheet information and the three-month post-exit follow-up study.

The first section in Part 4 details the status of participants' lives at the time of exit from the Trial, drawing on information collected from the exit summaries completed by primary case managers (see Appendix 2). The participants' reason for exit and the status of participants' housing, substance use, mental and physical health, relationships, legal issues, debts, employment, education, and recreation, at the time of exiting the Trial are discussed. This information is also reported according to the type of exit made: either planned or unplanned.

The second section reports the findings of the three-month post-exit follow-up study. Of the 14 participants who had contact details available after exiting the Trial between 1 of October 2003 and 30 of May 2004, nine were able to be contacted and interviewed approximately three months after exiting the Trial. The findings of these interviews are presented along with other information collected throughout the participant's time in the Trial as case studies. Feedback on the participants' experience of being in the Trial is also included.

4.2 PARTICIPANT EXIT INFORMATION

A participant's exit was classified as either planned or unplanned using information from the exit summary sheet and the participant's final ITP. Planned exits occurred after participants had met with their PCM to discuss leaving the Trial, and left after having achieved significant treatment goals. Unplanned exits occurred when participants disengaged from the Trial and were exited due to lack of contact with the agency and their PCM, even after follow-up measures had been undertaken by their PCM.

When clients exited the Trial they were informed that they could re-enter the Trial at any time, either through making contact with their previous PCM or after consultation with another participating CSAS. At the time of analysing data, 10 participants had re-entered the Trial. These cases have been treated as continuous entries.

During the three years of the Trial, a total of 118 exits occurred, excluding participants not consenting to the evaluation and those who later re-entered the Trial. Of the 118 exits, information is available for 102 participants. Of these 102 participants, 88% (n = 102) were male and 12% (n = 102) were female. Seventy percent (n = 63)⁵ of participants who exited had been previously diagnosed with a mental illness, whereas 30% (n = 63) of participants who exited did not have a previous diagnosis. Sixty-six percent (n = 76) of those who exited had a previous legal history while 34% (n = 76) had no previous legal history⁶. These figures are consistent with the distributions of these characteristics reported in the profile section of this report.

⁵ Information on mental health status was only available for 63 of the exited participants.

⁶ Information on legal history was only available for 76 of the exited participants.

4.3 EXIT SUMMARIES

The following discussion only represents the exit status of Trial participants from whom an exit summary was obtained. The exit summary sheets contained information on participants reason for leaving the Trial (used to classify their exits as either planned or unplanned), and information about key areas of their life at exit such as drug and alcohol use, housing status, employment and education. Of the 118 exits, 82 exit summaries were received. Forty of these exits were planned exits and 42 were unplanned.

4.3.1 Reason for Exit

The participants' reason for exit was reduced through themeing and is conveyed in Table 4.1 below.

Table 4.1: Reasons for exiting the Trial, by overall, planned and unplanned exits.

Reason	Overall	Planned	Unplanned
Achieved goals/no longer needed support	22	21	1
Lost contact with client	15	0	15
Client disengaged	11	2	9
Missing	11	6	5
Client relocated	8	6	2
Relapse	5	0	5
Client relocated (family home)	3	3	0
Client relocated (disengaged after eviction)	3	1	2
Legal issues	2	1	1
Physical health issue	1	0	1
Other (not in frame of mind to work on issues)	1	0	1
Total	82	40	42

Consistent with the second-year report, most participants who had made a planned exit reported that they had achieved their goals and/or no longer needed support, whereas participants who had made an unplanned exit had done so due to lack of contact or client disengagement. All of those participants for whom relapse was reported as their reason for exit had done so in an unplanned way.

4.3.2 Exit Summary Information by Domain

The following discussion only represents the exit status of Trial participants where exit information was collected. Consistent with the information already presented in this report, valid percents have been reported.

Housing

Information regarding participants' housing status was available for 64 participants (37 planned and 27 unplanned). Consistent with the second-year report, the majority of participants (80%, n=64) had a positive housing outcome when they exited the Trial, residing in stable

housing at that time.

- Eighteen participants were in public housing (12 planned, six unplanned)
- Twelve participants were in private rental (seven planned, five unplanned)
- Nine participants were in supported accommodation/residential rehabilitation (six planned, three unplanned)
- Five participants were living with friends (four planned, one unplanned)
- Two participants were living with family (planned)
- Five were in 'other' - rehoused through another service, outreach property, or church (three planned, two unplanned).

The participants with generally positive housing outcomes were also more likely to have made planned exits.

The housing outcome for a smaller number of participants (20%, n=64) did not appear to be as positive:

- Four participants were sleeping rough at exit (three unplanned, one planned -exited due to aggression)
- Three participants' housing outcome were unknown but they had recently been evicted from their accommodation (unplanned)
- One participant was in hospital (unplanned)
- Five were in a rooming house (two planned, one unplanned)

All of the negative outcomes were mostly reported by participants who had made unplanned exits. One of the participants who exited in a planned way was sleeping rough and had exited the Trial due to aggression and being unmanageable. This participant later re-entered the Trial.

Substance Use

Information regarding substance use was reported for 65 participants (38 planned and 27 unplanned). From this group of 65, 63% had achieved significant improvements to their previous problematic drug-using behaviours when they exited the Trial. This was a strong outcome, given the level of dependency, poly-drug use and social disadvantage experienced by participants when they entered the Trial. Further:

- 34% were abstaining from all drug use (17 planned exits and five unplanned exits),
- 4% were stable and on substitute pharmacotherapies (all planned)
- 14% reported reduced/controlled or low use of substances at exit (eight planned exits, one unplanned)
- 11% were abstaining from certain drugs, but not all (no difference between planned/unplanned exits)

Of the 24 participants or 37% that continued heavy/chaotic/uncontrolled drug-use or had a relapse at the time of exit, most made unplanned exits (17).

Mental Health

A positive result was also recorded in regards to participants' mental health status at the time of exit. Of the 55 participants where information regarding their mental health status at exit was available, almost half reported mental health on exit to be improved or stable. Further, 12 participants reported no issues at all.

Five participants did, however, report ongoing issues (such as borderline personality disorder) but no further information was made available. Thirteen participants reported that their poor mental health was still having a negative impact on their life, resulting in: overdosing on medication, depression, anxiety and mood swings. The majority of participants who had improved mental health had made planned exits.

Physical Health

As with substance use and mental health, participants' physical health had improved for the majority. Sixty-eighty percent (37) of the fifty-four participants with information about their physical health at the time of exit (33 planned and 21 unplanned) reported improved/good health on exit. These participants had mostly made a planned exit (28). A further five participants reported no issues with their health.

Twelve participants, however, had health problems or poor health on exit, a majority of which were reported by participants who had made unplanned exits (nine participants).

Legal Situation

Information was available for 53 participants, the majority (60% or 32 participants) of which reported no legal issues at exit from the Trial. A further 21 participants had ongoing legal issues at the time of exit including such issues as: a warrant for arrest, incarceration, charges pending, court case pending, correction orders and breached parole. A higher number of participants who had made a planned exit (23) reported no legal issues at exit, whereas a higher number of participants who had made an unplanned exit (13) had ongoing legal issues.

Debts and Finances

Information on debts and finances was available for 45 participants (29 planned, and 16 unplanned). Over half of the participants had no debts (26) and 13 of these were also budgeting/saving/managing well. Most of these participants had made a planned exit. However, many of the participants (19) still had outstanding debts/financial problems at the time of exit.

Employment and Education

Information was available for 57 participants (31 planned, and 26 unplanned) in regards to employment and training exit outcomes. A majority (51%) of these participants experienced a positive outcome in regards to employment and education, given that the overwhelming majority of Trial participants were unemployed at the time of entry to the Trial. Further:

- 19 participants or 33% were employed when they left the Trial (13 fulltime and six part-time/casual)

- 10 participants (17%) were undertaking an education course.

A further six participants were considering educational courses at the time of exit. A majority of those who had a positive outcome made planned exits (26 planned exits, nine unplanned exits). However, 14 participants were still unemployed, most of whom had made unplanned exits (12 participants) and a small proportion of participants were not interested in work (six participants), with no difference in those making planned and unplanned exits. Two participants were receiving the disability support pension; both of these had made an unplanned exit.

Relationships and Social Support

Information regarding relationships and social support was available for 62 participants (37 planned and 25 unplanned exits). Seventy-two percent of these participants (45) were connected with family, children, partner, friends, and services that they viewed as positive. This is a strong result when compared against initial assessment (IRF) information where in almost all categories of family connections the majority of participants had no contact with these members. However, a number of participants were involved in relationships that were viewed as negative and often involved drug users/dealers, being in with the wrong crowd or having 'burnt bridges' (nine participants). A further eight participants had no contact or limited contact with anyone at the time of exit.

A majority of those who made planned exits had a positive outcome (30 participants), however, a slightly higher number of participants who made an unplanned exit were engaged in negative relationships (six unplanned, three planned). An equal number of participants that reported no contact or limited contact with anyone had made planned and unplanned exits.

