NATIONAL PARTNERSHIP AGREEMENT ON HOMELESSNESS

EVALUATION OF WESTERN AUSTRALIAN PROGRAMS

FINAL REPORT

PREPARED BY

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The evaluators gratefully acknowledge the assistance, cooperation and support of the 81 services which make up the 14 programs evaluated, the Department for Child Protection and our Reference Group. We also wish to express our deep gratitude to the 345 clients who shared their stories with us. Many of those stories were very moving and added immensely to our understanding of what the programs meant to those who were homeless or at risk of homelessness.
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SECTION ONE: OVERVIEW

Introduction
Under the National Partnership Agreement on Homelessness (NPAH) the Western Australian and Commonwealth Governments jointly committed $135.1 million over four years (2009-2012) to address homelessness. This report is the culmination of a two year evaluation from January 2011 to December 2012. It provides a background to the NPAH WA programs, an overview of evaluation methodology and issues, findings and key lessons and individual reports on 14 of the programs.

The WA Department for Child Protection (DCP) is the lead agency responsible for the coordination and implementation of the joint Commonwealth/State National Partnership Agreement on Homelessness. There are three key strategies in the Agreement that underpin the NPAH programs:

- Early intervention and prevention to stop people becoming homeless and to lessen the impact of homelessness.
- Breaking the cycle of homelessness by boosting specialist models of supported accommodation to keep people housed in long term stable accommodation.
- Improving and expanding the service system to ensure people experiencing homelessness receive timely responses from mainstream services.

The 14 programs covered by the evaluation are listed in table 1. In total there are 81 services provided by 41 non-government agencies across the 14 programs. In addition there is a Mobile Clinical Outreach Team (MCOT) that is funded by NPAH but staffed directly by the Health Department.

The purpose of the evaluation was to provide an independent assessment of the 14 NPAH programs to inform DCP’s policies, processes and future funding. It will also be used for national reporting and evaluation. The specific objectives of the evaluation were to:

- describe each of the 14 NPAH programs
- assess their implementation, effectiveness and efficiency by using the Evaluation Framework developed by Social Systems and Evaluation
- identify key lessons from the programs including identifying strengths and weaknesses of the programs.

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1 More detail on the funding for NPAH programs can be found in Appendix One. The table at Appendix One shows the Commonwealth and State contributions for services and capital works 2009/10 to 2012/13 and expenditure to 30th June 2012.

2 Department for Child Protection Fact Sheet: Joint Commonwealth/State Homelessness National Partnership Agreement Western Australian Initiatives Information Update.
Table 1: NPAH programs being evaluated

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Accommodation Support Workers (17 services)</td>
<td>Provides intensive support to homeless individuals statewide to secure and maintain stable accommodation and links them to mainstream services. Targets clients exiting specialist accommodation and other support services.</td>
</tr>
<tr>
<td>Street to Home Assertive Outreach (3 services)</td>
<td>Workers develop a relationship with people sleeping rough and support their access to mainstream services and accommodation. The outreach teams are supported by MCOT.</td>
</tr>
<tr>
<td>Street to Home Housing Support Workers (5 services)</td>
<td>Assists people who have been sleeping rough into stable, secure accommodation. It also assists people in crisis accommodation services to move into independent accommodation.</td>
</tr>
<tr>
<td>Rough Sleeper Assertive Outreach – Remote (2 services)</td>
<td>Provides assertive outreach support for rough sleepers in remote areas of Western Australia.</td>
</tr>
<tr>
<td>Support for Young People Leaving Child Protection (1 service)</td>
<td>Provides independent living options and develops living skills to assist young women leaving child protection and ensure that they are not homeless.</td>
</tr>
<tr>
<td>Support for Children in Homeless Accommodation Services (5 services)</td>
<td>Provides support to children and assists them in addressing issues associated with homelessness. Targets children living in or being supported by family accommodation homelessness services, Public Tenancy Support Services or Supported Housing Assistance Program.</td>
</tr>
<tr>
<td>Safe At Home (6 services)</td>
<td>Workers assess safety and support needs of women and children to stay in their own home and provide assistance to stabilise housing and increase security. Referrals come from domestic violence agencies or other accommodation and support agencies.</td>
</tr>
<tr>
<td>Service Type</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Domestic Violence Outreach</td>
<td>Workers in rural and remote locations provide support to women and children experiencing domestic violence. The service operates at the time of issuing a Police Order for the removal of the perpetrator when the Police Officer obtains the victim’s consent to release their details to a support service.</td>
</tr>
<tr>
<td>Keeping Kids Safe Project</td>
<td>Strengthens the responses for children in domestic violence accommodation services to improve integration with mainstream services.</td>
</tr>
<tr>
<td>Private Rental Tenancy Support Services</td>
<td>Work with families or individuals having difficulty maintaining tenancies.</td>
</tr>
<tr>
<td>Public Tenancy Support Services</td>
<td>Supports public housing tenants facing eviction.</td>
</tr>
<tr>
<td>Housing Support Workers – Mental Health</td>
<td>Provides dedicated support for people with severe and persistent mental illness who are homeless or at risk of homelessness and are ready for discharge from a specialist mental health inpatient unit.</td>
</tr>
<tr>
<td>Housing Support Workers – Corrective Services</td>
<td>Assists individuals to maintain their tenancies through maintaining appropriate standards and behaviours. Referrals are made from the discharge units at correctional facilities.</td>
</tr>
<tr>
<td>Housing Support Workers – Drug and Alcohol</td>
<td>Intensive support is provided to clients to secure and maintain stable accommodation. Referrals are from drug and alcohol agencies or from homelessness workers in some non-metropolitan areas.</td>
</tr>
</tbody>
</table>

**PREVENTING HOMELESSNESS**

The Australian Bureau of Statistics (ABS) uses the following definition of homelessness:

*When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:*

- *is in a dwelling that is inadequate; or*
- *has no tenure, or if their initial tenure is short and not extendable; or*
The prevalence of homelessness in Australia rose from 45.2 per 10,000 of the population in the 2006 Census to 48.9 per 10,000 in the 2011 Census. In Western Australia the rise was much less – from 42.3 per 10,000 in the 2006 Census to 42.8 per 10,000 in the 2011 Census.

Australia-wide Aboriginal and Torres Strait Islander people, who make up 2.5% of the Australian population, were substantially over-represented in the homelessness statistics accounting for 25% of all people who were homeless on Census night 2011. Of those classified as homeless, 75% were living in ‘severely’ overcrowded dwellings, 12% in supported accommodation and 6% in improvised dwellings, tents or sleeping out. These figures compare with 30% of non-Aboriginal homeless persons living in ‘severely’ overcrowded dwellings, 20% in supported accommodation and 7% in improvised dwellings, tents or sleeping out.

In Western Australia there were 9,592 persons classified as homeless on Census night 2011 of whom 35% were Aboriginal or Torres Strait Islander.

The ABS notes that the estimate of the number of Aboriginal people homeless on Census night is likely to be an underestimate ‘particularly for those staying temporarily with other households’.


*There is no single cause of homelessness. People at risk of homelessness typically face multiple difficulties. Underlying issues might include domestic and family violence, mental health problems, poverty or drug and alcohol addiction. Often, a single further pressure or event – job loss, eviction, poor health or relationship breakdown – can tip a person who is already vulnerable into homelessness. People without support networks, skills or personal resilience, or who have limited capacity due to their age or disability, can quickly become homeless. Those with the least resources are likely to remain homeless longer. When a person becomes homeless, even briefly, the impact can be long-lasting.*

*There are four main pathways into homelessness:*

- *Housing stress, often driven by poverty and accumulating debt*
- *Family breakdown, particularly driven by domestic violence*
- *Poor life transitions, particularly transitions out of the child protection system, prison or statutory care*

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6 Ibid p.5,6.
Untreated mental health and substance use disorders that lead to the loss of housing, education, employment, family and other relationships\(^7\).

The White Paper starts from the premise that homelessness can be prevented by tackling the structural drivers of homelessness, such as entrenched disadvantage and the shortage of affordable housing, and by targeting for support groups that are at particular risk of homelessness.

The NPAH programs evaluated here provide support to people most vulnerable to homelessness – those with mental health and/or drug and alcohol problems, those exiting statutory care or correctional institutions, rough sleepers, women experiencing domestic violence, children whose families are homeless and those who are at risk of losing their tenancies. The total budget for these programs was $53,876,821 over four years. Expenditure on the programs to 30\(^{th}\) June 2012 was $36,045,107\(^8\).

**Results at a glance**

Both this evaluation and an audit undertaken by the Western Australian Auditor General\(^9\) indicate that the 14 programs have been delivered in accordance with the Implementation Plan.

Between January 2010 to June 2012, 5,094\(^10\) individual clients were assisted, exceeding the 4,978 program target. In addition to the primary clients there were at least 5,611 children assisted bringing the total to 10,705 clients and their children affected by the NPAH programs.

Most programs exceeded their target of clients assisted. Only the Housing Support Workers – Drug and Alcohol program failed to reach its target by a significant amount, mainly due to two services operating for six months only because difficulties with recruiting workers.

The data show that workers have successfully obtained accommodation for homeless clients and supported them to maintain their accommodation. Where there have been mental health, drug and alcohol, financial and other problems clients have been linked to mainstream services.

For clients interviewed the support they received and the fact that they were able to be accommodated was life changing and in a few cases life saving. Some have been able to reunite with their children or re-establish lost connections with family and

\(^8\) Based on figures provided in the Western Australian Auditor General's Report 2012, *Implementation of the National Partnership Agreement on Homelessness in Western Australia*, p. 24.  
\(^9\) Ibid  
\(^10\) Irrespective of how many times a client may have engaged with a service each client only been counted once. The figure of 5094 is 116 less than the sum of primary clients assisted in table 2 because Street to Home Assertive Outreach and Street to Home Accommodation Support Workers have these clients in common. It is possible that in other programs also individuals may have been clients of more than one service but the numbers would have been very small. There is no way to tease this out.
friends. Being accommodated has led to improved health for those whose health was adversely affected by rough sleeping. Some have been supported to return to work or study. Some of those with addictions have been able to maintain sobriety. For many the NPAH programs have meant a restoration of dignity, self-respect, confidence and independence.

Ten programs had targets for clients maintaining their accommodation for 12 months. For all programs except the Rough Sleepers Assertive Outreach Remote (RSAOR) and the Housing Support Workers – Street to Home (HSW-STH), the target was 75% maintain their accommodation for 12 months. For the RSAOR and HSW-STH the target was 50%. Six of the ten programs met or exceeded their targets and four did not. In the case of the four programs that did not meet their targets it may be that had data quality been better it would have been possible to demonstrate that they too had met their targets. For some programs the 12 month follow up target of 75% may have been set too high as follow up after 12 months can be difficult to achieve, especially where clients have exited the program many months earlier. Success of programs such as the Private Rental Tenancy Support Program may be better assessed at case closure.

Twenty-nine percent of NPAH clients identified as Aboriginal. This exceeds the target of 11%. The 11% target was based on the estimated Indigenous homeless rate in the 2006 Census report released in 2009.\textsuperscript{11}

Data provided by the Department of Housing (DoH) indicates that 91% of NPAH supported clients allocated Department of Housing properties had retained their tenancies and were still accommodated after 12 months.

Table 2: Summary of results by program, 1 January 2010 to 30 June 2012

<table>
<thead>
<tr>
<th>Program</th>
<th>Primary Clients assisted</th>
<th>Program target for primary clients</th>
<th>Percentage Aboriginal primary clients</th>
<th>Additional household members assisted aged 0-17 years</th>
<th>Average length of service: months</th>
<th>Percentage of clients accommodated at recent/final contact period</th>
<th>Percentage of primary clients maintaining their accommodation for 12 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless Accommodation Support Workers</td>
<td>848</td>
<td>820</td>
<td>38%</td>
<td>1196</td>
<td>7.5</td>
<td>73%</td>
<td>78% - target met</td>
</tr>
<tr>
<td>Street to Home Assertive Outreach</td>
<td>200</td>
<td>150</td>
<td>27%</td>
<td></td>
<td>6.4</td>
<td>No target</td>
<td></td>
</tr>
<tr>
<td>Street to Home Housing Support Workers</td>
<td>437</td>
<td>485</td>
<td>15%</td>
<td>194</td>
<td>6.7</td>
<td>88%</td>
<td>65% - target met</td>
</tr>
<tr>
<td>Rough Sleeper Assertive Outreach – Remote</td>
<td>117</td>
<td>43</td>
<td>94%</td>
<td>54</td>
<td>6.8</td>
<td>25%</td>
<td>55% - target met</td>
</tr>
<tr>
<td>Support for Young People Leaving Child Protection</td>
<td>47</td>
<td>30</td>
<td>30%</td>
<td>50</td>
<td>6.3</td>
<td>100%</td>
<td>74% - target met</td>
</tr>
<tr>
<td>Support for Children in Homeless Accommodation Services</td>
<td>316</td>
<td>285</td>
<td>19%</td>
<td>NA</td>
<td>10.8</td>
<td>NA</td>
<td>No target</td>
</tr>
<tr>
<td>Safe At Home</td>
<td>569</td>
<td>600</td>
<td>17%</td>
<td>1080</td>
<td>5.3</td>
<td>91%</td>
<td>49% - target not met</td>
</tr>
<tr>
<td>Domestic Violence Outreach</td>
<td>512</td>
<td>500</td>
<td>30%</td>
<td>935</td>
<td>1.4</td>
<td>NA</td>
<td>No target</td>
</tr>
<tr>
<td>DV Child Support Workers</td>
<td>285</td>
<td>120</td>
<td>46%</td>
<td>NA</td>
<td>1.5</td>
<td>NA</td>
<td>No target</td>
</tr>
<tr>
<td>Private Rental Tenancy Support Services</td>
<td>702</td>
<td>637</td>
<td>4%</td>
<td>930</td>
<td>3.3</td>
<td>77%</td>
<td>52% - target not met</td>
</tr>
<tr>
<td>Public Tenancy Support Services</td>
<td>446</td>
<td>470</td>
<td>71%</td>
<td>682</td>
<td>7.4</td>
<td>78%</td>
<td>68% - target not met</td>
</tr>
<tr>
<td>Housing Support Workers – Mental Health</td>
<td>233</td>
<td>212</td>
<td>18%</td>
<td>102</td>
<td>9.4</td>
<td>82%</td>
<td>77% - target met</td>
</tr>
<tr>
<td>Housing Support Workers – Corrective Services</td>
<td>205</td>
<td>196</td>
<td>34%</td>
<td>178</td>
<td>4.0</td>
<td>64%</td>
<td>65% - target not met</td>
</tr>
<tr>
<td>Housing Support Workers – Drug and Alcohol</td>
<td>293</td>
<td>430</td>
<td>17%</td>
<td>210</td>
<td>8.5</td>
<td>76%</td>
<td>75% - target met</td>
</tr>
</tbody>
</table>
Accommodation a major challenge

The effectiveness of the NPAH programs depends in the main upon the services being able to access suitable public and social housing.

In WA in June 2011 51,000 people were on the public housing waiting list. This has doubled since 2004. The average waiting time was 113 weeks. Seventy-six percent of managers and workers responding to the 2012 on-line worker survey considered that waiting times for community or public housing had increased for their clients.

The private rental market is playing an increasing role in the State’s housing system and Government policy on housing actively promotes and supports private rental as a critical plank in providing affordable housing. A growing number of people who qualify for public and social housing are being pushed into the private rental market due to an acute shortage of public and social housing.

This is a major challenge in the current housing environment where where less than 1% of private rentals in WA are affordable for households that rely on Centrelink benefits as their main source of income. According to 94% of NPAH managers and workers responding to the 2012 on-line worker survey private rental accommodation is unaffordable for their clients.

No easy answers

As part of the evaluation NPAH workers participated in a 2012 workshop to look at what could be done to address accommodation shortages in Western Australia. Most of the suggestions involved changes to State or Local Government policies/plans/regulations, for example, easing building restrictions to increase the stock of one and two bedroom apartments and secondary dwellings (granny flats) close to the city and opening up secure night parking, town halls etc. for homeless people sleeping in parks or in their cars. Another suggestion was for one or more developments along the lines of the Elizabeth Street Common Ground (Victoria) or the Community Lands Trust model both of which involve some combination of public funding and private/corporate philanthropy.

Suggestions that could be implemented without policy changes but with some additional funding and possibly some new services included home sharing and head lease arrangements. A separate program to assist people facing homelessness to locate affordable private rental accommodation and to work to address misconceptions and prejudice in the private rental market was another suggestion. At present finding private rental accommodation for clients is undertaken by each NPAH service but it could possibly be more efficient and effective to have a

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12 WACOSS 2011 The Rising Cost of Living in WA, December 2011.

See also WA Legislative Assembly Community Development and Justice Standing Committee 2011, A Fading Dream- Affordable Housing in Western Australia, Report No. 8 in the 38th Parliament, pp. 21
dedicated resource. In the metropolitan area neither potential rental properties nor the larger real estate agents are restricted geographically. The program could also assist those NPAH staff for whom the private rental market is not a primary accommodation source to establish good working relationships with local real estate agencies and property managers.

**Regional and remote Western Australia**

NPAH programs have been implemented and are working effectively in all WA regional areas. Services do however face additional challenges, particularly in the more remote regions of the State.

There are fewer specialist services of all kinds in regional areas and those that exist tend to be located in regional centres. Emergency and transitional accommodation is generally lacking. The lack of referral options means that NPAH services are thrown back more on their own resources and those of the host agency.

In the State’s Northwest the lack of affordable accommodation for staff and clients has been particularly difficult. The Northwest has no suitable private rental accommodation for those on benefits or on low incomes and public housing is limited. Some NPAH services have experienced considerable problems with recruiting and retaining staff due to lack of accommodation and this has caused one service to cease operations. When clients who are housing ready cannot be accommodated it is distressing for staff and counter-productive for the client.

For women from regional areas escaping family violence, the lack of affordable alternative accommodation can mean that they have to relocate to other areas away from support networks. In more remote areas where most housing is subsidised for Government employees or owned by mining companies, separation from a violent partner can also mean loss of the house.

**Key Lessons**

There have been some very important findings that appear to be consistent across service and program areas. There are other findings that are service specific either in respect to the client population served or the geographic location of the services. These are discussed in the individual reports. Below is a summary of across program lessons.

**HOUSING AND SUPPORT CRITICAL ELEMENTS TO ADDRESS HOMELESSNESS**

The major finding of this evaluation is that the availability of affordable accommodation together with appropriate support to address the issues contributing to homelessness can achieve positive results and long term accommodation for even the most vulnerable clients.

The WA NPAH program strategy of assisting clients to access or maintain accommodation providing intensive short term support to stabilise their living situation and linking clients to mainstream services for ongoing support was shown

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15 Anglicare Australia 2012, op. cit.
to be successful.

NPAH HAS BEEN A CATALYST TO REFORM THE HOMELESSNESS RESPONSE IN WA

The development and implementation of the NPAH programs has afforded opportunities to progress the reform of the homelessness sector in Western Australia.

The NPAH has been an important catalyst for improving integration with mainstream services. NPAH services have provided clients with intensive case management, including linking clients and their children with mainstream services such as education, training, employment, mental health and drug and alcohol services.

The implementation of the NPAH has resulted in more effective working relationships between specialist homelessness services and mainstream agencies, for example the Department of Housing and the WA Police. It has also strengthened and streamlined processes for specialist homelessness services to work in a more collaborative manner to support mutual clients.

Seventy-five percent of respondents to the 2012 on-line survey for NPAH workers and managers considered that services for homeless people are better connected with each other as a result of the NPAH program.

NPAH HAS BEEN LIFE CHANGING

NPAH clients often used the words ‘it changed my life’ to describe the difference the NPAH programs had made in their lives. The evidence supports this. The programs have undoubtedly saved some lives where living conditions would have led to premature death or despair driven the client to suicide. In assisting clients to gain and maintain accommodation and supporting them through crises the programs have restored their dignity, self-respect and confidence. Clients have been able to get on with their lives, children have been supported to continue their normal activities and parents and children separated by homelessness, mental illness or drug and alcohol abuse have been re-united.

ASPECTS OF SERVICES THAT ARE MOST VALUED AND BENEFICIAL

There was consistency across all programs about those aspects of NPAH services that clients valued and found most helpful. Apart from obtaining accommodation, time after time clients nominated the support provided to them by their worker as the most helpful aspect of the program. Clients valued:

- a relationship with a single worker who understood their circumstances and who did all that he or she could to assist them
- workers treating them with respect, dignity and without judgment
- services that were not perceived as conditional on meeting a complex set of eligibility criteria or agreeing to a set of conditions
- workers actively advocating and negotiating on their behalf with other agencies, for example, the DoH and Centrelink
- the ability of workers to improve their material circumstances, for
example, by using brokerage funds to purchase whitegoods, furniture and household goods

- services working with them to address issues important to them and not those determined by the worker or the service
- support and assistance that was practical and relevant to their circumstances.

This work was made possible by the quality and commitment of the staff employed by the NPAH programs together with the program focus on intensive case management facilitated by the relatively low worker case loads (5-10 clients at a time per worker).

These findings are consistent with those from a large Australian study into the experiences of people on income support and welfare\textsuperscript{16}.

**LOTTERYWEST – BUILDING CAPACITY**

Lotterywest has supported the NPAH initiative through the provision of grants directly to non-government organisations funded through NPAH to provide new or expanded services. Grants were used to purchase vehicles, office equipment and furniture, minor and major capital works and organisational development. As at February 2013, these grants totalled $5,080,915.

These grants enabled the intensive, practical support that has been instrumental in the success of the program, for example by enabling workers to transport clients to appointments.

Lotterywest also provided three related grants, totalling $8,406,663 which are not part of this particular evaluation to the Salvation Army *The Beacon*, St Bartholomew’s Lime St and The Oxford (Youth) Foyer.

**BROKERAGE FUNDING**

Brokerage funding has been an important factor in NPAH programs’ success. Managers, workers, and clients valued flexible funding that could be used to address client specific needs. Most services used brokerage funding to purchase essential household items and goods to get clients established in accommodation. Family and domestic violence related services used brokerage funds to improve safety and security for women and their children leaving violent relationships.

Brokerage funds were used to assist young people to remain in school or participate in opportunities they otherwise would not have had such as joining a sporting club, having singing or dancing lessons or attending holiday camps. They were also used for therapeutic sessions, life skills or increasing parenting capacity.

A number of services used brokerage funding for TAFE courses or other vocational training to assist clients back into the workforce.

At times brokerage funds were used to assist with rent arrears or other outstanding

debt or to assist with bond money in order that clients could obtain or maintain accommodation.

**HOST AGENCY BENEFITS**

The decision to place NPAH services within NGOs providing related services to a similar client group has brought many benefits.

Workers indicated that often they were able to access in-house services for their clients. As a result clients avoided long waiting lists and client information was already available within the agency so that the client did not have to repeat their ‘story’. The result was a seamless, wrap around service that the clients reported as being easier for them. Often the clients did not seem to be aware that the particular service they were receiving was from a different program but rather felt it was just a component of the positive, comprehensive service.

In terms of the benefits for themselves, workers referred to being less isolated, being part of a team and having easy access to other programs within the host agency. A number of workers expressed the opinion that being part of a larger agency meant that they received on-going supervision and access to professional development that they otherwise might not have access to if their service was a stand-alone entity.

**HOUSING AS A PLATFORM FOR THE PROVISION OF HUMAN AND COMMUNITY SERVICES**

One of the successes of the NPAH was that the provision of housing provided a platform for the delivery of a wide array of social and human services to improve quality of life and outcomes for clients and their families. Housing became a place around which services could be anchored. Additional properties provided through the Nation Building – Economic Stimulus Plan and the National Partnership Agreement on Social Housing increased the supply of social housing dwellings and provided long term stable accommodation for people on low to moderate incomes and for homeless people supported through the NPAH. This has been a critical success factor.

**EXISTENCE OF NEEDED SERVICES AND WAITLIST TIME**

Services such as community mental health services for adults and children, drug and alcohol residential rehabilitation, counselling and therapeutic services for children and financial counselling had long waitlists. In some areas these services did not exist. The provision of intensive interim support from the NPAH programs was crucial in supporting clients in the interim waiting period before accessing these services.

**Recommendations**

Most of the recommendations made below apply to all NPAH programs, a few are service specific. In addition to these recommendations, suggestions for improvement have been made for some NPAH programs. These are included in the individual reports. It is recommended that:

1. Funding for all 14 NPAH programs should be continued.
2. Brokerage funding be continued with amounts periodically reviewed to ensure that they account for rises in costs of goods and services.
3. The commitment by the Department of Housing to allocate a proportion of housing to NPAH clients has been critical to the success of the NPAH programs and should be continued.

4. NPAH Housing Support Worker programs should not be established in areas where there is no realistic expectation of clients being accommodated in public or community housing or in the private rental market.

5. Funding for MCOT should be continued with safeguards to ensure that the fidelity of the model is not compromised.

6. Funding be sought for a program or service that can work to address some of the misconceptions and prejudices in the private rental market as they apply to people who are homeless or at risk of homelessness and assist individuals and services to locate affordable accommodation in that market.

7. The suitability of a housing support model for juvenile offenders should be reviewed and if necessary an alternative model developed to assist them into stable accommodation.
EVALUATION DESIGN AND METHODOLOGY

EVALUATION DESIGN
The evaluation design was based on The Western Australian National Partnership Agreement Implementation Plan Evaluation Framework (2009)\(^\text{17}\).

HIERARCHY OF INTENDED OUTCOMES\(^\text{18}\)
A Hierarchy of Intended Outcomes was developed to guide the evaluation (Appendix Two). The Hierarchy identified the inputs and enablers, outputs and lower level outcomes needed for the achievement of higher level outcomes. Only immediate impacts and intermediate outcomes were expected to be evident during the life of the evaluation. The ultimate outcomes were expected to take three to five years to develop.

In considering inputs and enablers the Hierarchy identified some requirements over which the Department for Child Protection had no control but which heavily influenced the outcomes that could be achieved. An example was conditions in the public and private rental markets.

RESULTS BASED\(^\text{19}\)
The overarching framework for the evaluation was results based (Friedman 2005). A result is defined by Friedman as ‘a population condition of well-being for children, adults, families and communities, stated in plain language’\(^\text{20}\). In essence, for the NPAH the desired population result is the reduction of homelessness in the community.

This approach fits the whole of community and collaborative nature of the response required to address homelessness under the National Partnership Agreement on Homelessness.

An indicator (or benchmark) is ‘a measure that helps quantify the achievement of a result. Indicators answer the question “How would we recognise this result if we fell over it?’”\(^\text{21}\). At a program level this involves considering:

- How much was done, for example, how many participants? Who were they?
- How well was it done, for example, were the participants the target group, did the clients engage? Was it responsive to local needs, etc?


\(^\text{20}\) Ibid, p. 19.

What were the results, for example, did the program meet its stated aims and objectives, what were the outcomes for participants, communities etc?

The evaluation was targeted at indicators rather than the population result per se which is beyond the scope to the evaluation in terms of timeframe and resources.

**MIXED METHODS**

The evaluation used both quantitative and qualitative approaches. Quantitative data were used to demonstrate whether the NPAH programs had engaged and accommodated their clients and whether, once accommodated, clients had been able to maintain their accommodation for at least 12 months, the indicator for most NPAH programs.

Qualitative data collected from clients, workers and key stakeholders through interviews and other means were used to add a nuanced view on what has and has not worked and why, and also to capture how individuals had experienced the interventions.

Triangulation of both methods and data sources was used to increase the validity and reliability of the evaluation findings.

**ETHICS**

The evaluation followed the Australian Government’s National Health and Medical Research Council’s guidelines established by its Australian Health Ethics Committee (AHEC) for research endeavours involving human subjects as well as the Guidelines for the AHEC’s Ethical Research on Indigenous Studies.

Consistent with the guidelines, all participation in the evaluation was strictly voluntary. Based on the principal of informed consent, potential participants were provided with sufficient information and materials to provide them with an adequate understanding of the evaluation process such that they could make an informed choice as to whether or not to agree to participate in the project.

Assurances were provided that no personal identifying data would be collected or used other than that required to make contact and responses would be reported using either de-identified data or in group summary form.

**REFERENCE GROUP**

A reference group was established to support the evaluation. Membership of the reference group was made up of DCP representatives with responsibility for the NPAH programs and homelessness information management, a representative from the Department’s Research and Evaluation section, a representative from the Western Australian Council on Homelessness and the evaluators.

**Methods**

Data gathering occurred between January 2011 and December 2012. The methods used are described below.
DOCUMENT, PROGRESS REPORT AND LITERATURE REVIEW

Available program documentation on each of the 14 programs was accessed and reviewed in order to inform the evaluation.

Each agency provided a Progress Report every six months. Most of the data in the Progress Reports came from the tracking sheets which were used in the quantitative analysis but the reports also included qualitative information about emerging trends and issues and achievements which was reviewed.

Brief literature reviews were undertaken for most of the 14 programs.

AGENCY AND STAKEHOLDER INTERVIEWS AND FOCUS GROUPS

Interviews were held with NPAH service managers and key stakeholders in 2011 with follow-up interviews in 2012. Initial telephone interviews with service managers were used to obtain preliminary information about the services.

All managers and some workers from the 81 services that made up the 14 NPAH programs were interviewed in 2011. Most but not all of these interviews were face-to-face. The interviews were semi-structured and an interview guide was used. All Street to Home managers and some of the other managers were reinterviewed in 2012.

Representatives from the Department of Housing and MCOT were also interviewed. A focus group was held with seven of the 14 the Police Family Violence Coordinators.

CLIENT INTERVIEWS

The original evaluation proposal called for 300 client interviews in 2011 and a further 300 in 2012. This could not be achieved. The client interviews proved very time consuming to arrange for both evaluators and agencies.

The initial approach involved randomly selecting 395 clients using July-December 2010 tracking sheets. However it soon became apparent that by September 2011 when the interviews were scheduled some agencies had lost contact with most/all of these clients. The problem was particularly acute in the domestic and family violence related services and it quickly became obvious that in many cases clients engaged with these services only for a short period.

In light of the difficulty in contacting people in the original sample the decision was made to substitute for those who were uncontactable a randomly selected person from the services’ current caseload. This worked reasonably well for some services but the process remained very time consuming as the worker had to contact the client to check that they were prepared to be interviewed, obtain their informed consent if the interview was over the telephone and provide the interviewer with the client’s contact details. Even when the client was contacted by the worker and agreed to an interview the nature of the client group meant that there were a considerable number of ‘no shows’ or it was impossible to contact the client by phone.

Given the difficulties experienced with first round interviews the requirement for a further 300 interviews in 2012 was reviewed and the decision made to continue first round client interviews in 2012 until 300 interviews were achieved. In the end 345
client interviews were completed. Nine Street to Home clients first interviewed in 2011 were reinterviewed in 2012.

Although fewer client interviews than intended were undertaken, data saturation was reached and no new information was forthcoming from later interviews. Despite all the difficulties, the data from the client interviews has been immensely rich.

It was unfortunate but unavoidable that only those clients whom the agencies could contact were able to be interviewed. It is possible that those with whom the agencies had lost contact may have had different opinions on the program.

MOST SIGNIFICANT CHANGE

The Most Significant Change (MSC) technique is a form of participatory monitoring and evaluation that engages stakeholders in deciding what sorts of change is to be considered significant. MSC has also been called the ‘story approach’. It entails the collection of significant change stories and the selection of the most significant of these stories by panels made up of stakeholders. Because the stories provide information about impact and outcomes, MSC can be used to help assess the performance of a programme, in this case selected NPAH programs.

An MSC question was included in the interview guide for the client interviews. This question was ‘Looking back over the time that you have been involved with [program name] what was the most significant change in your life?’

The evaluators reviewed all interviews completed by March 2012 and selected those stories they considered most significant for presentation at the Specialist Homelessness Services Conference May 2012. Attendees at the session presented by the evaluators were asked to consider the stories and select the most significant for Street to Home, the Private Rental and Public Tenancy Support Services, Safe at Home and Domestic Violence Outreach Services. This exercise usefully identified for the evaluators what changes an informed group considered the most significant. In the case of the Street to Home program the MSC stories selected at the conference have been used as case studies.

PARTNERSHIP ANALYSIS TOOL

The checklist component of the Partnership Analysis Tool (PAT) was used to examine collaboration in the Street to Home (STH) program. PAT was developed by VicHealth as a tool for organisations entering into or working with a partnership to assess, monitor and maximise its ongoing effectiveness.

ON-LINE WORKER SURVEY

On-line worker surveys were developed and distributed 2011 and 2012 using Survey Monkey. The surveys achieved 106 and 117 completed responses in 2011 and 2012 respectively. This response rate is sufficient for a sample error of +/- 5% with a 50:50

22 This outline of MSC draws mainly on the work of Dart, J. & Davies, R. 2005, The ‘Most Significant Change’ MSC, Technique: A Guide to Its Use which can be found at www.mande.co.uk/docs/MSCGuide.html accessed 12/12/2012,

split at the 95% confidence interval.

**CASE STUDIES**

Illustrative case studies were developed for 13 of the 14 programs. These case studies were either based on interviews undertaken for the evaluation or case studies prepared by the agencies. In all cases care has been taken to ensure that the subjects of the case studies are not recognisable. Fictitious names have been used and small details altered to assure anonymity.

**QUANTITATIVE DATA (INCLUDING DATA LIMITATIONS)**

In the absence of a national reporting system for NPAH, DCP developed its own system consisting of written Progress Reports and an excel client based tracking sheet for programs other than STH. The STH programs used the Infoxchange Service Record System, Street to Home (Infoxchange).

Preliminary analysis of tracking sheet data and Infoxchange was undertaken in December 2011. This analysis in conjunction with a similar analysis undertaken by DCP revealed some significant issues with data quality.

A number of agencies initially did not use a unique identifier or provide critical dates, for example, the date on which a client was accommodated and the date active case management ceased in closed cases. These were critical pieces of data needed for the evaluation.

Early in 2012 the Department for Child Protection put considerable effort into improving data quality with reasonable success by working closely with services to improve their data completeness and data quality. The data required further preparation by the evaluators to make it useable.

A major limitation with the tracking sheet and Infoxchange data was that agencies were not able to provide 12 month follow-up data on all clients. It was evident from the data that more clients had been accommodated for 12 months than agencies identified. At the same time there were a few cases where an agency misunderstood the requirement and indicated that a client had been accommodated for 12 months when this was impossible.

Another limitation was that final data provided to the evaluators still contained some missing dates, in particular the date on which clients had been accommodated. This date was essential to calculating whether a client had been accommodated for 12 months or indeed whether they had been accommodated at all. It could not, however, be assumed that because there was no accommodation date, the client had not been accommodated as often there was other evidence that the client had been accommodated.

A conservative approach was taken to calculating whether an agency had met its target percentage of clients to be accommodated for 12 months. Because the evaluators could not be confident that no accommodation date meant the client had not been accommodated or would not at some point in the future be accommodated, it was decided to base the 12 month calculation on those cases where it was evident that the client had been accommodated before 1st July 2011. This included:
• cases where the accommodation date was before 1\textsuperscript{st} July 2011 but the case had closed before 12 months had elapsed and there was no evidence that accommodation had been maintained

• cases where the accommodation date was before 1\textsuperscript{st} July 2011 and the agency indicated the client had or had not been accommodated for 12 months

• cases where there was no accommodation date but the agency indicated the client had or had not been accommodated for 12 months and there was supporting evidence, for example, a start date for the case before 1\textsuperscript{st} July 2011

• cases where there was internal evidence in the data that the client had been accommodated before 1\textsuperscript{st} July 2011 and had continued to be accommodated for 12 months, for example, the case had remained open for 12 months after the client was accommodated and there was no evidence of the accommodation ceasing.

While it is probable that a small number of cases closed without the client being accommodated in some way it is expected that these would have been more than balanced by the number of cases with an accommodation date before 1\textsuperscript{st} July 2011 where the client had been accommodated for 12 months but this could not be proved.

**Specialist Homelessness Services Collection**

The national Specialist Homelessness Services Collection (SHSC) commenced on 1 July 2011. Since then, Western Australian NPAH services have been participating in the SHSC by submitting their homelessness data to the Australian Institute of Health and Welfare (AIHW). At the time of the writing of the report the 2011-12 SHSC service level data was not available.

**Department of Housing and Mobile Clinical Outreach Team Data**

DoH provided data from its systems on NPAH Occupations (tenancies) between 1\textsuperscript{st} May 2010 and 30 June, NPAH Occupations between 1\textsuperscript{st} May 2010 and 30\textsuperscript{th} June 2012 and NPAH Vacations (tenancies vacated) between 1\textsuperscript{st} May 2010 and 30\textsuperscript{th} June 2012. These data covered adult and juvenile corrections (HSW-CS), Drug and Alcohol (HSW-D&A), Homelessness Specialist Homelessness Services (HASW) and Street to Home. The Mobile Clinical Outreach Team provided data on referrals and outcomes from 2010 – 2012.

**Interim report**

An interim report was presented to DCP in January 2011. The report drew on material collected in 2011. The focus of the interim report was on process rather than outcome. The report was not made public but group feedback on its content was provided to all programs except Rough Sleeper Assertive Outreach Remote and Keeping Kids Safe.
SECTION TWO: INDIVIDUAL PROGRAM REPORTS
PRIVATE RENTAL TENANCY SUPPORT SERVICE

The private rental market plays an increasing part in the overall functioning of the State’s housing system and Government policy on housing actively promotes and supports private rental as a critical plank in providing affordable housing. However, as more and more West Australians become reliant on the private rental market, conditions in the private rental market have become a key driver of homelessness among private rental tenants.

The combination of a severe shortage of affordable housing, increased demand for rental housing, the severe shortage of rental properties and greater competition for properties has pushed up rental prices exponentially. In fact rents have risen at twice the rate of inflation.

Rental costs in Perth are at historical highs. In some regional centres rents far outstrip those in the metropolitan area. The high cost and acute shortage of private rental properties for people on benefits or the minimum wage puts pressure on public housing and can drive up the level of homelessness in the community.

Private renters are the group of people most in housing stress. Housing stress among those in the private rental market in WA has grown massively in recent years. In 2006 62% of low and moderate income households were in housing stress in the private rental market. Given the exponential increase in rents since 2006 this figure is likely to be significantly higher.

Recent work by Anglicare showed how unaffordable the private rental market is for people on low incomes. Less than 1% (0.5% in fact) of private rentals across WA were affordable and appropriate for low income households who rely on Centrelink benefits as their main source of income. In Perth less than 4% of rentals are affordable for people earning less than $35,000 per annum.

Recent research shows that across the Perth metropolitan area between 30-40% of all private renters are experiencing housing stress. (This includes all private renters

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24 Parliament of Western Australia, Community Development and Justice Standing Committee 2011, A Fading Dream- Affordable Housing in Western Australia, Report No 8 in the 38th Parliament, Perth WA.


27 In a commonly used measure of housing stress families and singles are regarded as being in housing stress if their estimated housing costs exceeded 30 per cent of their disposable income and they were in the bottom 40 per cent of the equivalent income distribution, for example Harding A. et al 2004, Trends in Housing Stress. http://www.parliament.wa.gov.au/intranet/libpages.nsf/WebFiles/ITS+-+Housing+article+Harding/FILE/Housing+article+Harding.pdf


29 Parliament of Western Australia, Community Development and Justice Standing Committee 2011, A Fading Dream- Affordable Housing in Western Australia, Report No 8 in the 38th Parliament, Perth WA.

30 Australians for Affordable Housing (2011) and Trenwith 2011, op. cit.
and it is likely that the percentages will be much higher among those on low to moderate income in the private rental market.) In 20 of the 28 Perth metropolitan Local Government Authorities over 30% of private renters are in housing stress. It is likely this figure will have increased in 2012.

Private rents are also well ahead of government benefits and rental assistance, leaving more and more households in housing stress, particularly those in precarious and part time employment and those reliant on income support.

The White Paper on homelessness noted that there are fewer programs targeting private rental tenancies to prevent eviction leading to homelessness than there are for social housing tenants. Under NPAH, State and Territory governments have been encouraged to prevent evictions in all types of tenancies, including private rental, through tenancy support models.

Tenants in the private rental market who are at risk of homelessness are to be supported with tailored assistance, including financial assistance such as bond, rental and removal payments and non-financial assistance including guidance, support and referrals to appropriate support services.

The Private Rental Tenancy Support Service (PRTSS) is designed to assist eligible individuals or families experiencing difficulties maintaining a tenancy in the private rental market to stabilise and maintain long term accommodation.

The PRTSS aims to prevent eviction from private tenancy and possible homelessness and achieve long term, secure and stable housing in the private rental market.

The PRTSS is available to eligible families and individuals currently in a private rental tenancy who are at risk of eviction and homelessness, due to debt or other tenancy management issues. Participation in the program is voluntary.

Clients are referred to the PRTSS services by real estate agents and property managers and Government and non-Government agencies in the specified catchment area. Self-referral by clients is also accepted.

Target groups include men, women, families and individuals, young people aged 16-25 and people from culturally and linguistically diverse (CALD) backgrounds. The program target is for a minimum of 11% Indigenous clients.

The service agreement requires that funded services aim to achieve a 75% success rate with clients maintaining their tenancies for 12 months from the date support commenced.

Funding provided through the NPAH allowed the expansion of the existing National Affordable Housing Agreement (NAHA) program by 8.5 FTE as follows:

- expand existing CALD service by 1.5 FTE (total 3 FTE)
- expand one existing service by 2 FTE to cover the South West Metropolitan area (total 3 FTE)

• establish three new services as follows:
  o North West Metropolitan Area – 3 FTE
  o Albany – 1 FTE
  o Bunbury – 1 FTE.

This has provided a service system coverage of the whole metropolitan area (four services plus CALD) and country locations of Busselton/Margaret River, Peel, Geraldton, Bunbury and Albany.

Services funded under the PRTSS are:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Service Location</th>
<th>Provider</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West</td>
<td>Joondalup/Osborne Park</td>
<td>Australian Red Cross</td>
<td>3 FTE</td>
</tr>
<tr>
<td>Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>South West</td>
<td>Hilton - Kwinana-Rockingham</td>
<td>Anglicare</td>
<td>2 FTE</td>
</tr>
<tr>
<td>Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALD Metropolitan</td>
<td>Mirrabooka</td>
<td>Multicultural Services Centre WA</td>
<td>1.5 FTE</td>
</tr>
<tr>
<td>South West Region</td>
<td>Bunbury</td>
<td>Accord West (formerly Agencies for South West Accommodation)</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Great Southern Region</td>
<td>Albany</td>
<td>Anglicare</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

Evaluation data sources

Evaluation data sources included:

• tracking sheets and Progress Reports provided to DCP by each agency
• interviews, focus groups and workshops with managers and workers from all funded agencies in 2011 and 2012
• twelve responses to the on-line survey (five in 2011 and seven in 2012)
• interviews with 24 clients
• informal discussion with managers and staff
• review of relevant literature and documents.

Key features

The service delivery model is underpinned by a number of principles which guide how services operate:

• person centred: services respect and respond to the unique needs and circumstances of each person and tailor the service response to those
• intensity: workers are able to vary the intensity, length and regularity of
support they provide over time

- flexible and Individualised: services are structured around the needs of each person (client) or family and tailored to the individual’s needs
- timely: the service response is timely, depending on the nature of the crisis and the severity of the risk to the person’s tenancy. Services aim to intervene at the earliest opportunity so that the issues that put a tenancy at risk, be they unpaid rent, debt or other tenancy management issues can be dealt with to prevent eviction.
- mobile: workers visit tenants in their own home
- solution focused: services try to find and broker solutions to address the crisis and the factors that place a tenancy at risk
- client capacity and control: services aim to respect and strengthen the client’s capacity to resolve the issues that place their tenancy at risk.

The service delivery model consists of a number of elements working in combination:

- each client’s needs are assessed and a housing plan is developed
- early intervention aims to prevent eviction through case management plans to address issues that put the tenancy at risk
- brokerage funds are used to address issues that put the tenancy at risk
- advocacy is undertaken on behalf of the client with key agencies such as property managers, landlords, Centrelink, financial institutions and Government and community organizations
- positive relationships are built with property managers and landlords
- referral and assistance is provided to enable clients and other family members to access specialist services and support
- the tenant’s capacity to resolve tenancy issues and participate in social, community and economic life is supported and strengthened.

How much has the program done?
The target for the program is 30 clients a year per FTE assisted. This is based on a case load of ten clients per FTE at a time for an average of four months. Over 2.5 years this equates to 637 clients assisted. This target was exceeded with 702 clients (627 client 1s and 75 client 2s)\(^{32}\) assisted between January 2010 and June 2012.

\(^{32}\)Client 2s are other adults – usually partners of client 1 – living in the house with whom the worker has engaged. Client 2s do not have their own unique identifier in the data but are recorded on the same unit record as client 1. Only limited data are collected about client 2s.
Table 1: All clients (client 1 and client 2) worked with in a period by number of agencies operating

<table>
<thead>
<tr>
<th>Period</th>
<th>New clients</th>
<th>Ongoing clients</th>
<th>All clients in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>44</td>
<td>0</td>
<td>44</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>103</td>
<td>33</td>
<td>16</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>162</td>
<td>65</td>
<td>227</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>125</td>
<td>70</td>
<td>195</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>278</td>
<td>44</td>
<td>322</td>
</tr>
<tr>
<td>Total individuals</td>
<td>702</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For all agencies, except Multicultural Services Centre WA for whom the agreement commenced on 1st December 2009, the service agreement commenced on 1st January 2010.