Recreation and Leisure

Information was only available for 43 participants (26 planned and 17 unplanned) regarding recreation and leisure. Sixty-seven percent (29 participants) of which 24 exits were planned, were involved in some form of recreation or leisure activity, whereas 14 participants showed no interest (mostly unplanned). Of the participants involved in some form of recreation when they exited, most were involved in a structured type of activity (gym, cricket club, volunteer work, church, TAFE, football, theatre group, art, rugby, golf, working on car) but nine participants were involved in informal recreation (spending time with family, children, partner, going out with friends, reconnecting with friends).

4.4 CONCLUSION

The data presented in Part 4 of this report demonstrates that participants are benefiting from the Trial's response. Against each exit domain, whether that is substance use or employment and education, the results are positive, demonstrating the gains and marked improvements in the lives of many Trial participants. When contrasted with the profile of participants at Trial entry, it is clear to see that many participants are now in a position of improved health, greater housing stability, have reduced or are abstinent from problematic substance use, employed and connected to family and friends that they were once estranged from. Many of those who have achieved the above made planned exits from the Trial and benefited greatly from the Trial's response.

While these results are encouraging, there still remain a proportion of participants, many of whom made unplanned exits whose life was unstable at exit. Many of these participants remained engaged in problematic substance use, had ongoing mental and physical health problems, were unemployed, in short-term accommodation and remained disconnected from family and community. In light of this, participating services will need to focus on further developing strategies to engage and sustain this group in order to reduce the number of 'drop outs' or unplanned exits from the program.

4.5 THREE-MONTH POST-EXIT FOLLOW-UP INTERVIEW CASE STUDIES

The post-exit follow-up study investigated the outcomes of participants three months after they had exited the Trial and gathered feedback on their experience of the Trial. The post-exit interview primarily collected information over the same domains as the three-monthly ITP, specifically focusing on: accommodation, substance use, support services accessed, physical health, mental health, independent living skills, meaningful connections, education/employment and income, and significant life events (including legal). The interview also collected general feedback about the participants' experience of the Trial (see Appendix 6). Case studies were written up for all those who were interviewed.

4.5.1 Method

On their entry to the Trial, participants consented to possible contact for an exit follow-up interview. When participants exited the Trial, PCMs asked participants for at least two contact details and these were then passed on to the researcher via the exit summary sheet. An attempt was made to contact all participants who exited the Trial between 1 October 2003 and 30 May 2004, however, this was not always possible. The researcher made contact with participants as closely as possible to their time of exit, explaining the exit interview and arranging an interview time and place to suit the participant in three months with a subsequent reminder call closer to the interview date. The researcher then interviewed the participants as close to three months after exiting the Trial as possible. Participants again signed a consent form at the time of this interview, or in the case of phone interviews gave verbal consent and returned a signed consent form by mail.

A semi-structured questionnaire was administered that took between 45 minutes to an hour to complete (See Appendix 6 for a copy of the interview schedule, consent form and participants' information sheet).

Interviews were conducted between March and August 2004 at a variety of locations. Participants received \$20 on completion of the interview to compensate for any expenses incurred.

4.5.1.1 Limitations

The conclusions that can be drawn from the following case studies are limited by a number of factors:

- Due to resource constraints only those participants exiting the Trial in a one-off eight-month window were followed-up for an interview. As such, while these case studies provide meaningful information on client outcomes and experiences of being in the Trial, they are not necessarily representative of the entire exited population.
- While considerable efforts were made to contact all participants who exited in this time period, all but one of the participants who were followed-up had made planned exits. As such less is known about those making unplanned exits from the Trial.

4.5.1.2 The Sample

Twenty-nine participants exited between 1 October 2003 and 31 May 2004. Contact details were available for 14 of these participants, nine of which were successfully contacted and interviewed (31%, n = 29).

The fifteen participants who could not be contacted, could not be reached for a number of reasons:

- The participant's location was unknown as they had relocated or disengaged leaving no contact details (eleven participants)
- The participant was deceased (one participant)
- One participant was not followed-up over concerns for worker safety upon advice from the DACMC. This was one of the reasons this client was exited from the Trial.
- Two participants did not want to disclose their location or be contacted.

Of the 29 participants who had exited in the eight-month interview period, nineteen had made planned exits and ten had made unplanned exits. Consistent with the proportion of participants over the whole Trial; fifteen participants had exited from Flagstaff, eight participants from Hanover and six participants from Ozanam.

Interviews were conducted with nine participants, eight of whom had made planned exits from the Trial, and one an unplanned exit. The length of stay in the Trial for the participants interviewed varied from as short as three months to two years and five months. Of the nine participants that were interviewed, three were from Flagstaff, two were from Hanover and four were from Ozanam.

4.5.2 The Case Studies

The following nine case studies have been included in order to illustrate the complexity and disadvantaged circumstances of participants and to detail their involvement and progress as a consequence of being involved in the Trial. While the following nine case studies cannot be viewed as entirely representative of all Trial participants due to limitations in sampling, they do represent Trial participants who exited the Trial from 1 October 2003 and were contactable and willing to participate in a three-month follow-up exit survey.

These case studies are presented in chronological order and have drawn on various sources of information, including the participant's IRF (assessment), ITPs, exit summary sheet and exit follow-up survey. In doing so, the case studies describe the participant's background prior to entry, progress during the Trial, their situation at exit, three months after exiting the Trial, and also the participant's personal reflections on the Trial.

Please note that names have been changed to protect the participants' anonymity.

4.5.2.1 Case Study One – Matthew

Matthew entered the Trial in April 2003 and stayed for six months. Upon entering the Trial legal and family issues were of great concern and also the 'biggest influence' in Mathew's desire to change current circumstances. He was anxious about his pending court case and also angry and depressed about his family's resistance to rebuilding their relationship with him. Mathew stated that his 'high anxiety' was contributing to his current substance use and he was now ready to address his problematic drug use. In doing so he wanted to become abstinent from heroin and amphetamines and to reduce his cannabis use by attending residential withdrawal and a residential rehabilitation program. He also hoped to gain 'some stability' and eventually re-enter the workforce as well as resolve his legal issues and rebuild family connections. All of these goals were achieved by the time he exited the Trial.

Mathew's Background

Mathew was 29 years of age when he entered the Trial, unemployed and on the Disability Support Pension. He had been previously diagnosed with depression, was currently taking antidepressants and had a history of self-harming. Mathew had also reported a past history of sexual abuse. His contact with his parents and siblings was intermittent and he felt they offered him no support.

Using heroin 'on paydays,' combined with occasionally using amphetamines, while consistently using cannabis and alcohol daily was Mathew's regular pattern. He often used substances alone and regularly used more than one drug at a time, having last overdosed while using heroin three months prior to entering the Trial. It had been a few years since Mathew had sought assistance for his drug use, attending drug and alcohol counselling in 1999.

Before entering the Trial Mathew had been in crisis accommodation for three months and could not remember the last time he had a 'home'. While having not been imprisoned in the past, Mathew's legal history prior to entering the Trial included charges pending for breach of a community-based order and possession of heroin, as well as six prior convictions for burglary and theft, all drug-related.

What Happened to Matthew while he was in the Trial

In the early stages of being in the Trial Mathew was supported by his primary case manager to address his most basic needs and current state of crisis. Two months after entering the Trial Mathew was then supported by his primary case manager to access residential withdrawal, after which time Mathew entered a residential rehabilitation program attached to the Trial. At the time of exit, Mathew was still accommodated in residential rehabilitation and had been abstinent from all substances for four months. The intensive support he was now gaining from this service was the main reason for his exit from the Trial. At the time of exiting, Mathew had re-established contact with his mother and was in the process of considering accommodation options when he left rehabilitation. Legal issues had also been addressed during his time in the Trial.

Where's Matthew at Now?

When Matthew was interviewed close to five months after leaving the Trial he had continued to remain abstinent from all substances and was due to graduate from the program in two weeks. Matthew spoke of the personal gains and sense of community experienced while in residential rehabilitation. It had also been a safe place for dealing with his problems, including past sexual abuse. However, he was ready to leave and change direction and be free of the rules and guidelines. He planned to stay linked to a peer-support group, which he found valuable for life skills and discussion.

Matthew had stopped taking antidepressants during his stay in residential rehabilitation and stated his depression was 'drug induced' and no longer a problem. He felt physically healthier and had a 'clearer mind'. Matthew stated his legal issues had been resolved and he no longer had to attend court. He said he had been assisted with legal problems by his primary case manager who attended court with him and that the court cases had been adjourned until after rehabilitation and then dismissed.

By the time of the exit follow-up interview, Matthew felt very supported and had frequent contact with both parents and siblings. He reported going fishing with his father and brother, and doing things with his family. Matthew viewed family reunification as one of the most significant outcomes of the Trial for him, along with the resolution of legal issues.

Matthew was enjoying a TAFE course in accounting, stating that it was also useful in preparing him to enter the workforce. He intended on continuing with the course when he moved into supported accommodation in two weeks' time. Matthew was optimistic but feeling vulnerable at this time of transition.

4.5.2.2 Case Study Two – Graham

Graham entered the Trial via an outreach program in October 2002 and stayed for 14 months. He entered the Trial primarily with the goal to abstain from cannabis use, which he found problematic both financially and psychologically and hated being 'controlled by an addiction'. He also wanted to address his current state of homelessness; improve his financial and physical health situations and reconnect with his daughter. Graham's case manager noted Graham's previous diagnosis of ABI was a concern regarding his lack of motivation and insight into his substance use. Graham did not identify ABI as an issue. No change in his substance use was achieved either during the Trial or three months after exiting the Trial, with repeat attempts to engage Graham in treatment rejected. Graham did, however, access public housing while in the Trial and has continued to maintain it. He also became strongly involved in the Trial's Community Reintegration Program (CRP) where he received daily support. Self-management of his finances improved, however little information is available regarding progress in relation to his acquired brain injury.

Graham's Background

Graham was 37 years of age when he entered the Trial, unemployed and receiving the Newstart Allowance. Graham had an extensive homelessness history and had been staying in a rooming house for six weeks before he entered the Trial, and previous to this had been cycling in and out of crisis accommodation, friends' places and caravan parks. He did not feel like he had a home for at least ten years and had submitted an application for public housing just prior to entering the Trial. He had never been in public housing before.

Before entering the Trial, Graham had never previously accessed a drug treatment service. He had a reported history of using cannabis daily for the past fifteen years and had also been drinking alcohol three times a week before he entered the Trial.

Graham had a current debt to Centrelink and a previous legal history. He had continued to maintain contact with his mother and siblings, and also regular contact with friends (both drug-using and non-drug-using), but information about how supported he felt in these relationships was not available. Graham reported no contact with his daughter (16 years of age) or ex-partner, who he had last had contact with ten years ago.

Graham's physical health was a problem. He had previously received head injuries, and following this had been diagnosed with an ABI. Additionally, Graham required immediate attention for dental work, and chronic pain associated with arthritis. He was not on any medication and not linked into a GP. Graham had never been diagnosed with any mental illness, however, at the time of entry into the Trial he felt depressed and bored, occasionally experiencing suicidal ideation and feelings of hopelessness. Graham's primary case manager considered that Graham's inactivity and unemployment was of concern and believed him to have minimal insight into his addiction problems.

What Happened to Graham While he was in the Trial?

Graham continued to use cannabis daily and alcohol three times a week throughout his time in the Trial. Even though Graham continued to attend the Trial's Community Reintegration Program after exiting the Trial, he had decided to leave after 14 months, as he did not think the Trial could help him anymore with his substance use. Further, Graham viewed staff as not taking him seriously as he 'only used cannabis rather than harder drugs like heroin'. From the perspective of Graham's primary case manager, Graham was not prepared to deal with drug-related issues with relevant professionals and had been offered repeated support to access various treatment options since he entered the Trial. Graham stated at the exit follow-up interview that he felt residential withdrawal was not appropriate for him.

Graham did however successfully connect to the Trial's Community Reintegration Program, attending CRP regularly and at times full time. He was attending five days a week when he exited the Trial and was still connected to CRP at the three-month exit follow-up interview, attending at least a couple of times a week. CRP had provided Graham with training and educational opportunities and support to self-manage and reconnect with the community. He was also attending a personal support program (PSP).

Where's Graham at Now?

Graham had been in public housing for fifteen months by the time of the exit follow-up interview, paying his rent through Centrepay and repaying all debts. Graham was still linked into PSP and still receiving Newstart. He had not gained employment or attended any training outside of CRP, but felt supported and positive about his involvement in PSP.

At the exit follow-up interview, Graham stated he was linked to a GP and did go to ARBIAS for further testing while in the Trial, but no further information regarding diagnosis or treatment was forthcoming.

Three months after exiting the Trial, Graham had intermittent contact with his siblings and parents, who he reported feeling somewhat supported by. He still had contact with drug-using friends who he felt not at all supported by and non-drug using friends who he felt somewhat supported by. He stated he would like to see his daughter but was unable to do so because of his poor relationship with his ex-partner. When Graham was asked whom he would speak to if he had a problem, he stated 'nobody' as he found it hard to 'open up'.

Graham had mixed feelings about the Trial, particularly about the primary case management he had received. Graham stated that he had left the Trial as apart from CRP, it was not working for him and he didn't get along with his primary case manager, whom he felt was inexperienced. CRP, however, was highly valued by Graham as he felt like a real person there and was able to talk to people and staff about his problems. He continues to attend CRP several times a week.

4.5.2.3 Case Study Three – Megan

Megan entered the Trial in January 2003 and made an unplanned exit in March 2004 after receiving support for 14 months. She entered the Trial for assistance with her problematic drug use and to receive some help to 'get things together'. She also wanted a consistent worker to help her find housing, support her continuation of education and to find employment. In addition, she also entered the Trial in order to receive ongoing support and assistance to address her poor mental health. Three months after exiting the Trial, despite difficulties staying engaged with Megan throughout her time in the Trial she has continued to maintain stable accommodation (THM) for 18 months. Management of her psychiatric medication and her overall mental health state has also improved. She is also enjoying and continuing with her TAFE course. While Megan had remained abstinent from heroin for some time, she had used a range of substances in the week prior to the exit interview, these being cannabis, benzodiazepines, amphetamines and alcohol.

Megan's Background

Meagan was 20 years old when she entered the Trial, receiving a disability support pension, had a debt to Centrelink and was trying to complete Year 12 at TAFE. She had an extensive mental health history having been diagnosed with schizophrenia, depression and anxiety disorder in the past. Megan had been hospitalised three times in the twelve months prior to Trial entry, twice for drug-related complications and once for mental health reasons. Meagan was on medication to treat her schizophrenia and depression but had not been attending appointments with her psychiatrist and had ceased taking her medications. Meagan reported previous attempts at suicide and self-harm, but was not suicidal or self-harming when she entered the Trial. She had no previous legal history.

Heroin was Meagan's most-used drug at the time of entry to the Trial, however she also used cannabis daily and alcohol occasionally. Meagan had been in various forms of treatment for her drug use, and in all cases she completed the treatment and then began using again.

Both of Meagan's parents are deceased, and she left the interstate family home several years ago due to family problems. When Megan first came to Melbourne she lived with a relative, however shortly after this she became homeless and has moved through multiple forms of temporary accommodation such as crisis accommodation, hospital, residential withdrawal services, residential rehabilitation and transitional housing properties. In the early stages of being in the Trial Megan moved from the crisis accommodation service into transitional housing and was waiting to access public housing.

At the time of entry into the Trial, Meagan had intermittent contact with her brother and her extended family but received most of her support from professionals.

What Happened to Megan while she was in the Trial?

Meagan's primary case manager worked hard to stay engaged with Megan but reported that she had only been able to maintain minimal contact due to Megan's avoidance at times and missed appointments. However, through the assistance of the PCM Megan reconnected with her psychiatrist, resumed taking her prescribed medication and was supported to access transitional housing. While Megan's use of illicit substances fluctuated, there had been attempts at reducing use and also noted reductions in associated drug-taking risks.

The PCM reported that Megan had made an unplanned exit from the Trial due to lack of contact, while Meagan stated that she had left the Trial as she had got the support she needed at the time.

Where's Megan at Now?

At the time of the exit follow-up interview, Meagan had been in transitional housing for eighteen months and was content to stay there until her public housing application was approved. She was still using substances and in the seven days before interview she had used cannabis, alcohol, amphetamines, ecstasy and benzodiazepines. However, Meagan stated that she had been abstinent from heroin for some time, though she had lapsed in the past three months, and believed that being involved in the Trial had helped her stop using heroin. She commented that 'generally my substance use has decreased'.

Meagan remained linked into the same psychiatric service she had been in prior to the Trial (once every two months) and also a housing worker but had minimal contact with both. Meagan was enjoying and continuing with her TAFE course, though she was not sure what she would do after that. After leaving the Trial Megan was frustrated by not being able to contact her brother and had occasionally experienced suicidal thoughts.

Meagan felt that she had gained from being in the Trial. She was happy with her stable accommodation, she had received a computer for study, and was able to talk to someone when needed. In general, she felt she received little assistance with her drug use stating that she 'was already dealing with that prior to the Trial'.

4.5.2.4 Case Study Four - Craig

Craig entered the Trial in July 2002 and exited after being in the Trial for 19.5 months. Craig's stated reasons for entering the Trial were to 'abstain from drug use, access resources and supports the Trial could provide, improve his physical health and because this was his last chance to change'. Craig had achieved all of these goals at the time of the three month follow-up interview. He was in private rental and employed full time. He was abstaining from alcohol and other drugs and felt that his physical health had improved.

Craig's Background

Craig was 38 years old at the time of entry to the Trial, and was unemployed. At that time Craig's most used drug was Alcohol, although in the past he had been dependent on amphetamines and cannabis. Craig had made regular attempts to remain abstinent over the past eight years with no long-term success, and had frequent and severe relapses in substance use. Craig had frequent contact with DTS in the past, and on entry to the Trial he stated; 'I have been in over 40 detoxes and 20 rehabs and I've tried everything, this is my last chance'.