THE CLIENTS

The majority of client 1s were female (73%). The situation was reversed for client 2s with 55% being male. The average age of client 1s was 36 years (range 18 – 70 years). As figure 1 shows the percentage of Aboriginal clients\(^ {33}\) was low (4%) but there was a high percentage of CALD clients.

Figure 1: Cultural background of the client group

One hundred and fourteen client 1s (18%) identified themselves as having a mental health disability, including six who identified a dual diagnosis of mental health and drug and alcohol problems, 7% identified themselves as having a physical disability and 1% as having a problem with alcohol.

\(^ {33}\) Includes both client 1s and client 2s
Non-government agencies were the largest referral group (41%) followed by self (20%), government departments (19%), real estate agents (15%) and other (6%). In addition to the 627 client 1s and 75 client 2s there were 930 children involved ranging in age from 0 – 17 years. Household composition is shown in Table 2.

**Table 2: Household composition**

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>25</td>
<td>4%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>122</td>
<td>19%</td>
</tr>
<tr>
<td>Extended family</td>
<td>10</td>
<td>2%</td>
</tr>
<tr>
<td>Single female</td>
<td>80</td>
<td>13%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>268</td>
<td>43%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Single male</td>
<td>80</td>
<td>13%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>23</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>15</td>
<td>2%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>627</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

Twenty-two percent of client 1s were in the workforce, 29% were unemployed and looking for work, 2% were students and 47% were not in the labour force. The main source of income for client 1s when they started the program was other government payment.

**Figure 2: Income source**

Clients, managers and workers interviewed all report that that the private rental market is unaffordable and not a viable housing option for more and more people, including people on income support, people with low income and or those in insecure employment. One manager put it this way: ‘We are only scratching the surface of the crisis in the private rental market’. Clients on income support
described situations where property managers and landlords failed to renew their lease, claiming that they (the client) would be unable to afford the increased rental.

Many clients of the PRTSS are individuals and families with a stable history in the private rental market who face the threat of losing their tenancy as a result of financial hardship and rent arrears.

Financial hardship, financial instability and insecurity resulting in rent arrears are the main reasons why people’s tenancies are at risk. This may be caused by a combination of factors – lack of income to address unaffordable rent increases, the combined effect of rising debt, rising costs of utilities and the rising costs of living, or an unforeseen set of crises. For many people a small rent increase or increase in utility bills and living costs, or a crisis such as the loss of a job or health, can place a tenancy at risk, even when that tenancy had previously been sustainable. The gap between income and housing costs has grown dramatically over the last decade and is even more pronounced for Aboriginal and CALD households.

Many clients had been coping until a combination of events placed their tenancy at risk. This might include a drop in income due to insecure employment or loss of employment, health crisis, unsustainable rent increases, or the loss of a tenancy due to the sale of the property or the owners returning to the property. The combination of these unanticipated events and rising debt, rising costs of living and rising utility prices, including electricity prices which have increased 60% over the last 3 years, and rental increases impair people’s ability to pay their rent, placing the tenancy at severe risk. Clients’ stories demonstrate this.

As one Manager said:

*It is the rent increases, increasing costs of utilities and living costs that put people at risk of homelessness.*

Clients reported problems juggling rental payments with utility bills despite the availability of the Hardship Utilities Grant Scheme (HUGS), credit cards, other credit sources and telephone bills as significant issues. These bills are ongoing and rise constantly so even when a short term crisis that places the tenancy at risk is able to be resolved, tenants reported that they still faced rising bills, in addition to rising rents. Clients stated:

*Gas is what is killing us.*

*Phone companies charging me for three lots... I wanted a basic internet and phone... they lock you into contracts and I am still paying for it.*

*When I pay the rent I get behind on the gas... I am scrambling again with Telstra and gas.*

One consequence is that clients are increasingly seeking assistance not just with rental arrears, but also with utilities and daily living expenses.

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34 See case studies
35 Shelter WA & Housing Crises Committee for CaLD families 2012, *Housing Affordability for CaLD and Aboriginal Families: Research Briefing.*
36 Electricity prices are set to rise a further 40% over the next 2 years. See Shelter WA 2012, Pre-Budget Submission, October 2012, pp 2.
Rising rents are a major problem in all sites. Managers and workers reported that significant increases in rent (up to 30% in some sites) and increased demand for private rental properties continue to place serious upward pressure on private rents. Twenty-four percent of PRTSS clients are households of a CALD background. This trend is consistent with research carried out by the Housing Crisis Committee for CALD families and Shelter WA which shows that the crisis in the private rental market and the shortage of affordable housing is creating a homelessness crisis for CALD and Aboriginal households37.

In a tight rental market where there is a severe shortage of affordable private rental and a shortage of public and social housing people of CALD background face multiple barriers including language barriers, racism, negative attitudes of property managers and landlords38.

Staff and managers reported that the profile of PRTSS clients has shifted with more clients in work. In 2012 some agencies reported that more than half their clients are in paid work. Agencies reported that clients in employment feel shame and embarrassment about their circumstances.

One worker spoke about the vulnerability of workers whose income fluctuates due to their insecure work circumstances:

>This is such a shift. Not a good thing. People may have two incomes and other pressures and find themselves overcommitted in their rental. It was affordable but their circumstances changed.

This trend is consistent with recent Australian research by Sharon Parkinson which found that people in casual and non-permanent employment and self-employed households are most likely to struggle in the private rental market due to fluctuations in income39 40.

One client with two young children was forced to leave her private rental tenancy after the owners sold the house and gave her just two weeks’ notice. The client and her children stayed with family and friends and lived in her car while searching for another private rental. She was unable to find another private tenancy in the area appropriate to her children’s needs, so she returned to the small country town where she had previously lived. However, there were no private rental properties available in the town and she now lives with her two children in a community housing unit managed by the local Shire. Although not a private tenancy, this is a positive long-term housing outcome for this client.

Another client living in private rental with her four children was forced to vacate her

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38 ibid.


property because the property manager did not renew the lease, claiming that the client could not afford the increased rent. After seeking help from a number of agencies the client was referred to the PRTSS who supported and assisted her to find another private rental property.

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**ENGAGEMENT**

492 cases (78%) were closed by the end of June 2012. These cases were open an average of 100 days or just over three months (median 94 days, range 4 – 595 days). Two thirds of clients had left the program at four months and only 13% remained with the program six months or more.

**ACCOMMODATION**

As figure 3 shows the program has been reasonably successful in assisting clients to maintain their tenancy or to acquire a new tenancy, with a total of 77% of clients accommodated in existing or new tenancies on exiting the service.

**Figure 3: Tenancy outcome for recent/final contact period**

![Pie chart showing tenancy outcomes:]

- Tenancy Maintained: 64%
- New Tenancy Acquired: 13%
- Evicted: 8%
- Other: 8%
- Unknown: 7%

**PROGRAM HELPFUL**

Clients were immensely grateful for and appreciative of the support and assistance provided by the PRTSS services, which in many cases they believe saved them and their family from becoming homeless. For many clients the fact that the PRTSS service was able to assist them to resolve serious financial and other crises was of profound significance.

*The simplicity of falling down the hole is very quick and it is very hard to get out.*

*We were on the verge of eviction. We would have been on the street, my disabled*  

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41 Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.
partner and son.
They were brilliant. A life saver for us.
They have just been so helpful with so many things.

For clients one of the most helpful parts of the program was the financial assistance provided either through the brokerage funds or the other strategies used by PRTSS services to access funds to assist clients. This enabled them to pay rent arrears and other accumulated debts and bills.

One of the valued aspects of the PRTSS service was that workers are able to deal directly with and negotiate with the landlord about tenancy matters. This was greatly appreciated by clients.

The best thing was that they dealt with the landlord. I was getting all these nasty text messages from the owner and was on medication through stress. It reduced my stress from them dealing with the landlord.

[Worker’s name] assisted me to sort out issues with the Property Manager. Don’t owe as much in rental arrears now. They saved our neck. If it wasn’t for [agency] we would have been on the street.

Many clients greatly appreciated the solidarity that the PRTSS workers showed their family and the way they were always there to assist and support the client and his/her family through very difficult and trying times. Clients interviewed spoke about the value and importance of their relationship with the worker and the qualities and attributes of the PRTSS workers:

When I needed support she was there.
She stood by me. Never left me.
She was there for us. Back and forth she was there.
She was not a charity worker. She came into our life as a friend... She never says no. She has given me a lot of support. She makes that extra effort for us...

With what results?
This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

ACCOMMODATION MAINTAINED FOR 12 MONTHS
Information provided by agencies indicated that 135\(^{42}\) client 1s had maintained accommodation for at least 12 months. In addition to these clients, 332 other household members (for example, partners/children) living with the clients were reported to be accommodated. Three client 1s were reported not to have maintained their accommodation.

\(^{42}\) All of these clients are recorded as accommodated before 1st July 2011.
It is reasonable to assume based on the data that a further four clients accommodated before 1st July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 123 clients also recorded as accommodated before 1st July 2011 although some would undoubtedly have maintained accommodation for 12 months.

Thus of a potential pool of 265 eligible clients at least 52% (139 clients) were stably accommodated for at least 12 months. However on the available data the PRTSS could not be demonstrated to have met its target of 75% of clients stably accommodated for 12 months.

**Figure 4: Flowchart**

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**HOUSING RELATED BENEFIT**

Evidence from the Evaluation shows that the PRTSS program is assisting families and clients in the private rental market to deal with immediate and short term crises in their lives (such as rent arrears, eviction notices, inability to pay rent, accumulated debt) that cause them to be at serious risk of eviction and ultimately to be homeless. This is an important achievement.

Evidence from client interviews and case studies shows that the PRTSS services have achieved significant benefits for clients, including housing (and non-housing related) impacts. The PRTSS services have:

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43 These clients had maintained accommodation for at least 12 months while on the program.
44 Clients recorded as accommodated before 1st July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before 1st July 2011.
• reduced vulnerability to and risk of homelessness for some clients, as well as preventing homelessness for other clients

• successfully assisted clients who were facing eviction to retain their private rental tenancy

• enhanced client’s sense of autonomy and agency and their capacity to address issues that place their tenancy at risk

• bought stability and security to the lives of clients, as well as to their families and children.

**Benefits for Children**

Clients appreciated that the PRTSS workers are able to provide support and assistance to children. The parents with children were particularly concerned about the impact of their housing circumstances on their children. One client was deeply concerned about the psychological effect of her housing instability on her four children and was full of praise for all the PRTSS worker had done to assist and support her children in areas such as accessing childcare and counselling.

*She has given a lot of support to my children, to our family. She has assisted me with the children... She has the magic for our family... the children have grown with me.*

One client spoke about the willingness of the worker to accommodate parenting responsibilities.

* I like the way they work around my kids.*

Another client spoke with great feeling about the way the PRTSS worker had treated her and her children with dignity and respect. Speaking about the PRTSS worker the client said the worker was always respectful and supportive of her children and had assisted her children to access counselling.

*... Without [worker] we would be nowhere. I take my hat off to her... she went the extra miles... A thousand miles for my family... she was always there for us.*

**Short Term Benefits May Not Reduce Long Term Vulnerability**

All the clients interviewed valued and appreciated the support and assistance they received and acknowledged that the PRTSS was able to assist them to resolve short term crises, such as threats of eviction and rental arrears.

Clients reported that while their tenancy might be more secure in the short term as a result of contact with the PRTSS that does not mean they feel any more secure about their longer term accommodation circumstances in the private rental market.

This long term vulnerability is due to structural conditions in the private rental market which make the tenure unaffordable and unsustainable for an increasing proportion of the population on fixed and low to medium income or households in insecure work. These structural factors are compounded by many clients’ social and economic circumstances and the financial hardship they face.

This dilemma – that short term benefits do not necessarily reduce long term vulnerability – is recognised by clients and PRTSS workers.

Three clients used the term ‘band aid solution’ to describe the program. This was not
a criticism of the PRTSS services but simply an acknowledgement of the program’s limitations in addressing the larger structural factors which increase people’s vulnerability in the private rental market and which are a major cause of the problems people face in the private rental market.

They come out and see how we are going and make sure we are surviving. They do their best. But it is a band aid solution... The [agency] and all the others they try their best and they help out as best they can but at the end of the day the bills keep coming.

Thus, despite the benefits of the program, a proportion of clients interviewed were still pessimistic about their housing future.

It is important to stress this was a common but not a universal view. Three clients said that their future prospects in the private rental market are better now than before. In two cases this was because the family’s income had increased or become more secure, as a result of one person finding a new job or obtaining more secure income.

While some clients feel insecure in the private rental market in the longer term, this does not detract from the success and achievements of the PRTSS. It is important to restate that 52% of eligible clients were stably accommodated for 12 months, and it is probable that despite conditions in the private rental market making it difficult for clients to sustain tenancies this percentage would have been higher had more follow up been possible.

The case study below is one example of a family who see their long term prospects in the private rental market as being more positive, partly as a result of their contact with the PRTSS program.

**CASE STUDY 1**

Tom & Wendy are a young couple in their mid-20’s with four young children living in private rental property.

After Wendy was diagnosed with a serious medical condition Tom had to give up work to care for the children. Without the income they fell behind with rent and bills and received a number of termination and eviction notices. They sought assistance from a local financial counselling service that referred them to the PRTSS service.

The PRTSS service visited weekly and was able to:

- round up funds to pay rent arrears
- assist Tom to get his license
- assist in sorting out problems over moneys already paid to the landlord
- provide food hampers
- provide ongoing support and assistance

Tom said the service had been there to help them through the family’s crisis at a time of great stress and family problems. Tom particularly valued that the PRTSS was able to inform them about all the options available to the family.

Tom was full of praise for the PRTSS service.

Brilliant what they have done... they are brilliant people, life savers.
Tom said the family situation is more stable now as their income has increased and he is running his own business.

**LINKING TO SERVICES**

Many clients were linked to services while on the program. Table 3 provides a breakdown of the linkages made to various services.

**Table 3: Links to services while on the program**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Counselling</td>
<td>60%</td>
</tr>
<tr>
<td>Centrelink</td>
<td>56%</td>
</tr>
<tr>
<td>Other services</td>
<td>51%</td>
</tr>
<tr>
<td>Health Service</td>
<td>30%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>30%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>27%</td>
</tr>
<tr>
<td>Education Services</td>
<td>26%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>19%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>15%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>9%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>5%</td>
</tr>
</tbody>
</table>

In addition to the links made for clients, children were linked to school/childcare and to recreation in 22% and 19% of cases respectively.

From clients’ perspectives the knowledge that PRTSS workers have of services and resources that clients can access is a great strength of the program. One client said:

*They knew about all the other options that can help. We had no idea.*

**EMPLOYMENT AND TRAINING**

The data showed no change in the proportion of primary clients in employment, studying or looking for work between their first and final/most recent period in the program.

However, the qualitative data (client interviews and interviews with managers and staff) provides a different perspective on these issues and shows that many clients are actively engaged in employment and training and work and broader community and social activities:

- a number of clients choose to return to study, particularly TAFE and online courses.
- the majority of clients interviewed reported that they are already actively involved in social, community and economic activities. This might involve voluntary work, caring for a partner with a disability or health problems, caring for young children or an older partner or family member,
involvement in a local school or sporting club or making attempts to
develop new skills and capacities.

- an increasing proportion of the clients of the PRTSS are in fact working
  (see earlier discussion).

**CASE STUDY 2**

Mary was living in private rental with her four children. Since the children’s father returned
to his country of origin Mary has raised the children on her own solely on income support.

Mary was informed by the property manager/landlord that the rent would increase by $50
per week and told that because she was on Centrelink benefit she would be unable to afford
the higher rent. She was forced to vacate the property.

Mary, who has no family or relatives in WA, had nowhere to go and did not know what to do.
She had little money to afford a new house. Mary was deeply concerned. Mary sought help
from an NGO she found in the phone book. Initially they were unhelpful as they had strict
criteria she had to meet. Eventually they referred her to the PRTSS.

Mary was full of praise for the PRTSS worker who came out to see her promptly, assisted
Mary with an application for a new property, secured funds to pay moving costs such as
packaging and removalists and provided emotional and psychological support to her and her
children.

With the worker’s ongoing support and assistance Mary was able to obtain another private
rental property.

Mary said:

*If not for her I would not be in this strong a position. I am a confident woman now. She
  never rejected me. She never gave up.*

**Key Lessons**

Some of the key lessons in respect to the PRTSS apply specifically to the program,
whilst others apply to other program areas as well.

**Brokerage funds**

The brokerage funds are universally viewed as a highly successful mechanism to
support clients and promote change in the client’s circumstances. Managers and
staff interviewed stressed the enormous benefits of the brokerage funds in their
own right.

Clients did not refer specifically to brokerage funds but they reported that the funds
that were available to address rent arrears and or pay bills or other debts were
among the most significant aspects of the program.

**Positive relationships between clients and workers**

The client interviews pointed to the quality of the inter-personal relationship
between the client and the worker as a critical factor in achieving outcomes.

A distinctive feature of the client interviews was the extent to which clients placed a
high value on a supportive and trusting relationship between them and the PRTSS
worker as a factor contributing to the improvements in their circumstances. Clients
emphasised how important it is that the worker actively cares about them and their situation and that they feel accepted and not judged by the workers. Clients also valued persistent engagement and support and reliance. They appreciated that they could contact the PRTSS worker when they needed help, knowing that help does not depend on them meeting certain criteria or conditions.

**Advocacy with Property Managers and Landlords on Behalf of the Client**

Clients reported that one of the most helpful aspects of the PRTSS services is that they are willing to deal directly with and negotiate with the landlord about tenancy matters. This is greatly appreciated by clients.

**The Need for Action to Address Structural Issues**

The PRTSS is designed to provide support to people in the private rental market who are at risk of homelessness. Although there was considerable frustration expressed by interviewees at the failure of Governments to address the structural issues in the private rental market that place people at risk of homelessness this is beyond the scope of the PRTSS.

There is however a growing need to support and assist who are at risk of homelessness to find more affordable housing options in the private rental market. This is currently not within the scope of the PRTSS which is designed to assist people already in the private rental market.

At present finding affordable private rentals is done by most NPAH programs. There is an argument that devoting dedicated resources to this task would be more efficient and effective. Such resources could be located within the PRTSS or preferably in a new program.

**Summary and Conclusions**

As more and more West Australians become reliant on a private rental market which is acknowledged as the crisis point in the housing system, the PRTSS has proved to be a vital and essential program in the campaign to reduce and prevent homelessness.

Despite the structural problems causing rental market unaffordability, the PRTSS has proved to be successful for clients accepted into program. The program has assisted at least 52% (139) of clients plus 332 other household members to be stably accommodated for at least 12 months.

Had services been able to follow up more clients it is probable that this percentage would have been higher, despite conditions in the private rental market making it difficult for clients to sustain tenancies.

The Program has assisted families and clients in private rental to deal with immediate and short term crises in their lives that cause them to be at serious risk of eviction and ultimately to be homeless. This is an important achievement.

The evidence shows that the PRTSS has been successful in delivering housing and non-housing benefit for clients who are accepted into the program. It has:

- reduced vulnerability to and risk of homelessness for clients, as well as
Prevented homelessness for other clients

- successfully assisted clients who were facing eviction to retain their private rental tenancy
- enhanced clients’ sense of autonomy and agency and their capacity to address issues that place their tenancy at risk
- brought stability and security to the lives of clients, as well as to their families and children

The changes that have occurred in the private rental market over the last two years could not have been foreseen at the commencement of the program, and the PRTSS services have had to cope with the fallout from a worsening private rental crisis. The demand on PRTSS services is increasing.

A limitation of the PRTSS in its current form is its restricted capacity to impact on structural features in the private rental market that place more people at risk of homelessness. The PRTSS was designed at a time when the crisis in the private rental market was less obvious and improvements will be needed to strengthen the program’s capacity to reduce and prevent homelessness in the private rental market.

**Suggestions for Improvement**

Two types of improvements are suggested. The first type involves refinements to strengthen the PRTSS in its existing form. This includes:

- increasing the amount of brokerage funds available to services because the significant increase in private rents has meant that clients owe more in unpaid rent arrears
- ensuring that clients can re-engage with PRTSS services more than once, if and when their private rental tenancy becomes at risk again.
- resourcing PRTSS services to undertake increased advocacy on behalf of the client.

The second type of improvement would require a different program to assist people trying to locate affordable rental housing in the private rental market. This has been included as a recommendation in the overview section of the report.
The Government’s White Paper on homelessness recognises that:

**Social housing and boarding houses currently offer a ‘last resort’ housing service and as a result, people who are evicted from these tenures are very likely to become homeless and cycle through the human service and justice systems. Each year several thousand tenants leave social housing and seek crisis accommodation. This is disruptive and traumatic for tenants and their children and inefficient for government.**

It notes that some states have implemented successful support programs for those in social housing to prevent evictions which lead to homelessness and states:

**These programs identify people who are in the early stages of rental arrears or about whom complaints have been made in regard to antisocial behaviour. At-risk tenants are contacted face to face by a specialist worker, who can help to develop a plan of action and refer tenants to other services, such as financial counsellors, mental health services, education and parenting programs.**

The decline in the size and funding of the public housing sector over the last two decades and the effect of welfare targeting has meant that the composition of tenants in public housing has changed considerably. Public housing has become residualised and now mainly houses the most marginalised and disadvantaged tenants who are reliant on income support and social welfare services.

This has significant implications for a program like the Public Tenancy Support Service which is designed to provide intensive support to tenants in public housing.

### Description

The Public Tenancy Support Service (PTSS) supports public housing tenants facing difficulties maintaining their tenancy or whose tenancy with the DoH is at risk.

The PTSS provides intensive support to new and existing DoH tenants who may have previously experienced homelessness or who face challenges in sustaining and maintaining their tenancy. The PTSS aims to prevent DoH tenants from reaching the point of eviction and possible homelessness.

DoH may also refer an individual or family prior to them becoming a DoH tenant where the individual or family is considered at risk of homelessness due to previous

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46 Parliament of Western Australia, Community Development and Justice Standing Committee 2011, *A Fading Dream- Affordable Housing in Western Australia*, Report No 8 in the 38th Parliament, Legislative Assembly, Perth Western Australia, November 2011, pp 3

47 Parliament of Western Australia, Community Development and Justice Standing Committee 2011, *A Fading Dream- Affordable Housing in Western Australia*, Report No 8 in the 38th Parliament, Legislative Assembly, Perth Western Australia, November 2011.

circumstances or previous history with DoH.
Referrals come primarily from DoH, however other Government agencies and non-
government services may refer to the PTSS.
Participation in the program is voluntary, however it can be made a condition of a
DoH tenancy where there has been a breach of a prior tenancy agreement such as
debts, poor property standards or anti-social behaviour.
The PTSS can also assist clients in DoH housing who are not eligible for mental health
or disability support programs.

Services funded under the PTSS are:

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Service Location</th>
<th>Provider</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>North West Metropolitan</td>
<td>Joondalup</td>
<td>Mission Australia</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South West Metropolitan</td>
<td>Kwinana-Rockingham</td>
<td>Anglicare</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South East Metropolitan</td>
<td>Armadale, Gosnells &amp; Cannington</td>
<td>Centrecare</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Pilbara</td>
<td>Newman</td>
<td>Pilbara Community Legal Centre</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Pilbara</td>
<td>Roebourne</td>
<td>Pilbara Community Legal Centre</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>South West Region</td>
<td>Collie</td>
<td>Anglicare</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>Meekatharra</td>
<td>Meekatharra</td>
<td>Mission Australia</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Carnarvon</td>
<td>Carnarvon</td>
<td>Carnarvon Family Support Service Inc</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Kununurra</td>
<td>Kununurra</td>
<td>Kimberley Community Legal Services Inc</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Wheatbelt</td>
<td>Northam</td>
<td>Avon Youth Community and Family Services</td>
<td>2 FTE</td>
</tr>
</tbody>
</table>

**KEY FEATURES**
The support and assistance provided by funded services has a number of features:
- structuring services around the needs of each person or family (person centred services)
- providing intensive support and assistance with daily tasks and living skills
- early intervention to prevent eviction through case management plans to
  address issues that place the tenancy at risk
- varying the intensity of services and support over time
- visiting clients in their own homes
- using brokerage funds to address issues that put the tenancy at risk
• liaison and advocacy with DoH
• linkages and referral to other services and agencies so that clients can access specialist assistance and support
• building the tenant’s capacity to resolve tenancy issues and participate in social, community and economic life.

Evaluation data sources
Evaluation data sources included:
• tracking sheets and Progress Reports provided to DCP by each agency
• interviews, focus groups and workshops with managers and workers from all funded agencies in 2011 and 2012
• 25 responses to the on-line survey (11 in 2011 and 14 in 2012)
• 25 client interviews
• informal discussion with managers and staff
• review of relevant literature and documents.

How much has the program done?
The target for the program is 20 people a year per FTE assisted. This based on a caseload of 10 clients per FTE at a time for an average of six months. Over 2.5 years this equates to 470 people assisted. This target was not met with 446 clients (343 client 1s and 103 client 2s\(^{49}\)) assisted between January 2010 and June 2012. Table 1 shows the number of new and ongoing clients worked with by agencies in each six month period.

Table 1: All clients (client 1 and client 2) worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New clients</th>
<th>Ongoing clients</th>
<th>All clients in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>148</td>
<td>8</td>
<td>156</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>83</td>
<td>95</td>
<td>178</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>74</td>
<td>100</td>
<td>174</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>135</td>
<td>156</td>
<td>291</td>
</tr>
<tr>
<td>Total individuals</td>
<td>446</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For five agencies the service agreement commenced on 1\(^{st}\) January 2010, for two agencies it commenced on 1\(^{st}\) April 2010, for another two on 1\(^{st}\) of July 2010 and for one on 1\(^{st}\) October 2010.

\(^{49}\) Client 2s are other adults – usually partners of client 1s– living in the house with whom the worker engaged.
THE CLIENTS

The majority of client 1s were female (80%). The situation was reversed with client 2s with 72% being male. The average age of client 1s was 40 years (range 18 – 79 years). As figure 1 shows, the percentage of Aboriginal clients in the PTSS is particularly high while the percentage of CALD clients is low\(^{50}\).

**Figure 1: Cultural background of the client group**

Thirty-seven client 1s (11%) identified themselves as having a mental health disability, including six who identified a dual diagnosis of mental health and drug and alcohol problems, 20% identified themselves as having a medical, physical, sensory or intellectual disability and 6% as having a problem with alcohol. Seventy-five percent of referrals to the program were made by DoH with self (14%) being the next biggest referral resource, NGOs and other government departments each made a small number of referrals.

In addition to the 343 client 1s and 103 client 2s there were 682 children involved ranging in age from 0 – 17 years, bringing to 1,128, the number of people assisted by the program. Household composition is shown in Table 2.

**Table 2: Household composition**

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>24</td>
<td>7%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>73</td>
<td>21%</td>
</tr>
<tr>
<td>Extended family</td>
<td>23</td>
<td>7%</td>
</tr>
<tr>
<td>Single female</td>
<td>39</td>
<td>11%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>134</td>
<td>39%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Single male</td>
<td>28</td>
<td>8%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>7</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>343</td>
<td>100%</td>
</tr>
</tbody>
</table>

\(^{50}\) Includes both client 1s and 2s.
The main source of income for all client 1s when they started the program was other government payment. Twelve percent were in the workforce full or part-time, 15% were unemployed and looking for work, 1% were students and 72% were not in the labour force.

**Figure 2: Income source**

![Income Sources Pie Chart]

Clients generally have multiple and complex needs. This can include some of the following:

- mental health issues and co-occurring mental disorders and substance abuse issues
- unresolved debts from previous tenancies, for example, debts to DoH, utility bills
- poor relationships and communication with DoH
- inability to manage the property and home and a lack of independent living skills, for example, budgeting
- low income, financial insecurity and severe financial difficulties
- health related problems
- concerns to do with children such as child safety issues, school issues, poor parenting
- family conflict and family breakdown
- social isolation and limited knowledge of community services and community supports
- unemployment
- lack of awareness of their rights and entitlements.

The complexity and challenging nature of some client’s needs, particularly the severity of mental health problems and co-occurring mental disorders and substance

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51 Services report that the first five issues listed were generally the most critical client needs.
abuse issues, are difficult issues for PTSS services trying to resolve housing problems. This can include client behaviours that are challenging for staff to deal with. Workers require considerable time to build a relationship of trust with the client.

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**Engagement**

187 cases (55%) were closed by the end of June 2012. These cases were open an average of 224 days or seven and a half months (median 189 days, range 0 – 1078 days). Half of the clients still remained in the program at the six months mark, 30% at nine months and 15% for a year or more.

**Accommodation**

As figure 3 shows the program has been successful in assisting clients to maintain their tenancy with 78% clients maintaining their tenancy on exiting the service.

**Figure 3: Tenancy outcome for recent/final contact period**

![Tenancy outcome for recent/final contact period](image)

**Program helpful**

A common theme in client interviews was that the PTSS workers have been able to assist the client to address underlying problems and issues that required attention. A number of the clients interviewed appreciated that PTSS workers pushed them to address issues. One client said:

...*she has spent time with me and taken time to assist me. She is pretty firm and got me to get off my butt for my children... At first I did not like her but after a while I realised she was helping me.*

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52 Includes a small number of transfers within the Department of Housing stock.

53 Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.
Another said:

She was really good... A great kick up the bum for me... She was a blessing at the time. She helped me get into routine.

One client reported that because of the level of support provided by the worker she was able to address things that put the tenancy at risk but that were difficult for her to do. With the worker’s assistance and support the client was able to:

- remove tyres and rubbish that had accumulated at the house
- reduce a significant debt
- deal with family issues
- transfer to a better property in a better location
- obtain a larger walking frame
- deal with letters and correspondence
- get DoH to do things
- assist in managing property standards, particularly damage caused by teenage boys.

The client appreciated the ongoing support provided by the worker.

[Worker] was always there... If I feel down she is there to support and guide me... She has the time for me. She is like my backbone... She has made a lot of difference to my life.

The client reported that other family members wanted to sign up for the PTSS because they noticed what the program was able to achieve.

My sister-in-law saw how much [worker] was helping so she signed up as well.

For many clients it is these underlying issues that place their tenancy at risk, so the PTSS’s support and assistance to address the underlying issues is critical.

Clients appreciated the level of concern and support provided by the PTSS worker on underlying issues other than housing. One client said:

She is someone I can count on. Someone actually cares. She rings me.

An older client with mental health issues who felt isolated greatly appreciated that the PTSS worker came out to her house regularly and talked with her about things that were troubling her at the time. The client said:

She assisted me to get through things... I had suicide on my mind and talking to [worker] assisted me to get through... It has been marvellous... I thank [worker] talking to me about things.

Another client spoke about the compassion and concern shown by the PTSS worker who came out to visit her in hospital.

Oh gosh she has done so much... She has been so remarkable and just so brilliant. She is a treasure that lady... I thought she was just the declutter lady but as soon as she heard I was in hospital she came out to see me... She has helped me mentally.

Clients appreciated the way the PTSS workers treat them with respect and dignity.
One client described the PTSS worker this way:

*She does not judge me. Almost like a friend, a second daughter.*

Another client spoke about the ways that the PTSS worker’s compassion, concern and encouragement had been an important example for her.

*She encouraged me to stand up for myself... Said don’t give up, things will be okay... When she came she opened our lives. She is an optimist... She taught me things.*

Clients valued the way the PTSS workers are willing to come to their home and are able to work with them in their home context.

*I like the way they work around my kids.*

The brokerage funds are a highly successful mechanism to support clients and promote change in the client’s circumstances. Managers and staff stressed the enormous benefits of the brokerage funds in their own right. The comment of one Manager reflected the views of many of those interviewed:

*The brokerage is fantastic. A great innovation.*

Brokerage funds were used for a variety of approved purposes as part of a case management plan for each client or family. This might include:

- paying overdue or rent arrears
- paying unpaid utility bills and phone bills
- paying for the removal of excessive household waste and rubbish from the house
- assisting with bills and debts
- paying for car repairs
- purchasing white goods and household goods
- providing equipment and paying for garden cleanups and garden maintenance
- buying household cleaning products and equipment to assist with property maintenance and standards.

**CASE STUDY 1**

*Maria is a 71 year old living in a DoH property in an outer Perth suburb on the city’s edge. Maria values her independence and is reluctant to accept assistance. Maria also has trouble getting to appointments because of the distance from services.*

*Maria was having trouble looking after her property and DoH referred her to the PTSS service. At the time Maria, who has some history of mental health concerns, was struggling with mental health issues, family conflict, health issues and social isolation. Maria said that she was* ...going through a lot of emotions and was very isolated. It was all turmoil and I was not able to cope.

*The PTSS worker(s) visited weekly and/or fortnightly. Maria said the things that were most helpful were assistance paying bills, for example, electricity, assistance to get help around*
the house, assisting her to access health services and medication, assisting with daily household activities and having someone to talk to about issues.

Maria said the most significant change was having someone to talk to and assist with tasks that were proving too much for her.

At the time of the interview Maria said her housing circumstances were stable and her condition had improved.

**With what results?**

This section covers outcomes regarding maintaining accommodation for 12 months, linkages, training and employment and what PTSS has meant to the person. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

**ACCOMMODATION MAINTAINED FOR 12 MONTHS**

Information provided by agencies indicated that 9354 client 1s had maintained accommodation for at least 12 months. In addition to these clients, 277 other household members (for example, partners/children) living with the clients were reported to be accommodated. Six client 1s were reported not to have maintained their accommodation, including one deceased.

It is reasonable to assume based on the data that a further 26 client 1s55 accommodated before 1st July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 49 client 1s also recorded as accommodated before 1st July 2011 although some would undoubtedly have maintained accommodation for 12 months.

Thus of a potential pool of 174 eligible client 1s56 at least 68% (119 client 1s) were stably accommodated for at least 12 months. The Public Tenancy Support Service program approached but cannot be demonstrated to have met its target of 75% of clients stably accommodated for 12 months.

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54 81 of these clients are recorded as accommodated before 1st July 2011. The remainder were either missing the accommodation date or their most recent accommodation date was after 1st July but the agency considered that they had maintained stable accommodation despite a change of address. In all cases the clients had joined the program before 1st July 2011.

55 These clients had either maintained accommodation for at least 12 months while on the program or were open cases within a few days of being accommodated for 12 months.

56 Clients recorded as accommodated before 1st July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before 1st July 2011.
TANGIBLE IMPROVEMENT IN AREAS IMPORTANT TO CLIENTS

Client interviews show that clients valued the support and assistance provided by the PTSS workers because it produced tangible improvements in areas of their life that were important to them.

Clients valued that the PTSS worker was able to assist them to make improvements in some of the following areas:

- addressing problems that place a tenancy at risk such as poor property standards, hoarding, accumulated rubbish and anti-social behaviour
- improving property standards and cleanliness of properties
- removal of rubbish and material that has accumulated inside and outside the house
- communication and advocacy with DoH on the client’s behalf
- payment of rental arrears and tenant liabilities
- payment of bills and other debts, for example, electricity bills
- purchase of household items such as food, cleaning products, household goods, children’s items
- accessing other services, for example, health services, medical services, mental health services, financial counselling
- improved management of household finances and activities eg children’s behaviour, routines, payment routines
- support and assistance to children
• assisting with daily tasks and activities.

Asked to provide specific examples of tangible improvements one client said:

I was getting weaker on my legs. I had an old frame... She got some dollars to get me a large walking frame. It made a real difference.

I have trouble with reading and writing. She assists me with reading and writing.

She assisted me to keep my boys on the level. She has assisted in how I manage the house with them.

One client described how the PTSS worker had assisted her to use the local library and to get a computer and home internet and this had made life so much better for her and her children. The client said that the children were doing better at school as they could now do their homework at home (previously she had to walk them to the local library which was a considerable distance away). The client was also able to complete her study, thereby increasing her confidence and improving her future prospects.

INCREASED CLIENT CAPACITY AND CONFIDENCE

Clients interviewed spoke about the way that their confidence and outlook had changed as a result of contact with the PTSS service.

Many clients reported that they were at breaking point when the PTSS worker came into their lives and that contact with the PTSS program had transformed their lives.

She has been a blessing... I was close to breaking. She came along at the right time... its incredible...she has given me the confidence in myself... I can do it. I do feel confident that I can do it.

Another client said:

[Worker] has been an inspiration for us... He has been a wonderful support. If we had any problem we could chat with him. Even now he still supports us.

Many clients said they feel more confident and positive about their future.

We would not be here without [worker] and the program.

She encouraged me to stand up for myself.

We know we are going forwards not backwards.

I now see there is a positive future. She told me not to give up, that things will be okay. It has happened... I get that from [worker].

I am now setting a better example.

Clients interviewed reported improvements in their confidence to undertake daily tasks including:

• opening letters /replying to letters
• requesting assistance from PTSS workers and other agencies
• explaining circumstances to DoH and other agencies
• making plans to deal with issues
• paying rent and bills regularly
• managing bills
• managing the house better
• cleaning and maintaining the house better
• communicating and negotiating with other agencies more.

Clients reported a variety of ways that contact with the PTSS has contributed to improvements in their situation and circumstances. This included:
• better management of crises
• greater sense of confidence and mastery
• improved health and wellbeing
• improved life circumstances
• access to income, eg Centrelink benefits
• family reunification
• improvements in children’s behaviour and circumstances
• increased income support
• less reliance on government income support.

**Benefits for Families and Children**

Many clients interviewed spoke about the benefits that resulted for their children. This included assisting clients to care for and support their children better, directly supporting children and providing children with access to services and programs.

*The kids are much happier. Days are easier... we are in routine again.*

*We have more quality time for our family.*

*She got curtains for the kids’ room.*

*She assisted with developing a roster of chores to be done around the house. The kids now do chores around the house.*

*The kids are cleaning their room... Their behaviour has changed. They listen a lot better.*

PTSS workers have been able to access programs and services for children and this was highly valued by clients interviewed.

*The kids are doing stuff.*

**Linking to Services**

Most clients were linked to services while on the program. Table 3 provides a breakdown of the linkages made to various services.

In addition to the links made for clients, children were linked to school/childcare and to recreation in 46% and 32% of cases respectively.
Table 3: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>83%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>65%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>61%</td>
</tr>
<tr>
<td>Health Service</td>
<td>60%</td>
</tr>
<tr>
<td>Other services</td>
<td>52%</td>
</tr>
<tr>
<td>Education Services</td>
<td>27%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>23%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>21%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>16%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>14%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>11%</td>
</tr>
</tbody>
</table>

Clients reported that the PTSS workers have supported and assisted them to engage with services that previously they avoided, or of which they were unaware. Examples include:

- greater willingness to engage with some agencies eg DoH, Centrelink, DCP
- increased engagement with specialist services, for example, financial counselling, health services, mental health services, schools, emergency relief
- sustaining links with agencies over time
- increased involvement with some key services, for example, drug and alcohol, mental health
- access to Centrelink benefits increased.

EMPLOYMENT AND TRAINING
The data showed no change in the proportion of clients in employment, studying or looking for work between their first and final/most recent period in the program.

CASE STUDY 2

Rosemary is a single parent with six children who has been in a DoH house since February 2011 (prior to that she had been in private rental). Client and worker both say the house is small for the size of the family and children have to share rooms.

DoH referred Rosemary to the PTSS because of serious concerns over property standards and maintenance. The client was facing eviction and other government agencies (including DCP) had been involved.

Rosemary was suffering depression and was finding it difficult to care for six children.
PTSS worker contacted Rosemary and made initial home visit with the DoH worker. PTSS worker established weekly contact with Rosemary to address the issues placing the tenancy at risk.

The PTSS worker met weekly and then fortnightly with Rosemary. She assisted with a referral to mental health and provided ongoing support to address the property standards issue and the underlying causes of the problem.

PTSS worker also assisted with the management of the children and assisted the children to access services and support from within her own agency.

Rosemary said the program has had a major impact on her children. She reported that they are now doing more things, are cleaning their rooms and their behaviour has changed.

Rosemary said

*This program made a great difference... we would not be in this house if not for it... I would have been on the street homeless with my children.*

*I know I will do better in the next 6-12 months.*

PTSS worker reported that Rosemary made steady progress to address issues and then went backwards for a while as a result of personal issues. The issues have been resolved now and DoH have indicated they are happy with the current standards. PTSS worker says there have been notable improvements and the tenancy is not currently at risk.

**Key Lessons**

Some of the key lessons in respect to the Public Tenancy Support Service apply specifically to the program, whilst others apply to other program areas as well.

**Advocacy with DoH on behalf of the client**

Clients reported that one of the most valuable aspects of the PTSS was that workers deal directly with and negotiate with DoH about tenancy matters.

Many of the clients have chequered histories with DoH so they appreciated having someone who can liaise with DoH and contribute to improving the relationship. They reported that PTSS workers are able to improve communication between themselves and DoH.

Clients commented favorably on the advocacy and liaison that the PTSS workers undertake on their behalf with DoH. Many clients see this advocacy as one of the best aspects of the program. They appreciated that the PTSS workers advocate forcefully with DoH on issues such as property maintenance and repairs and property standards.

**Collaboration with mainstream services is being achieved although service integration is less common**

The clients of the PTSS have complex needs that require access to a range of mainstream services. These include substance abuse treatment, mental health care, health care, income support, financial counselling, welfare, assistance with daily living, education and early childhood services, legal and court services, job training and employment services.

The level of complexity and severity of client need requires a multifaceted response
as no one service can meet all client needs. (Such a multifaceted response can be described in a variety of ways - interagency collaboration, joined up, wrap around, integrated services).

All PTSS services accorded a high priority to this work. Managers and staff emphasised the importance and value of interagency collaboration and how this delivers better services and better outcomes for clients.

Each mainstream service has evolved independently and may have its own funding, eligibility criteria, service philosophies, waiting lists and geographical coverage. Often mainstream services may not tailor their services to the specific needs of people who are homeless, so the PTSS workers have to actively coordinate with and facilitate client access to mainstream services.

Active linkages between the PTSS and these other services and resources are being achieved to assist the target group to access resources and services.

The PTSS services are achieving interagency collaboration with mainstream services to meet client needs and they generally are successful in assisting clients to make positive gains in other areas such as mental health, alcohol use, life skills, recreation, management of money, advocacy, caring for children, income, employment, transport etc.

However, barriers still exist that make it more difficult for tenants to access the full range of services and support they need. One barrier is that some services have waitlists, which make it difficult for tenants to access services. Wait lists for financial counsellors (up to 6-8 weeks in some cases) and accessing mental health services remain problems. The lack of free counselling for clients who cannot afford to pay is also a problem.

**POSITIVE RELATIONSHIPS BETWEEN CLIENTS AND PTSS WORKERS ARE CRITICAL TO SUCCESSFUL OUTCOMES**

The findings from the client interviews pointed to the quality of the inter-personal relationship between the client and the worker as a critical factor in achieving outcomes. A distinctive feature was the extent to which clients placed a high value on a supportive and trusting relationship between them and the PTSS worker as a factor contributing to the improvements and changes in their circumstances.

Clients emphasised how important it was that the worker actively cared about them and their situation and that they felt accepted and not judged by the workers. Clients also valued persistent engagement, support and reliability. They appreciated that they could contact the PTTS worker when they needed help, knowing that help does not depend on them meeting certain criteria or conditions.

**HOUSING AS A PLATFORM FOR THE PROVISION OF HUMAN AND COMMUNITY SERVICES**

One of the successes of the PTSS (and the NPAH programs more generally) is that the provision of housing provides a platform for the delivery of a variety of social and human services to improve quality of life and improve outcomes for clients and their families.

In this way the provision of housing becomes a platform for the provision of support,
as well as the delivery of a wider array of human services. Housing becomes a place around which services can be anchored.

The findings show that PTSS services are able to meet client needs beyond just the provision and maintenance of housing and housing support (important though that is) and they generally are able to assist clients to make positive gains in other areas of their lives.

**DOH POLICY AND PRACTICE HAS A SIGNIFICANT IMPACT ON OUTCOMES**

The Department of Housing is a critical player in the PTSS. The success of the program is directly affected by DoH policy and practice.

Early referral of clients to the PTSS by Department of Housing staff is critical so that issues can be resolved before a tenancy is seriously threatened. Managers and staff reported that this is less a problem now than it was in the early stages of the program when DoH staff were referring clients too late, or they were referring clients who should have been referred to other programs, such as SHAP.

Managers and workers suggested that density of housing and lack of formal boundaries between tenants in some properties, particularly where there are tenants with mental health issues or drug and alcohol problems causes conflicts and leads to behaviour and then breaches that put people at risk of homelessness, for example, disputes with neighbours, anti-social behaviour.

The greatest frustration for clients interviewed was DoH’s failure to properly maintain their properties or to act on concerns raised by clients. Managers and staff also identified the failure of DoH to maintain and repair properties as a constraint on their capacity to prevent and reduce homelessness risk (by enabling clients to keep properties well maintained).

Staff and managers report that DoH has tried hard to support PTSS, particularly the officers within DoH offices who have responsibility for NPAH programs. There are still issues though with DoH such as turnover of DoH staff, staff shortages, transmission of information within DoH may not always work well and referrals may come in waves.