Craig was released from prison five months prior to entering the Trial and was still engaged in counselling with the prison at that time. Craig was in crisis accommodation when he entered the Trial and previous to this he had moved in and out of various forms of temporary accommodation for some time having stayed in hostels, crisis accommodation, A&D Supported Accommodation, friend's places, prison and sleeping rough. He had previously lived in public housing but had no current application for public housing.

Craig's physical health was a significant problem. He had Hepatitis C, poor liver functioning, as well as head injuries, suspected ABI, skeletal injuries and dental needs. At entry, Craig was taking medication for stomach ulcers and Naltrexone. Craig had not been diagnosed with a mental illness before entry to the Trial, but in the early stages of being in the Trial he was diagnosed with depression. He was connected with his mother, who he wanted to develop a better relationship with when he was, 'clean and sober'.

What Happened to Craig while he was in the Trial?

Craig made three attempts at long-term residential rehabilitation and many attempts at residential withdrawal (some successful, and some unsuccessful) during the 19 months he was in the Trial. On the third attempt he completed the residential rehabilitation program staying there six months and remaining abstinent. He attributes the success of this attempt to linking in with supports offered by the Church. During the times he was not in residential rehabilitation Craig stayed in various forms of accommodation such as crisis accommodation, hospital, sleeping rough, friends' places, rooming houses and transitional housing. After 18 months in the Trial Craig's public housing application was approved, but he was offered a place several hours away from his local area where he had built significant support systems. He appealed this offer, and one month later, just prior to exiting the Trial, Craig moved into a private rental property organised by the Church.

During his time in the Trial, Craig had periods of abstinence as well as relapses from both alcohol and amphetamines. On exit from the Trial, Craig had been abstinent from both alcohol and amphetamines for six months. During his time in the Trial, Craig accessed several different forms of D&A counselling at different services and AA at times. Craig stopped taking naltrexone six months into the Trial.

Physical health was an ongoing issue for Craig due to his hepatitis C condition. However, significant improvements in managing and monitoring this condition had led to improvements in his health towards the end of his time in the Trial.

Craig faced many significant life events during his time in the Trial, including ongoing mental health issues, eviction due to drinking, suicidal ideation, self-harm, relationship/family issues and the death of a friend, but despite all this was still able to improve his circumstances in many positive ways.

Craig did link up with CRP, which he attended regularly until he gained employment and no longer had the time. In the post-exit interview, he said he would still keep going to CRP if he was not working, due to the many supports and benefits it offered

On exiting the Trial Craig stated that he was ready to leave as he had achieved what he set out to do: was independent, had a job, a lifestyle without drug use, and was happy.

Where's Craig at Now?

After exiting the Trial, Craig has abstained from all drugs, apart from one lapse where he used amphetamines and alcohol. He received support from the Church at this time and has continued to remain employed and in his private rental property. During the follow-up interview Craig spoke of his many interests, most revolving around the Church. Craig was also gaining support informally from the residential rehabilitation he had been in prior to exiting the Trial. Craig had regular contact with parents and siblings who he felt somewhat supported by, and from non-drug-using friends who were very supportive. Craig stated that he was now financially independent and his physical health had improved significantly as he was no longer using drugs and was eating well.

For Craig, the Trial provided significant links to the Church via residential rehabilitation, which has continued to support him. Craig felt he had received considerable support from his

first primary case worker who he trusted, however his case worker moved on six months into the Trial leaving him to work with other case managers who he felt were never the same. Craig also gained invaluable support from the CRP, which he began when he first came into the Trial and attended when he was not in rehabilitation. Craig stated that he found the support and priority access to services offered by the Trial overall, very helpful in assisting him to make significant changes in his life.

4.5.2.5 Case Study Five - David

David entered the Trial via an outreach program in March 2002 and stayed in the Trial for two years. He entered the Trial to secure housing, give up drinking, link in with a D&A counsellor, monitor depression, deal with grief and loss issues, and look at financial management. David was looking for 'anything that could help'. He also wanted to gain access to his children and work on his relationship with his ex-partner. After being in the Trial for two years David achieved these goals. His mental health had improved, he had gained access to his children, was established in public housing; supporting himself through paid employment and no longer binge-drinking, preferring to have one or two drinks every now and then. As David had moved to a rural area, the interview was conducted by phone.

David's Background

David was 34 years old when he entered the Trial and was living in transitional housing after recently moving from crisis accommodation. Prior to this he had been living with family, friends and in rooming houses for more than 18 months.

David mainly used alcohol and had problems with binge drinking. He also used cannabis occasionally and had previously received D&A counselling which he did not complete. David had a history of non-fatal overdose, specifically with the combining of alcohol and 'pills'. He had been diagnosed with depression and bi polar disorder in 1997 and was on medication to help treat these disorders. However, he often stopped taking his medication, particularly when binge-drinking and would 'spiral out of control' and become depressed. He was in contact with a GP and his medication was under review. David reported having suicidal ideation and had made previous suicide attempts. At the time of entering the Trial, David was unemployed, and often when working in the past had lost the position due to non-attendance and physical violence.

David had a legal history and had been previously imprisoned. When he entered the Trial he also had charges pending for assault, drug trafficking, drink driving, and resisting arrest. David had experienced significant grief and losses in his life, having lost a child and other close family members in a short space of time. David had contact with his mother, but was not close to his siblings. He mixed only with other drug-using friends, had constant disagreements with his-ex partner and wanted to gain increased access to his two remaining children.

What Happened to David while he was in the Trial?

During the first six months David was in the Trial, he experienced many significant life events including non-fatal overdose, suicidal ideation, significant mental health issues, significant family relationship issues and arrest. Apart from the ongoing family relationship issues, the significant life events decreased after the first six months when David's life became more stable.

David moved into public housing from transitional housing one month after entering the Trial, and has sustained this form of housing ever since. One year into the Trial he transferred to a rural area to be closer to his children who had moved there with his ex-partner. After transferring, David continued to maintain contact and receive support from his PCM via the phone.

David was dependent on alcohol and engaged in binge-drinking most days of the week when he entered the Trial. Over the course of being in the Trial his consumption of alcohol slowly reduced and reached a point where he could control and limit his use of alcohol rather than binge-drink. There was a period, however, when David's alcohol use increased when he encountered significant child access problems and his mother had a major illness. Early on in the Trial David accessed and completed a residential withdrawal program and attended D&A counselling and AA regularly but did not maintain a link with these services when he moved.

Prior to David's entry to the Trial and in the first couple of months of the Trial, David's poor mental health was of significant concern and the result of his refusal to take prescribed medication when binge-drinking. After his medication was reviewed and changed and David's drinking became more controlled, his mental health stabilised, though he still had periods of depression. Significant to achieving this outcome was David's relationship with his GP, which has been maintained after successfully linking in with another supportive GP after his move.

David had ongoing significant family relationship issues associated with access to his children and his ex-partner. David's children were a high priority to him and early in the Trial he began attempts to build relationships, sought legal aid assistance to do so, and later transferred public housing properties to be near his children. Late in 2003, David was involved in court cases relating to formalising care arrangements with his children resulting in a relapse and intensive support from his PCM. In early 2004, the situation was resolved with David gaining increased care of his children. David also put effort into rebuilding his relationship with his mother, who by the end of the Trial was staying with David for visits.

David made significant improvements to his physical health while in the Trial, attending the gym after entering the Trial and continuing to do so, even when transferring out of Melbourne.

David participated in volunteer work from late 2003, and on exiting the Trial in March 2004, David was working full-time but employed on a casual basis. Prior to leaving the Trial David also completed 126 hours of community work for a CBO.

David exited the Trial as he had achieved all treatment goals. David said he left the Trial as he had 'been on it for years, and had now started work and was stable'. He felt he had 'settled down, was on the right track', and he had 'access to his children'. When he exited the Trial, David had control over his alcohol use and access to his children once a fortnight and part of

the school holidays. David was still experiencing some depression but was being monitored by his GP. He was in stable accommodation and was managing his finances.

Where is David at Now?

At post-exit, David's situation was similar to when he exited the Trial. However his employment had become more stable and he was now supporting himself on his own wages. David had links with the Church and was now a church volunteer and was also linked with an employment support agency. His physical and mental health continued to improve, and he was continuing to go to the gym regularly but still occasionally got depressed. David felt he had gained control over his use of alcohol. He said he had 'learned there are other ways to handle stress, and while he used to binge-drink, he could now have one or two drinks and stop'. He hadn't re-linked with AA as he felt he didn't need to. He had, however, been arrested and fined between leaving the Trial and the post-exit interview.

David felt his relationship with his ex-partner was now better than it used to be, and he also felt supported by his mother and children. David was avoiding drug-using friends and had gained a dog for company.

David said he had gained a greater awareness of his mental illness and services he could access from being in the Trial. David also received assistance with his public housing transfer, getting his rent and bills paid and generally stabilising his life. He found the regular contact from the primary case manager supportive as they understood the court cases he had to attend and he could talk to someone who knew what he had been through. David suggested that a PCM who could go out to regional areas and see him would be an improvement to the Trial.