**THE VALUE OF FUNDING PTSS SERVICES WITHIN HOST MULTI SERVICE AGENCIES**

Managers and staff interviewed point to the benefit of PTTS services being part of host agencies that provide multiple services. This makes it easier for workers to refer to and access services from other parts of the agency to meet the client’s needs.

**Summary and conclusions**

The Public Tenancy Support Services Program has made a substantial difference to the lives of people accepted into the programs, and to their children and families. Although firm conclusions are unable to be made about whether the PTSS met its target of 75% of clients stably accommodated for 12 months, the client interviews and data shows that 119 clients plus 277 other household members were accommodated for 12 months. In addition 78% of clients had maintained their tenancy for their most recent or final period on the program.
Importantly PTSS services are ensuring that public housing is a platform for the provision of support, as well as the delivery of a wider array of human services to people who are at risk of homelessness or who have experienced homelessness in the past. Housing has become a place around which services can be anchored.
A review of the literature on the links between homelessness and mental illness concluded that, regardless of how homelessness and mental illness are defined, homeless populations have a much higher prevalence of schizophrenia and other severe mental disorders than the general population\(^{57}\). Mental illness is both a possible consequence of homelessness and a risk factor for homelessness.

There is evidence that intervention strategies that focus on providing emotional and practical support and on strengthening ties in the community following discharge from hospitals and other institutions can contribute to preventing homelessness among people with a mental illness\(^{58}\).

**Description**

The Housing Support Workers – Mental Health (HSW-MH) program aims to prevent homelessness by providing dedicated support for people with a severe or persistent mental illness residing in a Specialist Mental Health Inpatient Unit who are homeless or at risk of becoming homeless.

The following services have been contracted to provide the HSW-MH program:

<table>
<thead>
<tr>
<th>Service name</th>
<th>Provider</th>
<th>Coverage</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSW-Mental Health</td>
<td>St Patrick’s Community Support Centre Ltd</td>
<td>Fremantle/Rockingham</td>
<td>1 FTE</td>
</tr>
<tr>
<td>HSW-Mental Health</td>
<td>Ruah Community Services</td>
<td>Royal Perth, Graylands, Sir Charles Gairdner, Armadale/Bentley</td>
<td>4 FTE + locum</td>
</tr>
<tr>
<td>HSW-Mental Health</td>
<td>Hills Community Support Group</td>
<td>Swan/Joondalup</td>
<td>1 FTE</td>
</tr>
<tr>
<td>HSW- Mental Health</td>
<td>Lamp Inc</td>
<td>South West</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>HSW- Mental Health</td>
<td>Anglicare WA Inc</td>
<td>Great Southern</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>HSW-Mental Health</td>
<td>Australian Red Cross Society</td>
<td>Goldfields</td>
<td>0.5 FTE</td>
</tr>
<tr>
<td>HSW-Mental Health</td>
<td>Centacare Kimberley</td>
<td>Kimberley</td>
<td>0.5 FTE</td>
</tr>
</tbody>
</table>


The support and assistance provided by the seven services funded to provide housing support for this program in general have the following features:

- work with nominated clinical staff at a Specialist Mental Health Inpatient Unit to assess accommodation and support needs
- use a case management model
- provide assistance to access accommodation
- use brokerage funds to establish or support accommodation
- provide client support for 6-12 months, including assistance to access existing mental health services
- link to mainstream services.

One service utilises the Critical Time Intervention (CTI) model developed by Columbia University for which it has purchased a licence.

CTI is an empirically supported, time-limited case management model designed to prevent homelessness in people with mental illness following discharge from hospitals, shelters, prisons and institutions. This transition period is one in which people often have difficulty re-establishing themselves in stable housing with access to needed supports. CTI works in two main ways: by providing emotional and practical support during the critical time of transition and by strengthening the individuals’ long-term ties to services, family and friends.\(^{59}\)

**Evaluation data sources**

The data sources for the evaluation were as follows:

- Progress Reports and tracking sheets provided to DCP
- interviews with managers of each service and some workers
- 28 client interviews
- 22 responses to the on-line worker surveys (11 in 2011 and 11 in 2012)
- data provided by DoH.

**How much has the program done?**

The target for the program is 11 clients a year per FTE assisted. This is based on a case load of eight clients per FTE at a time for an average of nine months. Over 2.5 years this equates to 212 clients assisted. This target was exceeded with 233 clients assisted between January 2010 and June 2012.

Table 1 shows the number of new and existing clients worked with by agencies in each six month period.

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\(^{59}\) [www.criticaltime.org](http://www.criticaltime.org)
Table 1: Clients worked with in a period by number of agencies operating

<table>
<thead>
<tr>
<th>Period</th>
<th>New Clients</th>
<th>Existing Clients</th>
<th>All clients in Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>45</td>
<td>0</td>
<td>45</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>46</td>
<td>35</td>
<td>81</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>63</td>
<td>86</td>
<td>149</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>41</td>
<td>120</td>
<td>161</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>38</td>
<td>100</td>
<td>138</td>
</tr>
<tr>
<td>Total individuals</td>
<td>233</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

One agency commenced on the 1 April 2010. All other agencies commenced on 1st January 2010 although some had a delayed start.

The Clients

There were slightly more female (53%) than male (47%) clients assisted by the HSW-MH. The average age of the clients was 38 years. As figure 1 shows the program considerably exceeded its target of 11% Aboriginal clients.

Figure 1: Cultural background of the client group

Ninety-eight percent of clients identified themselves as having a mental health disability, of these 31% identified a dual diagnosis of mental health and drug and alcohol problems. Most referrals (94%) were from inpatient mental health units, hospitals or community mental health services.

Agency managers described the client group as having severe and persistent mental health problems. Problems with drugs or alcohol and with domestic violence were common. For Aboriginal people grief and loss, and discrimination, together with a traumatic and chaotic social environment can compound the situation.

The clients’ descriptions of what was happening in their lives when they became involved with the program confirmed histories of serious mental illness (schizophrenia and major depression), drug and alcohol misuse, domestic violence
and relationship issues, suicide attempts, criminal convictions and housing instability.

I was in hospital for three months with severe depression as a result of an abusive marriage – physical and emotional abuse – over many years. I was left with no money. I had nowhere to go.

I had attempted suicide … I was in ICU for two weeks and nearly died. I had a lot of problems leading up to this. Both parents had died a few years before. My brother died two years ago. I was divorced … and so had no money. I had a serious breakdown with a girlfriend who took out a VRO unknown to me. [Some years before had a smashed back] and started to drink heavily – a carton of beer and a bottle of scotch a day. Basically everything got on top of me.

Suitable independent accommodation, ongoing support and linking to services were identified as the most critical needs for clients.

Although the majority of clients (65%) lived alone when they commenced the program, household size ranged from one to eight persons. In addition to the 233 clients assisted by the HSW-MH there were 102 children involved ranging in age from 0 - 17 years. Household composition is shown in Table 2.

Table 2: Household composition

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>Extended family</td>
<td>12</td>
<td>5%</td>
</tr>
<tr>
<td>Single female</td>
<td>68</td>
<td>29%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>42</td>
<td>18%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Single male</td>
<td>90</td>
<td>39%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>5</td>
<td>2%</td>
</tr>
<tr>
<td>Total</td>
<td>233</td>
<td>100%</td>
</tr>
</tbody>
</table>

On or prior to discharge from hospital/inpatient units 35% of clients were homeless. The remainder were living in a variety of accommodation types of which living with family was the most common (see figure 3 below).

The main source of income for the vast majority of clients when they started the program was some sort of government payment, only 10% had either full or part-time work. Most were either not in the labour force (54%) or unemployed and looking for work (33%).
How well has the program done its job?

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**Engagement**

129 cases (55%) were closed by the end of June 2012. These cases were open an average of 286 days or slightly over nine months (median 284 days, range 1 – 901 days). For the most part clients appear to have engaged well with the program – 87% remained with the program for at least three months, 70% for at least six months and 53% for at least nine months.

**Accommodation**

The program has been very successful in obtaining accommodation for clients and/or assisting them to maintain accommodation. Eighty-two percent are recorded as accommodated in their most recent/final period of contact, including 90% of those identified as homeless at the time of or prior to discharge. Most clients (85%) were recorded as accommodated before their case was closed.

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60 Whether someone was accommodated is based on the person having an accommodation date recorded. It is probable that those with an accommodation type but no date recorded were in fact accommodated.
By their most recent/final support period half of all clients were recorded as accommodated in public housing, 13% in community housing, 9% in private rental accommodation and 6% with family. The remainder were accommodated in a mix of private lodgings, lodging houses, caravans and other.

DoH data show 94 households identified with the HSW-MH program accommodated between 1st May 2010 and 30th June 2012. Five of these vacated their tenancy – one tenant was unable to cope due to mental illness, one vacated for an unknown reason and three were formally terminated or evicted.

Department of Housing data relate to households but it is reasonable to assume that there is a 1:1 relationship between a client in the program and a household identified as linked to the program. The most likely explanation for the discrepancy between tracking sheet data and DoH data is that not all HSW-MH cases were flagged by DoH staff.
Clients valued the personal support that they received from the HSW-MH program. Invariably the support was both practical and personal as is evident in the description by one of the clients:

[Worker] came to see me and started liaising and advocating for me with Homeswest. I told him the story about my children [placed with her ex-partner by DCP against her wishes]. He listened to my issues, helped with groceries, would take me to appointments, kept in touch, got the Homeswest house.

Asked what things provided by the program were most helpful to her this client said: Just having someone like [worker] who listens, who actually cares and will take action.

Identifying the most significant change in her life since she had been involved with the HSW-MH another client put it thus:

While [worker] got me accommodation and selected furniture it was her ongoing contact and support that was the most significant change. Basically [worker] was someone I could trust, who worked with me to make changes to plan for the future. She was wonderful.

**With what results?**

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

**Accommodation maintained for 12 months**

Information provided by agencies indicated that 82 clients had maintained accommodation for at least 12 months. In addition to these clients, 48 other household members (for example, partners/children) living with the clients were reported to be accommodated. Six clients were reported not to have maintained their accommodation.

It is reasonable to assume based on the data that a further ten clients accommodated before 1st July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 22 clients also recorded as accommodated before 1st July 2011 although some would undoubtedly have maintained accommodation for 12 months.

Thus of a potential pool of 120 eligible clients at least 77% (92 clients) were stably accommodated.

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62 75 of these clients are recorded as accommodated before 1st July 2011. The remainder were either missing the accommodation date or their most recent accommodation date was after 1st July but the agency considered that they had maintained stable accommodation despite a change of address. In all cases the clients had joined the program before 1st July 2011.

63 These clients had either maintained accommodation for at least 12 months while on the program or were open cases within a few days of being accommodated for 12 months.

64 Clients recorded as accommodated before 1st July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before 1st July 2011.
accommodated for at least 12 months. The Housing Support Worker – Mental Health program has met its target of 75% of clients stably accommodated for 12 months.

**Figure 5: Flow chart**

![Flow chart](image)

Very positively, independent data from the Department of Housing indicates that of the 42 mental health clients accommodated in public housing between 1\textsuperscript{st} May 2010 and 30\textsuperscript{th} June 2011, 95% (40) retained their tenancy for 12 months or more.

All clients interviewed were either in public or community housing. The clients interviewed verified just how important being suitably accommodated was for them.

**LINKING TO SERVICES**

Nearly all clients were linked to at least one service while on the program. Table 3 provides a breakdown of the linkages made to various services.

**Table 3: Links to services while on the program**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Services</td>
<td>95%</td>
</tr>
<tr>
<td>Centrelink</td>
<td>93%</td>
</tr>
<tr>
<td>Health Service</td>
<td>86%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>73%</td>
</tr>
<tr>
<td>Other services</td>
<td>72%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>50%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>42%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>31%</td>
</tr>
<tr>
<td>Education Services</td>
<td>31%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>25%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>12%</td>
</tr>
</tbody>
</table>
In addition to the links made for clients, children were linked to school and to recreation in 21% and 23% of cases respectively.

Client interviews confirmed that these links were made, in particular that they were linked into mental health services and to social networks.

Respondents to the 2011 and 2012 on-line worker surveys were split 50/50 on whether there was any difficulty in linking clients to the services they needed. In particular a majority of workers identified long waitlists for public housing, drug and alcohol residential rehabilitation, financial counselling or budgeting services, legal services and Home and Community Care services. However by the time their clients left the program most workers (73%) considered they had been able to link them to all the services they needed.

The specialist inpatient units play a crucial role in this program. Except in the country they are the referral source for the program and also refer the client to community mental health services. The joint assessment approach works well and information sharing on client management and risk were reported to be good. In general collaboration between the HSW-MH program and inpatient units was good. However there appear to have been a few instances when an inpatient unit did not make the necessary referral to community mental health services. In one such case the person had to wait three months for a service.

One country agency has reported communication problems with the local community mental health service. ‘There is no communication, only when they refer. They don’t tell me when they send clients to Perth’. The worker’s caseload is mostly dual diagnosis cases including paranoid schizophrenia and serious depression and a close working relationship between the HSW-MH and the community mental health team is important. The MOU between the agency and the community mental health team has been revised and it is hoped that a closer and more supportive relationship will result.

EMPLOYMENT AND TRAINING

The data show a small but encouraging increase in the number of clients engaging in full or part-time employment as they progress through the program – from 25 in the clients’ first six-month period to 35 in the clients’ most recent/final six-month period. There was a corresponding reduction in the number of clients who were unemployed/looking for work. There was no change in the number of clients not in the labour force.

In the interviews a number of clients mentioned that they were now employed or working towards employment or study.

HOPE

An intangible benefit on which a number of clients commented was that the program gave them hope. For example:

The actual talking and listening and understanding gave me hope. I had been so down that if it was not for my grandson I might have harmed myself...They changed my negative attitude to a positive one of hope and I now have a home.

The change has given me some hope for the future...Without [HSW-MH] I would have
CONFLICT, SELF-ESTEEM AND SOCIAL CONNECTIONS
The client interviews indicated that the provision of accommodation and the support they were given improved clients’ confidence and self-esteem. Information in the client interviews indicated reasonable social connectedness through family, friends and activities for most clients.

It lift my spirit up again. I was really down and out. I feel much happier now.

Having my own place and furniture, I now have a base where I can feel secure. Coupled with this is the weekly support by [HSW-MH] and they are so caring, supportive and they believe in me and my future. This has made me much more independent, confident and free.

Probably the most significant change has been the ability to get back to work. For me my mental well-being is derived from being able to feel good about what I do. Being able to work I can feel good about my abilities and what I can do. When I am not working I get very depressed because I don’t feel I am achieving or doing anything of value (male client about establishing his own business).

The change is significant in that it laid the foundation from which I could gain self-confidence and do other things like the counselling. I am now very positive about the future.

I was totally isolated and now I go out quite a bit. I have made some friends (male client now involved in a combined men and women’s group and a men’s shed).

I am now going out again because I was just staring at the four walls for a while

RELATIONSHIPS MAINTAINED OR RE-ESTABLISHED
Having the support of HSW-MH and their own homes has enabled clients to maintain contact with children or in some cases for the family to reunify.

I have my own proper home, have my sons staying over, I am happy in myself…If not for [HSW-MH] I would not have the contact with my children, nor my house, nor my stability and increased self-esteem. I owe them so much.

Things have changed greatly as I now have my children with me (female client who had been in a refuge on discharge from hospital).

They got me a roof over my head so I could get my kids back. It has given me stability and my own place, my own environment. But it is the support that is huge… (female client who had her children removed by DCP when she could not cope).

Because I now have stable accommodation and am off drugs and relatively stable mentally, I had contact with Legal Aid and applied to the Family Court about mediation for improved access to [daughter].

It is not only relationships with children that have been positively impacted by the program but also other family relationships.

I have a very supportive family, boyfriend and two beautiful sisters…I have caused them a lot of anguish in the past. The improvements due to [HSW-MH] have resulted in the family coming together.

I used to have problems with my adoptive parents. I would crash there drunk and fight
with my father. They had to phone the Police and take out a VRO. I think they are happy I am more settled and they drive up and see me every two weeks. I still sometimes argue with my father.

MENTAL HEALTH STABILISED

A service provider has noted that the client population experienced less hospital admissions associated with mental health relapse due to monitoring of mental health symptoms and reduced psycho-social stressors. Levels of medication compliance were also higher.

The client interviews confirmed that clients considered their mental health to have improved or stabilised as a result of the program. Some illustrative examples of this are:

A client, who had nowhere to go on discharge from hospital, said that since she has been in her unit she has not had to go back to the mental health unit...

...which is really good ...that’s been huge for me because I know I have a roof over my head.

For her the most significant change since being on the program was ‘My mental health – definitively’.

An Aboriginal client from a country town who had been previously living on the beach said:

I am taking my medication really well. I have become very independent, focused and strong within myself.

This client will soon go fruit picking to earn money to buy furniture for her unit. She is hoping to buy the unit in time.

A male client who has paranoid schizophrenia and who had previously been living in a lodging situation which he found extremely stressful said:

This new environment has enabled me to settle and my mental health has greatly improved. I have made new connections while maintaining old ones.

A woman who had lived for some years in a transitional mental health rehabilitation facility and then in a cottage on her parents’ property said after getting her own unit in a larger country town:

My mental health is good and I have overcome my eating disorder. I attend the gym nearly every day and I feel very fit and healthy. I attend [a day centre] and participate in programs there. I have an active social life and plenty of friends. A mental health nurse visits once a fortnight to give me an injection.

CASE STUDY

Selecting a case study for the HSW-MH was difficult because so many of the clients’ stories illustrate how life changing this program has been for them. This case study has been selected because it shows how the program has worked for an Aboriginal client.

John is a member of the stolen generation and had been abused as a child. He is university educated but following a family tragedy began to have mental health issues and threw in his profession. John has bi-polar disorder and depression which was diagnosed some years ago
when he was imprisoned for assault. He attends a metropolitan clinic and sees a clinical psychologist regularly.

At the time he was referred to HSW-MH John was living in temporary accommodation. He had been living with his partner, Marion, in a rented flat when the owner gave them 60 days’ notice. They could not find other accommodation. Marion returned to live with her mother who would not take John because he was Aboriginal and not of her religion. He and Marion were separated. John was ‘devastated’ and angry. John said ‘because of this situation I could not see much hope and I could not plan things’.

When [workers] came out to see John they treated him with ‘such dignity and respect’. They talked things through with him and advocated with DoH. John and Marion were housed within 2 – 3 weeks. [Worker] took John to look at the house, arranged the removalist and provided most of the furniture. The house is close to transport and shops.

[Worker] keeps in touch regularly and has helped John to put new furniture together. John said he found the ongoing support from and contact by [worker], together with the house and furniture, the most helpful things the program provided.

John and Marion are now settling into the house. Marion is very positive and talking to [worker] about doing a course. John has been invited to co-present with other Aboriginal people a session on Aboriginal issues to the agency. He is ‘very grateful for this opportunity to give something back’.

The change wrought by the program is significant to John because it has given him and Marion the capacity to move forward. He said the help he had received had made him feel ‘an authentic person’. ‘In a nutshell [HSW-MH] has changed my life’.

Key Lessons

The success of the HSW-MH program hinges on two factors: the support that the agencies provide to their clients and the capacity of the program to provide houses for clients within a relatively short time. Every client interview made reference to these two elements when talking about the difference the program had made in their lives or when discussing what they had found helpful.

Support

A striking feature of the client interviews was the supportive and trusting relationship which evolved between client and worker and the evident value clients placed on the worker keeping in touch. One of only two criticisms of the HSW-MH program made by a client related to staff changes. The client interviews confirmed the critical role played by staff selection, training and retention in the success of the program.

There were differences between the 2011 and 2012 on-line worker survey as to whether clients would be able to cope at the end of 12 months without the workers’ support. In 2011 four workers considered that client would be able to cope and five disagreed whereas in 2012 eight workers considered that clients would be able to cope and only one disagreed. Workers were split on how long, on average, clients should remain on the program. Two workers thought six months, four workers

65 This question was only asked in the 2012 on-line workers survey.
PROVISION OF HOUSING

Critical though support is to the success of the HSW-MH program, it would come to nothing if the agencies were unable to provide suitable accommodation in a timely fashion. It is clear from the client interviews that it is having independent accommodation that has enabled them to use the agencies’ support to make changes in their lives.

The role played by the Department of Housing and by the community housing sector in making the HSW-MH program work cannot be overestimated. In the current rental environment, public or community housing were the only affordable and sustainable options for all of the clients interviewed. This was confirmed by the 2011 and 2012 on-line worker surveys. All respondents considered that the private rental market was difficult for their clients to access because it was unaffordable.

Summary and conclusions

The HSW-MH program has been extremely successful in obtaining suitable accommodation for clients with serious mental health issues including schizophrenia and major depression. Once accommodated, the evidence indicates that with the program’s support, clients can maintain their accommodation at least in the medium term.

The client interviews indicate that HSW-MH program has made a substantial difference to clients' quality of life and that being accommodated and supported helps to improve and/or stabilise their mental health.

Suggestion for improvement

The relationship between the HSW-MH program, inpatient mental health units and community mental health services is important to ensuring that clients receive the mental health services they need. Workers are not mental health practitioners and should be able to expect close cooperation from the mental health system. In general, this appears to have been forthcoming but host agencies should ensure that strong memoranda of understanding are in place with the referring Specialist Mental Health Inpatient Units or community mental health services.
Prisoners being released from correctional facilities and young people leaving juvenile justice services are two of the groups prioritised under the NPAH policy ‘no exits into homelessness’. The Housing Support Workers Corrective Services (HSW-CS) initiative is intended to prevent homelessness for these two vulnerable groups.

The majority of prisoners and ex-prisoners are from severely disadvantaged backgrounds. As a group they are among the most disadvantaged in Western Australia. They have high levels of poor education, unemployment, mental health problems, learning and intellectual disabilities, poverty and drug and alcohol problems. Those with mental and cognitive disability and a history of abuse are grossly over-represented amongst the prison population, as are Aboriginal Australians. Aboriginal men, women and youth represent extraordinarily high numbers in prisons and this number is increasing rapidly.

A majority of prisoners are eventually re-incarcerated indicating that a high proportion of ex-prisoners are not rehabilitated by their prison term and are unable to integrate into society once released from prison.

Incarceration strips away the things that promote social attachment and integration, including secure and stable housing, family and social connections, income and employment. Men and women released from prison face a myriad of challenges upon release. Finding and retaining housing is chief among the re-entry challenges.

Suitable housing is a critical factor in prisoners making a successful transition from prison back into society after release. It is a foundation towards more successful re-entry and re-integration.

Incarceration places men and women at increased risk of housing instability and insecurity immediately upon release from prison. Housing instability impedes men and women’s ability to be successful in many areas after release.

Empirical evidence shows that stable and socially supported housing is associated with successful re-entry, staying out of prison and increased social integration for both men and women. Baldry found that of those who did not move their accommodation or moved just once within a year only 22% had been re-incarcerated.

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68 Ibid.
70 Ibid.
71 Baldry, E, McDonnell, D, Maplestone, P & Peeters, M 2003, Ex prisoners and accommodation: what bearing do different forms of housing have on social reintegration. AHURI Final Report No 46, August 2003.
at nine months, whereas of those who moved twice or more 59% were back in prison\(^{72}\).

Housing not only has implications for the men and women released from prison but also for their family members\(^{73}\).

**Description**

The HSW-CS program assists adults and young people exiting Corrective Services facilities and/or programs, Transitional Accommodation Support Services or prisoner re-entry programs to secure and maintain stable accommodation and avoid homelessness.

The following services have been contracted to provide the Housing Support Worker-Corrective Services program:

<table>
<thead>
<tr>
<th>Provider</th>
<th>Coverage</th>
<th>Service Location</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrecare</td>
<td>Men’s Correctional Facilities</td>
<td>Gosnells- Cannington</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Youth Futures</td>
<td>Juvenile Correctional Services</td>
<td>Joondalup</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Ruah Community Services</td>
<td>Women’s Correctional Facilities</td>
<td>Perth</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Geraldton Community Resource Centre</td>
<td>Murchison</td>
<td>Geraldton</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Accord West</td>
<td>South West</td>
<td>Bunbury</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

**Key features**

While each service works with a different client group, the support and assistance provided by each HSW has a number of features:

- referral from correctional facilities and correctional services
- in-depth and detailed assessment
- client centred case work and intensive support
- use of brokerage funds to address issues that place the tenancy at risk
- liaison and advocacy on the client’s behalf with DoH and other agencies
- assistance and support with referral and linkages to other services and agencies
- building the tenant’s capacity to resolve tenancy issues and participate in

\(^{72}\) Baldry et. al 2003, op cit.
\(^{73}\) Fontaine, J & Bass, J 2012, op cit.
social, community and economic life.

**Evaluation data sources**

The data sources for the evaluation were as follows:

- tracking sheets and Progress Reports provided to DCP by each agency
- interviews, focus groups and workshops with managers and workers from all funded agencies in 2011 and 2012
- nine responses to the on-line worker survey (four in 2011 and five in 2012)
- interviews with nine clients
- informal discussion with managers and staff
- data provided by DoH
- review of relevant literature and documents.

**How much has the program done?**

The target for the program is 16 clients a year per FTE assisted. This is based on a caseload of 8 clients per FTE at a time for an average of 6 months. Over 2.5 years this equates to 196 clients assisted. This target was exceeded with 205 clients assisted between January 2010 and June 2012.

**Table 1: Clients worked with in a period**

<table>
<thead>
<tr>
<th>Period</th>
<th>New Clients</th>
<th>Existing Clients</th>
<th>Total Clients In Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>13</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>51</td>
<td>13</td>
<td>64</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>39</td>
<td>37</td>
<td>76</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>50</td>
<td>44</td>
<td>94</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>52</td>
<td>64</td>
<td>116</td>
</tr>
<tr>
<td>Total individuals</td>
<td>205</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For all agencies the service agreement commenced on 1\textsuperscript{st} January 2010.

**The clients**

There were substantially more male (68%) than female (32%) clients assisted by the HSW-CS. The average age of the clients was 30 years (range 16-56 years). Thirteen percent of the clients were juveniles. As figure 1 shows the program considerably exceeded its target of 11% Aboriginal clients. This is unsurprising given the considerable over-representation of Aboriginal prisoners in the WA prison system.
Forty-two percent of referrals to the program were made by prisons, 39% by re-entry or similar programs and 19% by juvenile corrective services.

Forty-two percent of clients identified themselves as having alcohol and drug issues, 8% dual diagnosis mental health and alcohol and drug problems and 8% mental health issues. Just over half the clients lived alone. Household size ranged from one to eight persons. In addition to the 205 clients there were 178 children involved ranging in age from 0 – 17 years. Household composition is shown in Table 2.

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>11</td>
<td>5%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>22</td>
<td>11%</td>
</tr>
<tr>
<td>Extended family</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Single female</td>
<td>21</td>
<td>10%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>39</td>
<td>19%</td>
</tr>
<tr>
<td>Single male</td>
<td>90</td>
<td>44%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>13</td>
<td>6%</td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>3%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>205</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

The main source of income for most (77%) clients when they started the program was some sort of government payment, only 7% had either full or part-time work and 2% were students. Most were either not in the labour force (53%) or were unemployed and looking for work (39%).
Many clients had a long history of homelessness, as well as multiple, complex and entrenched problems that placed them at severe risk of housing instability, including:

- offending histories
- mental health issues and co-occurring mental health disorders and substance abuse
- drug and alcohol abuse
- poor literacy and numeracy
- debt
- lack of any possessions to make a home
- inability to manage the home and a lack of independent living skills, for example, budgeting
- lack of income support, low income, financial insecurity and severe financial difficulties
- health related problems
- concerns regarding families and children, for example, family reunification, dealing with DCP, child safety issues dealing with schools,
- family conflict and family breakdown
- lack of job readiness
- social isolation and limited knowledge of community services and community supports
- discrimination.

Around 40% of the clients had children so the NPAH services had to work closely with the Department for Child Protection and schools as well as assist clients to reunify with children, re-orient the client to parenting responsibilities, develop
parenting routines and skills, respond to family issues, deal with schools, assist with community integration and services for children, facilitate children’s access to services and deal with trauma, grief and loss.

Nearly 50% of the clients had a partner (and in a few cases a parent or sibling) so NPAH services also found themselves working with secondary clients in addition to the primary client. This not only adds to staff workloads, but may impact on service targets. Work with secondary clients, although taking significant time and resources may not always be reflected in service statistics or agency targets.

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**ENGAGEMENT**

118 cases (58%) were closed by the end of June 2012. These cases were open an average of 123 days or four months (median 190 days, range 1 – 518 days). For the most part, as figure 3 shows, clients appear to have engaged adequately with the program.

**Figure 3: Closed cases – length of time engaged with the program**

![Graph showing closed cases by length of time engaged with the program]

**ACCOMMODATION**

The program has been reasonably successful in obtaining accommodation for clients and/or assisting them to maintain accommodation. Sixty-four percent were recorded as accommodated in their most recent/final period of contact.\(^{74}\) A majority of clients (62%) were accommodated when their case was closed.

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\(^{74}\) Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.
Sixty-nine percent (90) of all accommodated clients were in public housing. The remainder were accommodated in a mix of community housing, private board, lodging houses, caravans, with family and other.

DoH data show 66 households identified with the HSW-CS program accommodated between 1st May 2010 and 30th June 2012. Eighteen of these vacated their tenancy – one tenant died, 12 were reincarcerated and five were formally terminated or evicted.

**PROGRAM HELPFUL**

Clients interviewed were extremely positive about the amount and quality of support and assistance provided by services.

I am so grateful for [agency] help and support. I don’t know what I would have done without them.

Very good service. Top marks. They keep me up to date and customer service is excellent.

The support they have provided has been great. Everything was helpful.

All services reported that the quality of the worker-client relationship is a critical factor and time is needed to build rapport and establish a trusted relationship with clients. However, clients are often wary of service provider agencies. As one worker put it, building relationships is part of the service philosophy:

We have a strong cultural ethos to build relationships

Managers and workers reported that a proportion of clients exiting from prison want to have minimal contact with agencies, so that can present challenges in building a relationship.

A number of agencies described their work as a form of ‘intensive case advocacy’ on behalf of the client, although they stress that is not at the expense of disempowering the client or creating an overreliance on the worker. This might include:

- negotiating with Centrelink over income support
- supporting the client with other agencies such as DCP, Centrelink and Corrective Services
- liaison with DoH, DCP and Corrective Services
- court and legal liaison
- attending court and meetings, for example, with DCP
- assisting in liaison with schools.

Clients interviewed spoke about the value and importance of the relationship with the worker and the qualities and attributes of the workers.

[Agency] have very nice people and are providing really good support. I would recommend them to others who need help.

Being part of the program has definitely improved my quality of life for me and my children. In a way they are like a second family. I get family support but [agency] is different. They are very caring, they stay in contact, help me feel more confident about
the future...they take that extra step.

I am so thankful to [agency] for what they have done for me. I have worked with a number of workers and they are all wonderful, supportive and non-judgmental. They really care and just don’t do it for the money.

Brokerage funds were used for a variety of approved purposes as part of a case management plan for each client or family. This might include:

- meeting the client’s immediate welfare need at the time of release
- setting up and fitting out the house, for example, blinds, furniture
- purchasing household goods and whitegoods, for example, fridges
- sourcing documentation such as birth certificates
- purchase and removal of furniture
- transport
- mobile phone credit
- shoes and clothing
- baby furniture
- safety items
- medical expenses.

The brokerage funds were universally viewed as a highly successful mechanism, particularly for the Corrective Services program, as clients come out of prison with nothing. The funds are able to be used to support clients and promote change in the client’s circumstances. Comments made by staff include:

It’s a massive strength and makes things happen.

It is fabulous to have... Women come out of prison with nothing. We can buy white goods, clothing, starter packs, linen, cleaning products, curtains... People often have no furniture and no heating.

There was some concern that the amount of funds is inadequate for people leaving prison as many have nothing and that the costs of living are rising so much that the brokerage funds should increase by the equivalent amount.

**With what results?**

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.
**ACCOMMODATION MAINTAINED FOR 12 MONTHS**

Information provided by agencies indicated that 3775 clients had maintained accommodation for at least 12 months. In addition to these clients, 42 other household members (for example, partners/children) living with the clients were reported to be accommodated. One client was reported not to have maintained their accommodation. It is reasonable to assume based on the data that a further four clients accommodated before 1st July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 21 clients also recorded as accommodated before 1st July 2011 although some may have maintained accommodation for 12 months.

Thus of a potential pool of 63 eligible clients 65% (41 clients) were stably accommodated for at least 12 months. The Housing Support Worker – Corrective Services program has approached but not fully reached its target of 75% of clients stably accommodated for 12 months.

**Figure 4: Flowchart**

Independent data from the Department of Housing indicates that of 30 Adult Corrections clients accommodated in public housing between 1st May 2010 and 30th June 2011, 83% retained their tenancy for 12 months or more78.

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75 75 of these clients are recorded as accommodated before 1st July 2011. The remainder were either missing the accommodation date or their most recent accommodation date was after 1st July but the agency considered that they had maintained stable accommodation despite a change of address. In all cases the clients had joined the program before 1st July 2011.

76 These clients had either maintained accommodation for at least 12 months while on the program.

77 Clients recorded as accommodated before 1st July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before 1st July 2011.

78 Department of Housing data relate to households but it is reasonable to assume that there is a 1:1 relationship...
Corrections clients were accommodated in the same time frame but only three (38%) maintained their tenancy for 12 months or more.

**HOUSING AS THE FOUNDATION FOR RE-ENTRY AND RE-INTEGRATION**

For the majority of clients interviewed the most significant change has been getting a DoH house. Clients reported that this has brought stability and security into their lives (and for children in some cases) and given them hope for a better life. Clients told us:

- **Most significant change was getting the house.**
- **The most helpful thing was getting the Homeswest house.**
- **Stable accommodation, my own place.**
- **I am looking forward to starting my life.**

For a proportion of the clients interviewed obtaining stable accommodation has been the critical foundation and first step in getting their life back in order. This was particularly the case for men and women with children. Clients said:

- **Getting the house has led to stability for me and the kids and I can now look forward to a more positive future.**
- **Things have changed a lot for us, me and my children. It is my own home.**

Simply providing housing is not necessarily the answer to successful re-entry. An important issue for men and women released from prison is the location of the housing. The location of the housing may assist men and women to separate themselves from their former social network and opportunities that originally contributed to their criminal activity.

For three clients interviewed the location of the housing was a critical issue.

One client told how he rejected an offer of housing because he was concerned about the house’s location which was in an area frequented by associates from his former life and time in prison. He was concerned that this would increase the chances of him returning to an offending lifestyle.

Another client spoke about the importance of the house’s location.

- **[Suburb name] is a long way from where I used to sell marijuana so I don’t run into people I used to know who were into drugs and they don’t know where I live and I want to keep it that way.**

A third client said:

- **Also this move has got me away from some of the family which got me into drugs.**

**CHANGES IN CLIENT CIRCUMSTANCES AND OUTLOOK FOR THE FUTURE**

Clients interviewed spoke about the way that their circumstances and outlook had changed as a result of contact with the HSW-CS and getting housing. Many felt more positive about their future.

One client said:
Because they got the Homeswest accommodation my life and that of the children is much more stable. Kids are doing well at school and now they don’t have to move...that changed outlook means that I am stepping away from my negative past which included breaking the law and prison. It means I am aiming for a much a more positive future.

Another client said that the most significant change resulting from contact with the HSW-CS was:

The change in myself.

The client continued:

Before this change I was in prison and my three children were staying in a country town with their father, which I was opposed to. I had no home to go to when I left prison and no prospect of support and it seemed unlikely I could get my children back. When [agency name] came on board they discussed with me what they could provide so I was able to plan for a much more positive future... Now I am in my own home, have my three year old daughter with me and with the support of Women’s Legal Service I am negotiating for visiting rights for my other children. I already have phone contact three times per week. Have good support now from my mother and siblings and I feel positive towards the future even though there are difficulties...

Why significant? Because I have changed in myself. I now believe I can plan, I can have some control and I now believe there is a positive future for me and my children.

**Benefits for Families and Children**

For clients with children the most significant change resulting from their contact with the HSW-CS has been family re-unification and the positive impact upon children and the family as a whole.

For women with children the shift from transitional accommodation to more secure and permanent housing was significant:

This made a huge difference as I was very stressed before as I had nowhere to go for me and the kids. This has been such a relief.

Having secure housing has made re-unification with children possible for some clients.

If it wasn’t for [agency] helping to fast track housing I would not have been able to get my three year old daughter back.

Having my own home means that I can now plan and advocate for my other two children and they can visit me and perhaps stay over.

Clients noted that children are more stable and secure and able to access services and support.

The kids are settled in school, boys have joined football. I am receiving ongoing counselling as are the two older children.

**Linking to Services**

Most clients were linked to at least one service while on the program. Table 3 provides a breakdown of the linkages made to various services. In addition to the links made for clients, children were linked to school and to recreation in 19% and
14% of cases respectively.

Table 3: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>77%</td>
</tr>
<tr>
<td>Other services</td>
<td>56%</td>
</tr>
<tr>
<td>Health Service</td>
<td>50%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>44%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>38%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>34%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>34%</td>
</tr>
<tr>
<td>Education Services</td>
<td>30%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>24%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>17%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>3%</td>
</tr>
</tbody>
</table>

Evidence from client interviews confirmed that clients were being linked to services. The information provided by clients indicates that NPAH workers have clearly played an important role in facilitating access to services and providing support to access services. Clients interviewed reported links with a range of services and agencies including:

- community legal centres, Legal Aid and lawyers
- government agencies such as DCP, Centrelink, schools
- DoH
- financial counsellors
- Food Bank
- other NGOs (Centrecare, Uniting Care West)
- local sporting clubs and churches
- counselling services
- local GPs.

**EMPLOYMENT AND TRAINING**

The data show a slight but encouraging increase in the number of clients engaging in full or part-time employment as they progress through the program – from 14 in the clients’ first six-month period to 20 in the clients’ most recent/final six-month period. There was a corresponding reduction in the number of clients who were unemployed/looking for work. There was no change in the number of clients not in
the labour force.

Two case studies of clients are now presented.

**CASE STUDY 1**

*James is a young father with shared custody of two young children who was referred to the NPAH service by the Department of Corrective Services (DoCS). At the time of the referral the client was the subject of an order and was due to go to Court over the matter. The client was homeless and had been sleeping on the street.*

The NPAH worker assisted the client to submit a priority waitlist application and communicate with DoH. This required the client, (with the NPAH worker’s assistance) to provide more evidence of parenting responsibilities. The NPAH worker supported the client during this time and assisted with issues arising from his parental responsibilities, including when he went to live with a parent. The NPAH worker also assisted the client with Court and DoCS matters.

James was offered a DoH house and the DoCS order removed. At the time of the interview James had been living in the DoH house for a couple of weeks. The client said:

> They got me the house and showed me that I can do things. It feels good.... I am looking forward to starting my life.... My kids can see we have a home.

**CASE STUDY 2**

*Two weeks before she was due to be released from prison Caroline had nowhere to live upon release. After approaching the Transition Manager in the prison, she was referred to the NPAH service. The worker made contact with her in prison to assess her circumstances and needs.*

Caroline had an outstanding debt to DoH and the worker worked with the client and DoH to establish a payment plan for the debt.

After advocacy and negotiation by the NPAH worker on her behalf she was offered a DoH house. This made it possible to re-unite with her children upon release.

Caroline was full of praise for the NPAH service and the worker. She said the most valuable aspects of the services were:

- support and advocacy to get the house
- negotiation of a debt reduction strategy with DoH
- assistance with payment of bills
- access to a financial counsellor
- assistance to get household goods, furniture and white goods
- information and assistance so that the client could access her various entitlements.

Caroline said the weekly/fortnightly contact by the worker felt intrusive at times but she acknowledged the meetings had been beneficial. Caroline said the most significant change was

> Keeping the family together.

Caroline was arrested again and the NPAH worker provided support and assistance at the time.
Caroline has successfully managed and maintained the property and her lease agreement was increased from three to six months and will soon be increased to 12 months.

Key Lessons

There are a number of key lessons in respect to the HSW Corrective Services.

**Many Young People who are Clients of the Program Lack the Life Skills and Experience to Live Independently in Public and Social Housing**

Staff from the agency working with young people said that the majority of young people lacked the life skills to be able to live independently. Workers were concerned that without these skills, the provision of housing to young people is ‘setting them up to fail’.

The agency reported that many young people lacked skills in budgeting, cleaning, food shopping, cooking and general house maintenance. The service reported that many do not understand that they are responsible for a property, for example for the cost of repairing any damage to the property. Clients also required intensive support in accessing services, such as Centrelink.

The agency argued that intensive and in-depth support needs to be provided to young people inside the correctional facility and after their release, to make the program work. This is likely to have contributed to the low percentage (38%) or three out of eight Juvenile Corrections clients who maintained their Department of Housing tenancy for 12 months or more.

These problems are compounded when clients in custody are referred just weeks or days before their release. As a result workers do not have enough time to work with young people to prepare them for independent living. To address these issues the agency has invested its own resources to develop and deliver a program inside correctional facilities to develop young people’s lifeskills so that they have greater capacity to live successfully in a community setting.

**Lack of Emergency Accommodation and Transitional Accommodation for People Exiting Prison**

The lack of emergency and transitional accommodation for people exiting prison was identified as a major issue, particularly in rural and regional areas. This is also an issue identified by the youth service, which reported that the majority of young people are unwilling to reside in hostels.

**Staff Turnover**

Staff turnover has been an ongoing issue for a number of services. Three of the funded services have had three different staff across the life of the Project.

Anecdotal information from interviews with staff and managers pointed to a number of factors that contributed to high staff turnover. These included the challenging nature of some clients, the short term nature of the contract positions, uncertainty about the future of the program, and the level of salaries compared to other positions. A number of staff interviewed who were soon to leave the program indicated that they were moving to more secure and better paid positions.
ASPECTS OF SERVICES PROVIDED BY THE HSW THAT ARE MOST VALUED AND BENEFICIAL

Clients were consistent about aspects of the HSW services that were most valued and helpful:

- they are able to establish and build a relationship with a single worker who understands their circumstances and does all that they can to assist the client
- the worker treats clients with respect, dignity and without judgment
- the services provided by the worker are not conditional on the client meeting a complex set of eligibility criteria or agreeing to a whole set of conditions
- the worker actively advocates and negotiates on the client’s behalf with other agencies, for example the DoH and Centrelink
- the worker is able to make a tangible difference in client’s lives through improvement in their material circumstances, for example by the use of brokerage funds to purchase whitegoods, furniture and household goods and household items such as toilet paper, cleaning products, food, crockery, curtains
- the worker is able to work with the client to address issues that are important to the client and not dictated to or determined by the worker
- the support and assistance provided by the worker is practical and relevant to the client’s circumstances.

The client interviews pointed to the quality of the inter-personal relationship between the client and the HSW-CS worker as a critical factor in achieving outcomes. Clients placed a high value on a supportive and trusting relationship between them and the HSW-CS worker as a factor contributing to the improvements and changes in their circumstances.

Clients valued persistent engagement and support and reliance and appreciated that they could contact the HSW when they needed help, knowing that help does not depend on them meeting certain criteria or conditions. This is particularly important for people who have been in prison.

PRIVATE RENTAL IS NOT A VIABLE OPTION

Private rental is not a viable option for the vast majority of clients. Service providers interviewed said that the lack of affordable rental properties, prohibitive cost of private rental housing, lack of income and negative attitudes of property managers and landlords are all barriers. All six workers who responded to the 2012 worker survey identified that the private rental market is difficult for clients to access because it is unaffordable.

HOUSING AS A PLATFORM FOR THE PROVISION OF HUMAN AND COMMUNITY SERVICES

One of the successes of the HSW-CS as evidenced by the client interviews is that the provision of housing provides a platform for the delivery of a range of social and
human services to improve quality of life and improve outcomes for clients and their families.

Other than access to suitable and affordable housing, clients of the program have a variety of complex and entrenched needs that require access to a range of mainstream services. This might include substance abuse treatment, mental health care, health care, income support, assistance with daily living, education and early childhood services, legal and court services, job training and employment services.

The services are clearly meeting client needs beyond just the provision and maintenance of housing and housing support (important although that is) and the client interviews show that services are generally assisting clients to make positive gains in other areas of their lives.

Summary and conclusions

Evidence from the evaluation shows that the speedy provision of housing and the delivery of housing related support by the various HSW services are making a significant difference in the lives of clients accepted into the program. Evidence shows that the program is:

• assisting clients who exit from prison to gain and maintain housing
• successfully linking clients to mainstream and specialist services
• reuniting families
• assisting men and women and young people who exit from prison and/or the corrective services system to re-enter and reintegrate into their communities
• enabling former incarcerated people to turn their lives around
• bringing security and stability to the lives of children.

Suggestion for improvement

In view of juvenile offenders’ limited independent living skills and their requirement for intensive support, the suitability of a housing support model for juvenile offenders should be reviewed and if necessary an alternative model developed to assist them into stable accommodation. This has been included as a recommendation in the overview section of the report.
Drug and/or alcohol misuse are recognised as both causes and consequences of homelessness. The prevalence rate of alcohol and substance misuse is higher among the homeless than in the general population and there is evidence that once people become homeless, alcohol and substance misuse increases. Co-morbidity with mental health disorders is common. Stable housing during and after treatment is important for successful treatment as it reduces the likelihood of relapse.

The Housing Support Worker – Drug and Alcohol program (HSW-D&A) is an integrated response to homelessness and substance misuse treatment that is likely to improve outcomes for clients. To be eligible for the program clients must be currently engaged in treatment, completing a residential treatment program or have a history of previous engagement with treatment services and a willingness to re-engage.

Description

This program works with clients who have undertaken treatment for drug and alcohol issues and who might otherwise become homeless after exiting the treatment services or while they are receiving assistance with their substance abuse. Intensive support is targeted at clients to secure and maintain stable accommodation. A key element of the support is to assist with addressing substance abuse but it also aims to address a range of associated issues through linkages with mainstream services in order to achieve long term, secure, stable housing. Referrals are from the drug and alcohol agency which is discharging the client or from homelessness workers in non metropolitan areas.

The following services have been contracted to provide the HSW-D&A program.

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http://ahuri.ddsn.net/publications/download/80568_pp

80 Didenko, E. & Pankratz, N. op. cit.
Table 1: Funded services

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Support Drug &amp; Alcohol South West Metro</td>
<td>Anglicare</td>
<td>Fremantle/Rockingham</td>
<td>1.5 FTE</td>
</tr>
<tr>
<td>Housing Support Drug &amp; Alcohol North West Metro</td>
<td>Mission Australia</td>
<td>Warwick/Joondalup</td>
<td>1.5 FTE</td>
</tr>
<tr>
<td>Housing Support South East Metro</td>
<td>Mission Australia</td>
<td>Cannington/Gosnells/Armadale</td>
<td>1.5 FTE</td>
</tr>
<tr>
<td>Housing Support Drug &amp; Alcohol North East Metro</td>
<td>Swan Emergency Accommodation</td>
<td>Midland/Mirrabooka</td>
<td>1.5 FTE</td>
</tr>
<tr>
<td>Housing Support Drug &amp; Alcohol Peel</td>
<td>Anglicare</td>
<td>Peel</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Housing Support Drug &amp; Alcohol Fitzroy Crossing</td>
<td>Nindilingarri Cultural Health Services</td>
<td>Fitzroy Crossing</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Housing Support Drug &amp; Alcohol South West</td>
<td>Centrecare</td>
<td>Bunbury</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Housing Support Drug &amp; Alcohol Pilbara</td>
<td>Pilbara Legal service</td>
<td>Hedland</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

**Key features**

The support and assistance provided by the eight services funded to provide housing support for this program in general have the following features:

- intensive support to assist clients to obtain and maintain long-term stable housing
- integration and collaboration with specialist drug and alcohol services
- active support to clients to access mainstream services, including education employment and training and assist them in practical ways to settle into their community
- use of brokerage funds to establish or support accommodation
- case management approach.

**Evaluation data sources**

The data sources for the evaluation were as follows:

- Progress Reports and tracking sheets provided by DCP
- interviews with managers and workers from each of the eight services
- 15 client interviews

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0.5 FTE employed in Palmerston.
• data provided by DoH
• 12 responses to the on-line worker survey (seven in 2011 and five in 2012)

How much has the program done?

The target for the program is 20 clients a year per FTE assisted. This is based on a case load of 10 clients per FTE at a time for an average of 6 months. Over 2.5 years this equates to 430 people assisted. This target was not met. There were only 293 clients assisted due primarily to two country services operating for one reporting period only and a slow start by other programs in the first six months.

Even allowing for this, only two agencies came close to achieving their targets. Interviews with managers and information from the Progress Reports indicate that suitable referrals are an issue for this program. Table 1 shows the number of new and ongoing clients worked with by agencies in each six month period.

Table 1: Primary clients worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New clients</th>
<th>Ongoing clients</th>
<th>Repeat clients</th>
<th>All clients in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>29</td>
<td>0</td>
<td></td>
<td>29</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>70</td>
<td>27</td>
<td></td>
<td>97</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>62</td>
<td>77</td>
<td></td>
<td>139</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>62</td>
<td>107</td>
<td></td>
<td>169</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>70</td>
<td>98</td>
<td>1</td>
<td>169</td>
</tr>
<tr>
<td>TOTAL INDIVIDUALS</td>
<td>293</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The service agreement start date was 1st January 2010. One country program did not operate until the January – June 2012 reporting period due to recruitment problems associated with the lack available housing in the area. Another country service had experienced similar problems but in April 2011 was able to recruit a person whose partner was already employed in the town. This program ceased in the July – December 2011 reporting period after the worker left town and the service was unable to recruit another worker due to lack of available housing.

The clients

The client group was fairly evenly split between males (52%) and females (48%). The average age of primary clients was 36 years (range 15 – 63 years). The percentage of Aboriginal and CALD clients assisted by this program is reasonably high.
Two hundred and sixty-seven clients (91%) identified themselves as having an alcohol and/or drug related disability, including 113 (39%) who identified as having a dual diagnosis of mental health and drug and alcohol problems, 2% identified themselves as having a problem with mental health and 2% as having a medical or physical disability.

Managers/workers described the client group as homeless people whose alcohol and other drug use was a factor in their ability to secure and maintain stable, long-term accommodation. Because of program requirements nearly all clients were or had been engaged with drug and alcohol treatment services. Some had co-morbid mental health issues, for example, anxiety and depression. Financial problems and relationship issues were common. Those coming from residential treatment units may have experienced problems settling back into the community. Aboriginal people from families and/or communities where drinking is entrenched may have been ostracised when they decided to give up the ‘grog’.

The clients’ descriptions of what was happening in their lives when they became involved with the program confirmed histories of drug and alcohol misuse, domestic violence and relationship issues, mental health and other health problems and housing instability.

I was hooked on drugs – anything and everything. I had lots of anger issues and having failed relationships... I spent time on a park bench and was moved on by Police... I am in extreme pain but there is a warning sign on the computer about drugs and doctors are restricted in what they can give me. I had my teeth pulled out at the start of the year. Now I have no teeth. I take pride in the way I look and now I can’t smile.

I was in rehab and had nowhere to go when I left. It is pretty stressful in rehab to try and sort out your life with nowhere to go. [Client lost her children when they were apprehended by DCP. She is now in a re-unification program].

I had a breakdown and was in a mental ward for six weeks.

Suitable independent accommodation, ongoing emotional support, drug and alcohol and financial counselling and social supports were identified by managers as the
most critical needs for this group of clients. Some also required mental health, domestic violence and re-unification (with children) services.

In addition to the 293 clients there were 210 children ranging in age from 0 – 17 years involved in the program. Household composition is shown in Table 2.

**Table 2: Household composition**

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>10</td>
<td>3%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>25</td>
<td>9%</td>
</tr>
<tr>
<td>Extended family</td>
<td>8</td>
<td>3%</td>
</tr>
<tr>
<td>Single female</td>
<td>55</td>
<td>19%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>74</td>
<td>25%</td>
</tr>
<tr>
<td>Single male</td>
<td>95</td>
<td>32%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>14</td>
<td>5%</td>
</tr>
<tr>
<td>Other</td>
<td>12</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>293</td>
<td>100%</td>
</tr>
</tbody>
</table>

The main source of income for all clients when they started the program was other government payment (see figure 2). Fourteen percent were in the workforce, 64% were unemployed and looking for work, 3% were students and 16% were not in the labour force.

**Figure 2: Income source**

![Income source chart](chart)

**Referrals**

Referrals were mainly from drug and alcohol services as would be expected (see figure 3). The residential alcohol and drug services were the largest referral source. The second most common source of referrals were the metropolitan Community Drug Service Teams. Only one metropolitan service received a substantial number of referrals from both residential services and Community Drug Service Teams.
The country Community Drug Service Teams were the largest single source of referral to country HSW-D&A but referrals came from other sources as well.

The uneven spread of referrals from the Community Drug Service Teams suggests that potentially the teams could refer more cases than they currently do. This would require increased and persistent promotion from the HSW-D&A and may result, at least initially, in an increase in unsuitable as well as suitable referrals but would probably be worthwhile in the long run. The following comment taken from a Progress Report suggests that such promotion will come at a cost.

[Agency] has also worked very hard to promote our services to the referring DAO (drug and alcohol) services and this has seen a slight increase in referrals. Staff changeover and lack of handover at referring agencies seems to impact on referrals to our service. The constancy of this cycle and the time taken for workers to continually promote the NPAH program impacts on case efficiencies...

**Figure 3: Referral source**

![Pie chart showing referral sources]

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**Engagement**

140 cases (48%) were closed by the end of June 2012. These cases were open an average of 259 days or about 8½ months (median 242 days, range 0 – 708 days). Sixty percent of clients remained in the program for at least six months, 46% for at least nine months and 31% for at least a year.
ACCOMMODATION

The program has been successful in obtaining accommodation for clients and/or assisting them to maintain accommodation. Seventy-six percent were recorded as accommodated in their most recent/final period of contact. Most clients (79%) were accommodated before their case was closed.

By their most recent/final support period 47% of all clients were recorded as accommodated in public housing, 13% in private rental accommodation and 5% with family. The remainder were accommodated in a mix of private lodgings, community housing, lodging houses, caravans and other.

Figure 4: Accommodation type in the most recent final period of support

As figure 5 shows the program has been moderately successful in assisting clients to maintain their tenancy or to acquire a new tenancy. Half of those with the tenancy outcome ‘other’ appear to have been accommodated, i.e. they had an accommodation date. Most of these were in boarding/lodging house situations or had returned to their family.

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82 Whether someone was accommodated is based on the person having an accommodation date recorded. It is probable that those with an accommodation type but no date recorded were in fact accommodated.
DoH data show 124 households identified with the HSW-D&A program accommodated between 1st May 2010 and 30th June 2012. Fourteen of these vacated their tenancy – two died, one was housed by a community housing organisation, two gained a private lease, six vacated because of changed circumstances or they were unable to cope, and three were formally terminated or evicted.

In a competitive and largely unaffordable private rental market HSW-D&A clients are mainly reliant on DoH for permanent accommodation.

A prominent challenge for this client group is their inability to secure a rental property because they either do not have a history of renting or they have lost a tenancy, for one reason or another, resulting in black listing on the national real estate register (Progress Report).

An issue that has begun to emerge in the Progress Reports and the 2012 on-line worker survey is the increased wait for DoH accommodation. One agency observed:

Clients waiting to be housed are doing more ‘couch surfing’ and their anxiety levels have escalated. As a result of this their drug and alcohol relapses have increased.

PROGRAM HELPFUL

In addition to assisting clients to maintain their existing tenancies or to obtain new ones, manager and client interviews and the Progress Reports indicated that the services are flexibly supporting clients in many aspects of their lives including:

- support to continue with their drug and alcohol treatment
- support in times of crisis – relapse, family issues, mental health issues,

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83 Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.

84 Department of Housing data relate to households but it is reasonable to assume that there is a 1:1 relationship between a client in the program and a household identified as linked to the program. The most likely explanation for the discrepancy between tracking sheet data and DoH data is that not all HSW-MH cases were flagged by DoH staff.
financial problems

- support to whole families to ensure they are linked with appropriate services
- support to access mainstream services
- assistance with independent living skills.

One manager commented:

_Because of where they are in their rehabilitation some people need to cut off from their previous social circles and they are lonely. A lot of time is spent trying to make connections and create new social support networks. We help them to set boundaries with neighbours who may also have these [same] problems. We work around focus on recovery and not getting involved. They are very vulnerable._

Contact is likely to be frequent in the first few months and then scaled back. Concern was expressed by some managers and workers that there will be clients who will need support for longer than 12 months if they are to sustain long-term accommodation.

Clients interviewed were appreciative of the support that they had received from the HSW-D&A. Obtaining accommodation and the personal support was what they found most helpful about the program. However it was evident that clients were given practical and material help as well. A client who had been housed for 12 months and was just off the program said:

_Helping me obtain accommodation – I credit [agency] for that because they came to the interview and within a few weeks I was offered this place. I don’t think it would have happened without them. Some food relief and a washing machine. [Worker] encourages me. I have been taken out for coffee a couple of times. She phones and I see her every now and then. Great._

Another client said

_[Worker] got me onto the Homeswest priority list. I was on the ordinary list. She kept seeing me every fortnight and was on the end of a phone. She kept me on track in attending AA meetings. She was able to get a $400 grant to assist me with furniture for the house. She got me a big Christmas hamper. I moved on the 15th of December._

**With what results?**

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

**ACCOMMODATION MAINTAINED FOR 12 MONTHS**

Information provided by agencies indicated that 96\(^85\) clients had maintained

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\(^{85}\) 85 of these clients are known to have been accommodated before 1st July 2011, the remainder were either missing the accommodation date or their most recent accommodation date was after 1st July but the agency considered that they had maintained stable accommodation despite a change of address or because of the
accommodation for at least 12 months. In addition to these clients, 91 other household members (for example, partners/children) living with the clients were reported to be accommodated. Four clients were reported not to have maintained their accommodation and two clients were deceased.

It is reasonable to assume based on the data that a further five clients accommodated before 1st July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 28 clients also recorded as accommodated before 1st July 2011 although some would undoubtedly have maintained accommodation for 12 months.

Thus of a potential pool of 135 eligible clients at least 75% (101) were stably accommodated for at least 12 months. The Housing Support Worker – Drug and Alcohol program has met its target of 75% of clients stably accommodated for 12 months.

**Figure 6: Flowchart**

Independent data from the Department of Housing indicates that of 68 Drug and Alcohol clients accommodated in public housing between 1st May 2010 and 30th June 2011, 90% retained their tenancy for 12 months or more. This is a very positive outcome.
LINKING TO SERVICES

Nearly all clients were linked to services while on the program. Table 3 provides a breakdown of the linkages made to various services. As would be expected with this client group, the highest number of linkages were with drug and alcohol services. The number of links to mental health services were consistent with the proportion of clients who identified themselves as having mental health problems in addition to their problems with drugs and/or alcohol.

The interviews confirmed that the HSW-D&A supports clients to link to mainstream agencies, for example:

- She assists me to get appointments.
- [Worker] put me onto a chiropractor. It improved my quality of life 50%.

Access to mainstream services needed for this client group was constrained by services’ waitlists. The on-line worker surveys identified long waitlists for community mental health services, domestic violence counselling services and for financial counselling/budgeting services in particular. Access to community drug and alcohol services was not problematic but the manager interviews and the on-line worker surveys indicated that in some areas access to residential rehabilitation may be a problem.

Table 3: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug and Alcohol Services</td>
<td>90%</td>
</tr>
<tr>
<td>Centrelink</td>
<td>89%</td>
</tr>
<tr>
<td>Health Service</td>
<td>76%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>64%</td>
</tr>
<tr>
<td>Other services</td>
<td>63%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>54%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>48%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>45%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>33%</td>
</tr>
<tr>
<td>Education Services</td>
<td>28%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>11%</td>
</tr>
</tbody>
</table>

In addition to the links made for clients, children were linked to school/childcare and to recreation in 28% and 27% of cases respectively.
**EMPLOYMENT AND TRAINING**

The data showed a small but encouraging increase in the proportion of clients engaged in employment or study between their first and final/most recent period in the program. Progress Reports identified clients gaining employment as amongst the program’s achievements, for example:

*Other achievements have been clients establishing and maintaining themselves in employment. Through gaining employment a client has commenced purchasing his own home through the DoH’s Keystart programme. One client has been working in retail, another is doing motor trimming, one has been employed to work in the mines, & another is doing scaffolding and roofing work. Other clients are considering courses at TAFE & Catalyst Clemente. Another has established his own business & is doing restoration of furniture at his home. A client who has been on the programme for four months is part of an Art Exhibition in August and will have some of his paintings on display.*

Three of the clients interviewed were engaged in study with a view to gaining employment and two had started part-time work. One of the clients said:

*I have been a full-time student since last February [2011] and signed up in late November to do a Certificate IV in Laboratory Technology. Laboratory Technician is what I want to be.*

**REBUILDING RELATIONSHIPS WITH FAMILY AND FRIENDS**

Relationships with families and friends can be destroyed by alcohol and drug addictions. Managers have noted that as a result of HSW-D&A some clients have been able to rebuild these relationships. The client interviews provided some evidence of this, for example:

*[A significant change was] getting my family back together. I am now able to see my granddaughter.*

Homelessness and addiction in a parent can adversely affect children. Several clients commented on how gaining stable accommodation had improved the lives of their children.

*I got a house within three days. Now I have the certainty of my own home and the kids are more settled.*

*The program has made a great difference in that I now have somewhere to live, something that is mine, where I can’t be kicked out of. It is stable and my son will not have to change schools again like he had to do in the past.*

*The children are happier.*

**RE-unification with children**

One of the consequences of alcoholism or drug addiction, particularly when associated with homelessness, is that the safety and wellbeing of children can require that DCP remove them from their parents’ care. Maintaining sobriety and obtaining a house can pave the way to re-unifying children with their parents. Managers identified this as one of the results they were seeing from the program. The case study below is one example of this.
TURNED LIFE AROUND / MAINTAINING SOBRIETY

Many of the clients interviewed commented to the effect that the program has turned their lives around.

I have got back on my feet...I would be lost without them.

Control - being able to say no, especially to alcohol. I am stronger within. I can walk the talk. I am grown up. I have been able to think like an adult. Deal with it instead of avoiding it... I have fallen a couple of times but I haven't given up.

It has given me my self-respect back. They didn’t just give a food voucher and send me away. They were interested in me as a person. They are willing to help as far as they can if you show you are ready.

Helped me restart life basically. I was going nowhere abusing alcohol. I started again and got back into school. My health returned. I credit it all to [agency].

CASE STUDY

Flora is the mother of three children under 15 years of age who was referred to [agency] from residential rehabilitation. The children are in the CEO’s care as a result of Flora’s long-term use of methamphetamine and her previous involvement with its manufacture and sale. A previous attempt at reunification failed. Flora was committed to overcoming her addiction but faces financial challenges, a poor housing record and strained family relationships.

HSW-D&A visited Flora in rehabilitation and established a solid working relationship with her. The worker successfully advocated for Flora to be allocated a transitional three bedroom house despite being a single mum with limited financial means so that the children could stay overnight as part of the reunification process. The worker supported Flora to link to parenting support services, medical services, alcohol and drug counselling and counselling for the children. She provided financial assistance to help Flora deal with historical debt and provided transport to important appointments.

The worker attended all DCP case management meetings and provided feedback to the case worker. Flora said:

She came to DCP meetings. They are usually on her day off but she still comes. It is pretty important.

Flora has been clean and sober for 18 months. She has completed Certificates III and IV in Community Services and is currently completing a work placement where she has been offered paid work. She has attended counselling sessions with her children and has gradually built up time with them. She expects to have their full-time care by the end of 2011. Flora now has a DoH house. Asked what difference the program made to her Flora said:

I know that I have got support when things get really stressful. Someone cares. It makes it easy to say I am struggling a bit. Practical things like if I am struggling to get to urinalysis.

Flora has been on the program for 12 months but worker will continue to support her for another six months to provide support when reunification happens.

Looking back over the time she was on the program Flora said that the most significant change in her life was that:

89 Based on a client interview and an edited agency case study.
I have a house – somewhere the kids can come and it is home.

Key lessons
There are a number of key lessons specific to the HSW-D&A.

Housing must be available for workers and clients
In areas like the Kimberley and Pilbara where housing is either not available or available only at extraordinarily high rental, unless accommodation can be made available for workers and there is some guarantee of timely housing for program participants, a program like the HSW-D&A should not be implemented.
The Fitzroy Crossing and Hedland services received an extra $15,000 per annum per FTE to compensate for the fact that worker housing was not included in the package but in spite of this additional funding the agencies concerned still found it difficult to recruit staff and start-up was significantly delayed. The Fitzroy Crossing service has since closed.
In Hedland, at the time of the 2012 evaluation visit, the worker had six clients on her books, one was housed and four were housing ready but despite an expectation that DoH would make housing available there was no indication of when that would be. There were just not houses available for DoH to allocate. The clients were engaged with the service and with the local mental health/drug and alcohol service team. The situation was distressing for those involved and potentially counterproductive for the clients who were highly motivated by the expectation that they would secure stable housing.

Relapse
The possibility that clients may relapse while in the program needs to be factored in to the program. Not all clients are able to ‘kick’ their problems the first time round and triggers can be unexpected, for example, death of a friend or relative, relationship breakdown. The targeted average of 12 months support is difficult if relapse occurs close to a case being closed as ongoing support would enable the service to ensure that both the tenancy and recovery are maintained.

Mental health services
Mental health and alcohol and drug comorbidities are common among HSW-D&A clients therefore timely access to mental health services is important. There has been at least one example of accommodation breaking down when a client with serious mental health problems could not be immediately linked to a mental health service. All workers responding to the 2012 on-line worker survey indicated that there is a long waitlist for community mental health services.

Financial services
Financial problems were identified by managers as one of the main issues faced by HSW-D&A clients. Inability of clients to manage money and pay bills can put tenancies at risk, therefore access to financial and budgeting services is important. All workers responding to the 2012 on-line worker survey indicated that there is a long
waitlist for financial and budgeting services.

**PRIVATE RENTAL NOT AN OPTION**

Managers have advised that private rental is not an option for most HSW-D&A clients. The main source of income for the majority of clients is New Start (75%) and at current rents the private rental market is not affordable for them. In addition, because of their addictions and unemployment clients often have debts from non-payment of rent and property damage and may be blacklisted by property managers.

**LOCATION OF ACCOMMODATION IS IMPORTANT**

For this client group it can be important that their new accommodation is away from access to drugs, people they knew in prison and friends and acquaintances who may try to tempt them back into old habits. If a client is allocated public housing in a location that is unsuitable for them it is important that, with the support of the HSW-D&A, they are able without penalty to refuse the property.

**Summary and conclusions**

The HSW-D&A program successfully obtained accommodation for clients and has met its target of 75% of clients accommodated before 1st July 2011 supported to maintain their accommodation for twelve months.

Public housing was the most common accommodation type and 90% of these clients accommodated before 1st July 2011 maintained their accommodation for twelve months.

The program has linked nearly all of the clients to the services they need and there is evidence that as a result of being on the program and accommodated clients are returning to study or getting back into the workforce. Maintaining sobriety, rebuilding relationships and re-unification with children are other benefits from the program.

In the Pilbara and Kimberley lack of affordable housing options for workers and clients adversely impacted HSW-D&A services.

The program has, however, fallen short of its target of 430 clients assisted by 32%. While this was mainly due to two services operating for only six months of the 2½ year period, there was also a shortfall in referrals to all services. It is unlikely that this shortfall is due to lack of demand. More likely it is due referral agencies not making referrals when suitable clients present possibly because they are unaware of the program or lack understanding of what clients are suitable for referral.

**SUGGESTION FOR IMPROVEMENT**

It is recommended that HSW-D&A services develop a program of ongoing promotion to residential rehabilitation services and to Community Drug Service Teams.

NPAH Housing Support Worker programs should not be established in areas where there is no realistic expectation of clients being accommodated in public or community housing or in the private rental market. This has been included as a recommendation in the overview section of the report.
The Government’s White Paper on homelessness noted that the inability of specialist homelessness services to move people into affordable housing contributes to high turn away rates in those services and to people moving from one specialist service to another, or back to the streets.

The White Paper states that services should be able to provide differential levels of support to people who are homeless, depending on their needs\(^{90}\).

The decline in the size and funding of the public housing sector over the last two decades\(^{91}\) and the effect of welfare targeting has meant that the composition of tenants in public housing has changed considerably.

Public housing has become residualised\(^{92}\) and now mainly houses the most marginalised and disadvantaged tenants who are reliant on income support and social welfare services\(^{93}\).

This has significant implications for a program like the Homeless Accommodation Support Worker Program which relies on timely access to public housing to house clients.

**Description**

The Homelessness Accommodation Support Worker services (HASW) provide intensive support to homeless individuals and families and people who have experienced homelessness.

The goal of the HASW is to assist and support individuals and families to move from temporary and crisis accommodation into long term secure housing and to secure and maintain stable accommodation. The HASW also assists individuals and families to effectively link with mainstream services.

HASWs work with clients to address other issues and needs that impact on the tenancy, including employment, education and training, health, financial management and community and social participation.

Funded services are shown below.

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91. Parliament of Western Australia, Community Development and Justice Standing Committee 2011, *A Fading Dream- Affordable Housing in Western Australia*, Report No 8 in the 38th Parliament, Legislative Assembly, Perth Western Australia, November 2011, pp 3
<table>
<thead>
<tr>
<th>Coverage</th>
<th>Service Location</th>
<th>Provider</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consortium Model-</td>
<td>Joondalup</td>
<td>Centrecare, Joondalup Youth Support Services and Patricia Giles Centre</td>
<td>3 FTE</td>
</tr>
<tr>
<td>North West Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North East Metropolitan</td>
<td>Midland</td>
<td>Swan Emergency Accommodation</td>
<td>1 FTE</td>
</tr>
<tr>
<td>North East Metropolitan</td>
<td>Mirrabooka</td>
<td>Mercy Community Services</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South West Metropolitan</td>
<td>Fremantle</td>
<td>Fremantle Multicultural Centre</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South West Metropolitan</td>
<td>Fremantle/Rockingham</td>
<td>Virgin Care, Rockingham Community Services</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South East Metropolitan</td>
<td>Armadale/Gosnells</td>
<td>Mission Australia</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South East Metropolitan</td>
<td>Gosnells/Cannington</td>
<td>Centre Care, Cannington Community Services</td>
<td>1 FTE</td>
</tr>
<tr>
<td>South West Metropolitan</td>
<td>Bunbury</td>
<td>Accord West</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Pilbara</td>
<td>Karratha</td>
<td>Pilbara Community Legal Centre</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Peel</td>
<td>Mandurah</td>
<td>WestAus</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Kimberley</td>
<td>Derby</td>
<td>Marnin Bowa Dumbara Aboriginal Corporation</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Murchison</td>
<td>Geraldton</td>
<td>Geraldton Resource Centre</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Wheatbelt</td>
<td>Northam</td>
<td>Share and Care</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Great Southern</td>
<td>Albany</td>
<td>Anglicare</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Goldfields</td>
<td>Kalgoorlie</td>
<td>Australian Red Cross</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

The agreements for the majority of HASW services commenced on 1st January 2010. Three services commenced later, one on 1 April 2010, one on 1 July 2010, and one on 1 January 2011.

Key features

The support and assistance provided by each HASW has a number of features:

- working closely with NAHA and specialist homeless accommodation services
- enabling access to housing (public housing, social housing and private rental) and liaison with housing providers

\[^{94}\] Initially the FTE was shared .05 between Australian Red Cross in Kalgoorlie and Esperance Crisis Accommodation Support Service but the latter withdrew from the program in 2011.
• liaison and advocacy with DoH
• in-depth and detailed assessment of client and family needs
• structuring services and intensive support around the needs of each person or family (person centred services)
• providing intensive support and assistance with daily tasks and living skills
• varying the intensity of services and support over time
• visiting clients in their own homes
• using brokerage funds to address issues that put the tenancy at risk
• using brokerage funds to establish a new tenancy
• linkages and referral to mainstream and specialist services and agencies so that clients can access assistance and support
• building the tenant’s capacity to resolve tenancy issues and participate in social, community and economic life.

Evaluation data sources
Evaluation data sources included:
• tracking sheets and Progress Reports provided to DCP by each agency
• interviews, focus groups and workshops with managers and workers from all funded agencies in 2011 and 2012
• 51 responses to the on-line survey (23 in 2011 and 28 in 2012)
• interviews with 35 clients\textsuperscript{95}
• informal discussion with managers and staff
• data provided by DoH
• review of relevant literature and documents.

How much has the program done?
The target for the program is each FTE to assist 20 clients a year. This is based on 10 clients at a time supported for an average of six months. Over 2½ years this equates to 820 people assisted. The target was met with 848 (770 client 1s and 78 client 2\textsuperscript{96} assisted between January 2010 and June 2012. Table 1 shows the number of new and ongoing clients worked with by agencies in each six month period.

\textsuperscript{95} Of the clients interviewed 82\% were in public housing, 12\% were in social/community housing and 6\% were in private rental at the time of interview.
\textsuperscript{96} Client 2s are other adults – usually partners of client 1s – living in the house with whom the worker has had some engagement.
Table 1: Total number of clients (both clients 1 and 2) worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New clients</th>
<th>Existing primary clients</th>
<th>All primary clients in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>73</td>
<td>1</td>
<td>74</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>217</td>
<td>67</td>
<td>284</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>163</td>
<td>193</td>
<td>356</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>209</td>
<td>219</td>
<td>428</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>186</td>
<td>256</td>
<td>442</td>
</tr>
<tr>
<td>Total individuals</td>
<td>848</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The clients

The majority of client 1s were female (79%). The situation was reversed with client 2s with 72% being male. The average age of primary clients was 32 years (range 19 – 73 years). The percentage of Aboriginal and CALD clients assisted by this program is notably high\(^97\).

Figure 1: Cultural background of the primary client group

One hundred sixty-five client 1s (21%) identified themselves as having a mental health disability, including 49 who identified a dual diagnosis of mental health and drug and alcohol problems, 7% identified themselves as having a problem with alcohol and 4% as having a physical, sensory or intellectual disability.

In addition to the 770 client 1 and 78 client 2 there were 1196 children involved ranging in age from 0 – 17 years bringing the total number of people supported by this program to 2054. Household composition is shown in Table 2. Nearly 70% of clients are parents (or grandparents) with children, 53% are single females with children.

\(^97\) Includes client 1s and 2s.
Table 2: Household composition

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>14</td>
<td>2%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>78</td>
<td>10%</td>
</tr>
<tr>
<td>Extended family</td>
<td>17</td>
<td>2%</td>
</tr>
<tr>
<td>Single female</td>
<td>111</td>
<td>14%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>408</td>
<td>53%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Single male</td>
<td>108</td>
<td>14%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>23</td>
<td>3%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>770</td>
<td>100%</td>
</tr>
</tbody>
</table>

The main source of income for all clients when they started the program was some form of government payment. Twelve percent were in the workforce in full or part-time work, 22% were unemployed and looking for work, 5% were students and 59% were not in the labour force.

**Figure 2: Income source**

In addition to long periods spent homeless and/or in precarious housing, clients have complex and multiple needs that require ongoing and intensive support. This can include:

- mental health issues
- family and domestic violence,
- long periods of unemployment
- disabilities
- severe financial deprivation and hardship, and lack of income
• trauma from life events including death of a partner and children, family and relationship breakups, migration
• inability to care for self and children
• serious health issues
• caring responsibilities for children with serious health issues and behavioural problems
• language difficulties (inability so speak English).

How well has the program done its job?
This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

Engagement
420 cases (55%) were closed by the end of June 2012. These cases were open an average of 230 days or over seven months (median 209 days, range 0 – 721 days). Two thirds of clients remained in the program for at least six months, 46% for at least nine months and 23% for at least a year.

Accommodation
The program has been moderately successful in obtaining accommodation for clients and/or assisting them to maintain their tenancy. Seventy-three percent are shown as accommodated in their most recent/final period of contact.98 Nine percent of these had the tenancy outcome ‘other’.

Figure 3: Tenancy outcome for recent/final contact period99

DoH data show 282 households identified with the HASW program 100

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98 Whether someone was accommodated is based on the person having an accommodation date recorded. It is possible that those recorded as ‘returned to family’ or ‘other’ where no accommodation date was recorded remained in that accommodation.

99 Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.
accommodated between 1st May 2010 and 30th June 2012. Twenty-five of these vacated their tenancy – seven tenants vacated for reasons deemed acceptable by DoH, nine vacated due to changed circumstances, one vacated because of disruptive behaviour, two vacated because of harassment and six were formally terminated or evicted.

**PROGRAM HELPFUL**

The HASW program (like the other NPAH programs) is designed to enhance clients’ sense of autonomy and operates to promote the client’s priorities and interests. The goal is to build client’s sense of autonomy and control over their housing situation and their lives.

HASW services respect client choice and tailor services to client needs and client circumstances. Services ensure that client goals are self-directed rather than imposed or controlled by the worker or agency.

Clients interviewed highlighted the benefit of this approach and described how HASW services assisted them to:

- get their lives back in order
- re-establish a stable base for their children
- recover a sense of self-worth
- regain control and dignity in their lives
- get a sense of security
- deal with issues if things get too bad
- rediscover hope and future possibilities.

Many clients described how the HASW program has given them back control, respect and confidence they had lost because of the crises swirling around them. One client put it this way:

> First time in a long time that I have a sense of control over my own life. I felt helpless before. One problem and difficulty after another. No support, no money, trying to keep children in school, studying, threatened loss of home and children, DV. Just impossible to cope... Now given control again and supported. You’re not on your own and have the strength and confidence to act and improve the life of my children

One client described the HASW worker this way:

> The original support she gave was just brilliant...not just the housing...she was also good for emotional support. That was really nice. It didn’t feel like she was just doing a job. It felt like she actually cared.

The client appreciated that she could contact the HASW worker if things went bad:

> ...if things go wrong there is someone to help. Just a bit of personal security in the fact

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100 Department of Housing data relate to households but it is reasonable to assume that there is a 1:1 relationship between a client in the program and a household identified as linked to the program. The most likely explanation for the discrepancy between tracking sheet data and DoH data is that not all HSW-MH cases were flagged by DoH staff.
Clients valued the ongoing support provided by workers. In particular, they appreciated that the HASW workers can be contacted if matters became too much for them or they needed someone to talk to about issues. For many clients having someone to talk to about issues or to assist during difficult times was one of the most helpful and useful parts of the program:

Part of the security is knowing if an issue comes up I can phone [agency] and they will talk things through or take action.

[Agency] provided someone to talk to who really cared about me. I was so alone and it made such a difference knowing there was someone I could contact who did care.

If we have any problems we can call [worker] or a Homeswest officer and they will talk them through with us and help us.

They are there if I need help.

Someone I can phone up if really worried and they will come out and help me deal with things.

Now have a good house and help with other things, like reading and writing letters anytime I require it.

One client said the ongoing support was even more important than the housing:

The house is great but more important is the back up support for 12 months after the initial help with the same worker.

With what results?

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

ACCOMMODATION SECURED

For the majority of clients interviewed securing permanent housing was the most significant change resulting from the program.

One client who had been evicted from private rental and was forced to move her children constantly between family and friends and emergency and transitional accommodation said:

The most significant change has been moving into the DoH house... The house made a huge difference as I had been blacklisted. Getting the housing has meant that the children and I are much more settled.

Another client who moved from private rental to emergency and transitional accommodation and then into public housing following the death of his wife and son spoke about the importance of obtaining public housing:

Knowing that I have a house and knowing that the kids are safe... The change is significant for me because I have lost a wife and a son but I have two children left and their safety and wellbeing is the most important thing. It is lovely to see them smile
and be settled and have friends and stability.

Many clients described how being accepted into the HASW program and receiving a housing allocation has transformed their lives. They feel more secure and their lives and those of their children are more stable. Clients said:

*Getting our own house that was affordable was the most important thing. It is a good thing for us.*

*The housing was the most important thing. The security of having somewhere to live and not stressing out.*

*Without this house I would be homeless.*

A mother with three young children said getting a house was the most important thing in life.

*I have never had a house of my own before I got the place, got the house and [I am] settled for life.*

Clients valued the support and assistance provided by the HASW worker to navigate their way through the DoH housing approvals process. This was particularly important for clients who had been told by DoH or agencies that they were ineligible for DoH housing and those clients whose application had been rejected. Many of the clients said they were unable to do that themselves.

The types of support and assistance with housing applications valued by clients included:

- letters of support
- interpreting and explaining documents
- assistance writing letters
- completion of DoH forms and application
- liaison with DoH on the client’s behalf
- gathering and providing supporting documentation
- lobbying and advocacy on the client’s behalf with DoH
- following up applications
- addressing issues that made the client ineligible for DoH housing, for example, past debt
- assistance in appealing DoH decisions.

Many clients described how the HASW worker assisted to get them onto the DoH priority waiting list:

*The refuge could not get me on the priority list. [Worker] got me on the list.*

Another client said the assistance provided to apply for private rental housing was the most helpful part of the program.

*Definitely applying for housing was most helpful. I had never done that before...my partner in the past did everything...I was nervous being a single mum and not having a job. I was not confident I would even get a house.*
ACCOMMODATION MAINTAINED FOR 12 MONTHS

Information provided by agencies indicated that 247\(^{101}\) client 1s\(^{102}\) had maintained accommodation for at least 12 months. In addition to these clients, 276 other household members (for example, partners/children) living with the clients were reported to be accommodated. Thirteen clients were reported not to have maintained their accommodation.

It is reasonable to assume based on the data that a further two clients\(^{103}\) accommodated before 1\(^{st}\) July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 59 clients also recorded as accommodated before 1st July 2011 although some would undoubtedly have maintained accommodation for 12 months.

Thus of a potential pool of 321 eligible clients\(^{104}\) at least 78% (249 clients) were stably accommodated for at least 12 months. The Housing Accommodation Support Worker program has met its target of 75% of clients stably accommodated for 12 months.

Figure 4: Flowchart

![Flowchart Image]

Independent data from the Department of Housing indicates that of 156 HASW

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\(^{101}\) 75 of these clients are recorded as accommodated before 1\(^{st}\) July 2011. The remainder were either missing the accommodation date or their most recent accommodation date was after 1\(^{st}\) July but the agency considered that they had maintained stable accommodation despite a change of address. In all cases the clients had joined the program before 1\(^{st}\) July 2011.

\(^{102}\) While it is probable that when a client 1 maintains accommodation this is true for client 2 as well, however no data is collected on client 2. Their numbers are however reflected in the number of other household members accommodated.

\(^{103}\) These clients had either maintained accommodation for at least 12 months while on the program or were open cases within a few days of being accommodated for 12 months.

\(^{104}\) Clients recorded as accommodated before 1\(^{st}\) July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before 1\(^{st}\) July 2011.
clients accommodated in public housing between 1\textsuperscript{st} May 2010 and 30\textsuperscript{th} June 2011, 96\% retained their tenancy for 12 months or more\textsuperscript{105}. This is a very positive result.

**IMPROVEMENT IN CLIENT CIRCUMSTANCES**

Clients interviewed reported major improvements in their circumstances as a result of involvement in the HASW program. This included:

- stable housing
- better management of crises
- better management of money and budgeting
- access to entitlements, for example, income support, family benefits, school concessions, HUGS
- greater sense of confidence and mastery
- improved health and wellbeing
- improved life circumstances
- improvements in children’s circumstances such as greater housing stability and security, improvements in behaviour, regular attendance at school, having their own room and greater privacy.
- increased income support.

The overwhelming majority of clients interviewed were profoundly grateful for what the HASW has been able to do for them and their family.

For a number of clients a key result is that the HASW program assisted them to achieve a greater sense of control of their lives. One client described how the HASW had assisted her to regain control and dignity in her life:

*The whole experience of the DV homelessness, requiring and asking for help has taught me so much as a mother supporting children. Such a struggle to get anywhere that having appropriate and timely help from a caring, respectful and reliable worker allows you to gain control and your dignity. This is what the accommodation and support program provided for me and before them the refuge. Such crucial services that are greatly needed.*

Clients were wholehearted in their praise for the role played by the HASW program and the HASW workers in transforming their lives

*This is a fantastic program...staff are very good and helpful.*

*I don’t know where I would be without this.*

*[Worker] has been amazing. Whenever I have issues I can ask.*

*Without [worker] I would not be in this house.*

*Everything about this program has helped...nothing has gone wrong.*

*It felt miraculous.*

\textsuperscript{105} Department of Housing data relate to households but it is reasonable to assume that there is a 1:1 relationship between a client in the program and a household identified as linked to the program.
[Worker] has been unbelievably helpful.  
[Agency] is a great organization...without them there is no way I would have my own house.  
I cannot speak highly enough of the staff, of [worker]. They saved my life.  
[Worker] was magnificent. Helped to get DoH house.  
Program is absolutely magnificent. Wish I had known earlier. People are fantastic.  
The program does work. I’m an example of that.  
It is unbelievably helpful.

Many clients said the stability and security resulting from having their own home enabled them to plan for the rest of their life:  
I am looking to go to University to study conservation biology. [Worker] helped me find out what I needed to do and what courses to do.  
I feel secure and confident in housing and can plan my life.  
More content now and feel safe that we are settled and don’t have to worry about where we have to go next or sleep in the car. Stable now.

LIVES TRANSFORMED

For a substantial number of clients interviewed their contact with the HASW has been life changing. For that they were immensely grateful.  
Very happy first time in six years that I feel a sense of security. I wake up every morning and pinch myself. After six years of hell now settled.

For some clients contact with the HASW saved their life.  
Before the change I was living in my car, separated from my partner, had debts and had been unable to see my children. Felt I had nothing to live for and was contemplating suicide and would have taken my life... Basically [agency] saved my life as I was suicidal and was going to take my own life and I had nothing to live for and no future... If it was not for [agency] I would be dead.  
Thank you for [agency] - if not for them I would not be here now.

The case study below is an example of a client who said her life and that of her children was transformed.

**CASE STUDY 1**

Rose was in private rental with two young children and partner, but had to move out due to partner violence and the house being trashed.

Rose moved between family and friends. Her children lived with her parents and she visited them there. Rose had been to DoH many times and had tried private rental again but was blacklisted because of the damage her partner caused at the previous house.

She spent time in a refuge. The refuge told her about [agency]. Rose was originally not accepted into the HASW program, so she made a direct appeal to the agency and then was accepted into the program. Rose said she had no help till she met the HASW.

The HASW assisted Rose to access public housing for herself and her two children. The client said:
She opened me right up to be able to speak about my problems...She broke through the walls... I have the strength to get up every morning...I’m a good mum...I’m a good person...I deserve this home... All the steps we did... all the appointments that we had made me stronger and stronger and stronger.

Rose said the program has given hope that had been lost because of her previous traumatic past life. She said that the program had put a roof over her head and her children have somewhere to call home and has completely turned around the life of children. Rose said she wakes up every day and can’t believe how lucky she is.

About the HASW the client said:

I wouldn’t have been where I am without her... I would never ever have been able to think like this if it wasn’t for her...She’s stopped me from apologizing. We talked about everything from the past and to what I want in the future and how I can get there.

I see my small family getting better and better.

Rose said the program has helped her confidence, gave her skills in budgeting, and housekeeping and greater self-worth.

I just want to thank you guys for changing my life. There are no words I can find to express my gratitude, appreciation... My heart is full of love because of you guys.

IMPACT FOR CHILDREN, YOUNG PEOPLE AND FAMILIES

Many of the clients interviewed were parents of young children. They described how when they were homeless or in precarious housing they went to great lengths to keep the children together and in the same school, and tried to limit the fallout for their children.

Clients said they had been deeply worried about the impact of their housing situation on children in terms of security, safety, emotional wellbeing, health and education and connections to family and friends, poorer educational outcomes and health, lack of financial and emotional support, unsafe situations such as sharing with strangers or living in overcrowded houses, breakup of the family, lack of money for food, heating, books, clothing, furniture and activities, and difficulties keeping children at the same school and with the same circle of friends.

For clients with children the benefits from the HASW service were greatest for their children. The effect of the HASW has been on future generations of family members, particularly children and young people. One client said:

I have a home and feel so happy. Getting into the program put a roof over my head and a home for my children. They have somewhere to call home.

Clients described some of the changes for their children:

My children are more secure and confident...more happy.

The kids are very much settled. They feel safe have their own rooms, own games, own privacy...Two youngest are very happy...children are much more lovable.

The most helpful thing was helping the kids out, getting a house and roof over their head. Thank so much for it.

Kids are more happy. We got a house and back together again.

The change is significant because it has given me and the kids’ stability.
Home provided stability for me and my children. The kids have their own backyard and friends close by.

[Agency] have been really wonderful. Because of their assistance and support we are closer as a family and happier as individuals.

The most significant thing is helping the kids out getting the house and a roof over our heads. Thanks so much for it.

Being able to have backyard for kids to play in and garden... Kids got to have their playground and go to school.

One client said her child’s health had improved significantly as a result of having contact with the HASW program. Her previous house was old, cold and leaked badly, causing health problems for her young child who suffered from asthma. The child was always sick and spent a lot of time in hospital. The client said that since she had been part of the HASW program she had obtained a DoH house, with the result that her child was no longer sick and the family’s health had improved considerably.

For some clients having secure housing has made re-unification with children possible.

Before the change I was in refuge with my son. I could not get access to my daughters, I had little support and no idea what the future would bring. The change occurred when [worker] came along and my son and I were in a house within two weeks... The change is significant because getting the house meant that the girls would be here 35% of the time whereas before in the refuge there was no access.

For one client having secure housing helped him to reunite with his partner and his children.

Without [agency] I would not have been able to get back with my partner. Apart from when we separated I have been her carer for seven years.

**CASE STUDY 2**

Annie is a grandparent who has care of her grandchildren. She took over their care because of the mother’s drug use and failure to look after the children.

Annie had no stable housing at the time she took over care of her grandchildren. She had some history in DoH housing but because of family and other circumstances was not currently eligible. She was working and took redundancy to care for the children full time.

She lived in various places, car, family, hotels and refuge. Had lived in car for a few days before refuge. Annie talked with DCP to get assistance and emergency housing.

DCP and emergency housing providers assisted with referral to the HASW that assisted in getting priority DoH housing.

DoH offered one property that was not suitable (only three bedrooms) and the NPAH worker assisted to find a more suitable property.

HASW assisted with furniture, food and petrol vouchers and a few outstanding bills. They also assisted Annie to access family tax benefits for the children.