4.5.2.6 Case Study Six – Grant

Grant entered the Trial in April 2002 and received support for 22 months. Upon entry he wanted to receive support and assistance to abstain from cannabis and alcohol, and resolve gambling problems, homelessness, unemployment and feelings of isolation. At the time of exiting the Trial Grant had largely achieved these goals. When interviewed three months after leaving the Trial Grant was still in public housing, was engaged to be married, had rebuilt relationships with family and was employed full-time. He had paid back his debt and had his substance use under control, now only drinking socially.

Grant's Background

Grant was 37 years old when he entered the Trial. His primary substance-use problems were with cannabis and alcohol, particularly cannabis which he had been using daily for the past sixteen years. However, he had been abstaining from both substances for most of the previous seven months after having completed a withdrawal program. He socialised with other substance users and stress often contributed to a relapse in use. When he entered the Trial he had significant gambling debts that continued to increase. Upon entry he had no suicidal ideation, but reported being previously diagnosed with both depression and an anxiety disorder.

He was living in crisis accommodation when he entered the Trial and had stayed in a hostel, other crisis accommodation services, with family, and in private rental in the five months previous to this. He had no legal history and was receiving Newstart assistance. He was looking for work and had previously completed a tertiary degree that he wanted to use. He was in contact with siblings and friends who he saw occasionally. Grant had physical health problems including dental and head injuries.

What Happened to Grant While he was in the Trial?

Grant went into transitional supported accommodation two months after entering the Trial where he remained for seven months and then moved into public housing for the remainder of his time in the Trial.

When Grant entered the Trial he had largely been abstaining from the use of cannabis and alcohol, however when he entered transitional housing he relapsed and continued to use heavily for three months. At this time he disconnected with his church and financial counsellor due to guilt. About a year into the Trial he was still using cannabis moderately (one-to-two joints per week) and alcohol occasionally but at the time of exit from the Trial he was abstaining from all drug use.

Grant had an existing relationship with the Church when he came into the Trial. He broke this link during his relapse, but re-established contact after he planned to abstain from all substances again. Grant was reunited with family approximately a year after entering the Trial and at this time began job-hunting, and gained a part-time job. Grant attended the Trial's Community Reintegration Program briefly, but when he moved into public housing the distance was too far to travel.

Grant began financial counselling about six months after entering the Trial in order to assist him to pay his gambling debts, but stopped when he relapsed. There is no information whether he re-linked with the financial counsellor after his relapse. However, on exit it was reported that he had no debts. When Grant exited the Trial he was 'back on his feet' and his substance use was under control. He was employed full-time and was in stable public housing, with no debts.

Where is Grant at Now?

Grant was interviewed by phone three months after leaving the Trial as his work commitments made it difficult to have a face-to-face interview. At this time Grant was still in public housing and was only drinking socially. He remained connected to the church, and attended every day before work. Grant's physical health had improved, which he attributed to a herbal supplement he had been taking. Grant was in a long-term relationship and was engaged to be married, he had friends in the church, and felt he had better communication with his siblings and their families. He felt very supported in all of his relationships and was now working six days a week, 8-6pm.

Grant commented that his time in the Trial had made him aware of what support was available, helped him access services and gave him an avenue to fix many areas of his life at once: 'the pressure was off me and I could focus on cleaning up my act'. He stated that support was available when he relapsed and there was someone to talk to. Grant also valued the financial assistance he received as well as having a solicitor to assist with dealing with his debts.

4.5.2.7 Case Study Seven – Melissa

Melissa entered the Trial in December 2001 and received ongoing support for two years and five months. While in the Trial the main focus of support for Melissa was to stabilise and improve her poor mental health, reduce her current state of crisis, assist with housing, assist in rebuilding her relationships with her family, and to reduce the number of risks attached to her drug use. Melissa achieved these to a degree; she accessed and has continued to maintain public housing. There have been significant improvements in her relationship with her parents. While at the post-exit interview Melissa felt that her problems with drugs had improved as she no longer used whatever she 'could get her hands on' she was still injecting heroin, mainly with her boyfriend on 'paydays'.

Melissa's Background

Melissa was 24 when she entered the Trial, staying in crisis accommodation and displaying chaotic and irrational behaviour due to her poor mental health state. Melissa had been previously diagnosed with schizophrenia and also drug-induced psychosis, having last been assessed 3-4 years ago. She had previous involvement with the Homeless Outreach Psychiatric Service and hospitals. Melissa had been medicated for drug-induced psychosis for the past four years and urgently needed reassessment. According to case notes antipsychotic medication was making her confused, disoriented and disconnected. She was experiencing mood swings and was using amphetamines to maintain a normal state.

The extent of Melissa's drug use on entry to the Trial could not be clearly established due to her poor mental health and erratic behaviour, however she regularly engaged in poly-drug use which included the use of amphetamines, heroin and benzodiazepines or 'whatever was available'. Her primary case manager commented at assessment that her drug use appeared to be one of self-medication in order to cope with her homelessness and mental health problems. Melissa's housing situation had been very unstable for some time and before entering the Trial she had been in a psychiatric ward, rooming houses, crisis accommodation and residential rehabilitation, all of which she had been asked to leave. Melissa had a number of physical health problems including liver disease and weight problems. She needed assistance with hygiene and cooking and wanted to improve her relationship with her parents. She was receiving the Newstart benefit and had no previous legal history.

What Happened to Melissa While she was in the Trial?

Melissa entered the Trial as she wanted ongoing support. At this time she was actively pursued by her PCM as she was in a severe state of crisis and required assistance with 'everything'. Melissa stated she had no plans for the future. Melissa's housing situation in the early stages of the Trial was unstable, however significant improvements were made. Not long after entering the Trial she was evicted from crisis accommodation and moved into a rooming house for a short time and was then admitted to the psychiatric ward at the Alfred Hospital. Prior to her hospital discharge, transitional housing was secured for her and is where she stayed for the next 12 months. Following this Melissa moved into an alcohol and drug supported accommodation (ADSA) program for 10 months. At first Melissa was difficult to engage in the program but

was successfully engaged after a time. Melissa then moved to public housing for the remaining five months she was in the Trial.

Melissa engaged in unpredictable poly-drug use when she entered the Trial, which included the use of heroin and amphetamines. After a short time a pattern of using on paydays (fortnightly) emerged. Naltrexone was considered as a treatment option early in the Trial but could not be used due to risk factors associated with her mental illness. Six months into the Trial Melissa began to use non-prescribed morphine as well. At this time the main goal was to work on relapse prevention for Melissa's fortnightly (pay day) use of heroin. A year into the Trial, Melissa's drug use increased due to availability of heroin and morphine and she experienced a non-fatal overdose. Not long after the overdose Melissa went into a residential withdrawal program but left early and continued to use chaotically. She did, however, remain in the ADSA property but was not engaged in support for a period of time. Melissa's drug use then returned to fortnightly heroin use and attempts to address this pattern of use were unsuccessful, continuing as such when she exited the Trial.

Early in the Trial, Melissa was admitted to a psychiatric ward. After this, attempts were made to engage Melissa with the mobile support team for outreach support and to also link her into a psychiatric clinic, all of which proved difficult. During her first year in the Trial Melissa experienced ongoing mental health issues, suicidal ideation, isolation and depression. These episodes did, however, cease a bit over a year into the Trial, coinciding with the successful change in medication and a reduction in associated side effects. Engagement with mental health services remained an ongoing difficulty with Melissa. A year and eight months into the Trial she was not attending any mental health services apart from a GP to fill her prescription; however she was also not experiencing any significant life events.

An awareness of family dynamics was an ongoing goal for Melissa and her relationship with her parents improved dramatically throughout her time in the Trial. Melissa was also arrested for street prostitution a year into the Trial and goals to cease prostitution were achieved a short time after this occurred.

Melissa stated she had exited the Trial after some time as she had achieved what she had wanted to, stating that she was 'set up, off the streets, not on drugs full-on, and in a settled relationship' with her parents.

At the time of exit she was established in public housing in her desired area, her mental health was stable, she was still using heroin fortnightly but with less risk, she was in a steady relationship with her boyfriend and had resolved many issues with her family. However, Melissa's financial situation was still precarious, as she required regular assistance from relief agencies in order to manage. She also had an outstanding prostitution charge.

Where is Melissa at Now?

Melissa was interviewed three months after leaving the Trial and at this time was still in public housing with her boyfriend, whom she felt very supported by. Melissa continued to inject heroin on paydays but reported not using other substances and felt she was 'no longer addicted to drugs', as she had been 'using every day and anything' she could 'get her hands on in the past', whereas she was now only using fortnightly.

At the time of interview Melissa was no longer supported by a mental health service, as she found them too invasive but did see her GP in order to get her medication. Melissa still had contact with her past Trial Primary case manager, although informal and infrequent. Melissa reports her physical health has improved as she has lost weight through working on eating habits. However, she still did not feel confident with paying bills, budgeting, eating or dieting. At the time of the exit interview Melissa was feeling under pressure due to the legal issues her boyfriend was experiencing.