NPAH worker provided assistance and support, vouchers, counselling and support with children.

Annie said the most significant change was getting the house:
Housing was what was needed most. Helping to get the house. Now don’t have to go from house to house, got our own place and they have their own rooms... We are more content now, feel safe and settled that we don’t have to worry where we have to go next or sleep in the car.

Annie said that the children are more settled and content, feel safe and have their own rooms and own privacy. The children more lovable, and the oldest is not frightened to come and give a kiss and hug.

Annie said her daughter had had her eyes opened and she was trying to get a job to help the children.

LINKING TO SERVICES

Most clients were linked to services while on the program. Table 4 provides a breakdown of the linkages made to various services.

Table 3: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>82%</td>
</tr>
<tr>
<td>Health Service</td>
<td>64%</td>
</tr>
<tr>
<td>Other services</td>
<td>47%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>46%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>44%</td>
</tr>
<tr>
<td>Education Services</td>
<td>39%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>37%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>22%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>19%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>14%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>11%</td>
</tr>
</tbody>
</table>

In addition to the links made for clients, children were linked to school/childcare and to recreation in 41% and 37% of cases respectively.

EMPLOYMENT AND TRAINING

The data showed a small but encouraging increase in the proportion of primary clients in employment, studying or looking for work between their first and final/most recent period in the program.

The client interviews provide an expanded picture of people’s involvement in employment and their local communities.
Many clients want to find voluntary and/or paid work, but are limited by their responsibilities to care for their own children or for a partner.

A number of clients interviewed are active volunteers in their local school, local church and sporting clubs and local community organisations. Others are involved in community situations such as helping older people or working or assisting at their local church.

At least six of the clients interviewed reported that they are considering returning to or commencing study including TAFE and University.

**Key lessons**

There are a number of key lessons specific to the HASW program.

**The model works**

The combination of housing clients in affordable and adequate accommodation whilst delivering sustained and intensive support for a period of up to 12 months after the person has been housed (and longer in some cases if needed) has been successful in preventing and reducing homelessness for NAHA clients.

The HASW program has been able to deliver housing and intensive support to some of the most vulnerable members of the community. This includes people who in the past were considered too difficult by mainstream services or who cycled through the homeless system. It has assisted them to have and retain a permanent home. It has assisted significant numbers of children to exit from homelessness to long term accommodation.

**Addressing practical needs**

Clients valued that HASW was able to address real and tangible needs they had. It assisted them to overcome crises that have persisted for years and improved their material circumstances.

Housing and ongoing support provided by HASW, the links and support to access mainstream services and the financial assistance provided through the brokerage funds were able to address major issues and problems which caused clients and their children immense stress, anxiety and worry.

Clients experienced significant improvements in their material circumstances. Clients also made the point that having these major crises and problems addressed, created the space and the opportunity to meet other needs.

The brokerage funds were a highly successful mechanism to address immediate needs, to support clients and to promote change in clients’ circumstances. Every manager and staff member interviewed stressed the enormous benefits of the brokerage funds in their own right.

The only area for improvement identified with the brokerage funds was the need for more funding.

**Collaboration with mainstream services**

HASW clients have complex and multiple needs that require access to a range of
mainstream and specialist services including substance abuse treatment, mental health care, health care, income support, financial counselling, assistance with daily living, education and early childhood services, legal and court services, job training and employment services.

Active linkages between the HASW and other services have assisted the client group to access resources and services. All services accord a high priority to this work. A high level of interagency collaboration has been achieved and clients have been assisted to make positive gains in areas such as mental health, alcohol use, life skills, recreation, management of money, advocacy, caring for children, income, employment, transport etc.

However, barriers still exist that make it more difficult to tenants to access the full range of services and support they need. One barrier is that some services have waitlists which make it difficult for tenants to access services. Wait lists for financial counsellors (up to 6-8 weeks in some cases) and access to mental health services remain problems as does access to free counselling.

**POSITIVE RELATIONSHIPS BETWEEN CLIENTS AND HASW WORKERS ARE CRITICAL TO SUCCESSFUL OUTCOMES**

The client interviews pointed to the importance of relationship-based interventions. In particular, the quality of the inter-personal relationship between the client and the worker is a critical factor in achieving outcomes. A distinctive feature of the client interviews was the extent to which clients placed a high value on a supportive and trusting relationship with the HASW worker as a factor contributing to the improvements and changes in their circumstances. Overall, the HASW services have been able to deliver a personalised service to clients through respectful and collaborative engagement with the client’s own goals.

**THE PROVISION OF SUITABLE PUBLIC HOUSING IS CRITICAL TO SUCCESS**

The Department of Housing is a critical player in the HASW. The success of the program is directly affected by DoH’s capacity to allocate and supply adequate public housing stock in a timely manner, as well as DoH policy and practice, for example, DoH’s application processes.

The lack of public housing stock and resultant delays in allocation of housing are ongoing concerns.

In mid-2011 managers and staff expressed concern that the recently implemented Three Strikes policy would have the effect of pushing some families into homelessness. In 2012 service providers and managers were more definitive arguing that the policy was pushing individuals and families into homelessness. Service providers cited examples of individuals and families who were homeless because of the policy.

**PRIVATE RENTAL IS NOT A VIABLE OPTION**

Private rental is not a viable option for the vast majority of clients. The lack of affordable rental properties, prohibitive cost of private rental housing, lack of references and/or a rental history, lack of income and negative attitudes of property
managers and landlords are all barriers. Despite their best efforts many clients had tried but were unable to secure private rental. A number of clients escaping family violence had made efforts to secure private rental but were blacklisted because of damage caused at a previous house by an ex-partner.

**Summary and conclusions**

The evidence shows that the HASW has been successful in preventing and reducing homelessness among clients (and their families) accepted into the program. The program is successfully moving people from crises and transitional accommodation and other forms of precarious housing and homelessness into sustainable, secure and affordable housing. Seventy-eight percent of clients accommodated before 1st July 2011 maintained their accommodation for at least 12 months.

Based on the findings from client interviews, HASW is having a substantial impact on people’s lives. For the majority of clients interviewed participation in the HASW program has been life changing. Some clients believed the program saved their lives. Of particular importance is the impact of providing housing and intensive support upon children. Nearly 70% of HASW clients have children whose lives have been affected by the family’s experience of precarious housing and homelessness. The positive impact of the program upon children was cited by clients as one of the most significant result from the program.

The evidence shows that the HASW services are ensuring that the provision of housing is a platform for the provision of support, as well as the delivery of a wider array of human services to people who have experienced homelessness. Housing has become a place around which services can be anchored.
The Street to Home (STH) program uses a collaborative model and comprises three assertive outreach teams (AOT), five housing support worker (HSW) services and a mobile clinical outreach team (MCOT) which provides mental health services to rough sleepers. Altogether seven non-government agencies are involved in delivering the program. MCOT is funded by NPAH but is staffed by the Department of Health.

The STH program is based on models successfully trialed in the United Kingdom\(^\text{106}\) and the United States (Common Ground)\(^\text{107}\) which recognise that people sleeping rough are unlikely to seek help and consequently the models have a strong focus on outreach – taking support to the person\(^\text{108}\).

Traditional outreach work with homeless people usually includes:

- contacting people where they are sleeping rough
- working to establish relationships with them
- undertaking an assessment of their needs
- making appropriate referrals to accommodation and other services
- providing further support as appropriate\(^\text{109}\).

Assertive outreach in STH differs from traditional approaches in three ways. Firstly it is a specific means to end a rough sleeper’s homelessness. Secondly it is part of a broader policy response that provides access to long-term housing and support. Thirdly it takes a persistent approach and aims to work with people over the medium to long-term and to persistently engage people sleeping rough\(^\text{110}\).

The STH process used by the successful Common Ground organisation in New York City involves:

- establishing an accurate registry of street homelessness by identifying individuals who are permanently living on the street in a neighbourhood
- prioritising for housing those who are most vulnerable by means of a vulnerability index that calculates the impact of disease and other risk factors
- simplifying the process for helping individual secure permanent housing and assisting them in all aspects of the process

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\(^{107}\) Common Ground [http://www.commonground.org/?page_id=21](http://www.commonground.org/?page_id=21)


\(^{109}\) Homeless Link Handbook

\(^{110}\) Phillips et al 2011 op. cit., p.17.
• arranging for personalised services, for example, mental health
counselling, job training, financial management, to assist individuals with
maintaining their new homes and creating stable and purposeful lives.\textsuperscript{111}

The Western Australian STH model combines assertive outreach with housing
support but they are provided by separate agencies. Only in Fremantle is assertive
outreach and housing support provided within the same agency, albeit by a
notionally separate team. The three agencies that provide assertive outreach run day
centres which operate as drop-in centres and offer a range of services to people who
are homeless. The five agencies that provide housing support have access to a range
of accommodation types including crisis, short and transitional accommodation,
lodging houses and community housing. There is no lead agency. The challenge for
all agencies is to collaborate effectively in order to provide an integrated service to
those living on the streets but desirous to move into stable and sustainable long-
term accommodation.

Description
The aim of the STH program is to work directly with rough sleepers and to provide a
coordinated response to their complex needs. The overall objective of the program is
to ensure that people who are sleeping rough, and people who are at risk of
returning to primary homelessness, achieve long term, secure, stable
accommodation.\textsuperscript{112}

ASSERTIVE OUTREACH TEAMS
The AOTs make initial contact with rough sleepers wherever they are living or
spending time with the aim of building trust and confidence and working with them
to address their basic needs, including linking them with MCOT. The AOTs work in an
integrated way with the STH HSWs to link rough sleepers into accommodation. The
model is predicated upon the STH HSW working with rough sleepers engaged by
AOTs to access accommodation and then providing the ongoing support. However
there is provision for AOT workers to continue to support rough sleepers in
accommodation until a relationship is established with the HSWs.

HOUSING SUPPORT WORKERS
The HSWs assist people who have been sleeping rough into stable, secure
accommodation. Workers also assist people living in crisis accommodation services
to move into independent accommodation in the community and provide support to
maintain that accommodation.

\textsuperscript{111} Common Ground Street to Home Program http://www.commonground.org/?page_id=21
\textsuperscript{112} Primary homelessness includes people living on the streets, sleeping in parks, squatting in derelict buildings,
living in improvised dwellings such as sheds, garages or cabins, and using cars or railway carriages for temporary
shelter. Secondary homelessness includes people who move frequently from
one form of temporary shelter to another including friends, relatives, emergency accommodation, refuges and
lodgings.
MOBILE CLINICAL OUTREACH TEAM

MCOT takes referrals from AOTs, and more recently HSWs, and works with rough sleepers with the aim of undertaking a comprehensive assessment of mental health, drug and alcohol and general health needs and then providing treatment or referral to other services as indicated by the assessment. MCOT is street-based and clients are seen where they are comfortable – where they live, in cafes, parks etc.

The following services have been contracted to provide the Street to Home Program

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>Initial staffing</th>
<th>Additional Funding from 1 April 2011 to 30 December 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assertive Outreach</td>
<td>UnitingCare West Tranby</td>
<td>Perth</td>
<td>2 FTE</td>
<td></td>
</tr>
<tr>
<td>Assertive Outreach</td>
<td>Ruah Community Services</td>
<td>Perth</td>
<td>2 FTE $100,000 (1 FTE)</td>
<td></td>
</tr>
<tr>
<td>Assertive Outreach</td>
<td>St Patrick’s Community Support Centre</td>
<td>Fremantle</td>
<td>2 FTE</td>
<td></td>
</tr>
<tr>
<td>Housing Support Worker</td>
<td>St Bartholomew’s House</td>
<td>Perth</td>
<td>2 FTE $100,000 (1 FTE)</td>
<td></td>
</tr>
<tr>
<td>Housing Support Worker</td>
<td>55 Central</td>
<td>Perth</td>
<td>1 FTE</td>
<td></td>
</tr>
<tr>
<td>Housing Support Worker</td>
<td>The Salvation Army</td>
<td>Perth</td>
<td>3 FTE $100,000 (1 FTE)</td>
<td></td>
</tr>
<tr>
<td>Housing Support Worker</td>
<td>Foundation Housing</td>
<td>Perth and Fremantle</td>
<td>3 FTE $50,000 (0.5 FTE)</td>
<td></td>
</tr>
<tr>
<td>Housing Support Worker</td>
<td>St Patrick’s Community Support Centre – Sister’s Place</td>
<td>Fremantle</td>
<td>.75 FTE</td>
<td></td>
</tr>
<tr>
<td>Mobile Clinical Outreach Team</td>
<td>South Metropolitan Area Health Service</td>
<td>Metropolitan</td>
<td>3.5 FTE$^{114}$</td>
<td></td>
</tr>
</tbody>
</table>

The service agreements for all STH programs commenced on 1st January 2010.

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113 During the planning stages of Street to Home it was recognised that clients with complex needs may require longer term and/or intensive support, in addition to the 12 month support period originally provided by Housing Support Workers. Funding to provide additional support for this client cohort was included in the Street to Home budget and provided to the above services, commencing in April 2011.

114 Until July 2012 MCOT comprised a manager, 2 clinical nurse specialists and a part-time consultant psychiatrist. As at January 2013 the team was reduced to a clinical nurse specialist and a part-time consultant psychiatrist.
KEY FEATURES
The support and assistance provided by the eight services funded under the STH program has the following features:

- AOTs actively locate and engage rough sleepers
- AOTs address the most pressing needs of rough sleepers including linking with Centrelink, registration with the Department of Housing and referral to MCOT
- A partnership approach to service delivery which employs a joint case management approach to assist and support clients
- Collaboration between AOTs and HSWs to ensure clients secure and maintain accommodation and engage with mainstream services
- HSWs provide ongoing support to ensure clients maintain their accommodation and assist them to engage with or continue treatment with general health, mental health and drug and alcohol services
- HSWs assist with financial problems and link clients to community supports and mainstream services such as employment, education and training to establish or re-establish social networks
- MCOT provides assertive clinical assessment and treatment, within and outside business hours for rough sleepers with serious mental illness and/or substance misuse issues referred by AOTs and more recently by HSW.

The Guidelines for Street to Home make it clear that it is the HSWs who are responsible for liaising with the DoH and other services to secure housing.

Managers from the seven agencies, together with representatives from the Department of Child Protection (DCP), the Department of Housing (DoH) and MCOT, meet quarterly to manage the program. The meetings are chaired by DCP. There is also a monthly combined team meeting attended by representatives from each STH team. The combined team meeting provides an opportunity to update on vacancies, pending referrals and emerging issues. Updates are provided to the managers’ meeting.

Evaluation data sources
The data sources for the STH evaluation were:

- Progress Reports and Infoxchange, Service Record System, Street to Home
- Face-to-face interviews with all managers and some workers in 2011 and telephone interviews with managers in 2012
- On-line worker surveys completed by 14 respondents in 2011 and 20 in 2012
- 43 client interviews and nine client re-interviews
• Partnership Analysis Tool completed by all managers
• data provided by DoH and MCOT
• literature and document reviews.

How much has the program done?
Each assertive outreach worker supports a minimum of five clients for approximately six months (10 clients per annum). They may work outside of normal office hours. Each HSW supports a minimum of ten clients for approximately six months (an average of 20 clients per annum). The target for the AOTs over 2½ years is 150 clients and for the HSWs is 485 clients.

Table 1: Street to Home clients worked with over 2 ½ years

<table>
<thead>
<tr>
<th></th>
<th>Combined AOT/HSW</th>
<th>AOT only</th>
<th>HSW only</th>
<th>Total clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street to home</td>
<td>116</td>
<td>84</td>
<td>321</td>
<td>521</td>
</tr>
</tbody>
</table>

As Table 2 shows, AOTs have exceeded their target number of clients while HSWs have not reached theirs. Only one HSW service reached (and exceeded) its target.

Table 2: Clients worked with over 2 ½ years by program type

<table>
<thead>
<tr>
<th>Type</th>
<th>No. agencies</th>
<th>clients</th>
<th>Re-referred clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOT</td>
<td>3</td>
<td>200</td>
<td>9</td>
</tr>
<tr>
<td>HSW</td>
<td>5</td>
<td>437</td>
<td>15</td>
</tr>
</tbody>
</table>

Self-referrals (36%) are the largest referral source for AOTs followed by government and non-government agencies (28%), Specialist Homelessness Services Crisis Accommodation (12%), family or friends (11%), host agency (7%) and other or unknown (8%).

Only a quarter of HSW referrals were from the AOTs. Nearly half (47%) were internal referrals from the host agency and the balance (29%) were referrals from a variety of government and non-government agencies (11%), self, family or friends (10%) or Specialist Homelessness Services (7%).

Street to Home clients
To enable a complete picture of the client group the client characteristics have been presented for the STH program as a whole and for the AOT and HSW programs individually.
Street to Home (combined AOT and HSW)
There were substantially more male (66%) than female (37%) clients assisted by the Street to Home Program. The average age of the clients was 41 years (range 17-88 years). As figure 1 shows the program has exceeded its target of 11% Aboriginal clients.

Figure 1: Cultural background of the client group

Fifty-two percent of clients identified themselves as having a mental health issues and 52% as having drug and alcohol issues. Thirty-four percent identified themselves as having both mental health and drug and alcohol problems. Forty-five percent had health problems.

Managers described the client group as homeless – sleeping rough, couch surfing, in crisis accommodation – and often having drug and alcohol and mental health issues, usually in crisis and having very few belongings. One manager commented that they are an ‘eclectic group – some were quite well established and have ended up homeless – not the classic type of person who drinks too much’.

The client interviews confirmed this picture. It was evident that for men and women in STH a downward spiral into homelessness can be as a result of misfortune, alcoholism, drug misuse, mental illness, relationship breakdown or domestic and family violence.

While some of those interviewed had been living on the streets for most of their lives, for others it was a new and distressing experience.

Those who had been living on the streets for many years tended to tell of sad and abusive childhoods.

[I first became homeless] when I was 11 and it was too hard because 25 years ago there were no places like [day centre]. My stepfather was beating up my mother all the time too.

If homelessness was more recent and not related to alcohol or drug misuse, mental illness or family violence it was usually related to misfortune of some kind, for example, failing health, loss of income or loss of affordable accommodation, which the person did not have the financial or other resources to withstand. The following account by a man who had been on the street for three years was not unique among
those interviewed.

The reason I have been on the streets was trying to take everything on my own shoulders, I was sick. I had a back injury. I hurt my back. I damaged my back and I couldn’t work anymore. But I was still trying to look for work but I was in constant pain and I couldn’t get work and I got behind with the rent and trying to struggle on New Start - $500 a fortnight – that barely paid the rent on the unit and so I got behind in the bills and everything. I didn’t realise it at the time I was having a lot of pressure and getting really depressed and that and I just couldn’t handle the pressure and just walked in one day, I was behind in the rent, well behind in the rent and there was no hope of me ever paying it because there was no way I was going to get a job and I couldn’t manage on New start and I just walked into the real estate and said here are the keys to the unit.

Just over half the clients (55%) lived alone: household size ranged from one to eight persons. As well as the clients there were 194 children involved with the program. Household composition is shown in Table 3.

Table 3: Household composition

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>33</td>
<td>6%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Couple with non-child dependents</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Extended family</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Single female</td>
<td>80</td>
<td>15%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>63</td>
<td>12%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Single male</td>
<td>264</td>
<td>51%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>8</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Unknown</td>
<td>38</td>
<td>7%</td>
</tr>
<tr>
<td>Total</td>
<td>521</td>
<td>100%</td>
</tr>
</tbody>
</table>

The main source of income for 86% of clients when they started the program was some sort of government payment, only 6% had either full or part-time work. Most were either not in the labour force (65%) or unemployed and looking for work (26%).
**Figure 2: Income source**

- Disability support pension: 35%
- Other Government payment: 51%
- No income / awaiting benefits: 4%
- Other/unknown: 7%
- Waged/Salaried/Own business: 3%

**Assertive Outreach Teams**

Sixty-six percent of AOT clients were male, 27% were Aboriginal and 4% CALD. Many (74%) had drug and alcohol issues and/or mental health issues (62%). Seventy-two percent had health issues.

Other than accommodation, AOT service managers identified mental health, drug and alcohol and health as the most critical needs for rough sleepers. One manager added financial support as another critical need.

The income source for most clients (85%) was some form of government payment, either disability support pension (38.5%) or other government payment (46.5%) but for 12% it was ‘other’, 2% wage/salary and 1% had no income.

Forty-seven percent lived alone.

**Housing Support Workers**

Sixty-five percent of HSW clients were male, 15% were Aboriginal and 9% CALD. A number (45%) had drug and alcohol issues and/or mental health issues (47%). Thirty-two percent had health issues.

The income for the vast majority of clients (88%) was some form of government payment, either disability support pension (36%) or other government payment (52%). Fifty-nine percent lived alone.

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**Engagement**

347 STH (67%) cases were closed by the end of June 2012. These cases were open an average of 209 days or nearly seven months (median 154 days, range 0 – 802 days). For AOTs the average was 195 days or 6.4 months (median 151 days and range 0-614 days) and for HSWs the average was 204 or 6.7 months (median 154 days and range 0-802 days).
Clients appear to have engaged adequately with the STH program as a whole – 63% remained with the program for at least three months, 44% for at least six months and 35% for at least nine months. AOT clients initially engaged more strongly than HSW clients – 71% of AOT clients remained with the program for at least three months compared to 59% of HSW clients. There was no difference between AOT and HSW clients at the six month mark – 44% of clients from both groups were still with the respective programs. More HSW clients remained engaged at the nine month mark than AOT clients (35% and 28% respectively). Given the model these percentages are as expected.

**ACCOMMODATION**

The STH program has been very successful in obtaining accommodation for clients and/or assisting them to maintain accommodation. Eighty-eight percent are recorded as accommodated in their most recent/final period of contact[^115]. Most clients (93%) were accommodated before their case was closed.

As table 4 shows the most common accommodation types were public housing and lodging house.

**Table 4: Most recent accommodation type – all STH cases**

<table>
<thead>
<tr>
<th>Accommodation Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Housing</td>
<td>159</td>
<td>31%</td>
</tr>
<tr>
<td>Lodging House</td>
<td>149</td>
<td>29%</td>
</tr>
<tr>
<td>Other</td>
<td>39</td>
<td>8%</td>
</tr>
<tr>
<td>Community Housing</td>
<td>36</td>
<td>7%</td>
</tr>
<tr>
<td>Private rental</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Shared Housing</td>
<td>18</td>
<td>3%</td>
</tr>
<tr>
<td>SAAP</td>
<td>14</td>
<td>3%</td>
</tr>
<tr>
<td>Returned to family</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Boarding - Private</td>
<td>9</td>
<td>2%</td>
</tr>
<tr>
<td>Caravan</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>No accommodation recorded</td>
<td>63</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>521</td>
<td>100%</td>
</tr>
</tbody>
</table>

**PROGRAM HELPFUL**

All interviewed clients were very appreciative of the fact that they had been housed. Nearly all clients had only positive things to say about the support they received.

> If I need any support I can come to STH or [service]. For example the Street Doctor comes to agency twice a week and I have been seeing the doctor who has my records

[^115]: Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.
for three years. This is important as I have asthma, high blood pressure, had an operation for [condition], had lots of ear infections when and colds when sleeping out.

He helped me with a lot of things. He helped me with transport to get to places because a lot of places I could not get to because I did not have a lot of money at that stage. Plus he helped me with talking to me, explaining things. Giving me papers so I could work things out. [He] explained to me how to go about trying to work the money out. Because at that time I had given up on everything... He was absolutely there for me in actual fact...

Because I can ring [worker]; she visits me and I know if I have a problem or question, she’ll help me.

Most helpful – just the fact that, well [worker] was the thing I found most helpful because there is a person you can ring up and say I need this or I don’t know how to do this, or who do I see about this. It is a resource you can use. When I didn’t know who to go to or how to get something or how to handle something I would ring [worker] and she would tell...

Friendship and support all rolled into one.

Just actually finding the place. They said we could find our own place and everything and they would help us out with the move but they actually found a place for us and they drove me to Homeswest to get a bond. They drove us there to move all our stuff in. Just pretty much everything they done was helpful.

Without being overly critical, two clients from one service felt that they needed more support than they were given. One said:

They were bloody good. [Agency helped the client save the bond and to relocate when the lease was up]. However once you are in the house it is like you no longer exist.

With what results?

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

Accommodation maintained for 12 months

Information provided by agencies indicated that 115\(^{116}\) STH clients had maintained accommodation for at least 12 months and fifteen had not. It is reasonable to assume based on the data that a further twelve clients\(^{117}\) accommodated before 1st July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 55 clients also recorded as accommodated before 1st July 2011 although some would undoubtedly have maintained

\(^{116}\) 103 of these clients are recorded as accommodated before 1\(^{st}\) July 2011. The accommodation date of the remainder was after 1\(^{st}\) July but before the end of September 2011 and the agency considered that they had maintained stable accommodation. In all cases the clients had joined the program before 1\(^{st}\) July 2011.

\(^{117}\) These clients were open cases accommodated before 1\(^{st}\) July 2011 and with no evidence that their accommodation had ceased.
accommodation for 12 months. Thus of a potential pool of 197 eligible STH clients\textsuperscript{118} at least 65\% (127 clients) were stably accommodated for at least 12 months. These figures include four clients case managed by AOTs only of whom two were stably accommodated for 12 months and two were not. The remaining 193 clients were case managed by a combination of AOTs and HSWs or by HSWs only.

The HSW component of STH has a target of 50\% of clients accommodated for 12 months or more. No target was set for AOTs. As 193 of the eligible clients were HSW clients and 125 (65\%) were accommodated for at least 12 months the HSW services have met and exceeded their target.

**Figure 3: Flowchart – HSW component**

Very positively, independent data from the Department of Housing indicates that of the 70 STH clients accommodated in public housing between 1\textsuperscript{st} May 2010 and 30\textsuperscript{th} June 2011, 90\% retained their tenancy for 12 months or more\textsuperscript{119}.

The eight of the nine clients who were re-interviewed after about 12 months had all maintained their accommodation and continued to consolidate the gains made on the program. One client moved overseas in accordance with his stated intention when first interviewed. This move had proved successful for him.

\textsuperscript{118} Clients recorded as accommodated before 1\textsuperscript{st} July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before 1\textsuperscript{st} July 2011.

\textsuperscript{119} Department of Housing data relate to households but it is reasonable to assume that there is a 1:1 relationship between a client in the program and a household identified as linked to the program.
LINKING TO SERVICES

Managers indicated that AOTs were able to meet many of the clients’ needs through referral, internal agency resources, advocacy, brokerage and case management. Day Centres play an important role.

Once the client is engaged with the [agency] Day Centre there is access to mobile GP, Centrelink team, disability advocacy, medication, mental health nurse, food and showers. You can wrap around services. It makes sense to have the AOT attached to the Day Centre.

HSWs are required to provide ongoing support to ensure clients maintain their accommodation and to assist them to engage with or continue treatment with general health, mental health and drug and alcohol services.

Managers said that HSWs provided such support as clients needed for up to 12 months using a case management approach. For example one manager stated:

[Needs are met] through access to brokerage and the means to purchase essential items, food vouchers, transport, advocacy and referrals, information for good decision-making choices, assistance with basic budgeting, information and support around sustaining housing. These things are done through case management, identifying goals and needs and developing a case plan.

and another:

If they relapse into family violence, fighting, drug and alcohol misuse, the HSW tries to find out why and what assistance can be put in place to ensure they still have housing. [The worker] sets up counselling or medical appointments and tries to get them back on track if they fall off.

The data show that all STH clients were linked to at least one service while on the program. Table 5 provides a breakdown of the linkages made to various services.

Table 5: STH clients links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>87%</td>
</tr>
<tr>
<td>Health Service</td>
<td>43%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>39%</td>
</tr>
<tr>
<td>Other services</td>
<td>29%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>27%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>21%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>15%</td>
</tr>
<tr>
<td>Education Services</td>
<td>9%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>6%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>3%</td>
</tr>
</tbody>
</table>

The AOTs had a target of 50% of clients accessing health supports including mental health and drug & alcohol services. This target has been exceeded – 69% of AOT...
clients were linked to health services, 48% to drug & alcohol services and 56% to mental health services.

EMPLOYMENT AND TRAINING
The data do not enable an analysis of changes in employment status. The fact that 21% of clients were linked with employment and training services is encouraging. A small number of those interviewed and who were now housed were contemplating a return to the workforce. One client was already doing volunteer work

_I was ready to check out 10 months ago. I wanted to commit suicide and I don’t feel like that today. I have got a chance to have some sort of quality of life and kick off again and none of that would have happened if it was not for the S2H program. I have been able to do volunteer work. I am starting to look at paid employment, getting off the pension and study._

Having gained confidence in herself to move forward one client was planning to work with street kids.

_In March, this March I plan on going to TAFE...and doing my Community Services Certificate and Youth Work Certificate...I want to work with [agency] as a liaison officer or youth worker...I have always wanted to do that because I know street kids will relate to someone who has been there and done it._

Another client who already had tertiary qualifications saw re-training as her way back into the workforce.

_In March, this March I plan on going to TAFE...and doing my Community Services Certificate and Youth Work Certificate...I want to work with [agency] as a liaison officer or youth worker...I have always wanted to do that because I know street kids will relate to someone who has been there and done it._

LIVES AND SANITY PRESERVED
Perth Registry Week 2012 identified 93 people\(^{120}\) (59% of those surveyed) in the Cities of Perth and Vincent with high mortality risk, that is classified as vulnerable on the Vulnerability Index\(^ {121}\). STH does not use the Vulnerability Index but STH data showed that 81 (40%) AOT clients displayed tri-morbidity – co-occurring psychiatric, substance abuse and chronic health conditions. Eight were over the age of 60. Although the length of time on the streets is not recorded in the data it is probable that many of these clients would have been on the streets for more than six months and would be classified as vulnerable.

It is likely that for some interviewed clients the STH program quite literally saved their lives, either because their age and health issues were such that they would not

\(^{120}\) Ruah Community Services, 2012 Perth Registry Wekk 2012: Less Homelessness

\(^{121}\) The Vulnerability Index is a tool for identifying and prioritizing the street homeless population for housing according to the fragility of their health. It is a practical application of research into the causes of death of homeless individuals living on the street conducted by Boston’s Healthcare for the Homeless organization, led by Dr. Jim O’Connell. The Boston research identified the specific health conditions that cause homeless individuals to be most at risk for dying on the street. Juneau Economic Development Council
http://www.jedc.org/forms/Vulnerability%20Index.pdf downloaded 10/01/13
have survived much longer on the streets or because they had contemplated suicide.

At least two of the AOT clients interviewed probably would have died had they not been assisted by the program. One recently housed man in his 60s, who spent many years in prison and on the streets and who had been a chronic alcoholic, had very serious cognitive and physical impairments. His partner was in hospital following a limb amputation as a result of an untreated infection picked up on the streets. Both needed Home and Community Care and other services and in the opinion of the worker would have died if they remained on the streets. Another client needed ongoing treatment for HIV which would not have been possible had he and his partner not been housed. The sister of a third client had died on the streets.

Several of those interviewed thought they would have committed suicide had they remained homeless. One man, who had also stopped drinking as a result of STH, said that for him:

The most significant change [as a result of the program] would be that I want to live well. Ten and a half months ago I would have committed suicide if I could have.

Mental illness, drug abuse and social isolation are ‘plausible consequences’ of homelessness as well as risk factors for homelessness. Homelessness can also exacerbate pre-existing mental health issues.

The constant fear, danger and victimisation may result in people becoming emotionally distressed and the development of a mental illness.\(^\text{122}\)

One very articulate woman with serious health problems who had been sleeping in her car and then living in lodgings commented:

[The program] saved my life. That sounds like and exaggeration but it’s not. I was at the stage living in the lodge and nothing was happening and I had considered suicide. It had dawned on me but I wasn’t in my right mind back then. I was running out of options and I was running out of hope and if [worker] hadn’t walked in and told me that there was hope to get out, I really don’t know what I would have done. I don’t think I would have killed myself but I did think about it but I definitely would have ended up being carted away to a mental institution and assessed and maybe kept for a few days or whatever because my behaviour was becoming very irrational. I was becoming paranoid. There was a time when I spent days lying in bed and I wouldn’t get up. I think the mental toll of being homeless is the worse thing, more than anything. It destroys your self-esteem. I have always been a very assertive confident person and all of a sudden I wasn’t any more.

Another young man with pre-existing mental health issues spoke about his relief at being put on the STH program after spending several months in short-term accommodation. This young man had been placed in shared accommodation but this had broken down after some months due to mutual incompatibility and he was awaiting other, more suitable, accommodation.

It actually helped me out a lot. When I first got put on the program I was pretty much heavily depressed because I knew that I could not stay here [crisis accommodation]

\(^122\)St Vincent Mental Health Service Melbourne, & Craze Lateral Solutions op cit.

forever. It was really hard to hold a job back then. I didn’t really know where I was going. When I got on the program and they found a place for me it took a lot of stress off my shoulders. Pretty much at that stage if I didn’t get put on a program I don’t know what would happen with me. It was pretty much the worst stage that I have been in for depression. As soon as I got put on the program I had a lot of ease come in. A lot of stress off my shoulders.

HEALTH IMPROVED

The data showed that 45% of STH clients had health problems. A considerable percentage (60%) of interviewed clients revealed some very serious or debilitating health problems - cancer, arthritis, diabetes, renal failure, liver damage, HIV, back problems. In some cases these were the result of alcoholism and life style but in others they were a misfortune with which the clients did not have the financial and other resources to cope. Life on the streets exacerbated health problems due lack of shelter, poor diet, lack of rest and lack of medical attention.

Eight interviewees said that their health had improved since they had been housed. One client observed:

My health is much improved now from 12 months ago and a lot has to do with my accommodation. For example I used to get lots of colds and ear inflections while sleeping out. Now I have a nebulizer, puffer. I am warm and secure.

For another with chronic back pain:

One big difference is sleep I guess. When you can go to bed in a bed you can sleep. You don’t sleep on the streets believe me. When you are out on the streets I used to through tiredness sort of drift off about 20 minutes at a time. You just don’t sleep for any period of time. You are forever waking up. You hear noises whatever. You can’t you are very vulnerable. You realise you are very vulnerable when you are asleep in derelict houses or wherever. Because there are other people around at that time...My health has improved, [I am] sleeping properly and feeling safe.

And for another in poor health the most significant change has been:

Getting my own unit and STH was responsible for this. I was like a gypsy staying with family and friends, then [agency] on weeknights and then on the beach with others. My health was not good and made worse by sleeping rough.

BENEFITS TO FAMILIES AND CHILDREN

Family breakdown can be a cause of homelessness and also a consequence of homelessness. Gaining suitable accommodation can prevent family breakdown, enable women and men to reunify with children and facilitate re-establishing family ties.

When asked what difference STH had made in their lives ten clients spoke of family relationships. For some it was around being able to have their children with them now they had a house or at least to have greater contact with them.

Having my own place means that my youngest son can sleepover sometimes and others can visit.

I have got [daughter] with me now so that’s really good.

Without STH would not have qualified for the DCP reunification program
Being able to get the home and keep it. My children are my first priority and it is giving them a home and stability. I didn’t want to be on the streets any more. I wanted a home.

We can have our grannies.

For others having suitable accommodation meant their relationship with their parents improved.

Being able to see my parents and family again. They have come back to WA and I have settled now and that makes it possible.

Bit closer to my parents now.

The following case study is an interesting example of STH preventing family breakdown and a child almost certainly going into foster care. Most of the case study is in the woman’s own words. She had been on the program for about a month when interviewed and was accommodated by DoH with her grandchild a few days after the interview. Additional information to bring the case up-to-date was provided by the AOT in December 2012.

The case was one of the MSC stories presented at the Specialist Homelessness Services Conference in May 2012. The woman said that DCP was prepared to place her grandchild in foster care while she found somewhere to live but she had refused. If this is correct, better and cheaper alternatives would have been for DCP either to actively advocate and follow through with DoH on the woman’s behalf as STH does (a letter was promised) or to subsidise private rental accommodation.

**CASE STUDY 1**

I was renting private and the people I was renting from they were living in a house that his parents were letting them have for free but the parents sold it so they wanted to move back into the house that I was renting and so I had to leave and I have just been unable to get private accommodation apart from the fact that it is way out of my league financially. That’s one factor and you are up against so many other people and I was only receiving New Start payment and it is not a lot of money.

Up until my daughter went to prison I was working full time and I took over Sophie who has always been with me. I had to give up my work because it was just too difficult because Sophie was just over five. It was too difficult to work all night and the come home and look after a little five year old for the day. I ended up having a breakdown and that’s when I got put on drugs for depression and I went onto Centrelink payments. This is the first time I have ever been on New Start.

I went straight to Homeswest, I went to DCP, I went to every welfare agency. It was degrading, very degrading.

I am living in my car and Sophie lives with me. If it was me it would not matter because I am old and have had my time but my granddaughter is nine years old. In April I got a letter saying she was educationally at risk. She is picking up a little bit now because I have had a talk to one of the teachers there. I spoke with the psychologist and she said she would keep her eye on her and all that sort of thing but it has got to the stage where she is crying. She doesn’t want to go to school. Because when we had our home everyday her friends would come home to our place and she would be playing and happy. She can’t bring friends home to her house. Come home and you
can play in the back seat! Or have sleepovers. You can’t do anything like that and she is missing out and missing dreadfully.

Change: What happened?

It was just pot luck. I happened to ring another welfare agency in Perth that I had had contact with earlier in the year to see if I could go back there and maybe they could try again and she said to me ‘oh look why don’t you try [agency]’ so I rang and [worker] I left my phone number and my name and [worker] rang me straight back. As I say I had no idea. I roughly gave her, a rough version and her and [another worker] came out to the park where I was staying and sat with me and you know what was happening and all that sort of thing – yeah. I signed up.

The situation now?

It was so different – they listened and they cared. They gave me hope. They immediately put me on the Homeswest priority list. Gave me food – good stuff – fruit etc. and this is ongoing. [Worker] phones me 2 or 3 times a week just to say hello and check how I am going. Gave me a voucher on Good Samaritans for warm clothes. It has only been 4 weeks but their support over this time has been wonderful.

My situation now is that I am still in my car but am hopeful of getting accommodation soon and am getting a huge amount of emotional and practical support from [workers].

The significant change?

The change is significant because I now have hope for a better future. When I first phoned [worker] I was at my lowest point – helpless and hopeless. All this has now changed and I am hopeful and positive.

The client continued to be supported by the AOT for about three months after she moved into her house and then by the HSW for about nine months. She is stably housed with her granddaughter and according to the AOT has ‘done brilliantly’.

**DIGNITY, SELF-WORTH, STABILITY AND INDEPENDENCE**

Intangible but nevertheless important benefits from the STH spoken of by many of the clients as the most significant change (after suitable accommodation) wrought by STH were the restoration of dignity, self-worth, stability and independence.

- Just being independent. Having a place of my own. Electricity, water, shower and everything. Come to appreciate running water when living in bush land.

- Happier, a lot happier. Independence. I can go out into the backyard and be happy.

- Autonomy, self-worth, self-determination, Looking after myself. I enjoy vacuuming and keeping the place clean. When clean I feel better about myself.

- Just doing my own thing.

- It has given me a platform to get my life in some semblance of order and stability – not meandering too much now.

- Feel more confident and more happy.

**CASE STUDY 2**

This case study was chosen as the most significant change story for STH by two
groups of participants at the Specialist Homelessness Services Conference May 2012. Their reasons for selecting this story were listed as:

- downward spiral into chaos
- desperate attempts to just survive, hit rock bottom with addiction and prostitution
- enormous risks in her environment
- very significant and quick turnaround.
- word of mouth gets her to know about the service
- stabilises quickly
- importance of housing that is long term
- the friendship and support and practical help (furniture) is valued
- reunified with child.

The key issues for the group were:

- depth of descent
- level to which health and safety was compromised
- the turnaround was dramatic and sustained (underlining theirs).

The story was based on an interview with the client at which the worker was present to provide support. The story is told in the client’s own words.

**Situation before change:**

I was in a violent relationship and only stayed because I had nowhere else to go to. He was very controlling. I was sleeping in a car and then ended up in a refuge. I went back and stayed a little bit longer but it was the same thing. I went to a friend’s place but it did not work out. I then came to a lodging house. I was in a bad way. I was addicted to medication and alcohol. I was prostituting for quite some time.

I was sexually abused two years ago and going downhill. I was on medication which was taking control. I tried to kill myself. I had major depression, anxiety, panic attacks. I was hospitalised.

**Change: What happened?**

A friend mentioned [agency] to me. After I was accommodated [in lodgings] I was brought into Street to Home. I was given support and friendship. I got independent housing very quickly and furniture. It pretty much set me up. I had nothing. [Worker] is there for advice. I was linked to mental health services.

**The situation now?**

I am living in a Homeswest Unit. I have been there for nearly a year. It is good to have my own place. I now have [my child] with me. I am waiting on a transfer [to larger accommodation] which will make life a lot easier.

**The significant change for person?**

Having the accommodation and stability. I did not have anywhere else to go. I was on the street. I had been very erratic – floating around.
SERVICE INTEGRATION

Managers’ 2012 interviews confirmed that as a result of the STH program service integration among agencies working with rough sleepers or providing crisis accommodation in the inner city has increased. A number of the agencies have banded together to form the Perth Homelessness Sector Network. The network is working at an operational level across the inner city to streamline service provision to clients. In the words of one manager:

There is now a committed group outside of Street to Home services working to support homeless people...This will continue regardless of the outcome of Street to Home. Integration is vastly improved and there is a greater commitment to work together to support this group.

Mobile Clinical Outreach Team

When it commenced in August 2010, MCOT received all its referrals from the three AOTs and dealt only with rough sleepers. MCOT reported that this was not universally understood or accepted and caused some tensions with services. MCOT would consult with and advise HSWs but did not accept referrals from them. If necessary MCOT brokered mental health services for clients with mainstream mental health providers.

Referrals were restricted to AOTs because of concern that MCOT would be inundated by the demand for its services. This did not prove to be the case and in 2012 MCOT broadened its criteria to include referrals from STH HSWs. The decision to expand MCOT’s referral pathway to HSWs was agreed to in a combined meeting with DCP and the three components of Street to Home (AOTs, HSWs and MCOT). The first referral by a HSW to MCOT took place in June 2012.

Referral does not mean that long-term treatment will result. The first step is a comprehensive assessment to determine what is required. If the person does not require mental health services per se the case will be transferred to appropriate services, for example, generic counselling, domestic violence services, aged care assessment or drug and alcohol treatment. If the client is already linked with a Mental Health Clinic, MCOT will liaise with that clinic to see if MCOT can value add to that service or make contact on behalf of the client to address any concerns from the client’s perspective. MCOT’s key role is to transition the client into mainstream mental health services if required and appropriate.

HOW MUCH HAS MCOT DONE?123?

Up until August 2011 MCOT had received 86 referrals and activated 25 of these as cases. Fifty-six referrals were for consultation/liaison or the client did not engage. The duration of service for closed cases ranged from 1.5 months to 13.5 months – average 4.75 months. Discharged clients are transitioned into standard mental health clinics.

MCOT data indicate that all clients were high need, vulnerable and in sub-optimal health. 75% had co-morbid drug and alcohol issues (primarily alcohol plus cannabis

123 Data provided by MCOT
and solvents), 36% suffered from psychosis and 64% had mixed emotionally unstable personality disorders, anxiety or affective disorders. Clients ranged in age from 19-64 years (average age 34), 25% were Aboriginal and 54% were male.

From September 2011 MCOT to December 2012 received 43 referrals from AOT’s and HSW’s. Fourteen of those 43 referrals were picked up as MCOT clients and six remain active clients of MCOT. The duration of engagement ranged from one month to 6.4 months.

The client numbers are lower than expected and MCOT has advised that it is not getting the referrals that it should although it believes there are people on the streets who would benefit from its services. It appears that STH services are not always clear about what constitutes mental illness and tend to refer clients with behavioural issues or personality disorders, for example, anti-social behaviour, aggression, alcohol and drug misuse and criminal activity, rather than those with psychotic, affect or anxiety disorders. This has led to misunderstandings and a clash in expectations.

Most MCOT clients were referred by the one assertive outreach team. This team has the most comprehensive understanding of mental illness and the type of client likely to benefit from MCOT’s services as the host agency has been a contracted mental health services provider since 1993.

MCOT is not set up to do psychological counselling or behaviour management but will consult and refer appropriately.

**HOW WELL AND WITH WHAT RESULTS?**

Despite teething problems around referrals, STH managers and workers alike recognised the value of MCOT and the unique service it provides. Nearly all AOT and STH personnel (13 out 14 respondents to the on-line worker survey in 2011 and 19 out of 20 in 2012) considered MCOT to be a critical component of the STH program. As one manager put it:

> *The most critical needs are around mental health. Once mental health is stabilised it is easier to address other issues. It is hard to work out what is what. Having MCOT is really useful.*

In 2011 MCOT reported that for its clients the average Health of the Nation Outcome Scale (HoNOS) score had reduced from 20.83 on activation to 10 on discharge (the lower the score the better the outcome). As at August 2011, 16 MCOT clients had been housed and four were awaiting DoH allocation. Sixteen clients had been linked to a variety of services.

Nine of the 14 clients that were picked up by MCOT since September 2011 have been housed and all currently maintain their accommodation with support from the HSWs. The remaining five clients have declined some housing options due to their personal preferences. MCOT along with the HSWs are attempting to source appropriate housing for two of the five clients who did not accept any housing.

The following case studies provided by MCOT give a flavour of its work.

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124 HoHOS is a widely used routine clinical outcome measure.
CASE STUDY 3

Aamir is a middle eastern man in his 30s year who experienced atrocities under the Saddam Regime in Iraq after he had fled his own country. He eventually was assisted by the Red Cross and made his way to Australia with six other men.

On arrival to Perth he was given accommodation in a northern suburb but lost contact with the other men which he developed some rapport. Aamir enrolled in English classes and started to develop some belonging to the local community.

After a period of time DoH were getting complaints about his behaviour in his unit. He started to pull out light switches and pull trees out of his garden. Unfortunately he lost his accommodation and ended up living in a park in the Northbridge area.

He was picked up as a client of Street to Home AOT and a referral for assessment was sent to MCOT.

MCOT conducted an assessment of his mental state and immediately knew that there was an underlying mental illness. MCOT commenced work with him though due to language barriers it took some time to gain some history from him.

On several occasions he became hostile towards staff and smashed a worker’s phone. He was admitted to a Psychiatric hospital and with MCOT’s involvement in ward rounds and other supports he remained in hospital for nearly three months. Aamir was commenced on medication and an improvement in his mental state was noted, his behaviour had settled and there was no hostility.

During his time as an inpatient, housing was sourced through the NPAH and a unit was available in the northern suburbs. On discharge he moved to unit and continued to be supported by STH and a related service.

His care was transferred to the local mental health clinic which continues to support him. He has maintained his accommodation for well over a year and continues with English and Guitar lessons.

CASE STUDY 4

Len is a middle aged man with a long history of schizophrenia who was living on a bench in an inner suburb. He was well known to local mental health services though due to his itinerant lifestyle could not be followed up by the service.

He was picked up as a client of by an AOT and referred to MCOT. MCOT became involved and liaised with a local clinic for admission. Len was housed in a hostel and support put in place. He had extremely poor hygiene and chronic alcohol abuse. His treatment mainly consisted of a depot medication as compliance was a major issue as was his alcohol misuse. It became clear the he had some physical problems with incontinence and an admission to address these issues was arranged. MCOT also provided incontinence pads as he was wetting the bed at the lodge and was nearly evicted several times. It was felt best that he was placed under the Public Trustee in order to minimise his money to buy alcohol. With his money restricted Len improved and had meals on wheels arranged. His appetite improved and his drinking has diminished though due to ongoing issues he was eventually evicted.

Fortunately he ended up in hospital and STH sourced other accommodation in the Hills area. Len remains in his current lodge and although he may obtain small amounts of alcohol his use remains low.
**Changes to MCOT**

In July 2012 MCOT was transferred from the South Metropolitan Health Service to the North Metropolitan Health Service and initially co-located with the Mental Health Emergency Response Line. It was transferred to the Inner City Mental Health Service in January 2013. Changes have reduced its current staff to one full-time nurse specialist and the part-time psychiatrist. Concern has been expressed that the fidelity of the program is now at risk.

MCOT’s relocation and the consequent restructuring of reporting lines occurred independently of DCP. The challenge is for departments to work closely together to deliver interdependent programs and services. DCP is now in discussion with the Mental Health Commission which is working to rectify the situation. The Mental Health Commission is liaising with the North Metropolitan Health Service to ensure that any change to the availability of staffing was associated with the transition to their management of the program and that all resources are now fully deployed.

MCOT has been very successful in working with a very vulnerable and difficult client group and is an essential component of the STH program and it is vital that staffing numbers are restored and that its role is not compromised by current or future changes.

**Partnership and collaboration**

The Western Australian model for STH is unique. Assertive outreach to, and housing support for, rough sleepers are not only provided by different workers but also different agencies.

Within the model AOTs do not secure housing for clients, although they may source short-term or emergency accommodation and HSW do not undertake outreach to rough sleepers. MCOT takes referrals from both AOTs and HSW – a recent innovation that has been welcomed by HSW services.

That Ruah, UnitingCare West and St Patrick’s Community Services are contracted to provide assertive outreach is appropriate in that these agencies provide a range of services to support people living on the streets. Similarly it is appropriate that agencies such as Foundation Housing, St Bartholomew’s, The Salvation Army and 55 Central, which are in the business of providing accommodation services, are contracted to provide housing support. None of the agencies provides a complete package of services.

It is, however, a complex model and with eight services plus MCOT involved, a partnership approach is critical to the success of the STH program.

There are structures in place to support a partnership approach, namely the quarterly managers’ meetings chaired by DCP and attended by all services, MCOT and DoH and the monthly STH team meetings. These meetings are intended to monitor and improve client outcomes, streamline service delivery, discuss and develop client management techniques, refine *Policy and Guidelines* and inform improvements to the operational aspects of Street to Home.\(^{125}\)

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\(^{125}\) Ibid, p.8.
An independent shared STH database, *Infoxchange*, is used to facilitate joint work. Service providers are bound by the terms and conditions set out in a letter of agreement on information sharing between STH providers. The database is intended to record and share detailed client information, aid the development of joint case management and support plans and make referrals to MCOT. STH providers are ‘required to enter detailed, accurate and transparent client information’\(^{126}\).

Whether *Infoxchange* is fully effective in supporting joint work across two or more agencies is doubtful. Apart from some common data, agencies working with a client maintain separate data within the database. This is far from ideal. MCOT has advised that AOTs do not consistently use *Infoxchange* to make referrals although this is the required process.

Managers have different views on the effectiveness of the partnership although there is evidence of improvement over time. There remain reservations about the funding model among some agencies. One manager’s comment that ‘Street to Home is getting better – it is not perfect’ sums up the situation quite well.

To get a better understanding of how agencies view the STH partnership the checklist component of the VicHealth *Partnership Analysis Tool* (PAT) was used to assess the current status of the STH partnership and to suggest areas that need attention. All STH managers completed the checklist. The highest possible aggregate score is 175 and for each section the highest possible score is 25. The Tool assigns the following values to the total score:

- **35-84** The whole idea of a partnership should be regularly questioned.
- **85-126** The partnership is moving in the right direction but it will need more attention if it is going to be really successful.
- **127-175** A partnership based on genuine collaboration has been established. The challenge is to maintain its impetus and build on the current success.

The average total score across all STH managers is 121\(^{127}\) placing the STH partnership toward the upper end of ‘The partnership is moving in the right direction but it will need more attention if it going to be really successful’.

Table 6 shows the score for each section in the checklist. The lowest scores are in ‘Making sure partnerships work’, ‘Minimising the barriers to partnerships’ and ‘Reflecting and continuing the partnership’.

This table needs to be considered in conjunction with figure 4 below which shows responses to the workers on-line surveys on partnership issues.

\(^{126}\) Guidelines for Street to Home op. cit.

\(^{127}\) The scores of three managers indicated that in their view it was a ‘partnership based on genuine collaboration’ and one manager’s score indicated that the ‘whole idea of a partnership should be regularly questioned’.
<table>
<thead>
<tr>
<th>SECTION</th>
<th>DESCRIPTION</th>
<th>AVERAGE STH SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determining the need for partnership</td>
<td>Perceived need, clear goals, shared understanding &amp; commitment, willingness to share, perceived benefits outweigh costs</td>
<td>18</td>
</tr>
<tr>
<td>Choosing partners</td>
<td>Common ideologies, interests &amp; approaches, core business partially interdependent, good relationships, partnership brings prestige, variety among members for a comprehensive understanding of issues</td>
<td>18</td>
</tr>
<tr>
<td>Making sure partnerships work</td>
<td>Managers support the partnership, partners have the skills for collaborative action, roles responsibilities and expectations clearly defined, strategies to enhance skills, simple administrative, communication &amp; decision-making structure</td>
<td>16</td>
</tr>
<tr>
<td>Planning corroborative action</td>
<td>All partners involved in planning &amp; setting priorities, partners communicate &amp; promote the partnership in their own organisations, some staff have roles that cross boundaries between agencies, lines or communication, roles and expectations are clear, decision-making is participatory, responsive &amp; accountable</td>
<td>18</td>
</tr>
<tr>
<td>Implementing corroborative action</td>
<td>Common processes standardised, investment of time, personnel &amp; material, collaborative action &amp; reciprocity are rewarded, adds value does not duplicate, opportunities for regular informal contact</td>
<td>18</td>
</tr>
<tr>
<td>Minimising barriers to partnership</td>
<td>Differences in priorities, goals &amp; tasks addressed, core group of skilled committed staff, formal &amp; informal mechanisms for information sharing &amp; dispute resolution, strategies to ensure alternative views expressed</td>
<td>16</td>
</tr>
<tr>
<td>Reflecting on and continuing the partnership</td>
<td>Processes for recognising &amp; celebrating collective achievement, demonstrated outcomes, need to continue the collaboration, resources available to continue partnership, way of reviewing range of partners &amp; bringing in new members</td>
<td>16</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>121</td>
</tr>
</tbody>
</table>
The on-line worker surveys had two questions specific to the STH partnership. The first of these was ‘The roles, responsibilities and expectations of partner agencies are clearly defined and understood by all’. As can be seen from figure 4, which compares responses in 2012 with those in 2011, there has been some increase in the proportion of workers who agreed with the statement – from 36% in 2011 to 45% in 2012. However the fact that in 2012 after 2½ years of operation 55% still did not agree with this statement indicates this is an area needing attention.

The second question was ‘The transfer of clients from the Assertive Outreach Team to a HSW is seamless’. In 2011 38% agreed with this statement and in 2012 45% agreed. This low response signals another area that needs attention. One of the managers interviewed in 2012 observed that when a HSW became involved at a very early stage, even if he/she did no actual work beyond attending case meetings, it helped a relationship to form and kept the focus on the client. This may be one way forward.

Figure: 4: Clarity of roles and seamlessness of transfers – worker surveys 2011 and 2012

Regarding joint case management, it appears that there have been some excellent examples and also some not very good ones. The key to this is probably well summed up in the following comment which, although it refers to MCOT, could apply to any STH service:

*When there is a good, clear care plan, the benefits to clients are more than what MCOT can do by itself. You cannot believe the enormous gains people have made. Remarkable client outcomes which have not been achieved before.*

Interestingly the client interviews gave no hint of any problems in transferring from an AOT to a HSW.

Putting together the information from the manager interviews, PAT and the on-line worker survey, the PAT assessment ‘The partnership is moving the right direction but will need more attention if it is going to be really successful’ seems to be correct. If the STH partnership is to continue, effort needs to be put into clarifying roles and
responsibilities (and ensuring that these are well understood), developing a memorandum of understanding between agencies on how the model is to work and establishing strong protocols. Joint training would help to build greater understanding.

Key Lessons
There are a number of key lessons or findings in respect to the STH program.

Street to Home Works
First and foremost, STH is successfully engaging with rough sleepers and those at risk of becoming rough sleepers and enabling them to be securely and sustainably housed. Both AOTs and HSWs have met and exceeded their targets for linking clients to health related services and stable accommodation. For many clients STH has been life changing. The program works.

A Partnership Exists But It Needs More Attention
Eight agencies working in partnership to provide services to rough sleepers provides significant challenges. The partnership is working but there are still teething problems to be overcome. The transition from AOTs to HSWs is not seamless and there is still some lack of clarity around roles, responsibilities and expectations.

If the partnership is to continue the roles, responsibilities and expectations of the parties must be fully developed, an MOU put in place and strong protocols established. The does not appear to be a common STH model and while tensions around the concepts of ‘housing first’ versus ‘housing ready’ were not as evident in 2012 as they were in 2011 (perhaps because it is now ‘housing available’?) there may be some divergence on which rough sleepers AOTs should be engaging.

MCOT
MCOT has not been flooded with referrals from AOTs as initially expected. The decision for MCOT to accept referrals from HSWs as well as AOTs has been welcomed by HSW agencies. There is no doubt from the MCOT data and from the client interviews that irrespective of referral source both AOTs and HSW are managing clients with serious mental health issues.

Services’ understanding of MCOTs role needs to be strengthened and stronger relationships forged with some agencies. MCOT has provided evidence that suggests AOTs are not referring and perhaps not engaging with some rough sleepers who are mentally ill and who would benefit from MCOT’s services. Some of these were identified during Registry Week. Joint training and case presentations may be the answer.

For all AOTs and most HSWs, MCOT is a critical component of STH.

12 Months May Not Be Long Enough For Some Clients
While most clients should be able to cope without intensive case management support at the end of twelve months there are likely to be a small number of cases whose tenancies will be at risk without ongoing support. Most AOTs and HSWs (70%)
responding to the on-line worker survey have suggested clients should be able to remain on the program for 18 months to two years.

**HOUSING SUPPORT WORKERS**

Clients referred from within the HSWs’ host agency share the same characteristics as those referred by AOTs. The client interviews show that many have been rough sleepers and suffer from mental health, drug and alcohol and health problems. If the decision is made to adopt a different funding model for STH there would be considerable value in maintaining HSW in the current agencies.

**Summary and conclusions**

AOTs, HSW and MCOT have successfully worked together to engage with rough sleepers and people at risk of rough sleeping to link them to services and to settle them into stable accommodation.

The AOTs have met and exceeded their target of 50% of their clients accessing health supports, including mental health and drug and alcohol services. They have also met and exceeded their target of 150 clients over the 2½ years.

The HSWs have met and exceeded their target of 50% of their clients stably accommodated for 12 months but fallen short of their target of 485 clients assisted.

MCOT is valued by agencies as an essential component of STH and the decision to expand its referral base to include HSWs has been welcomed. It has had demonstrable success in working with an extraordinarily vulnerable group of people. MCOT has, however, been adversely affected by the move from the South to the North Metropolitan Health Service. The fidelity of the program and the program itself must now considered to be at risk. It is vital that DCP, the North Metropolitan Health Service and the Mental Health Commission work closely together to rectify these issues.

The STH program is a genuine partnership but for it to be really successful more work is needed, particularly around making sure the partnership works, minimising barriers to partnership and continuing the partnership.

**SUGGESTIONS FOR IMPROVEMENT**

Several actions to improve the STH program are suggested.

1. The STH management group (with DCP support) should establish a project to clarify roles and responsibilities and to develop a memorandum of understanding and protocols between agencies on how the model is to work.
2. Provide opportunities for joint training involving all STH services.
3. Review *Infoexchange* with a view to ensuring full information sharing and easy monitoring of program targets.
4. Review referral pathways for MCOT to ensure that MCOT staff are fully utilised in providing mental health services to people experiencing primary homelessness.

A recommendation for continued MCOT funding with safeguards to ensure program fidelity has been included in the overview section of the report.
ROUGH SLEEPER ASSERTIVE OUTREACH - REMOTE

According to the ABS ‘When a person does not have suitable accommodation alternatives they are considered homeless if their current living arrangement:

- is in a dwelling that is inadequate; or
- has no tenure, or if their initial tenure is short and not extendable; or
- does not allow them to have control of, and access to space for social relations’¹²⁸.

In the case of the two Rough Sleeper Assertive Outreach – Remote (RSAOR) services clients may be sleeping rough in the bush or in camps. They lack the financial and personal and sometimes the physical and psychological means to access alternative accommodation. The majority of the clients is expected to be Aboriginal and may include families, youths, single adults, couples and women with children.

Services are based in Broome and Kalgoorlie. These are regional centres for a number of remote Aboriginal communities and also have reasonably sized resident Aboriginal populations. Cultural security¹²⁹ is therefore very important for these services.

Housing availability is a big issue in both communities. There is limited public housing available and waiting lists are long. Private rental accommodation is unaffordable for those on Centrelink benefits. In Broome, for example, median rents are substantially higher than Perth and vacancy rates low¹³⁰.

Description

Rough Sleeper Assertive Outreach – Remote aims to provide rough sleepers with:

- support to secure and maintain stable accommodation
- support to access mainstream services and accommodation
- support to return to country if appropriate
- brokerage funds to ensure services are responsive to client needs and to facilitate and integrate approach between specialist homelessness services and mainstream agencies.

Funded services are shown below.

¹²⁹ A program’s cultural security is the accord between the intent, nature and conduct of all work within the program with the values and cultural sensitivities of the recipients, in this case Aboriginal people, often from traditional backgrounds.
The contract of service for the Broome Homelessness Drop-in Centre commenced on 1 January 2010, and the service commenced in May 2010. Centacare Broome is a Diocesan-based agency which delivers Emergency Relief, NPAH HSW – Mental Health and Return to Country Programs.

The RSAOR service is based in a newly built Drop-In Centre run by Centacare. Centacare Broome is not an Aboriginal organization. One of its three RSAOR staff is a Kimberley traditional owner.

The contract of service for the Bega Garnbirringu service commenced on 1<sup>st</sup> October 2010 and the service commenced in December 2010. Bega Garnbirringu is an Aboriginal controlled organization and all the staff working in the RSAOR program are local Aboriginal people.

The RSAOR service is housed within the Social Support Unit which provides a number of other programs including the Homeless and Fringe Dweller Project, Sobering Up Shelter, Drug and Alcohol Counselling, Bringing them Home Counselling, a Youth Support Program and a Prison Re-entry Program. There is a close working relationship between the RSAOR program and the Homeless and Fringe Dweller Project. The parent agency is a primary health care provider for Aboriginal people in the region.

Both services employ male and female workers.

**Key Features**

The support and assistance provided by the two services has the following features:

- assertive outreach
- day support
- engagement with rough sleepers to provide support to maintain stable accommodation
- support to visitors who need assistance with basic needs including assistance to return home if stranded (Bega Garnbirringu only at the time of writing)
- intensive work with 10 clients for an average of 12 months using a case management approach.
Evaluation data sources

Evaluation data sources included the following:

- tracking sheets and Progress Reports provided to DCP by each agency
- interviews with managers and workers from the two services
- nine responses to the on-line worker survey (three to the 2011 survey and six to the 2012 survey)
- three client interviews.

How much has the program done?

The target for the program is each service to assist 10 clients a year. Over 2.5 years this equates to 43 people assisted. The target was greatly exceeded with 117 clients\(^{131}\) (96 client 1s and 21 client 2s) assisted between July 2010 and June 2012. Table 1 shows the number of new and ongoing clients worked with by agencies in each six month period.

Table 1: All clients (clients 1 and 2) worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New Clients</th>
<th>Ongoing Clients</th>
<th>All Clients In Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>July – Dec 2010</td>
<td>10</td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>54</td>
<td>4</td>
<td>58</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>36</td>
<td>56</td>
<td>92</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>17</td>
<td>59</td>
<td>76</td>
</tr>
<tr>
<td>Total individuals</td>
<td>117</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The Clients

The majority of clients were female 61%. The average age of client 1s was 40 years (range 18 – 68 years). As expected the percentage of Aboriginal clients assisted by this program is extremely high\(^{132}\).

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\(^{131}\)Workers may work with two adult clients in a family group or household – these are designated as client 1 and client 2.

\(^{132}\)Includes client 1s and client 2s.
Figure 1: Cultural background of the primary client group

Referral sources are shown in table 2. The outreach workers themselves accounted for a third of referrals. For Centacare the Homeless Breakfast Centre (Father McMahon Place) is an important point of contact with rough sleepers.

*If there was no breakfast we would spend more time trudging around the meat works. Most come to breakfast and it is easy to have a chat.*

Bega Garnbirringu RSAOR receives internal referrals for clients using other Bega Garnbirringu services and also outreaches to clients about whom they become aware.

### Table 2: Referral source

<table>
<thead>
<tr>
<th>REFEREE</th>
<th>NUMBERS</th>
<th>PERCENTAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outreach Worker</td>
<td>32</td>
<td>33%</td>
</tr>
<tr>
<td>Community Agency</td>
<td>23</td>
<td>24%</td>
</tr>
<tr>
<td>Day Centre</td>
<td>16</td>
<td>17%</td>
</tr>
<tr>
<td>Self</td>
<td>14</td>
<td>15%</td>
</tr>
<tr>
<td>Drop in Centre</td>
<td>5</td>
<td>5%</td>
</tr>
<tr>
<td>Government Agency</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>2%</td>
</tr>
</tbody>
</table>

The Bega Garnbirringu service described its client group, all of whom were Aboriginal, as follows:

*They are homeless – couch surfing, sleeping in cars or have no structures. Lots of people came into town from Warburton and the Ngaanyatjarra Lands at Christmas and are living behind the pepper trees. They planned to leave but have not because of funerals etc. Funerals are almost weekly and some are dealing with them the wrong way, i.e. with alcohol. Alcohol is an issue, not usually drugs. Mental Health issues are part of the life style. They are dealing with grief and loss and there is no recovery time.*
Centacare described its client group as sleeping on the beach or camping in the mangroves or at the old meat works or if they had public housing being close to breach because of family members living with them uninvited and being disruptive, violent, noisy and messy. Chronic alcoholism is a major problem and undiagnosed mental health problems are also evident.

The usual home of the clients is shown in table 3. Based on the data less than 10% of clients seemed to be from remote communities, however based on agency interviews this may be an underestimation. Both Kalgoorlie and Broome are regional centres and people come from other locations, for example, Ngaanyatjarra Lands, Fitzroy Crossing, for medical treatment, funerals, to visit family etc and get ‘stuck’.

Table 3: Usual home of client by program location

<table>
<thead>
<tr>
<th></th>
<th>Kalgoorlie RSAOR</th>
<th>Broome RSAOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broome</td>
<td>0</td>
<td>54</td>
</tr>
<tr>
<td>Other Kimberley</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Kalgoorlie-Boulder</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Other WA</td>
<td>11</td>
<td>1</td>
</tr>
</tbody>
</table>

Forty-three designated clients (45%) identified themselves as having an alcohol or drug related disability, including nine who identified a dual diagnosis of mental health and drug and alcohol problems, 4% identified themselves as having mental health issues and 18% as having a medical, physical, sensory or intellectual disability.

In addition to the 117 clients there were 54 children involved ranging in age from 0 – 17 years. Thirty percent of the client group were parents with dependent children.

Household composition is shown in table 4.

Table 4: Household composition

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>16</td>
<td>17%</td>
</tr>
<tr>
<td>Couple with children</td>
<td>3</td>
<td>3%</td>
</tr>
<tr>
<td>Extended family</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Single female</td>
<td>25</td>
<td>26%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>22</td>
<td>23%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>2</td>
<td>2%</td>
</tr>
<tr>
<td>Single male</td>
<td>23</td>
<td>24%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>4</td>
<td>4%</td>
</tr>
<tr>
<td>Total households</td>
<td>96</td>
<td>100%</td>
</tr>
</tbody>
</table>

The data are not collected for the second client.
The income source for 96% of client 1s was some form of government payment. Three percent were in the workforce.

**Figure 2: Income source**

![Income source chart]

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful. 26 cases (27%) were closed by the end of June 2012. These cases were open an average of 208 days or just under seven months (median 182 days, range 0 – 636 days). Half the clients remained in the program for at least six months, 20% for at least nine months and 12% for at least a year.

Engaging with rough sleepers in the medium to long-term to support them to access and maintain housing is an important component of the RSAOR program. Both services indicated that there was no time limit on engagement. They work with a client for ‘as long as it takes’. Centacare commented that

> The process of engagement can take a while and can involve workers regularly connecting up with the client at the breakfast program, out in the community or at camp sites. An individual case plan is gradually developed. Some clients can disappear for a few weeks or months then appear again at the breakfast program.

**Accommodation and housing**

A major service delivery issue for RSAOR is access to affordable housing. The private rental market is out of reach for rough sleepers so there is heavy reliance on public housing which is in short supply. DCP has advised that the program is expected to use the existing DoH priority waitlist. However the caseload of ten clients per FTE in 12 months does allow for some long-term support and both services do attempt to obtain accommodation for their clients where this is appropriate.

Bega Garnbirringu refers to and advocates for clients with DoH and also refers to the Australian Red Cross, which has an NPAH housing program. Bega Garnbirringu’s advocacy role includes acting as an cultural adviser between clients and DoH staff.

Centacare has built a strong relationship with DoH and to an extent the RSAOR is
treated by the DoH in Broome in the same way as other NPAH programs, nevertheless access to housing is an ongoing issue.

Workers in the team are constantly prioritising and reprioritising their client list to ensure those with most urgent needs are concentrated on when they need support. We work as best we can within the guidelines of the contract but with no real stock of houses we put a lot of effort into ongoing support to our clients not really knowing when we can get them into a house of their own.

Despite the lack of formal arrangements with DoH, the Broome program in particular has been quite successful in assisting clients to obtain long-term accommodation. Across both programs 23% of client 1s have been accommodated in public housing. Emergency accommodation is lacking in Broome. A plan to build an Indigenous Visitors Hostel has stalled. In Kalgoorlie the short stay Kalgoorlie Indigenous Visitors Facility opened in late November 2012 and was fully operational in January 2013. It is managed by the Australian Red Cross and the relationship with Bega Garnbirringu is still developing. Bega Garnbirringu is expected to be a source of referral to the Facility.

Neither Broome nor Kalgoorlie has transitional accommodation. In Broome, Foundation Housing has some low cost lodging house type accommodation which Centacare has recently been able to access for selected clients. Both agencies stated that transitional housing is needed.

[Transitional housing] gives an opportunity to work with people in a property with greater flexibility. It is an opportunity to up-skill them and to prepare them for bills. For example, clients cannot afford air conditioning but houses have it. It gives greater capacity to work towards independence. It is difficult to up-skill some clients when they have their tenancy. If mistakes are made in transitional housing it is easier to support the client (Centacare staff member).

**RETURN TO COUNTRY**

According to AHURI ‘[a] return to country approach currently underpins homelessness policy on Indigenous rough sleepers in the Northern Territory ... [and] remote South Australia and Western Australia...’134 People accessing regional centres such as Broome can be unable to return to their home communities for financial or logistical reasons. To an extent this is evident in the service specifications for Broome and Kalgoorlie which include provision for returning visitors to country, if appropriate.

Assisting people to get back to country is a component of the Bega Garnbirringu service. Workers talk to clients about returning and discuss ways of getting back, including paying the fare or providing petrol money. No data have been collected on how many people have been assisted.

Helping people to return to country is not part of the Centacare service at present but is being looked at as part of the West Kimberley Homelessness Plan. LotteryWest funding is being sought to develop a sustainable model.

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DAY SUPPORT

The Broome Homeless Drop-In Centre is central to the Centacare RSAOR service. It provides three substantial and healthy breakfasts a week to rough sleepers and itinerants. There are also toilets and showers. On Mondays the Broome Regional Aboriginal Medical Service (BRAMS) holds a clinic at the Centre providing generic health checks, for example, blood pressure, sugar/urine, and on Fridays Centrelink attends. Numbers attending the Centre for breakfast fluctuate from 20 to 100.

Bega Garnbirringu provides breakfast and soup to local camps and a support service to walk-in clients.

[Workers] can sit down, listen and have a cuppa and a yarn which can be all that is needed. They can identify issues.

With what results?

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011 unless otherwise stated.

GAINING AND MAINTAINING ACCOMMODATION FOR 12 MONTHS

Long-term accommodation was acquired for 40 of the 52 client 1s who joined the program before 30th June 2011. Most commonly (40%) this was living with family. Of the remainder 15% were in public housing, 8% in community housing, 6% in private rental and 8% in ‘other’.

Nine client 1s had an accommodation date before 30th June 2011. Four were recorded as having remained in their accommodation for 12 months and one as not. There was no information on the other four. Seven other client 1s were recorded by agencies as having been accommodated for twelve months or more and four as not. These either did not have an accommodation date or fell slightly outside the start or accommodation date parameters. It is reasonable to accept that the seven client 1s have been accommodated for 12 months or more. In all but one case, those clients recorded as accommodated for 12 months or more were in public housing.

Thus of a potential pool of 20 eligible clients at least 55% (11 clients) were stably accommodated for at least 12 months. The RSAOR target of 50% or five clients a year stably accommodated has been met.

In addition to the eleven client 1s, at least thirteen other household members (for example, partners, children) living with the clients were also accommodated for 12 months or more.

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135 Clients recorded as accommodated before 1st July 2011 or identified by the agency as being stably accommodated for 12 months or not accommodated, and as having commenced before or shortly after 1st July 2011.
Figure 3: Flowchart

Access to accommodation has made a significant difference to rough sleepers. A man who had been homeless for seven years and living in the bush said:

*Accommodation [was the most significant change]. Just to come in and shut the door and lock it. It is really nice to have that privacy. Just simple things that people take for granted.*

**LINKING TO SERVICES**

Most clients were linked to services while on the program. Table 5 provides a breakdown of the linkages made to various services.

In addition to the links made for clients, children were linked to school/childcare and to recreation in 21% and 7% of cases respectively.
**Table 5: Links to services while on the program**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>87%</td>
</tr>
<tr>
<td>Housing</td>
<td>77%</td>
</tr>
<tr>
<td>Health Service</td>
<td>65%</td>
</tr>
<tr>
<td>Other services</td>
<td>46%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>19%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>18%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>17%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>14%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>9%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>8%</td>
</tr>
<tr>
<td>Education Services</td>
<td>6%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>2%</td>
</tr>
</tbody>
</table>

**EMPLOYMENT AND TRAINING**

The data showed no change in the proportion of clients in employment, studying or looking for work between their first and final/most recent period in the program. However, client and agency interviews indicated that some clients are taking tentative steps toward training or employment. A Centacare client said:

*I am working now – four hours a week and trying to swing eight hours.*

Bega Garnbirringu gave as an example of clients re-engaging with employment, education and training, a young pregnant woman in her twenties sleeping rough with her partner who wants to get a house and go to TAFE. The agency is assisting her to apply to DoH for housing.

**RETURN TO COUNTRY**

Bega Garnbirringu reported that it has successfully assisted clients to return to their homes in remote communities. No figures are available on how many.

**LIFE CHANGES**

Both Bega Garnbirringu and Centacare reported that clients have made life changes as a result of engaging with RSAOR. The first case study below is an example of a senior Aboriginal man who has been an alcoholic being supported to maintain sobriety and consequently his house. The second case study is a young Aboriginal woman with mental health and drug and alcohol issues who has found she is pregnant and wishes to make changes in her life.
CASE STUDY 1

John is a senior member of the Aboriginal community who has been with the RSAOR program for nearly 12 months. He is now living in single person accommodation as he had to move from his previous house after he lost his partner. He currently has his son staying with him while he waits for accommodation for himself and three children. He hopes this will not be long.

John has had problems with alcohol and has been 'back and forth' to a rehabilitation centre. He has not drunk for about a year, however he has serious health issues and has recently been in hospital for some weeks with an ulcer that will not heal.

John met the RSAOR worker when his house was broken into. The worker started to visit. The worker saw the Police and DoH to get a notice put up banning alcohol and drugs on the property. John said:

I find it really makes it easier. I was on relapse all the time. People used to come and bring alcohol.

... [Worker] has been a big support to me. When I am stressing out he comes to talk to me. He still takes me to get where I want to go like the post office. Taxi vouchers don’t last long. Doing shopping [worker] will drop me and go about his business. I give him a ring to pick up. Money can now go on food.

I am no longer drinking or smoking. I am asthmatic. I feel much healthier now. I don’t have people smoking in the house.

When John first moved into his house he did not have a table or chairs and was sleeping on the floor. The worker got him a table and six chairs and he now has a bed and mattress.

John described the program as being:

Like a strainer post. It kept me on my feet, kept me strong. I am really grateful that really appreciate it.

The worker has built a rapport with John who trusts him. He believes that John is comfortable with him and does not want to leave the program. There are no suitable support services available for John and the worker is afraid that he will ‘fall down’ without RSAOR. He has seen this happen with others. RSAOR is sufficiently flexible to enable the worker to continue to provide support for John if required.

CASE STUDY 2

Maria, a young girl in her twenties with mental health and drug and alcohol issues who is sleeping rough found out she was pregnant. She decided that she wanted to change her life and get it together. She came in to talk to RSAOR and sought assistance.

RSAOR started to build a relationship with Maria, matched her with a particular worker and supported her over time to make the necessary changes as she was ready.

Key Lessons

There are a number of key lessons or findings in respect to the Rough Sleepers Assertive Outreach - Remote service.
CULTURAL APPROPRIATENESS OF SOME DOH PRACTICES

Both agencies raised the issue of DoH’s cultural awareness and security. For one agency this was about awareness of the diversity of Aboriginal culture and cultural issues across the region – ‘We have had to explain to DoH about a client who can’t go home for cultural reasons’.

For the other agency DoH’s requirement that a client respond within three days to an offer of a house was problematic and inappropriate for traditional people. When homeless people are moving between family members or communities they do not have a permanent address and can be difficult to locate quickly. If not located in time they lose the opportunity for a house.

LOCALS VS THOSE FROM OTHER COMMUNITIES

‘Why can’t locals be given priority [by DoH for housing]’ was the question asked by a traditional owner. This issue also came up in Derby. It arises because of the long waitlist for public housing and the fact that ‘out of towners’ are sleeping rough whereas locals may be living with family, albeit in overcrowded and unsafe conditions. There is no easy answer to this question when public housing is in short supply.

CHALLENGES OF ALCOHOL AND FAMILY OBLIGATIONS

According to Centacare most RSAOR clients are or have been chronic alcoholics as are many of their extended family. There are a number of issues associated with this.

- when people are trying to get away from alcohol they have little chance of success if they are allocated houses in close proximity to others with the same issues.

- controlling family members who drink is a very difficult problem for clients who have been housed. ‘One of my clients is being harangued by people coming to drink. [The person] is too frightened to say no. [The person] is an ex-alcoholic. We have done a restraining order but no solution has been found’.

- vulnerable people, many of whom are quite senior and may never have had a tenancy before, can be threatened by extended family and fear retribution if they refuse accommodation. ‘People will come at night to seek refuge but they may be under the influence’.

LENGTH OF SUPPORT

There seemed to be an expectation by agencies that clients will come off RSAOR after 12 months. For some Aboriginal clients struggling with alcohol, mental and general health problems this may be too soon. There are limited alternative services and once relationships and trust have been established, clients can be reluctant to transfer to another service even when one is available. Workers responding to the 2012 on-line survey variously suggested that support should be available for 12 months, 18 months, 24 months and 36 months. For most long-term support will not be needed but for a small number withdrawing support may result in a return to
homelessness. For these clients low level, ongoing long-term support may be the preferred option.

The service specifications state support is to be provided on an individual needs basis and may be longer term if required.

**RECRUIT LOCAL STAFF**

Both services emphasised the importance of local staff to the success of the program. Community connections, good leadership and a willingness to learn were seen as more important than qualifications. Aboriginal staff bring an understanding of local relationships, cultural practices and protocols to the program.

**LOCATE WITHIN AN EXISTING AGENCY WITH CREDIBILITY IN THE ABORIGINAL COMMUNITY**

Locating RSAOR within an existing agency with credibility in the Aboriginal community which provides other related services to the community is advantageous. As long as there is a good ‘fit’ between RSAOR and other agency programs all are strengthened and clients benefit from the opportunity to cross-refer. For example:

- [RSAOR] dovetails into existing services. We deliver the Emergency Relief Program and Return to Country Program. These can integrate with the Rough Sleepers where appropriate.

  Helps raise the profile of Centacare as a service provider to homeless people, caring about meeting the needs of clients.

The Broome Homeless Drop-In Centre has made a substantial contribution to the Broome RSAOR by providing a constructive and non-threatening way to make contact with and engage rough sleepers. The Centre also provides rough sleepers with access to a nutritious meal, showers, medical services and Centrelink. For marginalised people with few social connections outside immediate family it provides a place that is alcohol free to socialise and meet people.

**TWO DIFFERENT PROGRAMS**

Bega Garnbirringu and Centacare programs are quite different in terms of the number of clients case managed and accommodated. In part this is due to the former not commencing until the January – June 2011 period but this cannot be the whole explanation. There are two obvious differences in the services – Centacare’s Broome Homeless Drop-In Centre and Bega Garnbirringu’s additional focus of returning rough sleepers to their communities as well as working intensively with them to find alternative accommodation or housing.

If clients are returned to their communities then accommodation in the regional centre ceases to be an issue and contact with RSAOR presumably ceases as well.

The Bega Garnbirringu breakfasts are provided by the NAHA funded Homeless and Fringe Dweller project not by RSAOR although the two work closely together. The Centacare Homeless Breakfast Centre is coordinated by the RSAOR workers who attend each session. This may make a difference to access to potential clients.
Summary and conclusions

The Bega Garnbirringu and Centacare RSAORs are two seemingly different programs both of which are making a difference for rough sleepers in their respective communities.

SUGGESTIONS FOR IMPROVEMENT

Centacare is supporting more clients and is successfully assisting them to gain and maintain accommodation. However, DoH’s requirement that a client respond within three days to an offer of a house has been problematic at times and is inappropriate for traditional Aboriginal people. The three day requirement as it applies to traditional people should be referred to DoH for review.

Bega Garnbirringu is successfully assisting individuals and families to return to their communities. This is not currently part of the Centacare RSAOR but is being looked at as part of the West Kimberley Homelessness Plan. While this is appropriate, DCP should consider whether there is any way in which the development of a suitable model could be expedited.
SUPPORT FOR YOUNG WOMEN LEAVING CHILD PROTECTION SERVICES

Transitioning from out of home care to independence is a priority under the National Framework for Protecting Australia’s Children 2009-10. The vision is that:

All young people transitioning from out of home care to independence receive support from governments, non-government organizations, family members and/or carers, business and the community to experience an effective transition and reach their full potential for social and emotional participation.¹³⁶

The White Paper on homelessness identifies young people leaving statutory care as being at high risk of homelessness. These young people are one of the groups prioritised under the NPAH policy ‘no exits into homelessness’. Support For Young Women Leaving Child Protection Services is an initiative intended to prevent homelessness for this vulnerable group.

The literature indicates that young women leaving child protection care or who have previously been in child protection care may experience a range of problems such as substance abuse, mental health problems, a lack of parenting skills or a general lack of life skills. They are more likely to have lower educational achievement and be at risk of a wider range of social problems, including homelessness than young people who have not experienced out of home care.¹³⁸

Description

The aims of the Support for Young Women Leaving Child Protection Services (SLCPS) program are:

- support for young women leaving child protection care or who have previously been in child protection care
- provision of independent living options, including support to young mothers to live independently long term
- assisting young women leaving child protection care to develop living skills


• ensuring the young women are not homeless
• provision of education programs, mediation, family support, and parenting support programs
• liaison and linkage to specialist services such as employment education and training and counselling to assist young women and children to move into stable, long term housing.

Parkerville has been contracted to provide the program.

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for Young Women Leaving Child Protection Services</td>
<td>Parkerville Children and Youth Care, Inc.</td>
<td>Metro-wide</td>
<td>1.5 FTE</td>
</tr>
</tbody>
</table>

**KEY FEATURES**

The support and assistance provided has in general the following features:

• referrals received primarily from DCP
• support is provided to young women residing in purpose built independent living units
• average of 12 months support
• needs of young women currently in the program seen as a priority in respect to new referrals
• priority referrals are young women with
  - a history of offending behaviour and substance use/misuse
  - a history of being disruptive or causing harm to others
  - presenting with and/or their child presenting with serious child protection issues
  - extreme physical mobility limitations
  - assessed as severely intellectually challenged and/or registered with Disability Services Commission
  - florid mental health problems
• all participation must be on a voluntary basis
• case management via an action support plan
• identification of relevant community services for the young woman or her children
• encouragement and support to the young woman to access the relevant community services
• empowerment and advocacy are the service’s guiding principles.
Evaluation data sources

The data sources for the evaluation were as follows:

- Progress Reports and tracking sheets provided to DCP by the agency
- Manager interview
- Interviews with eight clients
- Three workers (one in 2011, two in 2012) and one manager in 2011 responded to the online worker survey for a total of four responses.

How much has the program done?

The target for the program is twelve young women a year to be assisted for an average of twelve months. Over 2.5 years this equates to 30 people assisted. This target was exceeded. The number of individuals assisted between January 2010 and June 2012 was 47. Table 1 shows the number of new and ongoing clients worked with by agencies in each six month period.

Table 1: Clients worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New Clients</th>
<th>Ongoing Clients</th>
<th>All Clients In Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>13</td>
<td>0</td>
<td>13</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>14</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>8</td>
<td>4</td>
<td>12</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>7</td>
<td>7</td>
<td>14</td>
</tr>
<tr>
<td>Total individuals</td>
<td>47</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The service agreement commenced on the 30th October 2009.

The clients

The clients were all female with an average age of 18 years (range 15 – 24 years). High percentages of clients were from Aboriginal or CALD backgrounds.
Six clients (13%) identified themselves as having a mental health disability, including one who identified a dual diagnosis of mental health and drug and alcohol problems, three clients identified themselves as having an intellectual disability. Slightly over half the referrals were from the Department for Child Protection (55%) with the remaining referrals coming from NGOs (17%), self (11%), NAHA agencies (11%) and ‘other’ (6%).

In addition to the 47 clients there were 50 children ranging in age from 0 – 36 months. Household composition is shown in Table 2.

**Table 2: Household composition**

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single female</td>
<td>10</td>
<td>21%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>35</td>
<td>75%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The main source of income for all clients when they started the program was other government payment, none was in work. Most were either not in the labour force (81%) or unemployed and looking for work (9%). Five (10%) were students.

**How well has the program done its job?**

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**ENGAGEMENT**

37 cases (79%) were closed by the end of June 2012. These cases were open an average of 193 days or just over six months (median 127 days, range 4 – 577 days). This is considerably short of an average of twelve months support outlined in
program aims and there was substantial variation in the extent to which the young women engaged with the program – only 65% remained with the program for at least three months, 39% for at least six months and 29% for at least twelve months.

**ACCOMMODATION**

The program has been very successful in obtaining accommodation for clients and/or assisting them to maintain accommodation. All are recorded as accommodated in their most recent/final period of contact\(^{139}\). As table 3 shows, the most common accommodation type was shared housing followed by public/community housing.

**Table 3: Accommodation type in most recent/final contact period**

<table>
<thead>
<tr>
<th>Accommodation Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Housing</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Other</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>Private rental</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>Public Housing</td>
<td>11</td>
<td>23%</td>
</tr>
<tr>
<td>Returned to family</td>
<td>7</td>
<td>15%</td>
</tr>
<tr>
<td>Shared Housing</td>
<td>17</td>
<td>36%</td>
</tr>
<tr>
<td>Total</td>
<td>47</td>
<td>100%</td>
</tr>
</tbody>
</table>

**With what results?**

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1\(^{st}\) July 2011.

**ACCOMMODATION MAINTAINED FOR 12 MONTHS**

Information provided by the agency indicated that 25\(^{140}\) clients maintained accommodation for 12 months or longer. In addition to these clients, 63 other household members (for example, children) living with the clients were also accommodated. Six clients were reported not to have maintained their accommodation.

It is reasonable to assume based on the data that another client accommodated before 1st July 2011 maintained accommodation for at least 12 months\(^{141}\). There was insufficient data to make a judgement about three clients also recorded as

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\(^{139}\) Whether someone was accommodated is based on the person having an accommodation date recorded. It is quite possible that most of those recorded as living at home or in other accommodation for whom no accommodation date was recorded remained in that accommodation.

\(^{140}\) This includes two clients indicated as accommodated for 12 months in the penultimate contact period but as unknown in the final contact period.

\(^{141}\) The case remained open for 14 months after the client was accommodated and there is no record of the tenancy ceasing in that time.
accommodated before 1st July.
Thus 74% (26 clients) of eligible clients\textsuperscript{142} were stably accommodated for at least 12 months – this is close enough to conclude that the program reached its target of 75% accommodated.

**Figure 2: Flowchart**

All of the young women interviewed remained in transitional accommodation at Parkerville’s premises in Armadale. All of them expressed immense satisfaction at having a place of their own to reside in and feeling confident that they would be able to achieve permanent accommodation in the future with the support and help of the SLCPS service.

One theme that consistently came through the interviews was the fact that Parkerville responded in a timely fashion to their need for housing. Most interviewed noted that it was only one day, two at the most before Parkerville assigned them a place to live. All were placed in Parkerville’s transitional accommodation. Of note is that six women interviewed indicated that the reason DCP referred them to the service was because they were having conflict with their foster carer and the placement appeared to be in danger of breaking down.

All eight women interviewed said that having a place of their own was very important to them. Not only did it provide them a ‘set of rules’ to live by but also at the same time allowed them to make ‘independent’ decisions, something they suggested was difficult in a fostering setting. It is noted that in the Progress Report of 1 January to 30 June 2012 from the service indicated that living within a set of rules appeared to be what the women residents frequently struggled with the most. All the young women interviewed expressed a hope that they would be able to be

\textsuperscript{142} Clients recorded as accommodated before 1st July 2011 or identified by the agency as being stably accommodated for 12 months (or not accommodated) and as having commenced before 1st July 2011.
successful in getting into public housing (one young woman noted that she had been on the waiting list for two and a half years). In contrast staff who responded to the on-line worker surveys felt that DoH would not be able to provide accommodation for the SLCPS clients, and some felt that the local DoH staff did not go out of their way to accommodate SLCPS client’s needs. Staff also felt that DoH housing was not viable due to the long waiting lists and that the private rental market generally seemed beyond the young women’s reach.

**LINKING TO SERVICES**

Nearly all clients (94%) were linked to at least one service while on the program. Table 4 provides a breakdown of the linkages made to various services.