Melissa's relationship with her parents improved during her time in the Trial; she no longer had to lie to her parents all the time, and felt her relationship with her family was now supportive. Melissa commented that the Trial PCM had also offered much support to her mother who was worried about her at this time. Melissa felt if not for the Trial she wouldn't have accessed stable accommodation. She said she was still using but the Trial had made her think twice about it. Melissa found the case management excellent and liked the support she received.

4.5.2.8 Case Study Eight – Heath

Heath entered the Trial in January 2004 and received support for only three months. Heath's main goals were to access residential rehabilitation in order to abstain from his alcohol use and to receive assistance with housing. He was successful in accessing rehabilitation through the Trial; however, he had two relapses while in this program which required him to leave the premises for a time but he re-entered not long after each relapse. Both depression and post traumatic stress disorder emerged as significant problems for Heath, which he felt he was gaining control of and treatment for at the time of the three-month post-exit interview. Heath was no longer drinking alcohol at this time and was still engaged in counselling at the residential rehabilitation service for depression and substance use. Heath's isolation from his family remained unresolved three months after exiting the Trial and was an ongoing concern for him.

Heath's Background

Heath was 50 years old when he entered the Trial and wanted to abstain from daily alcohol use, which he viewed as problematic. Heath entered the Trial through a crisis accommodation service, prior to which he had been in both a residential withdrawal service and a residential rehabilitation program, both of which he had completed. No further accommodation history was available prior to this, however Heath did state he felt he hadn't had a home for longer than two years.

Heath was unemployed when he entered the Trial and his main source of income was Newstart. He was engaged with a Job Network agency but not with any other services. Heath had prior convictions for non-drug related crimes; however he had never been imprisoned. Depression and anxiety were observable areas of concern for Heath, but on entry to the Trial he had not been previously diagnosed with any mental illness. At the time of entry to the Trial, Heath had no relationships with anyone apart from professionals but wanted to rebuild relationships with his children.

What Happened to Heath while he was in the Trial?

There was little information available about Heath's progress while in the Trial as he exited three months after entry and no ITP was completed and submitted to the researchers. However, in the post-exit interview Heath indicated that he had been diagnosed with depression and PTSD while in the Trial and had received treatment in the form of medication and counselling. He had also received specific counselling for his alcohol use and linked into Alcoholics Anonymous, which he attended during his time at the crisis accommodation service.

Heath exited the Trial as he had entered residential rehabilitation; however, it is not known why his PCM did not continue with ongoing support during this time. Exit information highlights that Heath was still suffering from depression and anxiety but was not using alcohol as he was in residential rehabilitation. Heath had no contact with his family at this time and his main relationships were with support workers. He was, however, gaining an interest and enjoyment in art.

Where is Heath at Now?

Since leaving the Trial Heath has suffered two relapses but reconnected with the residential rehabilitation program after each occasion, once through the support of the CSAS that he stayed in at the time and the second time after the rehabilitation service contacted him. The first time Heath relapsed and left residential rehabilitation was immediately after he exited the Trial and had a change in his medication for depression and the second relapse occurred following a letter from his daughter. He went to a public housing property in a rural area that was being held for him and then returned to residential rehabilitation two weeks prior to the post-exit interview, after being sent a train ticket by the rehabilitation service.

Heath was not drinking at the time he was interviewed. He was receiving counselling in the residential rehabilitation program for depression and substance use. Heath's antidepressants were reviewed in the week before he was interviewed and he said this was helping, although he was still experiencing suicidal ideation. He also said 'he now felt more aware' of his problems.

Heath remained isolated from his family and had tried to contact his ex-spouse regarding his children but received no response to date. Heath had intermittent contact with his sister through letters that gave him some support but overall spoke of feeling entirely isolated and withdrawn, with no one he could talk to.

Heath stated that while he was not in the Trial very long, the case management was good, and the counselling had helped him get off the booze. The Trial had been able to get a public housing property for him quickly due to his age and link him into further treatment.

4.5.2.9 Case Study Nine - Nathan

Nathan entered the Trial in May 2002 and received ongoing support for two years. When Nathan entered the Trial he wanted to address his alcohol dependency, homelessness situation and mental health problems. He also wanted to 'feel normal and to have a life again'. Nathan also entered the Trial for support as he felt isolated, 'overwhelmed' and wanted assistance in exploring community supports. At the time of exiting the Trial most of Nathan's goals had been achieved. He had remained in public housing for two and a half years; his mental health had improved, and he was in control of his drinking. He was also looking at finding some casual work again but still felt socially isolated, commenting that he found it 'difficult to connect with people' and would 'never change'.

Nathan's Background

Nathan was 28 years old when he entered the Trial after being referred by the CSAS chaplain as he was struggling to manage his alcohol use, which was now having a significant impact on his life. At this time he was living in public housing where he had been for the past nine months. In two years prior to accessing this public housing Nathan had been in and out of various forms of temporary accommodation and treatment services from sleeping rough for extended periods of time to crisis accommodation and also residential rehabilitation and transitional housing.

He was dependent on alcohol when he entered the Trial and wanted to abstain from its use. He was also using cannabis occasionally but had been successfully abstaining from using heroin for the past two-and-a-half years. Nathan had been in various forms of drug treatment in the past.

Nathan had been previously diagnosed with depression and anxiety and was also self-harming prior to entering to the Trial. At the time he entered the Trial, Nathan had no suicidal ideation but this was being monitored because of his history of depression. He was not on medication for depression but had previously taken antidepressants. Nathan had occasional contact with his parents who he had recently reconnected with, however did not feel supported by them and was currently considering employment and educational options. He was receiving the Disability Support Pension, and also had a debt to Centrelink. Upon entering the Trial, Nathan's personal hygiene was poor and his overall physical health was a concern.

What Happened to Nathan While he was in the Trial?

Nathan continued to maintain his public housing throughout his time in the Trial, leaving only to attend residential withdrawal three times in the first six months. While Nathan made progress to overcome his alcohol addiction there were ups and downs along the way. After a further six months in the Trial, Nathan relapsed once again following contact with his family, resulting in a two-week binge including heroin, alcohol and cannabis. Following this relapse, Nathan went into residential withdrawal once again, after which time he abstained from alcohol and other substances throughout the remainder of his time in the Trial.

Nathan's primary case manager made continual attempts to link Nathan into counselling to help him manage his anxiety and depression, firstly with his past drug and alcohol counsellor, then with Relationships Australia, then with a private psychologist, all of whom Nathan disengaged from early on or did not attend initial meetings. Finally, a successful link was made two years on with the on-site counsellor at the CSAS, where Nathan had previously been for a 12-week counselling program. Nathan completed the counselling and felt he had 'improved control over his anxiety', and that the counselling had enabled him to get out of his flat and think about going to work.

A major focus of the Trial was to increase Nathan's social support, however attempts were largely unsuccessful. Early in the Trial Nathan was reunited with his family, however the relationships were not maintained. Attempts to link Nathan to the Trial's Community Reintegration Program also failed. Swim passes, a football membership and a mobile phone were also purchased in an attempt to reduce social isolation and get Nathan out of his flat. There were discussions of Nathan getting a dog but this did not occur. Nathan began to attend a CAE course and had a work placement a year into the Trial; however, the course was not completed.

With a permanent place to stay, Nathan's self-care and physical health improved dramatically throughout his time in the Trial. He began to eat well, was cooking for himself, exercising and had improved his personal hygiene.

When Nathan left the Trial his exit summary sheet stated that Nathan had been in public housing for two and a half years, his mental health was good, and he was starting to get out regularly. He was sober, and was looking into finding some casual work.

Where is Nathan at Now?

Three months after exiting the Trial, Nathan expressed that he was feeling depressed and isolated and had not been able to make any connections in the community. He had no contact with family and was not accessing any support services apart from Lifeline, which he called when in a crisis. While Nathan no longer felt he had a problem with alcohol he had self-harmed and also attempted suicide in the three months since leaving the Trial. He was considering reconnecting with the Trial, or possibly with the counsellor he had gone to through the Trial, but was ambivalent about this, stating it was no longer a 'drug and alcohol problem'.

Nathan had begun a writing course by correspondence but was no longer interested and thought he might send it back. He had many ideas of gaining support such as joining a cricket club or volunteering, and also thoughts of getting a dog for company but had not put any of these into action at the time of the interview. He had worked in hospitality since leaving the Trial but ceased, as the environment was not drug-free. He was still receiving a Disability Support Pension.

Nathan stated that the drastic improvement in his personal hygiene and physical health was one of the major benefits he received from being in the Trial. He also considered the Trial, particularly the counselling, helpful in getting him sober. He valued the support given by the counsellor for his depression and anxiety, 'which helped greatly just to get me out of the apartment'. Nathan also valued the support and reliability of the primary case manager he had throughout his time in the Trial: 'when they said they would do something they would do it'.