### Table 4: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrelink</td>
<td>85%</td>
</tr>
<tr>
<td>Health Service</td>
<td>66%</td>
</tr>
<tr>
<td>Other services</td>
<td>47%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>45%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>43%</td>
</tr>
<tr>
<td>Education Services</td>
<td>40%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>30%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>28%</td>
</tr>
<tr>
<td>Financial Counselling</td>
<td>19%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>17%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>6%</td>
</tr>
</tbody>
</table>

In addition to the links made for clients, children were linked to school/childcare and to recreation in 34% and 13% of cases respectively.

All of the young women interviewed were provided with a range of referrals for health, education and parenting services. The client record data from 2012 indicated that three of the interviewed were seen as needing mental health services. One of the women interviewed disclosed long standing depression and the need for mental health services. Juxtaposed with this is the response from both workers who responded to the on-line worker survey in 2012 that indicated there was long waiting time for community mental health services for both adults and for children. To a lesser extent there was concern about the waiting lists for counselling and therapeutic services for children, for DV counselling and support services, and for parenting programs.

**EMPLOYMENT AND TRAINING**

The data show an encouraging increase in the number of clients returning to study as they progress through the program – from five in the clients’ first six-month
period to ten in the clients’ most recent/final six-month period. There was a corresponding change in the number of clients not in the labour force. No client was employed.

Six of the young women interviewed reported that they were supported to continue their education. One young woman spoke of being able to remain in the same school she had been attending while in foster care and another spoke of being enabled to attend a high school program where she could work at her own pace in a supported environment. Another spoke of working to complete her high school education. Others spoke of being supported by Parkerville and DCP to pursue a TAFE or a university career. One woman indicated that she had been helped to get work experience at an equine centre and attend a TAFE equine program. Another woman spoke of gaining DCP’s support to study molecular biology. As one woman said, ‘I have a future now’.

CONFIDENCE AND MATURITY
The second theme that arose in the interviews with the young women was that as a result of the support and services provided to them by their worker, the young women not only gained a range of life skills such as cooking and shopping but they also ‘gained confidence’ in themselves. The young women said that they also felt that they had matured significantly and learned ‘how to see the world differently’. They said that they felt they were becoming ‘independent’ and ‘self-reliant’. Of the women interviewed all indicated that the service had made a significant difference in their lives. Besides maturation, they reported a range of outcomes, the most frequently reported was ‘being free’ of domestic violence.

FAMILY TIES MAINTAINED OR RE-ESTABLISHED
One woman reported that she was no longer using drugs and as a result reunification had commenced with one of her two children. Another young woman was able to get her younger child back in her care. Successful reunification of a child with a biological parent is a major and significant outcome from the SLCPS initiative.

Two women also reported that as a result of the SLCPS services they were able to resume or maintain contact with their biological parent (for one 15 year old woman after not having contact for with her mother for 13 years). One young woman indicated she was able to maintain positive contact with her foster mother. She said that as a result of being able to live independently and perhaps as a result of being able to see things in a more mature fashion, she and her foster mother were able to resume a positive relationship.

INDEPENDENT LIVING SKILLS
Assisting young women to gain increased independent living skills through empowerment, advocacy, and support is a key principle of SLCPS. All components of the evaluation of the SLCPS suggest that the SLCPS provides very pragmatic and intense coaching and mentoring and support to the young women to develop or increase their independent living skills. Six young women interviewed reported that they had definitely been supported to gain these essential living skills in a very concrete and practical way and that it had increased their self-confidence and
perceived efficacy. This was affirmed both by the management interview and worker survey of 2011.

**CASE STUDY**

This 22 year old woman was referred to the SLCPS by DCP. She has two daughters, one age four and the other age two. At the time of interview she was also 7½ months pregnant. She reported that she was able to move into SLCPS’s transitional accommodation ‘almost immediately’.

By her own report she had been living ‘all over’ after separating from her violent partner and leaving her mother’s home after what appeared to be verbal violence on the part of her mother. (This was affirmed by the fact that she, with the help of the SLCPS service, was subsequently able to take out a VRO against her mother.) Part of the conflict with her mother was the refusal of her mother to allow the young woman to resume care of her two year old daughter whom the mother (the child’s grandmother) wished to continue to care for. The young woman fled her mother’s home with her four year old child but not the two year old.

Subsequently the SLCPS service and DCP have secured the return of the woman’s two year old daughter. The young woman also reported that, with the help of SLCPS service, she now has her four year old child in kindergarten.

SLCPS is also supporting her to take out a VRO against her partner who is said to be violent towards her.

After her initial placement in SLCPS transitional accommodation she ‘broke some rules’ and had to leave the accommodation. She reported that the SLCPS service supported her in the community and now has allowed her back into their transition accommodation. Currently, she has been in the transitional accommodation for three months and SLCPS have indicated that she can extend her stay until after her baby is born. Once the birth has occurred SLCPS say they will help her secure permanent accommodation.

The young woman reports that now that she has had ‘some space and time to think about things, to contrast how things were before (homeless, violent partner, not having her youngest child in her care, having lots of bills) and how they are now and where I want to be – i.e. my own home, 3 healthy kids, and no violent partner’… ‘I know I have changed the way I think about things and the way I look at things. I have matured in my thinking and what is best for me and my children and this is important for all of us into the future.’

**Key lessons**

**TIMELY RESPONSE**

It would appear that a key feature of the success of SLCPS is the service’s capacity to provide a timely response. Most young women indicated that they were provided accommodation if not immediately in one to two days. Given that the women were either in danger of losing their current accommodation or had been ‘couch surfing’ or in less suitable situations and that several had children in their care, a timely response was critical not only to engaging with the young women but in terms of securing her and her child/ren’s safety.

**INTENSITY OF SUPPORT REQUIRED**

The service noted in its Progress Report of 1 January to 30 June 2012 that a recurring
issue for the service is the high level of support needed by the young women. The service found that the young women generally had no positive experience in living independently and as was noted in the self-report of the women interviewed they also struggled with having appropriate life skills and frequently they needed parenting skills. The result was that the service was required to provide intensive support to the young women. This appeared to result in some young women being part of the service in excess of the targeted average of 12 months.

SUCCESS IN SUPPORTING REUNIFICATION

Another key lesson learned was the importance of working, generally in partnership with DCP, to either commence or achieve reunification of a child/ren with the young woman who was participating in the SLCPS service. Reunification should be the preferred option where possible and appropriate for a child and is usually the goal of the biological parent. A number of the young women interviewed indicated that the SLCPS service was integral in them either keeping their child in their care or achieving their return.

The SLCPS’s active support for the young women to find secure accommodation, to enhance their parenting skills, and to learn vital life skills is a key way to achieve reunification or at least commence the process.

MAINTAINING CONTACTS WITH BIOLOGICAL PARENTS

Support to the young women to establish or maintain contact with their biological parents, generally their mother has generally had a positive effect. As described above, one young woman age 15 was helped to contact her mother with whom she had had no contact for 13 years. As many children in foster care report, whether or not living with their family of origin is possible for them, the right and need to know their family is very important. Having the SLCPS provide such support and outreach is a critical aspect of a comprehensive program for young women leaving child protection care.

CONTINUING SECONDARY AND TERTIARY EDUCATION

Part of comprehensive support to young women leaving child protection care is the support to continue their education. It was also noted in the service’s Progress Report that the majority of young women in the program were supported to engage in some form of educational activity.

As is well documented, young people who have experienced out of home care have poorer educational outcomes than children and young people who have not experienced out of home care.\(^\text{143}\) The SLCPS involvement in supporting the young women’s education is a key lesson learned for success of such a program and for the young women participants.

SUSTAINABLE HOUSING
As consistently indicated throughout this evaluation report, the issue of secure affordable and stable accommodation is the primary goal of all the funded programs. All the young women interviewed had made significant progress towards becoming ‘housing ready’ but were awaiting access to on-going housing. Their primary aim appeared to become eligible for DoH accommodation but workers had limited confidence this would occur. Furthermore it is dubious whether young women on New Start or on low wages if they are successful in finding employment would be able to afford private rental accommodation.

ACCESS TO MENTAL HEALTH SERVICES
Also as consistently found throughout the evaluation process, there appears to be limited availability and long waiting lists for access to mental health services both for adults and children. Without such access, the achievement of both sustainable housing and quality of life and safety for both young women with mental health issues and their children can be seen to be in question.

Summary and conclusions
Although the majority of young women were being supported for less than six months, the SLCPS has been highly successful in assisting young women leaving care to obtain and maintain accommodation. The service is also supporting women to develop independent living skills and assisting them with education and the development of parenting skills.

It also appears that the service has achieved less tangible outcomes such as supporting young women to gain confidence in themselves and to feel as if they and their children have a ‘future’.

Other concrete outcomes are both the commencement or achievement of reunification with children as well as helping the young women to reconnect with their biological or foster mothers.
The Government’s White Paper on homelessness states that:

There is substantial and growing evidence of the impact of homelessness on children. The instability and chaotic nature of homelessness can have profound effects on a child’s physical health and, psychological development and academic achievement. A critical impact on children is disrupted schooling, which in turn can increase the risk of homelessness in adulthood. Children who are homeless and those living with domestic and family violence are at greater risk of behavioural problems and poor developmental outcome\textsuperscript{144}.

The White Paper recognises that homelessness services were not resourced with children in mind and are often not able to provide specialist support to children.

**Description**

The aims of the Support for Children who are Homeless in Family Situations (CHF) program are:

- to provide support to children primarily between the ages of 4 to 14 who are residing in families who are currently living in or being supported by Family Accommodation Homelessness Services, Public Tenancy Support Services, Supported Housing Assistance Program (SHAP) or NAHA Services
- to assist the children in addressing issues associated with homelessness
- to provide services to children to overcome the trauma and disruption resulting from their homeless experience.
- to ensure children are linked into and regularly attending school
- to provide children with opportunities to take part in ‘normalised’ recreational activities they otherwise may not be able to access.

Funding provided through the NPAH allowed the expansion the existing NAHA program by six FTE as follows:

- expand one existing service by 1 FTE to cover the Northern Metropolitan area (total 4 FTE )
- expand one existing service by 2 FTE to cover the South Metropolitan area (total 4 FTE)
- three existing NAHA funded CALD specialist services were funded for 1 FTE each to provide support to children from Culturally and Linguistically Diverse backgrounds both within their services’ clientele and referred from other NAHA/PTSS/SHAP services.

The following providers have been contracted to provide the service:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sky (NPA)</td>
<td>Centrecare, Inc</td>
<td>South Metropolitan</td>
<td>1</td>
</tr>
<tr>
<td>Support and Counselling Services – SACS</td>
<td>Parkerville Children and Youth Care (Inc)</td>
<td>North Metropolitan</td>
<td>2</td>
</tr>
<tr>
<td>Fremantle Multicultural Support for Children Who are Homeless in Family Situation</td>
<td>Fremantle Multicultural Situation</td>
<td>South Metropolitan Multicultural Services</td>
<td>1</td>
</tr>
<tr>
<td>Multicultural Children Support Service</td>
<td>Multicultural Services Centre of Western Australia, Inc</td>
<td>Multicultural Services</td>
<td>1</td>
</tr>
<tr>
<td>Multicultural Kids in Focus</td>
<td>Women Health Care Association Inc</td>
<td>Multicultural Services</td>
<td>1</td>
</tr>
</tbody>
</table>

The contract for SACS and Sky Plus services commenced on 1st January 2010, the contracts for the other services commenced on 1st April 2010.

**Key features**

The support and assistance provided by the various services which are part of the funded program area have in general the following features:

- use a case management model
- counselling for children
- recreational, health, and educational support
- interagency collaboration.

Early in the program service providers realised that to maximise outcomes for children, they also needed to provide some family support and skill development to parents. This was acknowledged by the DCP as long as the major portion of the work remained directly with the children.

Managers were quite articulate about the goals of CHF services. They indicated these to be:\[145:\]

- helping children and young people reach their potential
- increasing the child’s capacity to trust, to enhance their self-confidence

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145 The list provided summaries the goals identified across all five services. Not all goals were identified universally across all services bar the provision of recreational and educational supports to children and young people via the use of brokerage funding and support to parents to enhance their capacity to enhance their children’s growth, development and functioning, generally through either addressing the parent’s own problems or enhancing their parenting capacity.
and self-esteem

- support the child/young person to enroll in and stay in school
- support the child/young person’s educational attainment
- providing recreational and social opportunities for children and young people
- helping CALD children and young people and their parents integrate into Australian society
- enhancing the parent’s capacity to meet the social, emotional, developmental and educational needs of their children
- connecting parents to community services
- supports to parents to address their own social and emotional issues so that in turn they were better able to meet the needs of their children
- providing parenting skill development and behavioural management skills.

Actualising these goals was assisted by the use of brokerage funds, provision of in-house services available in the funded service itself, through the programs available in the host agency or via referral to other agencies.

It is important to note that three services (three FTE) focus specifically on children and families from multicultural backgrounds for whom English is not generally their first language while the other two existing services were expanded by three FTE and generally focus on non CALD children and families.

**Evaluation data sources**

Evaluation data sources included the following:

- tracking sheets and Progress Reports provided to DCP by each agency.
- interviews with 58 parents and 17 children (The parents were the mothers and in one instance the father of children engaged with the program. The 58 parents had 104 children and young people in total to whom the program provided services and support.)
- interviews with the five service managers
- seven responses to the 2011 on-line worker survey and eleven to the 2012 on-line survey.

**How much has the program done?**

The target for the program is 20 children assisted a year per FTE for an average period of six months. Over 2.5 years this equates to 285 children assisted. This target was exceeded with 316 clients assisted between January 2010 and June 2012. Table 1 shows the number of new, ongoing and repeat clients worked with by agencies in each six month period.
Table 1: Clients worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New Clients</th>
<th>Ongoing Clients</th>
<th>Repeat Clients</th>
<th>All Clients In Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan – June 2010</td>
<td>70</td>
<td></td>
<td></td>
<td>70</td>
</tr>
<tr>
<td>July – Dec 2010</td>
<td>100</td>
<td>29</td>
<td></td>
<td>129</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>40</td>
<td>80</td>
<td>1</td>
<td>121</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>39</td>
<td>60</td>
<td>7</td>
<td>106</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>67</td>
<td>37</td>
<td>3</td>
<td>107</td>
</tr>
<tr>
<td>Total individuals</td>
<td>316</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THE CLIENTS

Boys made up 57% of the client group and girls 43%. The average age of the children was nine years (range 1 – 15 years). The breakdown into age groups is shown in figure 1.

Figure 1.: Age groupings of children assisted

As figure 2 shows the children from a CALD background were the largest client group assisted, this is expected given that half of the workers funded through this program focus on CALD clients. Only Sky and SACS worked with children from Aboriginal or other backgrounds. The program as a whole has surpassed the target of 11% Aboriginal and Torres Strait clients.

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146 Cases closed and regarding-opened.
147 SACS and Sky programs also have five workers through NAHA to work with children of Indigenous and other backgrounds.
Eighty-eight percent of children/parents identified no disability or health issues. ‘other’ (6%) was the most commonly identified disability followed by intellectual disability (3%) and mental health (2%).

As figure 3 shows the majority of referrals to the program were made by NAHA services. The referral sources are consistent with the program’s aims.

Household composition of the children’s family of origin is shown in Table 2. Single parent families predominate.

Table 2: Household composition

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple with children</td>
<td>106</td>
<td>33%</td>
</tr>
<tr>
<td>Extended family</td>
<td>6</td>
<td>2%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>193</td>
<td>61%</td>
</tr>
<tr>
<td>Single male &amp; children</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Total</td>
<td>316</td>
<td>100%</td>
</tr>
</tbody>
</table>
Children’s accommodation upon entry into the service is shown in figure 4 below, however it is likely that most/all of the children were actually living with their families and the housing types represent their families’ housing type.

Figure 4: Accommodation on entering the service

How well has the program done its job?

This section covers clients’ engagement with the program and whether clients found the program helpful.

204 cases (65%) were closed by the end of June 2012. These cases were open an average of 327 days or nearly eleven months (median 236 days, range 0 – 1411 days).

A constant theme from almost all of the parents interviewed was that the time in the program for themselves and their children was too short. All felt that a longer period of service was needed to sufficiently address their children’s issues as well as their own. Comments like ‘six months is not long enough’, ‘the program needs to be longer’ were consistently expressed. One parent said, ‘the program made a huge difference for my son, his behaviour here (at home) and at school. Unfortunately since the (CHF) worker stopped working with him, he has been suspended from school a couple of times’. Another who had found accommodation for the family said it would be ‘good if the service was extended longer as we still need help now’.

All managers also felt that the time limit was too short both to address the complexity of the presenting issues and to help ensure the sustainability of gains and outcomes made by the children/young people and their families. Workers responding to the 2012 on-line worker survey considered children should be able to remain on the program for 12 to 18 months.

The service specifications for this program indicate that clients are to be supported for an average of six months but can be supported for longer if necessary. Given the views of clients and service providers and the fact that on average cases remained

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148 A small number of cases commenced several years before the program started. Some of these cases may have been transferred from the existing NAHA funded SACS and Sky programs.
open for nearly eleven months (median approximately eight months) perhaps the service specifications should be similar to those of HSW-MH (i.e. clients supported for an average of nine months).

The responses in respect to access to services reported in the on-line worker survey identified a long waitlist for community mental health services for children/young people (67%) and for adults (33%). Also noted was a long waitlist for therapeutic services for children (44%).

CALD SPECIFIC ISSUES
A significant theme was the difference in service delivery issues for children/young people and their families from CALD backgrounds. For the most part these families, especially the mother who made the contact with the CHF service, did not speak English and speaking through an interpreter, generally a telephone interpreter, made communication with services more complex and fraught. Also because a number of those from CALD families were either refugees or asylum seekers there was the additional barrier of the family not trusting service deliverers such as government workers (no distinction seemed to be made between government employees or those from the non-government sectors) and the Police as well as a general fear for their immigration status should they seek help.

SATISFACTION WITH SERVICES
The parents who were interviewed consistently expressed their satisfaction with the service both for their children and themselves. All 17 of the children who were interviewed spoke of how much they enjoyed the service and how they wish the service could be an on-going one as they indicated that they really enjoyed the discussions they had with their CHF worker and the different activities they were able to engage in with their worker.

He talked to me, he listened to me
He helped me deal with my anger
I’m happier now because of my worker
Helped me to think about the future
Made me a better person
Made me feel better about me!

The comment ‘everything was helpful’ was repeatedly made by both parents and young people. One mother said, ‘the changes (in her son) are really positive for him and his future and better for us a family unit.’

Those things seen as helpful included counselling for their children and supports to them as adults both in terms of parenting but particularly in respect to assistance regarding court processes and assistance with meeting with DCP. While all clients interviewed were satisfied with the service, suggestions in addition to extending the time the service could be provided included a suggestion that more specific services for teenagers could be included. Juxtaposed with this were comments about how important and helpful the service had been for teenagers thus suggesting that
services to adolescents may have varied across service or workers. Also suggested was the need for more CALD and bi-lingual workers.

**With what results?**

This section covers outcomes regarding linking to mainstream services and what the program has meant to children and their parents.

**LINKING TO SERVICES AND SUPPORTS**

All children were linked to services and/or provided with support while on the program. Table 3 provides a breakdown of the linkages made to various services. The linkages made are in accord with the aims of the program and service goals.

**Table 3: Links to services while on the program**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recreation services</td>
<td>77%</td>
</tr>
<tr>
<td>Transport</td>
<td>72%</td>
</tr>
<tr>
<td>Connected to social networks/sport</td>
<td>70%</td>
</tr>
<tr>
<td>Education Services</td>
<td>70%</td>
</tr>
<tr>
<td>Mentoring</td>
<td>62%</td>
</tr>
<tr>
<td>School</td>
<td>54%</td>
</tr>
<tr>
<td>Group</td>
<td>49%</td>
</tr>
<tr>
<td>Other services</td>
<td>43%</td>
</tr>
<tr>
<td>Counselling</td>
<td>43%</td>
</tr>
<tr>
<td>Individual Protective Behaviours</td>
<td>26%</td>
</tr>
<tr>
<td>Health Service</td>
<td>23%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>7%</td>
</tr>
</tbody>
</table>

**Support and Counselling for Children Valuable**

One consistently recurring theme was the value of the support and counselling for the children/young people.

Among the outcomes identified by managers from the support and counselling
provided to children were:

- increased confidence
- development enhanced communication skills
- more appropriate behaviour
- increased linkages to mainstream Australian society.

Interviews with parents and children supported this view. For example, one case involved therapeutic counselling with a six year old child who was very angry and aggressive towards his siblings and threatening towards his mother. He was also destructive towards household property and had problematic school behaviour. His mother reported that as a result of the therapy his anger was explored and reduced and his behaviour moderated.

Often counselling or support was provided to children and young people by individualised contact with one of the CHF counselling or case management staff in the five programs.

Description of services provided portrayed a non traditional use of counselling services. In some of these instances children and young people did not identify that they were being provided with counselling services. Rather they spoke of visits by the worker either in their home or at school where they and the worker talked about things that were problematic for the child/young person. This talking was characterised by the worker being said to ‘listen’ to what was troubling them and helping the child/young person to deal with the problem. For the most part this listening and talking was not office based. Children and young people said this talking made them feel they could trust the worker and learn how to deal with issues such as being bullied, which was a significant problem for the children and young people interviewed as well as how to deal with their anger – repeatedly raised as an issue for them.

Another theme that came through in respect to support and counselling for children was the impact on the children and young people’s self-confidence and self-esteem. As one mother said, ‘my kids are more confident in themselves’, and another, ‘it [the counselling and support] helped my children look at people in the eye’.

For those children/young people who were in the multi-cultural services the support also aimed at gaining better integration with the school and Australian society. These children were from families who were primarily refugees or asylum seekers and where generally English was not their first language. Support also involved helping the child/young person to develop social skills. An example of this was a young boy who was the smallest in his class and was being bullied. His mother reported that after working with the service’s worker the bullying ceased and he improved in respect to his school performance as well as his attitude toward school and his sense of security and safety there.

CASE STUDY

This mother had two children, a son and a daughter. The 12 year old son was struggling with the death of his brother who had been killed in a car accident as well as the loss of
another brother who had been sent to prison. The young person had withdrawn from social
activities and was said not to have any friends. He had previously been in the Rainbow
Program, a program for children who have experienced significant loss though death,
divorce, domestic violence and the like but was reported as not being able to ‘connect’ with
the program. The daughter was also said to have ‘issues of her own’.

The CHF worker visited and spent time talking with the boy and provided counselling for him.
Brokerage funds were also used to buy school uniforms and his books required for school.
While the boy is still ‘fairly isolated’, it is reported that he is coping better emotionally as he is
opening up and talking to the worker about his issues. A male role model was provided to the
boy via a mentor provided by an agency to which the CHF worker referred him. The worker
also provided support to the daughter. Their mother further reported that the worker was
available to her as a confidante about her concerns for her children. As a result the whole
family is functioning more positively.

**SCHOOL PERFORMANCE ENHANCED**

A second clear theme was the positive impact the service had on the
children’s/young people’s school performance. Managers considered improved school performance to be one of the outcomes for children and the client interviews supported this. Parents interviewed repeatedly commented that with the support of the CHF worker their children’s school performance increased overall with a concomitant reduction in behavioural problems for the children/young person both at home and at school.

Nine parents specifically commented on the importance of establishing an on-going relationship for the child/young person with their worker. This trusting, secure relationship meant that the child/young person had someone to talk to about the issues that were of concern to them. This relationship also was seen as supporting the children/young people with social skill development which in turn made their schooling and school relationships easier for them.

One mother reported that as a result of the CHF worker’s help, ‘my whole household
is calmer, my children are more settled and my son has a better attitude. He has
learned to express himself in words not through negative actions’.

The provision of one-to-one tutoring, school uniforms, and holiday camps and activities, some of which involved the workers taking the children on outings to experience new opportunities, also helped improve school performance. Also noted was the provision of protective behaviours programs for the children/young people.

**PARENTS SUPPORTED**

Managers considered that outcomes from the program for parents included:

- having capacity to focus on the education of their children
- having enhanced parenting skills
- accessing needed services by being provided with referral to agencies and programs such as financial counselling, Centrelink, legal services, drug and alcohol programs, and literacy and numeracy programs
- increased integration into Australian society.
Children in turn benefited from their parents taking more responsibility for their care, education and their safety and well being.

Parents when discussing the changes that had occurred for their children said that their children ‘behaved better, listened more’. They ascribed these both to the intervention by the CHF counsellors with the children and to the support they received.

This support has included assistance to enhance their parenting skills. As one mother said, ‘I didn’t know how to parent properly ... our lives were chaotic’. Others made comments such as ‘they (the CHF worker) helped me take my role as a parent back’, and ‘I feel more close to my children (now)’.

Parents also reported that they learned better living skills like preparing healthy foods for themselves and their children.

A mother who was involved with DCP, said because the CHF worker supported her and attended meetings with DCP with her, she didn’t feel ‘so alone’. As a result the mother reported that she felt that DCP ‘listened to her more’. The mother also said that the worker being present resulted in the worker advocating for the mother, something the mother felt she could not have done on her own.

One of the most poignant comments was made by a parent who was really struggling. She said, if not for the worker’s service, (I) don’t think I’d be here today – (it was) lifesaving’.

**Key lessons**

A number of key lessons about successful delivery of services are noted.

**IMPORTANCE OF SUPPORT, COUNSELLING, AND MENTORING FOR CHILDREN/YOUNG PEOPLE**

A key lessons for CHF is the benefit of intensive on-going support and counselling to children and young people coupled with the provision of material and practice supports. Given the vulnerability for children and young people as a result of being in families where homelessness has occurred and the reasons for this homelessness, it is critical that the trauma experienced by the children and young people is addressed.\(^{149}\)

It is reasonable to conclude that by providing counselling and establishing a relationship with the child/young person where the child trusts the worker and where the child feels they can talk with the worker about concerns they have will have an impact. This support and counselling can be seen as beginning to redress the children and young persons’ trauma and help them regain their confidence and self-esteem. Loss of confidence and self-esteem is frequently associated with trauma such as being homeless and experiencing the factors that resulted in that homelessness.

The provision of material and practice assistance such as the purchase of school uniforms, paying for school books, and enrolling in holiday activities/camps and

sporting activities coupled with the counselling and interpersonal support was seen by the service and the children and their parents as vital to children and young people and their healing\textsuperscript{150}.

Parents interviewed also saw in at least three instances that part of comprehensive support to children/young people was the provision of a mentor who was the same gender as the child/young person. The reason for this was seen as enabling the child to have an appropriate role model. This would be particularly important for male children in female single parent households.

**SUPPORT TO PARENTS**

The findings suggest that part of comprehensive service to support children and young people is support to their parents. Of particular importance appeared to be support to enhance parenting skills, increase their financial management acumen and the achievement of sustainable housing. Given the difficulties of the latter both in terms of the public and private rental market, further systemic responses are likely to be required rather than from the individual service.

**CALD SPECIFIC SERVICES AND BARRIERS**

Half of the CHF workers are in CALD specific services. These services face issues that contribute to the complexity of the delivery of support to children and young people who are homeless in families. As indicated above most if not all of the CALD clients seeking assistance through the CHF service who we interviewed had been or currently were homeless due to domestic violence. This was coupled with vulnerability due to having come to Australia generally from countries where Police and government agencies were not viewed with trust or as those who could be turned to for help and protection. This frequently led to seeking services being seen as an option of last resort.

The issues for children and young people who have witnessed domestic violence adds another level of distress experienced by the child/young person and to the complexity of service delivery. Such service delivery requires intervention of a specific nature aimed at helping the child/young person understand what occurred in their family and to ensure that the child does not feel that in some way they were responsible for the violence or that they should have done something to prevent or intervene which is a common response of children who witness family domestic violence.

Furthermore given that most of the parents did not speak any or very little English, the use of telephone interpreters added to the complexity of communication and a likely general level of frustration and stress both on the part of the clients and the workers.

\textsuperscript{150} While the term healing was not generally used specifically, parents talked about how much happier, more secure etc their children were whereas children and young people spoke more specifically about the positive impact of their worker had for them and the opportunities and concrete material things that they were provided with helping them to feel better about school and themselves.
LENGTH OF SERVICE
Repeatedly the adults and the children/young people interviewed noted a need for a longer period of service. This finding suggests that there may be a need to look at the current CHF model to consider if a longer period of service involvement may be warranted both in terms of current client needs but also in terms of impacting on the sustainability of change results for the children and young people involved.

Summary and conclusions
It has been demonstrated that the Support to Children who are Homeless in Family Situations is meeting its targets. Key to the success of the program is the provision of an integrated and comprehensive service that includes support and intervention both to the child or young person and to their parents. As the literature suggests, support and intervention not only with the children and young people who are a part of the program but also to their parents is important. The CHF services’ support to parents appears to have resulted in parents improving their parenting skills and being supported to address their own issues so that, as result, they are better able to support and nurture their children.

SUGGESTIONS FOR IMPROVEMENT
Three key issues have risen consistently, the consideration of which potentially can lead to further enhancement of the CHF services.
Firstly, the specific needs of children and young people who have witnessed family violence, particularly those from CALD families, suggests that addressing these needs should become one of the features of the CHF program.
Secondly the very specific and unique needs of families from CALD backgrounds in terms of language issues and the psychosocial issues inherent in being a refugee or an asylum seeker and the impact this has on clients’ relationship to government and non government services require addressing. The multi-cultural agencies are generally in the best position to do this and the decision to fund them is very appropriate. The language barrier for parents and the complexity of using interpreters needs further exploration.
The third issue suggested for further consideration is the finding that clients of the CHF service have consistently indicated a need for flexibility in the time frame for service delivery.

152 DCP also already funds a DV Children’s Counselling program for NAHA children.
Safe at Home (SAH) reflects a sea change in community attitudes to family and domestic violence from the expectation that the victim would leave the family home to it being the violent partner who should leave\(^{153}\).

In recent years models of service aimed at supporting women who have been subject to family and domestic violence to stay in their homes have been implemented in most Australian states and territories\(^{154}\). These models recognise that:

- in some cases women and children who are in a violent situation will fare better and face less disruption if they are able to remain in the family home, rather than having to relocate to achieve safety
- Violence Restraining Orders can be effective in ensuring that the perpetrator of domestic violence does not have access to his victims.

The literature indicates that good practices to enable more women to stay safely in their own homes include:

- Police proactively offering the option of staying in the home and the removal of the violent partner
- Courts shedding their reluctance to provide orders protecting women and children’s rights to remain in the family home
- support services and government departments providing information and resources to enable women and children to remain at homelessness
- mainstream or specialist services providing risk assessment, safety upgrades and safety planning
- addressing the accommodation, financial and counselling requirements of the violent partner\(^{155}\).

Despite the proliferation of models designed to assist women and children to remain in their own homes there has been only limited evaluation of their effectiveness and there are indications that sustainability may be an issue. According McFerran (2007)

> One of the common issues emerging across the various models is the problem of sustaining the family home as an accommodation option. Indeed, the emerging evidence from the models is that women and children staying home may have a greater struggle with financial sustainability than security. For example, after a family

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\(^{155}\) McFerran op cit.
law settlement the property may have to be sold if a woman cannot raise the finances to buy out her ex-partner’s share. Rental accommodation, in turn may be unsustainable on one income.

However, McFerran continues:

*Client feedback from the NSW pilots is that staying in the home, even as an interim measure is preferable to leaving. It allows time for considered choices and for a planned transition to the next accommodation choice...*  

Violence Restraining Orders are a key enabling mechanism for women and children to stay in the family home. Their effectiveness is crucial to the program. Thus although VROs are a matter for Police and Courts and outside the scope of the evaluation, we have sought Police comment on this issue which are reflected in the Domestic Violence Outreach section. Furthermore to clarify findings from the interim report, clients in the current interview process were asked whether they currently had a VRO in place and with what results. These responses will be discussed below and in the Domestic Violence Outreach section.

Communicare’s DV Outreach Breathing Space Perpetrator Response Service has been funded through NAHA to provide the state-wide perpetrator response for the Domestic Violence Outreach program and to the Safe at Home program. The service is briefly discussed in this chapter.

**Description**

Safe At Home aims to:

- support for women and children experiencing domestic violence to stay in their housing following domestic violence, when it is safe to do so
- provide specialist workers to assess safety and support needs of women and children to stay in their own home, where it is safe to do so
- provide brokerage funds to stabilise housing and increase security.
- uses linkages to Police through a Memorandum of Understanding and local protocols
- undertake risk assessment and an upgrade of security to the home and safety planning in order to ensure confidence and safety.

Services funded under this program are:

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157 McFerran op cit.
<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safe At Home Initiative -</td>
<td>Patricia Giles Centre Inc</td>
<td>North West Metro</td>
<td>2 FTE</td>
</tr>
<tr>
<td>North West Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe At Home Initiative -</td>
<td>City of Stirling</td>
<td>North East Metro</td>
<td>2 FTE</td>
</tr>
<tr>
<td>North East Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe At Home Initiative -</td>
<td>Ruah Community Services</td>
<td>South East Metro</td>
<td>2 FTE</td>
</tr>
<tr>
<td>South East Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe At Home Initiative -</td>
<td>The Lucy Saw Centre Association Inc</td>
<td>South West Metro</td>
<td>2 FTE</td>
</tr>
<tr>
<td>South West Metropolitan</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe At Home Initiative -</td>
<td>South West refuge Inc</td>
<td>South West</td>
<td>2 FTE</td>
</tr>
<tr>
<td>South West Region</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safe At Home Initiative -</td>
<td>Share &amp; Care Community Services Group Inc</td>
<td>Wheatbelt</td>
<td>2 FTE</td>
</tr>
<tr>
<td>Wheatbelt</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Key features**

The support and assistance provided by the various services which are part of the funded program area have in general the following features:

- using a case management model
- assisting women with obtaining a Violence Restraining Order
- undertaking a risk assessment of the client’s living arrangements
- providing safety upgrades to the accommodation
- providing access to refuge accommodation if the situation becomes unsafe
- making appropriate referral to other relevant services
- establishing linkages through a Memorandum of Understanding with the WA Police as well as working relationships with other relevant local agencies. It is noted that the MOU with the Police is aimed at providing guidance for Police operational practice and for clarifying roles and responsibilities.

**Evaluation data sources**

Evaluation data sources included the following:

- tracking sheets and Progress Reports provided to DCP by each agency.
- interviews with managers and workers from the six services
• interviews with the a current and previous worker from the DV Outreach Breathing Space Perpetrator Response service
• 22 responses to the on-line worker survey (10 to the 2011 survey and 12 to the 2012 survey)
• 50 client interviews
• brief literature review.

How much has the program done?
Between July 2010 and June 2012, Progress Reports show that SAH received over 3470 referrals.

The target for the program is 50 clients a year per team of two. Over 2½ years this equates to 600 people assisted. The program fell slightly short of its target with 569 clients assisted between July 2010 and June 2012. Table 1 shows the number of new and ongoing clients worked with by agencies in each six month period.

Table 1: Clients worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New clients</th>
<th>ongoing clients</th>
<th>Repeat clients</th>
<th>All clients in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>July – Dec 2010</td>
<td>73</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>162</td>
<td>54</td>
<td>1</td>
<td>217</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>172</td>
<td>143</td>
<td></td>
<td>315</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>162</td>
<td>181</td>
<td>1</td>
<td>344</td>
</tr>
<tr>
<td>Total individuals</td>
<td>569</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The service agreements for all agencies commenced on 1st July 2010.

The clients
All clients were female. The women’s average age was 36 years (range 17 – 72 years). The cultural background of the clients is shown in figure 1.

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158 It was unexpected to find that in 2012 there was one male client interviewed as the SAH program is designed to support women clients remain in their home following domestic violence.
Figure 1: Cultural background of the primary client group

Referral source is shown in table 2. Police were the largest referral source (53%) followed by women’s domestic violence services (23%). It is interesting to note that although Police and women’s domestic violence services were the most common referrer eleven of the women interviewed reported that they were made aware of the SAH program and referred to it by a broad range of agencies and personnel such as DCP, the Centrelink social worker, their DoH officer, non-government agencies and their local GP.

Table 2: Referral source

<table>
<thead>
<tr>
<th>Source</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police</td>
<td>301</td>
<td>53%</td>
</tr>
<tr>
<td>Women’s Domestic Violence Services</td>
<td>130</td>
<td>23%</td>
</tr>
<tr>
<td>Other</td>
<td>45</td>
<td>8%</td>
</tr>
<tr>
<td>Victims Support Service</td>
<td>21</td>
<td>4%</td>
</tr>
<tr>
<td>DCP - Co Located Workers</td>
<td>20</td>
<td>4%</td>
</tr>
<tr>
<td>Transferred from another SAH Service</td>
<td>14</td>
<td>2%</td>
</tr>
<tr>
<td>DCP</td>
<td>14</td>
<td>2%</td>
</tr>
<tr>
<td>Self</td>
<td>13</td>
<td>2%</td>
</tr>
<tr>
<td>Department for Housing</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Breathing Space</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Legal Service</td>
<td>3</td>
<td>1%</td>
</tr>
</tbody>
</table>

Eighty-eight women (15%) identified themselves as having a mental health disability, including 18 who identified a dual diagnosis of mental health and drug and alcohol problems, 6% identified themselves as having a problem with alcohol and 5% as having a medical, physical, sensory or intellectual disability.

In addition to the 569 women there were 1080 children involved ranging in age from
0 – 17 years. Household composition is shown in Table 4.

**Table 3: Household composition**

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single female</td>
<td>100</td>
<td>18%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>451</td>
<td>79%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>17</td>
<td>3%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>569</td>
<td>100%</td>
</tr>
</tbody>
</table>

The main source of income for all clients when they started the program was other government payment. Thirty-three percent were in the workforce, 7% were unemployed and looking for work, 2% were students and 60% were not in the labour force.

**Figure 2: Income source**

How well has the program done its job?

This section covers clients’ engagement with the program, whether accommodation was obtained/maintained and whether clients found the program helpful.

**ENGAGEMENT**

320 cases (56%) were closed by the end of June 2012. These cases were open an average of 161 days or just over five months (median 116 days, range 0 – 605 days). A third of women remained in the program for at least six months, 21% for at least nine months and 11% for at least a year.

**PROGRAM HELPFUL**

The clients were unanimous in describing the positive impact that the Safe at Home Services has had in their lives and the lives of their children. All clients interviewed were extremely satisfied with the SAH service. They made comments such as ‘everything they did helped’, ‘couldn’t fault them’, they always had time to talk to
All six managers interviewed were of the opinion that the SAH services of their respective agencies both enhanced the personal safety of the women and their children and also provided a range of other important benefits such as helping women to know more about domestic violence and its consequences and linking the clients with other services such as financial counselling. One extremely important outcome that managers noted was the fact that as a result of the SAH workers’ support, children were enrolled in and attended school. Seven workers also reported that in addition to providing the safety audits, developing safety plans and assisting with modification of the home in which the woman and her children resided, linking women and their children to adjunct services was a valuable result of the SAH service.

Many women also reported that the SAH service continued to provide services to them over the entire time they were with the program. At times it was difficult to know if the clients were reporting services they received from SAH or from the refuge/host agency. There is a close and collaborative relationship between the SAH service and its host agency which benefits the clients immensely as generally the host agency has greater flexibility in terms of service delivery and a larger resource base to draw on. Irrespective, the outcome is that women and their children received an integrated, intensive service which appeared to be quite comprehensive.

The only negative comments were that in a few, agency specific, instances clients were frustrated because they had trouble contacting the worker, having the worker return their call, or there was delay between contact and worker’s response to their request for service.

With what results?

This section covers outcomes regarding maintaining accommodation for 12 months, linking to mainstream services, training and employment and what the program has meant to the client. Assessing whether a client has maintained their accommodation for 12 months requires that they commenced with the program and were accommodated before 1st July 2011.

Accommodation Maintained for 12 months

Information provided by agencies indicated that 109 clients had maintained accommodation for at least 12 months. In addition to these clients, 242 other household members (for example, partners/children) living with the clients were reported to be accommodated. Five clients were reported not to have maintained their accommodation.

It is reasonable to assume based on the data that a further ten clients

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159 102 of these clients are known to have been accommodated before 1st July 2011, the remainder were either missing the accommodation date or their most recent accommodation date was after 1st July but the agency considered that they had maintained stable accommodation despite a change of address. In all cases the clients had joined the program before 1st July 2011.

160 These clients had either maintained accommodation for at least 12 months while on the program or were
accommodated before 1\textsuperscript{st} July 2011 maintained accommodation for at least 12 months. There was insufficient information to make a judgement about 119 clients also recorded as accommodated before 1\textsuperscript{st} July 2011 although some would undoubtedly have maintained accommodation for 12 months.

Thus from a potential pool of 243 eligible clients\textsuperscript{161} it can be demonstrated that at least 49\% (119) were stably accommodated for at least 12 months. However, it is not possible to show from the available data that the Safe at Home program met its target of 75\% of clients stably accommodated for 12 months, although it may well have done so.

Figure 3: Flow chart

The data do not allow any direct assessment of the number of clients able to stay in the family home compared with the number for whom other accommodation has been necessary. However the data do show the number of clients already accommodated when they started SAH\textsuperscript{162}. Accommodation dates were available for 518 clients (91\%) of whom 85\% were already accommodated when they started SAH and were not shown to have changed accommodation in their most recent/final period on the program. It is reasonable to assume that most of these women were still in the family home although this cannot be conclusively demonstrated.

Of the 119 women who were demonstrably accommodated for 12 months, 84\% were already accommodated when they started SAH and did not change their accommodation. Twenty-one or 42\% of the fifty women interviewed indicated that

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\textsuperscript{161} Clients recorded as started on the program and accommodated before 1\textsuperscript{st} July 2011 and/or identified by the agency or from the data as having being stably accommodated or not accommodated, for 12 months.

\textsuperscript{162} Whether a client had changed accommodation immediately preceding SAH cannot be identified from the data as the instruction to workers if the client was already accommodated but they did not have a date was to record the day before program commencement as the accommodation date.
they were able to remain accommodated in the family home. Factors that seemed to contribute to this were consistently linked to the services provided by SAH. In particular comments were made about how important the safety audits undertaken by SAH, frequently in conjunction with the Police, were to clients. This safety audit of the clients’ living arrangement is the foundation of the assessment and intervention and safety planning.

A second factor was the modifications that were made to the family home to address the safety issues identified by the audit. Twelve of the women interviewed mentioned items such as security screens on the windows, providing a safe room in the house with secure locks and an extra heavy door so that they and their children could lock themselves into the room until the Police arrived should their partner attempt to break into their residence. They particularly felt this was important where their partner was known to be stalking them and where the VRO seemed to be of little deterrent. They also mentioned the mobile phone/duress alarm they were provided that allowed them to call directly to the Police. Managers and workers alike indicated that these modifications were essential to women being able to remain in the family home and that without access to brokerage funding the modifications could not have occurred.

Women mentioned the value, of having had sensor lights put in around their property so that they no longer had to constantly be vigilant that someone was approaching their residence. They could rely on the lights going on when someone approached. They said this was invaluable to their and their children’s peace of mind.

Women who were interviewed also mentioned that the SAH program assisted them to repair damage to their existing property that had occurred as a result of their partner’s violence. Workers and management reported that while they used brokerage funding for such repairs, they frequently contracted with community businesses which made such repairs at a reduced price to support the SAH program or at times volunteers in the community made the repairs and some on-going maintenance for free. Both a clear sign of a collaborative partnership between SAH and their local communities.

Another factor that contributed to remaining in the family home was the psychosocial support provided by the SAH workers. Clients interviewed indicated that this was as important to them as the physical modification to their property.

Thirty-one of the women interviewed spoke of the value not only of the assistance provided by the SAH worker in helping them seek a VRO, but also of the SAH workers attending Court and supporting them through the Court process. Staff also confirmed that they felt that supporting women through the Court process was a critical part of their role.

Another issue that appears to enable women and their children to remain in the family home was that their violent partner was compliant with the VRO. This was mentioned by five of the women interviewed. Additionally, three women interviewed mentioned that they felt safe because their violent partner was ‘in gaol’.

While a key component of the SAH program is to enable women and their children to
remain in their family home where it is safe to do so, for some women this is not the case. For 29 (58%) of the women interviewed it was not feasible\textsuperscript{163}. The reasons this was so included not being able to afford the accommodation, or the tenancy or mortgage being in the name of the violent partner who refused to change the lease/mortgage over to the client, or because the children or the woman herself felt unsafe in the residence. Examples were given of children being afraid to sleep in their own bedroom or where the mother had information to suggest that her violent partner had been in the house when they were not home, resulting in the woman not feeling safe. Three workers responding to the on-line worker survey also confirmed these were barriers to the woman and her children remaining in the family home.

While not a primary target for service delivery, scope to assess whether remaining in their home is safe for a woman and her children is important when women are referred by Police and this issue has not been clarified. SAH has provided practical support for women and their children where remaining in the family home is not safe.

\textbf{PROVISION OF SAFETY AUDITS}

A key component of the SAH program is the provision of safety audits in order to enhance the safety of women and children in their accommodation. As illustrated above, women consistently reported that this was vital to their physical and psychological well-being. Frequently these audits are done in conjunction with the Police, which as a number of women stated, increases their confidence that key safety issues are identified. It is also illustrative of a collaborative partnership between SAH and the Police.

Conversations with workers affirmed that the audits were critical to developing a means for the woman and her children to achieve safety in their accommodation. All managers interviewed spoke the safety audit (and the accompanying modifications) as the key component of the SAH program.