Nathan recognised how far he had come since he entered the Trial but was struggling and felt he ‘couldn’t connect’ and would ‘never change’.

4.5.3 Conclusion

It is easy when first glancing through these case studies to question the extent of gains made by individuals. However, when you compare all the positive gains made against the extremely disadvantaged personal circumstances experienced by participants prior to entering the Trial, significant improvements have been achieved in each case. These case studies further illustrate the value in directly engaging homeless drug users in the combined provision of housing, social health and treatment support.

Similarities in the needs of these individuals abound as evidenced in the background section of all nine cases. 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, moving in and out of temporary or transitional forms of accommodation prior to being in the Trial; were unemployed; using one or many forms of substances that they believed was problematic; 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. Six participants were in public housing, one participant was in private rental, one participant was in the process of moving into a THM property and one was about to move into supported accommodation when he exited residential rehabilitation. Except for one case study, the remaining eight cases had made significant changes to address their problematic drug use. At the time of the follow-up interview, four participants remained abstinent from all drug use, while the other four reported that they had maintained their 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 one participant was looking for work three months after leaving the Trial. The four participants who remained unemployed were completing treatment (two cases), undertaking a TAFE course (one case) or reported no plans.

Further, all participants recorded improvements to their physical and mental health throughout their time in the Trial, however one participant was notably quite anxious and depressed at the time of interview, having also attempted suicide since he left the Trial. Given the level of family and community disconnection experienced by participants, the level of family reunification achieved is 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 education support was also highly valued. The Trial’s ability to work with participants across a range of issues and to assist in resolving the state of crisis at entry was highlighted by some participants as critically important, as was the Trial’s ability to assist participants to access and also sustain their housing. The Trial’s Community Reintegration Program (CRP) was also singled out by those interviewed as a supportive service that offered them many opportunities and ongoing support. While only one participant listed an area for improvement which was for primary case

managers to go out to regional areas to support clients if needed, two others felt that their primary case manager/the Trial could have assisted them more with their drug and alcohol problems. They did not specify how this could occur.

4.6 CONCLUSION

Profile and Progress of Participants

The findings of this final-year report have continued to document the high level of social, economic and health disadvantages and subsequent needs among this homeless population of drug users. Trial participants have experienced long-term homelessness, extensive problematic substance use, high rates of mental illness, significant family breakdown, social isolation and poor health. Given the high-needs profile of Trial participants, these final-year findings support the objectives and strategies implemented as part of the HDDT. Strategies have focused on pro-actively engaging homeless drug users while they are staying within the CSAS, resolving their current crisis situation, while also commencing the process of providing continuity of care through a supportive primary case manager, with linkages and pathways to flexible and timely drug treatment, housing and community support services.

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. At the end of the Trial's third year, the median duration of treatment was approximately 13 months. While differences in approach exist, the duration of treatment achieved within the Trial is in contrast to the characteristically short participation of previous 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). Such results support the importance of using the CSAS as strategic sites for the engagement of homeless drug users while also highlighting the capabilities of homeless services, with added resources, to effectively engage this target population and work with them on a range of problems.

Not surprisingly, homeless clients with a mental illness consistently required longer periods of support, highlighting the level of vulnerability and need among this group. Further, while concerns existed prior to the Trial's commencement that by allowing a service to work 'long-term' with clients it would lead to very little movement and potential co-dependency between the case manager and the client, neither of these events have actually transpired. While the results of the Trial clearly show that there is a group of clients who require much longer periods of support, most are ready to move on once they have achieved their goals and are supported by their primary case manager to make that transition.

The stability of participants' housing as well as types of accommodation accessed has improved substantially as a consequence of being involved in the Trial. Data from the 'change over time' group, many of whom had higher support needs showed a steady decrease in the number of moves with continued involvement in the Trial. The Trial also had a significant impact on the types of accommodation that participants accessed, with participants overall accessing and sustaining less temporary forms of accommodation when compared to the 12 months prior to Trial entry. However, analysis of differing participant features showed that being a woman (many of whom had a mental illness), having a diagnosed mental illness and having a criminal history made it more difficult for some to find and maintain housing. Finally, the Trial has continued to experience housing pathway blockages due to the limited availability of affordable, long-term and appropriate accommodation.

Consistent with data collected at the initial assessment (IRF), cannabis and alcohol remained the most commonly used drugs by participants. There was a marked decrease in the proportion of participants in the longer-term 'change over time' group using cannabis and reported decreases also in the use of alcohol and amphetamines after two years' involvement in the Trial. While these results are positive given the higher levels of drug use and support needs among this group, there was, however, an increase in heroin use. While this increase appears to coincide with the increase in supply of heroin after a period of significant supply reduction in the street markets, it more importantly demonstrates the difficulties many face in trying to address their heroin dependency. The prevalence of poly-drug use was also high; however, there was a noted 10% decrease in this activity among the 'change over time' group after two years' involvement in the Trial. While progress data, exit data and feedback from primary case managers all support noted improvements in the drug-use patterns, levels of use and safer using practices among Trial participants, it has also highlighted the typically sporadic and opportunistic nature of drug use among a core group of participants.

Most participants experienced significant life events throughout their involvement in the Trial, both positive and negative, highlighting the complexity of clients' lives and the issues PCMs face when working with this client group. Continued involvement with the Trial significantly reduced arrests, evictions, physical health episodes and suicide attempts while also leading to a slight decrease in mental health issues and suicidal ideation among the longer-term and higher needs support group. Analysis of participant sub-groups also showed a number of differences. Participants with a diagnosed mental illness were more likely to experience almost all significant life events than those without a diagnosed 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 eviction compared to men. Further, 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.

Findings indicate that Trial participants require and use a wide range of services, consistent with the complex and disadvantaged histories of participants. There was also a higher demand for almost all services among participants with a mental illness. The most commonly used services, however, were those funded directly through the Trial. The allocation of targeted Trial resources and partnerships with other services, specifically drug and alcohol services, significantly influenced levels of access and degrees of flexibility in approach when 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 participants still experienced difficulties accessing services. These difficulties identify the challenges that exist in establishing flexible and accessible pathways into services for homeless drug users and the need for supported access. Ongoing work and advocacy is required by the HDDP and partner agencies in continuing to develop pathways in partnership with other service providers, which are specifically attuned to engaging and working with disadvantaged homeless drug users.

The emphasis of primary case management work has continued to remain spread across a number of goal domains with a slightly higher focus on improved social functioning goals and reduced substance-use goals. The majority of goals (86%, n = 4897) were achieved to some degree by participants during their time in the Trial, highlighting the Trial's success at establishing individual treatment plans with participants, and working towards achieving change across a range of interconnected issues.

Findings from the exit summary data collected at the time of the participants' exit shows positive results, demonstrating gains and marked improvements in the lives of many Trial participants. When compared with the profile of participants at Trial entry, 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. 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 a continued focus from the Trial on reducing the number of unplanned exits from the program.

Case studies

The nine exited Trial participants interviewed as part of the Trial's short-term three-month follow-up exit survey adds another layer of evidence that continues to support the Trial's approach and impact. All nine participants had very similar complex histories when they entered the Trial. However, three months after leaving the Trial, all nine participants remain in more stable and secure forms of housing. Except for one case study, the remaining cases had made significant changes to address their problematic drug use while four participants had remained in full-time work after leaving the Trial. 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.

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 support through 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.

Conclusion

These findings support the many benefits to implementing a longer-term relationship-based primary case management approach to assist homeless clients with problematic substance-use problems. As previously identified, utilising CSAS as strategic sites of engagement and crisis resolution are the critical first steps to stability and drug reduction in the short term, followed by the provision of a continuing therapeutic relationship with supported access to housing and treatment, with additional opportunities to participate in education, vocational training and community life.

Finally, the Trial's approach has allowed it to stay engaged with a group in the Trial who are severely disadvantaged and marginalised, constantly cycling in and out of crisis, have constant periods of mental instability and risk, are chronic long-term drug users and are socially disconnected. For this group, the Trial has remained engaged with and supportive of them and assisted them to sustain their housing and reduce the many risks associated with their drug use and mental illness while improving their overall stability. However, this group appear to need indefinite support linked to appropriate housing, may never participate in employment or be completely drug-free. Many challenges exist in supporting this severely disadvantaged group but the benefits to the individual, society and the economy in doing so will be significant and

reflect the resolve of both government and community agencies to deliver effective services to the most vulnerable in our community.

4.7 RECOMMENDATIONS

Findings from this final-year evaluation report into the Homeless and Drug Dependency Trial's continuous primary case management and pathways response has identified several areas of recommendation requiring further consideration and action. Given the extensive levels of evaluation and reporting during the Trial period, recommendations and/or future directions identified in other reports are not included in the following section. Please refer to these reports directly, which are listed on page 23.

4.7.1 Ongoing Provision of Support and Pathway Access

1. Significant changes among a large number of participants warrant the continuation of the Homeless and Drug Dependency Program (HDDP).
2. The most effective package of support involves several elements that need to be retained in their entirety if positive outcomes are to continue. These include the resolution of the chaos experienced by participants upon entry to the CSAS; pro-active primary case management that provides continuity of care; timely access to drug treatment services and health services; stable and affordable housing; participation in the Trial's Community Reintegration Program (CRP) and supportive access to educational and training opportunities.

4.7.2 Duration of Support and Treatment

3. Thirteen months appears to be the minimum period of involvement required by most participants to achieve greater stability and their goals. The flexibility, however, to work with clients longer than this period needs to also be retained for individuals requiring extended periods of support. Future targets set by government need to reflect these findings.
4. Findings suggest that there is a much higher needs sub-population (as evidenced among a proportion of the 'change over time' group) that appears to require lengthy, possibly indefinite support in order to maintain stability and to prevent a decline in their physical and mental health. Both the government and the HDDP need to provide capacity to do this without creating significant blockages that limit overall rates of participation. Required resources and how best to deliver this response needs to be examined more fully by the IAWP. Findings do suggest, however, that the CSASs are well placed to deliver ongoing support to this much higher needs group, if adequately supported to do so.

4.7.3 Housing:

5. Timely access to stable, affordable and supportive housing in the short to medium-term has been critical to achieving the results recorded to date. While specific THM properties have been allocated, the limited number of properties available compared to the increased number of participants entering the HDDP after July 2004 will negatively impact on achieving the early housing stability required by participants. The HDDP must therefore work with government and other community agencies to acquire additional THM properties and/or alternative housing options to address this gap.

6. In order to improve long-term housing outcomes, other options aside from public housing need to be investigated by the HDDP and prioritised as a key focus of future work. As Trial participants continue to move on after their involvement in the HDDP, the lack of provision in this area will severely impact on sustaining long-term change among this group and continue to limit movement within the HDDP.
7. Direct access to an after-care facility post-residential withdrawal needs to be established so that participants who were unable to directly access a THM property, residential rehabilitation or ADSA do not return to CSAs, the street or other drug-using environments, often resulting in a return to problematic drug use.
8. Work currently undertaken within the HDDT on an alternative housing model that more fully meets the support needs of the HDDP's more complex clients needs to move forward. This model must ensure that it accommodates, where possible, the range of client needs among this group.

4.7.4 Pathways and Cross-sector Partnerships

9. Participating CSAs have made significant changes in order to effectively assist drug-dependent and mentally ill clients entering their services and attached programs. They must, however, remain focused on supporting and extending existing cross-sector partnerships, particularly with drug treatment services, such as residential rehabilitation services and withdrawal services and, where required, initiate further partnerships with other service systems. Future partnerships need to include the mental health sector, disability services, GPs, dental services and the criminal justice system in order to break down a 'silos' approach to service delivery and to further enhance CSAs and HDDP client outcomes.
10. Homeless drug users are not a homogenous group. They need a range of treatment, health, housing and vocational choices that are accessible, flexible and supportive of individual needs. While Trial-funded services were the most used, many participants required a wide range of services. Participants however continued to face difficulties accessing much-needed services. While improvements have occurred, greater levels of change are needed, particularly in the broader drug treatment and mental health service systems in order to cater more fully to the needs of homeless clients with complex needs. Other service systems need to also consider more fully their response to this target group.
11. While the Trial has made progress in developing cross-sector partnerships and collaborations, the level of real integration between different service systems and changes in approach has been limited. A key learning from the Trial, reinforced at the Cross sector Partnerships Conference organised during the last year of the Trial, has been the high level of resources required to support these activities and the commitment needed by all services to make necessary changes and overcome challenges. Dedicated resources and a direct role by government in facilitating cross-sector partnerships and integration would greatly improve progress in this area.
12. Recommendations arising from the evaluation of the Cross-sector Partnerships Conference organized by the HDDT and held in May 2004 need to be viewed, where applicable in unison with recommendations from this report.

13. Recommendations arising from the evaluation of the Salvation Army's Bridge Residential Withdrawal Unit need to also be considered where applicable with the findings of this report.
14. IRF data identified that there was a high incidence of movement into or back to crisis accommodation or sleeping rough in the 12 months prior to Trial entry after discharge from hospital or prison. While continuity of care provided through the Trial improved this situation, findings have highlighted inadequate discharge and support processes post-prison and hospital release for individuals at risk of homelessness. Further, discharging a patient from hospital into crisis accommodation is often done without sufficient involvement of the CSASs, and while some participants reach the CSAS and find accommodation, others have to sleep rough or are placed in private hotels with HEF funds. A partnership and clear protocols between hospitals, prisons and the CSAS need to be established in order to improve client outcomes and address this gap.

4.7.5 Maintaining a Best-Practice Model

15. Pro-active engagement at the point where homeless drug users are in crisis; provision of continuity of care from that point onwards; a relationship-based approach to primary case management adopting a long term approach if needed; flexible and timely access to a range of drug treatment services; stable and appropriately located affordable housing; educational links and the Trial's Community Reintegration Program represent key elements of the Trial's best-practice model. Diluting this approach will lead to poor outcomes, not meet individual needs and restrict the level of access by a broad range of clients that have historically struggled to receive the treatment and support they need. With the reduction in project management and ongoing review mechanisms to those experienced during the Trial period, the IAWP and participating services will need to implement measures that allow for ongoing monitoring which supports best-practice endeavours.
16. The skills and approach by primary case managers lies at the core of the HDDT's best-practice model. However, client feedback, while largely positive, has identified in this report and other Trial evaluation reports that where primary case managers are not knowledgeable in drug and alcohol practice, lack empathy, are not prepared to pro-actively assist participants in real terms to address a range of problems or support the client to receive that assistance elsewhere, then feedback has been negative. The DACMC in each service must monitor this issue and take responsibility for reviewing practice and educating new staff on the HDDP's model of care and expectations of primary case managers.
17. Monitoring the harms associated with drug use and continuing to educate and support homeless clients to reduce these harms needs to remain a core activity of primary case management work. The high rates of poly-drug use among participants is one noted example of where a targeted health response to this issue is now required.

4.7.6 Building Staff Capacity and Retention

18. One of the Trial's greatest assets has been its staff and their commitment to the target group. An investment in capacity-building endeavours during the Trial has supported staff and greatly assisted in building the necessary skills base required by a wide range of staff. Ongoing workforce development strategies therefore need to be maintained and

extended upon, to not only meet the needs of new primary case managers but to also provide experienced primary case managers with opportunities to extend their knowledge and practice.

19. Future developments need to now include a comprehensive program that addresses mental health training gaps, while ensuring that all primary case managers are knowledgeable and confident in assisting clients with their drug and alcohol problems.
20. The skills set that the primary case manager applies to their work is critical to the program's ability to engage this disadvantaged and complex client group and work with them in an ongoing way to address a range of problems. Retaining experienced and skilled staff is therefore essential to achieving strong program outcomes. While the CSAS responded during the Trial period to consciously retain staff by building in mechanisms that allow for career advancement and greater remuneration linked to experience, resource constraints have limited the capacity at which this can be applied. Greater consideration by the IAWP and individual CSASs in addressing this gap is required.

4.7.7 Higher Need Groups

21. One of the successes of the Trial has been its ability to work with a wide range of participants experiencing homelessness and drug-dependency problems. Its model of service delivery appears universally applicable to homeless clients with various and complex needs entering the homeless service system. Having said this however, those within the Trial who had a mental illness (dual diagnosis), women (the majority of whom had a serious mental illness) and those with a legal history experienced greater difficulties maintaining their accommodation, had higher rates of substance use and were more likely to engage in poly-drug use. In light of these findings, the HDDP needs to consider its current model and determine whether there needs to exist additional strategies, not currently implemented, that are able to further assist these groups.

4.7.8 Unplanned Exits

22. While many of those who made unplanned exits did so after achieving significant goals, choosing instead to move on rather than formalise their exit, others disengaged prior to achieving the stability and support they needed. While a proportion of early exits are to be expected, the IAWP and individual services need to examine the nature and reasons for unplanned exits across the Trial, and implement strategies to address this issue and monitor outcomes.

4.7.9 Advocacy and Dissemination of Trial Research and Evaluation Findings

23. The HDDP needs to disseminate Trial findings more broadly in order to share learnings across government departments and with various sectors that may have contact with homeless clients, in order to support future activities directed at improving service delivery to drug-dependent homeless clients.
24. The IAWP and participating services need to implement a renewed advocacy strategy that considers final-year findings and is targeted at influencing policy direction. In

doing so, it should also work collaboratively with other research institutions and community agencies who have undertaken similar work and research into the needs of homeless clients, so that collective evidence strengthens this objective.

4.7.10 Maintaining an Evidenced-based Approach to Practice and Service Delivery.

25. As documented in the Trial's final-year capacity-building evaluation report (Rayner, August 2004), the HDDP needs to implement an ongoing evaluation framework to support the evidenced-based objectives of the HDDP. The evaluation framework needs to remain robust, manageable within the resources available and not a significant impost on staff.
26. Ongoing evaluation measures need to include a mechanism for client feedback that allows for the identification of gaps and areas for improvement, while also highlighting strengths.

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