\textbf{PROVIDING SAFETY MODIFICATIONS TO THE ACCOMMODATION}

As identified above safety modifications to accommodation is a primary thrust of the SAH program. One women whose husband was non-compliant with the VRO and who frequently came to the home late at night commented that she believed that these modifications (sensor lights and security screens) ‘saved my life’. Managers also noted the importance of these and, as identified above, reported creative ways of working with their communities to achieve these vital outcomes for women and their children.

\textbf{LINKING TO SERVICES}

All clients were linked to services while on the program. Table 4 provides a breakdown of the linkages made to various services.

\textsuperscript{163} While it is not possible to be certain it seems likely that the interview sample was biased toward women who had to leave the family home, perhaps because these were clients with whom the workers were still in touch.
In addition to the links made for clients, children were linked to school/childcare and to recreation in 30% and 28% of cases respectively.

**Table 4: Links to services while on the program**

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other services</td>
<td>78%</td>
</tr>
<tr>
<td>DFV Counselling</td>
<td>63%</td>
</tr>
<tr>
<td>DFV Outreach</td>
<td>52%</td>
</tr>
<tr>
<td>Health Service</td>
<td>49%</td>
</tr>
<tr>
<td>Centrelink</td>
<td>43%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>40%</td>
</tr>
<tr>
<td>Department of Housing</td>
<td>31%</td>
</tr>
<tr>
<td>DV Advocate (DCP)</td>
<td>25%</td>
</tr>
<tr>
<td>Children’s Counselling</td>
<td>23%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>18%</td>
</tr>
<tr>
<td>DFV Case Management Coordination</td>
<td>17%</td>
</tr>
<tr>
<td>Education Services</td>
<td>16%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>15%</td>
</tr>
<tr>
<td>Housing Community</td>
<td>11%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>8%</td>
</tr>
<tr>
<td>Family Support Hub</td>
<td>8%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>5%</td>
</tr>
</tbody>
</table>

**CHILDREN’S SCHOOLING**

Some women (15) reported the importance of being helped to get their children into school. SAH workers noted however that they were not always able to have the child remain in the school they attended prior to the violent incidence that brought them to the SAH service. Usually the reason for this was that women, who were unable to remain in the family home, either went to a refuge or into alternative accommodation. Where this change in residence resulted in the woman and her children no longer residing within the original school boundaries or where it was not really feasible to transport the children to back to the original school, then the child was faced with changing schools, likely adding another loss for the child as a result of their situation. Three workers in the worker survey indicated that they were able to ensure that children were registered for attending school. Five workers indicated that this school attendance was in the child’s original school. Managers indicated that they believed that if the women could remain in the family home where the children’s school and social networks were, for example, that the result would be
less disruption. As above, for some children this disruption could not be avoided.

**EMPLOYMENT AND TRAINING**

The data showed no change in the proportion of primary clients in employment, studying or looking for work between their first and final/most recent period in the program. However, 18% clients were linked either to employment or training.

**CONFIDENCE, SELF-ESTEEM AND ABILITY TO COPE**

Clients talked about the fact that the SAH service empowered them, helped them get their confidence and self-esteem back and gave them the courage to leave their violent partner. One woman stated that ‘they made me feel safer and more secure’. ‘I don’t feel scared’ anymore’ said another and a third indicated that ‘I feel I can manage now...where the VRO never did the trick’. One woman who was unable to speak English indicated how important to her it was that the worker helped her fill out the various forms that were required by various agencies and the Court. Another woman said ‘without SAH and left to my own devices, I would have taken him back’. Two of the six managers interviewed specifically noted the SAH service enhanced women’s resolve to leave their violent partners and increased their capacity to sustain that resolve.

In respect to capacity to cope, clients interviewed made mention of the importance of receiving support to enhance their parenting skills. As one client said, ‘they helped me learn how to be a parent’.

**FEELING SAFE**

As indicated above, many women commented that the safety audit and the safety plan contributed to them feeling more safe and secure. Women spoke of both DoH and private rental landlords making safety modifications to the property they resided in as recommended by the SAH audit. Both managers and workers made anecdotal comments that the safety audit and accompanying modifications were critical elements of the success of the SAH service.

Women interviewed also consistently mentioned that in addition to the support offered to them, the support and services provided either directly to their children or through referral was vital and significant for the children being able to feel safe once again. It is noted that some of these support and counselling services appear to have been provided by the SAH worker but some possibly may have been from the resources within the host agency.

**KNOWLEDGE ABOUT FAMILY AND DOMESTIC VIOLENCE**

Another consistent theme was the assistance that was provided to help the woman learn more about domestic violence and the nature of a violent relationship. One woman said ‘my worker gave me knowledge about unhealthy relationships’. She went on to say that she now knows how such a relationship affects her and her children and that she realises that she doesn’t have to remain in a violent relationship. Seven workers indicated that they felt that counselling referrals was integral to this.
SUITABLE ACCOMMODATION:

Women who could remain in their own homes generally were residing in accommodation that was suitable for their needs or at least what they and their children had prior to the domestic violence. Three women indicated that their original accommodation was too small for them and that they hoped to find larger accommodation, primarily through DoH housing. For women and their children for whom it wasn’t safe or feasible to remain in the family home finding suitable accommodation was difficult.

In respect to public housing, three clients interviewed and two workers told of clients needing larger accommodation to accommodate them and their children but because the clients had an outstanding debt to DoH they could not be considered for a change of accommodation until the debt was fully paid. These debts (which in one instance were due to falling behind in the rent as a result of legal expenses and in another as a result of the damage to the property caused by the violent partner) became problematic with significant consequences for the woman and her family. For example, at the time of the interview, one woman reported that she had paid over $2,000 towards the outstanding debt but still owed another $1,000. She had two teenage foster children in her care through a private family arrangement plus her own children. She indicated that she needed a five bedroom home and at present was living in a three bedroom DoH house. She spoke of two occasions where SAH provided food vouchers so she could make her scheduled debt payment to DoH.

Women desirous of public housing were faced with the dilemma of either waiting an inordinate amount of time before being offered public housing while staying in a refuge or in temporary accommodation or entering the private rental market which was frequently beyond the families’ affordability.

Women interviewed who were renting privately said that the rent was beyond their capacity to pay but because they had not been allocated a DoH property within a reasonable timeframe they were forced to rent something that in reality they could not afford. As a result six women or 21% rented either unsuitable accommodation or accommodation that was in ill repair and which the landlord was not amenable to fixing. As a consequence of paying greater rent than they could afford, family finances were stretched beyond capacity. This frequently resulted in the family seeking help for food or other essentials.

Sixteen workers felt that their clients could not access the private rental market as it was unaffordable for the client. Of interest is that while the majority of staff found DoH staff supportive of the NPAH programs, six did not. Agency managers noted that there was insufficient transitional accommodation at time for women seeking more stable accommodation.

PROVIDING ACCESS TO REFUGE ACCOMMODATION IF THE SITUATION BECOMES UNSAFE

All of the funded services either are hosted in a refuge agency or have strong links with their local refuge, thus temporary emergency accommodation is generally available if required. Five of the women said that when their partner found out where they were living or when it just ‘got too hard’; they were able to enter the refuge that they saw as part of the SAH service. As one woman indicated, going into
the refuge for a brief period of time helped her to stabilise her emotions and enabled her the space and time to consider what was best for her and her children.

**INTERAGENCY COLLABORATION**

Management and workers spoke repeatedly about interagency collaboration and how this resulted in better services to clients. The clients themselves also spoke about the benefits they felt they received from appropriate and efficient and timely referrals to other agencies. They particularly noted that the SAH staff had a comprehensive knowledge of what services were available.

It is noted that three of the managers indicated that their relationship with other agencies, especially the Police and DCP, had been strengthened as a result of either MOUs that have occurred as with the Police or as a result of closer working relationships and networking with other agencies. One service identified a range of strategies they used to provide awareness of their service and to encourage interagency collaboration and working relationships. Examples cited above illustrate the collaborative relationships between SAH, the Police, a range of government and non-government agencies as well as a partnership with their local communities.

This collaboration seemed quite positive in most areas in respect to the Police and several other agencies. At times these involved DCP, legal services such as Legal Aid, community legal services, drug and alcohol services, financial counselling, and some level of counselling usually from within the host agency. Particular note was made of instances where Police helped to undertake a safety audit of the woman’s property to guide needed modifications. This feedback was not consistent though, with some mentioning they considered that the Police did not make all referrals they could, that DCP did not always support women leaving violent situations and that mental health services were in short supply or had long waiting lists.

**CASE STUDY**

Paula is a woman who has four children and was pregnant with her 5th child at the time she was linked with SAH. She had been residing in a DoH house in a regional area for approximately 2½ years. She had moved to the regional area from Perth due to a previous incident of domestic violence. As a result of the current episode of violence she contacted the Police who referred her to SAH. Initially Paula had agreed to seek a VRO but did not go through with it.

She initially went into a refuge for one week but then returned to the family home. Paula indicated that she was concerned for her and her children’s safety. When the SAH worker met her, the worker explained to her about a safety audit and a safety plan and with the help of the Police an audit was conducted. Following on from the safety audit, modifications were made to the home. These included changing the locks, special ‘clips’ put on the windows so no one could get in from the outside and DoH erected a fence around the back of the property.

Paula indicated that the SAH worker not only assisted with helping to make the house physically safe for her and her children but invaluable to her was the on-going support. She reported that her SAH worker was in regular contact with her and spent time helping her understand about violent relationships and what her options were. Paula also said that because she was in a regional area she has no family support and that the SAH worker...
Paula also spoke with her worker about the difficulties she was having managing her finances. As a result the SAH worker referred her to a financial counsellor.

Paula said that everything the SAH worker and the SAH program did ‘was helpful’ – they made things safer and provided emotional support to her.

She said that her ex came around several times initially but she had had no recent contact with him.

Paula indicated that the most significant impact her relationships with SAH had achieved for her and her children was that she is more knowledgeable about violence and is more alert regarding safety for herself and her children. She said as a result of SAH’s support to her, she feels stronger and is a more confident person.

Violence restraining orders

The way in which VROs have been identified by the women interviewed as problematic. The evaluation specifically asked women who were interviewed in 2012 questions about having a current VRO in place and the impact on them and their children. Information about VROs was also gained during the 2011 interviews. Of the 50 clients interviewed in 2011 and 2012, 38 currently had VROs in place, while 18 did not.

Two different aspects pertaining to VROs were raised. The first one was in respect to the Court granting and serving of the orders on the violent partner. The other was regarding the Police implementing and monitoring orders and responding to breaches.

One theme was the difficulty in being granted a VRO. In the 2012 interviews a total of four women or 14% indicated that a lack of evidence was the reason that either the VRO was not granted or that the Police felt they could not breach the violent partner when an incident occurred. While these numbers are small, these women indicated both a sense of frustration as well as pessimism that the legal system could assist them. Seven workers confirmed that in their case load between 50 – 100 percent of their clients sought VROs. Two workers indicated however that in their case load, between 75 and 100 percent of these were not granted.

A second theme was the difficulty of serving the VRO on the perpetrator. Four women or 14% reported that their partners were said to be unemployed with no fixed address. As a result the orders could not be served and thus could not be enforced as they had not been served on the respondent.

Another theme was the difference in response depending on whether the women were speaking about the Police’s initial response to an incident of domestic violence prior to seeking/granting a VRO as opposed to situations involving the

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164 The Police’s perspective on these issues will be presented in the following chapter on DV Outreach as the Outreach as a focus group was held with the Police Family and Domestic Violence officers as part of the evaluation process.

165 Please note, where the results are based on both 2011 and 2012 interviews. It is noted, otherwise the results are those from specific responses to the 2012 interviews only.
implementation of the order. Five women (24%) indicated positive satisfaction with the Police’s response to the initial call at the time of the violent incident.

Unfortunately such instances were in the minority of comments the women made in respect to the assistance they received from Police in such instances. Fourteen women or 50% indicated negative experiences with Police when seeking help post the VRO being granted.

Women spoke of specific instances where the violent partner would make threats to or attempt to intimidate the woman or her children however, it was indicated that the Police said there was no way to ‘prove’ the partner had violated the order. As a result of these instances 57% or 16 women with VROs said they felt that either they or their children were not safe. Three women noted that the advice from the Police in such instances was to suggest that the woman move somewhere the violent partner wouldn’t know where she and her children were, thus ‘revictimising’ the woman and her children as one service in their Progress Report suggested.

Women also spoke of there being a delay of several hours before the Police attended in response to the woman’s call for assistance.

It would appear that there are instances of both extremely positive responses to the seeking and implementing of violence restraining orders and their effectiveness for insuring the safety of women and their children and extremely negative ones. While the funded programs are not responsible for how VROs are granted or implemented, it is clear that the granting of the VROs and how they are implemented is a key issue that impacts on the safety and well-being for women who are victims of domestic violence and their children as well as on their on-going perception of feeling and actually being safe. Such also affects women’s capacity to address the psychosocial issues of having lived in a home where family violence is present and their capacity to cope, to care for and protect their children as well as helping their children deal with the consequences of having witnessed domestic violence, all of which is likely to have significant impact on women’s parenting capacity and capacity to sustain her current accommodation.

**Breathing Space Perpetrator Response Service**

Women (and their children) being able to remain in their own home is, in part dependent on services to the perpetrator of the domestic violence. The Breathing Space Perpetrator Response Service is available ‘to help men who are perpetrators of domestic violence to bring about positive changes in their lives’. Its goal is ‘empowering the client to take control of addressing their issues’. It offers ‘specialist services for men anywhere in Western Australia who want to change the way they relate to a partner/ex-partner and children’. The service provides ‘both individual support and links into other services and group programs that will support attempts to make change’. Communicare is funded to deliver the service.

The service began on the 1st of July 2010 and by 30 November, 2012 there had been 2097 referrals to the service with subsequent phone contacts by the service to those so referred. Currently they are receiving an average of 132 referrals a month.

Except in a few instances, the service is a limited to a telephone based referral
service. The service is primarily active and supportive listening followed by referral to either the host agency (Communicare’s) services or to other external agencies for counselling and support. It is questionable whether this limited of response is adequate to meet the needs of men who must leave and stay away from the family home for SAH to be effective.

**Key Lessons**

There are a number of key lessons or findings in respect to the Safe at Home service, a number of which also apply to the other program areas.

**SERVICE EFFECTIVENESS**

As with other programs that support women escaping domestic violence, clients were unanimous about their high level of satisfaction with the service. It would appear that a significant part of that satisfaction pertained not solely to the modifications to their home to make the home safer but the concurrent and ongoing support to the women, the one male who was interviewed, and to their children in respect to their material, practical and psychosocial issues. Once again, it would appear that the SAH service like others in this area strives to provide an integrated seamless service. This model of service delivery suggests that this is an effective model for addressing the underlying causes of homelessness in domestic violence situations and in working towards the achievement of sustainable housing for the victim of domestic violence and their children.

**CAPACITY TO REMAIN IN FAMILY HOME**

As indicated above, 29 or 58% of women interviewed felt they were unable to remain in the family home either because of financial reasons, or because their violent partner knew where they were, or because the family home posed too many negative and traumatic memories for the woman or her children. These families were either not always able to remain in the family home or chose not to do so. While the SAH program is aimed at supporting women and their children to stay in their family home, the support offered by the SAH program to women who could not do so provided valuable services to women who would otherwise not have had access to SAH type services.

**SAH SERVICES NOT SUITABLE FOR ALL WOMEN**

One of the major premises of the SAH service is that by the provision of support women can remain in their home, if it is safe to do so. As noted above home modification and ongoing support appear to be quite effective in achieving this. However as demonstrated in the client interviews, remaining in the original family home is not always safe or economically achievable, thus a significant amount of service delivery is in respect to modifying subsequent accommodation for the woman and her family. Part of the assessment process must be to identify whether remaining in the family home is suitable and affordable.

**LENGTH OF SERVICE DELIVERY**

The issue of length of service delivery is an issue across program areas and has been
discussed in the overview section of the report. It is noted that seven out of ten workers who responded to the question asked in the 2011 on-line worker survey indicated that they believed they would have been able to link their clients to all the needed services by the time their time with the service was complete.

**UNIQUE ISSUES OF WOMEN ESCAPING DOMESTIC VIOLENCE**

There are some significant and unique issues for women who have experienced domestic violence and for their children. Firstly one well known aspect of the cycle of domestic violence is the issue of the need by the perpetrator for power and control over the victims of violence. This need to control even after the woman has separated from the violent partner can lead, for example, to a range of predatory and threatening behaviours. Domestic violence as is well known involves not only physical violence but emotional, verbal, social and financial violence.\(^\text{166}\) This emotional overlay coupled with the various other forms of domestic violence exacerbates the housing issues and frequently complicates the issues and the safety planning which may not feature as predominately in some of the other funded program areas.

A further issue in working with women who have recently left a violent situation is the impact on her children. Children, who witness domestic violence may, at times, be caught in the cross-fire of parental violence and themselves be harmed. Harm to children witnessing domestic violence also results in significant emotional trauma for them.\(^\text{167}\).

Finally it is noted that, on average, women who leave a violent situation are likely to return to that violent partner a number of times\(^\text{168}\). This returning a number of times before the commitment is made and sustained to leave the violent situation will have significant impact both on service delivery and on achieving sustainable housing.

As a result of these complex and unique issues any service such as the SAH program needs to not only address the housing issues for the woman and her children but in order to for the woman to sustain housing, the issues described above and other associated ones must also be addressed before the housing specific issues can be attended to. Feedback from clients, workers and managers affirm that this is critical and also extremely resource intensive.

**VIOLENCE RESTRAINING ORDER**

Violence restraining orders appear to have variable responses both in obtaining them and implementing and monitoring them, particularly in respect to breaches of such orders. It is noted that responses reflected above do not include the Police’ perspective on the issue of VROs. This will be reflected in the section that follows in respect to DV Outreach services as a focus group was held with Police officers who

\(^{166}\) The Family Violence Professional Education Taskforce, NSW 1991.


\(^{168}\) Research on domestic violence has found that women leave on average 7 to 8 times before they are able to sustain leaving a violent situation permanently.
are part of the Police’s domestic violence response program. VROs are integral to ensuring the safety of women (and male) victims of domestic violence and their children. It would appear that VROs both in respect to the Court process and the implementation and monitoring of them is an area that warrants further scrutiny and interagency collaboration.

**Summary and conclusions**

The Safe at Home program is broadly meeting its client target, being only 31 clients short of the required target. It is noted that, irrespective of the shortfall in the number of clients, the SAH services appear to consistently be providing a comprehensive and seamless service to these clients and their children. This includes providing safety audits and subsequent modifications of the accommodation which are key and critical components of the SAH program.

Many key benefits to women and their children are in respect to support and intervention such as domestic violence education for the woman, enrollment and support to attend school regularly for the children involved and either intervention or referral to address issues such as financial management.

It cannot be demonstrated from the available data that SAH has met its target of achieving stable accommodation for at least 75% of its clients, although had there been more follow up possible it may have been shown to have done so. This issue also needs to be seen in the context of the unique, specific and complex issues associated with clients who are escaping domestic violence and in particular for their children who have either witnessed that violence or themselves been a direct victim rather than solely a secondary victim of that violence. Because of the complexity, the consequences of domestic violence, and the challenges inherent in addressing these, the issue of maintaining and sustainable housing is likely to be more difficult to achieve.

When clients present for whom remaining in the family home is not safe or feasible, then the screening and assessment process and the subsequent development of a safety plan with the client is a service the client may not otherwise have access to.
The Domestic Violence Outreach Program (DVOR) has built on the Domestic Violence Pilot Outreach Program which has been operating in Joondalup, Fremantle and South West Regions. It is aimed primarily at early intervention and connects victims and perpetrators of family and domestic violence with support services.

Communicare’s Breathing Space has been funded through NAHA to provide the state-wide perpetrator response for the Domestic Violence Outreach program and to the Safe at Home program. The service is discussed in the previous chapter.

The DVOR program relies on a close working relationship with the WA Police who connect both victims and perpetrators of violence with service providers. This relationship is covered by a memorandum of understanding (MOU) between the WA Police and the Domestic Violence Outreach Program service providers.

The MOU lists six principles which underpin the Domestic Violence Outreach Program:

- the safety of victims of family and domestic violence (FDV) and their children is the key focus
- individuals enacting violence and abuse will be held accountable through the criminal justice system
- women and their children, who seek to remain in their homes, should where possible, be able to do so and have the perpetrator removed
- addressing the occurrence of FDV is best achieved through a coordinated, collaborative and integrated response
- participating agencies play an important role in the Domestic Violence Outreach Program and will work together to contribute to a respectful and professional working relationship
- families and individuals will be encouraged to access Domestic Violence Outreach Service Providers, or any other related services, to prevent further FDV.

Description

The program provides:

- outreach to women at the time of a Police order for the removal of the perpetrator of domestic violence from the home
- support to women through referrals to a wide range of agencies including Crisis Care, medical practitioners, health services, legal services, mental health agencies, women’s refuges, drug counselling, Court victim support services, relationships counselling, domestic violence children’s
counselling services.

The following services have been contracted to provide the Domestic Violence Outreach – Domestic Violence Outreach Worker service:

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Domestic Violence Outreach Initiative – Goldfield Region</td>
<td>Goldfields Women’s Refuge Association, Inc</td>
<td>Goldfields Region</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Domestic Violence Outreach Initiative – Great Southern Region</td>
<td>Albany Family Violence Service, Anglicare WA, Inc</td>
<td>Great Southern Region</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Domestic Violence Outreach Initiative – Murchison Region</td>
<td>Chrysalis Support Service, Inc</td>
<td>Murchison Region</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Domestic Violence Outreach Initiative – Pilbara Region</td>
<td>Pilbara Community Legal Centre</td>
<td>Pilbara Region</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Domestic Violence Outreach Initiative – Peel Region</td>
<td>Pat Thomas Memorial Community House</td>
<td>Peel Region</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

**Key features**

The support and assistance provided by the services has in general the following features:

- primary source of referrals for women needing support due to domestic violence will be from the Police
- timely outreach service will be used to engage women who have been referred to the DVOR service
- offering support and referral will be a primary strategy for enhancing the safety and well-being of the woman and her children, including pursuing legal referral and support
- a case management model that is strengths based and task/outcome oriented and that includes assessment, social history and safety planning will be used
- brokerage funding will be used to support women and their children and to enhance the safety of their accommodation
- use of interpreters will occur when required
- follow up outreach should occur
- a collaborative interagency approach will enhance outcomes for clients.
Evaluation data sources
Evaluation data sources included the following:

- tracking sheets and Progress Reports provided to DCP by each agency
- interviews with managers of the five services
- eight workers provided input into the evaluation with three workers responding to the on-line worker survey in 2011 and four in 2012 and one worker being interviewed in person in 2012
- 19 women were interviewed
- seven out of 14 WA Police Family Protection Coordinators participated in a focus group discussion.

How much has the program done?
The target for the program is 50 people a year per FTE assisted. Over 2 years this equates to 500 people assisted. This target was slightly exceeded with 512 clients assisted between July 2010 and June 2012. Table 1 shows the number of new, ongoing, and repeat clients worked with by agencies in each six month period.

Table 1: Primary clients worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New clients</th>
<th>Ongoing clients</th>
<th>Repeat clients</th>
<th>All clients in period</th>
</tr>
</thead>
<tbody>
<tr>
<td>July – Dec 2010</td>
<td>69</td>
<td></td>
<td></td>
<td>69</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>164</td>
<td>6</td>
<td></td>
<td>170</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>136</td>
<td>11</td>
<td>4</td>
<td>151</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>143</td>
<td>21</td>
<td>11</td>
<td>175</td>
</tr>
<tr>
<td>Total individuals</td>
<td>512</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The clients
All but one client was female; the exception was classified as ‘diverse gender identity’. The average age of clients was 34 years (range 17 – 74 years). As figure 1 shows the percentage of Aboriginal clients was particularly high.

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169 The program commenced in July 2010.
Twenty-eight clients (6%) identified themselves as having a mental health disability, including eight who identified a dual diagnosis of mental health and drug and alcohol problems. 14% identified themselves as having a medical, physical, or intellectual disability and 7% as having a problem with alcohol.

As figure two shows the majority of referrals were made by Police.

In addition to the 512 clients there were 935 children involved ranging in age from 0 – 17 years. Household composition is shown in Table 2.

Table 2: Household composition

<table>
<thead>
<tr>
<th>Household type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple</td>
<td>4</td>
<td>1%</td>
</tr>
<tr>
<td>Single female</td>
<td>95</td>
<td>19%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>391</td>
<td>76%</td>
</tr>
<tr>
<td>Single female &amp; non child dependents</td>
<td>21</td>
<td>4%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>512</td>
<td>100%</td>
</tr>
</tbody>
</table>
The main source of income for the majority of clients when they started the program was other government payment. Twenty-seven percent were in the workforce, 11% were unemployed and looking for work, 2% were students and 60% were not in the labour force.

**Figure 3: Income source**

![Income source chart]

**How well has the program done its job?**

This section covers clients’ engagement with the program and whether clients found the program helpful.

**Engagement**

For most women involvement with the DVOR service was relatively short. 336 cases (66%) were closed by the end of June 2012. These cases were open an average of 42 days or about one and a half months (median 22 days, range 0 – 411 days).

**Program helpful**

All women interviewed bar one reported a high level of satisfaction with the DVOR service. For example, one said, ‘I didn’t know they could help me so much’. Another said, ‘I would have never expected it’.

Women spoke of both material and practical help such as being provided with brokerage money to purchase furniture and linen for the house, help with bond money and linking to financial counselling. Nearly one third (six) of the women interviewed spoke of the importance of the DVOR helping to make their house safe, an initiative undertaken jointly with the Police.

One woman said, (DVOR) ‘is a godsend, an absolute blessing’. Another said, I ‘don’t know where I’d be today without them (referring to the DVOR worker)’. One woman indicated the service ‘helped me transform my life’ and a second said the worker ‘empowered me, gave me strength’.

Only one woman qualified her satisfaction, saying ‘it’s been a little bit of help’
With what results?

This section covers outcomes regarding linking to services and what support provided by the program has meant to the women.

OUTREACH TO WOMEN

As indicated above, the women in the DVOR service were extremely positive about the quality of service they received from the DVOR service and the DVOR worker. Three women mentioned that the being asked by Police if they wanted a referral to the DVOR service served, as one put it, as ‘a wakeup call that I had to do something’.

In terms of the timeliness of the response, women were consistent in the importance of this. Twelve of the women specifically spoke to the timeliness of response. One woman said, ‘they responded promptly when I needed it’. Another said, ‘That’s what they gave me (a prompt response)’.

Nine of the women spoke of contact being made within 24 hours and this was confirmed by managers. It was noted that the outreach occurred in less than 24 hours for those women in refuges.

Three of the five managers interviewed affirmed the need to make contact with the women referred in a timely manner. They also mentioned that at times this was difficult for their staff due to distances in some instances and difficulty in reaching the women by phone.

One manager mentioned that a timely response was so critical because many of the women not only had experienced domestic violence which lead to them being referred to the DVOR service but were grappling with depression or other mental health problems and significant financial ones as well.

Anecdotal evidence from one worker stressed that responding as soon as the referral comes in is a priority for her, saying ‘women need us now, not next week’.

SUPPORT TO WOMEN

The interviews with clients and managers and the responses to the on-line worker survey confirmed that support and referral were an essential component in achieving positive outcomes for the women and their children. This support included things such as attending Court with the women, referral to appropriate agencies like mental health services either for the woman or her children, financial counselling (frequently through the host agency) or services to their children.

Given that the DVOR services for the most part are based in a refuge, at times it was hard to separate out comments that referred to DVOR and the DVOR worker as opposed to those that related to services that were provided by the refuge. Regardless of who was delivering the service, the result was that women and their children were receiving the services they required.

One woman said that the service provided her with advice on the options open to her and the pros and cons of each. Another woman spoke of the importance of the DVOR worker liaising with and advocating on her behalf with the Police and DCP.

In respect to support to children, one woman noted that the DVOR worker spoke with her children and helped them deal with their distress.
Managers spoke of a philosophy of ‘walking along side of’ clients. They saw this way of working as a more effective way to provide services resulting in less competition between service providers and a less hierarchal method of service delivery.

Other issues raised were the lack of financial management and parenting skills of many of the clients. Managers said services to address these were frequently not available and as a result the DVOR service had no other option but to take on delivering such services for their clients.

Comments made by women included:

( The DVOR worker follow-up) made me feel at ease.

They gave me the tools to help educate me.

I am a lot more independent now.

Amazing people, always attended Court with me, told me what to expect.

My future looks brighter now, I owe it all to the DVOR service.

SAFETY AUDITS

Undertaking safety audits is a key component of the DVOR program and is a significant strategy to enabling a woman and her children to remain in the family home. Unanimously the women spoke about the importance for them of the safety audit (and the subsequent modifications that were made to where they were residing). As one woman put it, ‘my children and I can now sleep at night without the worry that he (speaking about her violent partner) might come back.’

Of particular note is the need to conduct these as a matter of priority. Three managers reported that they saw this as a priority for the DVOR worker and that having the Police assist at times in conducting them value added to the process as well as enhanced collaboration between the DVOR service and the Police. The Police Family Violence Coordinators’ Focus group indicated that their goal would be to have all safety audits conducted within one day of referral.

MODIFICATIONS TO ENHANCE THE SAFETY OF THE ACCOMMODATION

There was universal acclamation of the modifications provided to the women’s residences to enhance safety and security. These modifications were frequency provided either for the family home where the woman and her children resided at the time of the violent incident or for a different residence where the woman had moved. Clients indicated that one primary reason for this was because they were unable to secure the tenancy of the family home. More frequently they stated that it was because they did not feel safe with the perpetrator of violence knowing where they were living.

The DVOR program has flexibility and is not restricted to modifications being primarily for the family home. This flexibility is critical particularly in rural and remote locations. All managers interviewed mentioned the importance of brokerage funding to make such modifications and as did two of the three workers in the 2011
worker survey.  

**FOLLOW UP OUTREACH**

All women interviewed referred to the importance of the on-going follow up that was provided by the DVOR worker. This follow-up was seen as an important and valuable part of the service for the women and their children and was integral in sustaining gains made through DVOR. One woman said: ‘they were always available to talk, help me deal with my anxiety and provided me reassurance, I don’t have to carry it all myself’. Another spoke of the importance of the DVOR worker being available to her child on an on-going basis to listen and talk to the child.

It is noted that two out of the five managers indicated that their DVOR service provided follow up to women for ‘as long as it takes’, with one manager indicating that they don’t close a case until the client decides to exit.

Two managers indicated that if client support needs exceed the identified time frames then a referral was made to another program within the host agency or to other community agencies. Such comments may be suggesting that the model is being implemented with a significant amount of flexibility.

**LINKING TO SERVICES**

Most DVOR clients were linked to services while on the program. Table 3 provides a breakdown of the linkages made to various services.

In addition to the links made for clients, children were linked to school/childcare and to recreation in 40% and 27% of cases respectively.

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170 Nb: The question pertaining to the value of brokerage funds was not asked in the 2012 worker survey.
Table 3: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other services</td>
<td>90%</td>
</tr>
<tr>
<td>DFV Outreach</td>
<td>88%</td>
</tr>
<tr>
<td>Centrelink</td>
<td>86%</td>
</tr>
<tr>
<td>DFV Counselling</td>
<td>63%</td>
</tr>
<tr>
<td>Health Service</td>
<td>59%</td>
</tr>
<tr>
<td>Connected to social networks</td>
<td>47%</td>
</tr>
<tr>
<td>Education Services</td>
<td>38%</td>
</tr>
<tr>
<td>Children’s Counselling</td>
<td>31%</td>
</tr>
<tr>
<td>Department of Housing</td>
<td>25%</td>
</tr>
<tr>
<td>Legal Services</td>
<td>23%</td>
</tr>
<tr>
<td>DV Advocate (DCP)</td>
<td>20%</td>
</tr>
<tr>
<td>Employment and/or Training</td>
<td>18%</td>
</tr>
<tr>
<td>DFV Case Management Coordination</td>
<td>17%</td>
</tr>
<tr>
<td>Drug and Alcohol Services</td>
<td>15%</td>
</tr>
<tr>
<td>Family Support Hub</td>
<td>12%</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>10%</td>
</tr>
<tr>
<td>Housing Community</td>
<td>9%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>8%</td>
</tr>
</tbody>
</table>

The clients interviewed stressed the benefits for themselves and their children of the referrals to and linkages with other agencies. Again, it is noted that a range of these services were frequently services within the DVOR host agency.

As with other program areas the issue of access to services was raised. One service in its Progress Report of January to June 2012 and three workers in the on-line worker survey indicated that access to legal aid was problematic. Also five workers indicated that access to financial counselling and budgeting was problematic as was access to therapeutic and counselling services for children.

Also noted in the worker survey by six workers and by four of the five managers was the absence of community mental health services for children and young people. Five workers indicated that there was difficulty in accessing community mental health services for adults. Four of the workers said that residential drug and alcohol services were not available at all. A majority of workers responding to the on-line worker survey also indicated that where these services did exist there were long waiting lists.

Five of the six managers indicated that waiting lists for mental health services both
for children and adults were problematic. Three of the managers indicated that in some areas, particularly in remote areas, mental health services were limited or nonexistent. One manager mentioned that in their particular area counselling services were only available on a fee-for-services basis. To address this, the agency reported that they held a ball in their local community to raise funds to pay for counselling for children in their services who required mental health counselling and therapy.

**Support to Break the Cycle of Domestic Violence**

The women’s comments show that the DVOR has been an important source of emotional support to enable them to break the cycle of family and domestic violence. Women interviewed indicated that breaking the cycle of domestic violence was a difficult for them with six of the women interviewed saying that they had either previously been in a violent relationship or reunited with their violent partners. Women indicated that with the support and counselling provided by either the DOVR worker or through referral to other agencies, they gained a better understanding of the cycle of violence and developed greater emotional and psychosocial strength to break the cycle of violence. Women said

*They gave me lots of understanding.*

*With their support I was able to stay away from DV, I don’t want to get back into that cycle ever again.*

*I get confused, and she (the DVOR worker) helps me to sort things out.*

*She gave me strength to follow through, helped me stand my ground.*

**Remaining in the Family Home**

Forty-three percent of women interviewed were able to remain in the place they had been residing at the time of the violent incident that resulted in them becoming a DVOR client. The interviews with these clients suggest that this was possibly due to three primary factors. The first was that the violent partner agreed to the woman assuming the tenancy or taking over the mortgage and the woman was financially able to sustain the expense. The second was that the violent partner was complying with the VRO where one existed or was not making any contact with the woman or her children. The third was the safety audit and the associated safety modifications to their home.

Juxtaposed to this was the inability of more than half (57%) of the women interviewed to remain in the family home. As was noted in the Police Family Violence Coordinators’ focus group, a number of men are not prepared to leave the family home and thus the only option left for the woman and her children is to relocate from the family home.

Seven of the women specifically commented that remaining in the family home was problematic because the perpetrator of the violence was unwilling or unable (as in the case of living in a mining company home) to transfer tenancy. Two services mentioned that this is exacerbated in areas where mining is dominant. In such instances the accommodation is allocated to the man and if he is not residing there, the woman and her children cannot remain. Anecdotal evidence from two services
indicated that, at times, there was a bit more flexibility about allowing the woman sufficient time to find alternative accommodation but this is not always the case. Another issue identified by women was that they and their children didn’t want to remain in the family home. One woman stated that there were just too many bad memories in that home and that her child was afraid of certain rooms in the house where the violence had occurred. Another woman spoke of the fact that she didn’t want her husband to know where she lived as he would ride by her home (the family home) every day on his way to and from work. She said that even though she had a VRO out that the Police were unable to intervene and that she felt frightened and intimidated by her husband’s behaviour.

A worker responding to the 2012 on-line worker survey and seven women indicated that remaining in the family home was not possible due to the cost being beyond their financial capacity. Four managers were of the same opinion. The inability to afford the cost of the family home coupled with a perceived lack of confidence by women that the VRO would provide a sufficient level of safety were seen by two of the workers responding to the on-line worker survey as the primary reasons women were unable to remain the family home.

Managers indicated that a key outcome for them was to reduce the disruption to the woman and her children. They believed that if the women could remain in the family home where the children’s school and social networks were that the result would be less disruption. As seen however by the comments from the women themselves, remaining in the family home was either not possible or not a desired option for some women.

One manager indicated because no alternative accommodation was available to the women, both in terms of crisis accommodation or transitional housing, some women remained in the family home ‘against their better judgment’. The manager went on to say, if (someone) would ‘build us the houses, this service will work well’.

Once women did secure accommodation, they spoke extremely positively about how the DVOR service provided modification to the house to help ensure their safety.

**Suitable and Sustainable Accommodation**

Consistently achieving suitable and sustainable accommodation was raised as a key issue. Those women interviewed who required alternative accommodation spoke of the fact that finding affordable housing was their top priority. They indicated that either what they found wasn’t affordable or what was affordable wasn’t appropriate. They also spoke of the long public housing waiting lists which meant that getting assigned a public housing home in reality wasn’t a viable option.

All three workers responding to the 2011 on-line worker survey\(^{171}\) indicated that access to public housing was the greatest need for their clients.

In regional areas particularly where mining is prevalent the private rental market would appear to be out of the reach of most women. Two women both of whom had large families commented that since they receive no child support for their children

\(^{171}\) Nb: This question was not asked in the 2012 survey
affording the private rental market seemed unsurmountable for them. Two other women with seven and eight children respectively said that they had difficulty finding suitable accommodation for their large families. The woman who had eight children said that she was ultimately forced to rent a house with no plumbing as nothing else was available that would accommodate her and eight children.

There were some unique issues in terms of availability of housing in remote areas in that most housing is either subsidised for government employees or were mining company houses and once the woman separated from the perpetrator of violence who was the mining company employee she was no longer eligible to remain in the company house.

One manager indicated that due to the lack of accommodation in their area the only option they had was to use brokerage funding to put the woman and her children up in a motel or, for those who came to the remote area from elsewhere, to use such funding to fly them ‘back where they came from’.

A final issue noted in the managers’ interviews and in a Progress Report was that achieving sustainable accommodation is complicated by women returning to their violent partner with one service estimating that 40% of women in their DVOR service returned to their partners. This issue was also raised in the section on the unique issues of women escaping domestic violence in the previous SAH chapter.

INTERAGENCY COLLABORATION

Interviews with managers, clients and Police Family Violence Coordinators confirm the value and importance of interagency collaboration. While all services reported that at least two MOUs were in place, they considered that use of informal networks and personal relationships was a more effective way to ensure a seamless, timely, and holistic approach to service delivery.

Managers and anecdotal information from two workers provided descriptions of different strategies used to enhance a more collaborative working relationship between themselves and other agencies. As one manager put it, interagency collaboration is ‘another link in the chain to providing holistic, wrap-around services’. It may well be beneficial that such strategies are shared with and encouraged across other program areas.

TIMING OF COUNSELLING

Two women reported that they were offered counselling services early on. The women said they refused the referral because as one woman said, ‘I was not in the right space at the time’. The second woman said similar.

It would seem that a re-thinking of when to offer counselling services may be warranted. One could speculate that at the time of the immediate domestic violence

\[172\] The reason for not receiving any child support payments appeared to be because the women’s violent partners did not pay any child support to them. One woman also indicated that because she was not permanent residents of Australia she and her children were not eligible for any benefits.

\[173\] MOUs referred to were the MOU with Police and with the Case Coordination Management Process. One manager suggested that there was an ‘agreement’ with DCP but did not label it as a MOU.
crisis and a time when there are numerous decisions she needs to make for herself and her children may not be a time when a woman can adequately consider undertaking ‘counselling’. It may be more beneficial to broach a referral for counselling at a later time. This could be once the immediate issues have been resolved and the woman has had more time to reflect on her situation and consider her needs in respect to undertaking counselling, as counselling is likely to be seen as a demanding and at times stressful endeavour.

**CASE STUDY**

*Belinda and her partner were high school sweethearts who had been together for eight years. She reported that all was well until he ‘got a drug habit’. After that he ‘beat me half to death’. At the time she had a 20 month old son and was pregnant with their second child. She said she was so frightened that she left their DoH house and went to live with her mother.*

*She was provided another DoH house but found out once she moved in that his relatives lived on the same street. As a result she did not feel safe and initially returned to her mother’s house.*

*Once her partner found out where she was, he became violent towards her again. Belinda contacted the Police Family Protection Unit who charged the partner with 24 counts of violence. She was so frightened that at this point she went into a refuge. She said she began to experience anxiety and panic attacks. She noted that she felt certain that if her partner found her, ‘I will be dead’.*

*She was referred to the DVOR service of which she said, ‘they were a great help, they knew other agencies and their help opened the doors’. ‘They were really good to me’. Belinda said that they helped her get a washing machine and install a duress alarm and cameras around her house. She said, ‘everything (they did) helped me feel safe’.*

*Her violent partner went to goal. While he was in goal, she said, ‘I was relaxed’. She reported that she lived on her own with her son and went back to TAFE. She said ‘I was starting to pick up the pieces, my son needed his mother and I was putting 100% into my son’.*

*She reported that subsequently her partner was released from jail. She still had a VRO in place but he has breached it nine times to date. She says, ‘I can’t sleep, can’t travel on public transport, I am having panic attacks again.’ She reports that her partner has been around to her house and has ‘threatened to kill me if he gets the chance’. She has returned to living at her mother’s. ‘I feel trapped’ she said.*

*Belinda indicated that the emotional support from her DVOR worker has been a mainstay for her. She said ‘they listen to me when I’m down; they sit with me while I cry and vent as I really don’t have too many people I can talk to’. Furthermore the DOVR worker has made referral for her for counseling and help with budgeting.*

**Violence restraining orders**

The use of Violence Restraining Orders is a key strategy used by DVOR services to enhance safety for women and their children. As indicated by three of the managers an important role of the DVOR workers is to encourage women to take out VROs and

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174 Please note, where the results in this section are based on both 2011 and 2012 interviews it is so noted. Otherwise the results are those from specific responses to the 2012 interviews only.
to assist women through that process. Thus the issue of VROs is an important one to the DVOR service and especially to their clients. It is noted that the DVOR service model specifically states that legal referral (which includes VROs) and support are to be provided by the DVOR services.

As with the discussion on VROs in the chapter on the Safe at Home service, there was disquiet about the granting, implementing, and monitoring of Violence Restraining Orders for women in the DVOR service.

**THE WOMEN’S PERSPECTIVE**

In respect to the granting of orders, nine of the women interviewed in 2012 had obtained VROs. Five of these women commented that they had to make repeated applications before they were granted the order. Workers in the 2012 survey indicated that between 60% and 70% of their clients sought VROs and approximately 70% of these were granted.

Women reported a differential response depending on whether their contact to the Police was about the initial incidence of violence or the implementation and monitoring of the orders. It appears that Police response to the initial incident of domestic violence was perceived more positively than their response to calls for assistance in implementing and monitoring the VRO.

Two women were positive about the response they received from Police. One woman said about the call out to the initial incident that ‘they were quick to respond’ and she was satisfied with the Police DV Officer.

Six women indicated that they had a negative response from the Police about implementing and monitoring of the VRO once granted. Four of the women were disappointed by what they perceived as a lack of response by the Police when they believed that their violent partners were breaching VRO and they felt their safety was at risk. Women also said that they were frustrated when Police did attend that they frequently said the woman had no evidence that would ‘prove’ that the man had breached the VRO. As a solution to the lack of evidence, one woman reported that the Police wouldn’t do anything ‘till a friend brought me a home security system, then they had the evidence to make (him) go to gaol.’

Women also appeared frustrated about the parameters of the VRO. For example, one woman said that the VRO ‘keeps him away from me but the Police say they can’t charge him with texts and mail (sent to her) even though the VRO says he is only to have contact through my lawyer’.

Nine women interviewed questioned the potency of the orders themselves. One woman stated ‘the VRO doesn’t stop him. He said he may as well do life in gaol and kill me to make me pay for sending him to gaol (the first time).’

Five of the women said that they feared any action on their part to stop the violence placed them at risk of retribution by the violent partner. One woman commented that a VRO is ‘just a piece of paper, it means nothing. I am really scared of what will

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175 NB; This question was not asked in the 2011 client interviews thus no information on the rate of VROs is available for the 2011 cohort of interviewees
happen when he gets out (of gaol)’.

**Police Family Violence Coordinators Perspective on VROs**

The seven Police Family Violence Coordinators who participated in the focus group indicated that there were three issues pertinent to VROs.

Firstly Coordinators were of the opinion that many women who sought or were granted VROs didn’t understand the parameters of such orders which were limited under the legislation. For example, a Coordinator said he felt women expected that if the Police charged a person with breaching an order that the violent partner would be immediately taken to gaol. The Coordinator noted that was not the case; that any action would have to ‘wait until it was heard by the Court’.

Family Violence Coordinators acknowledged the need for supporting evidence, which was mentioned by the women as difficult to provide. One Coordinator suggested that one solution that ameliorated this situation was the concrete evidence provided by home security cameras.

Secondly it was noted by one of the Coordinators, and others agreed, that different officers interpret Police powers pertaining to domestic violence differently. A Coordinator observed that there are a ‘raft of legislation, policy and practices’ and ‘it is unfortunate that some officers read the legislation and policy differently and may not all respond in the same way’.

Thirdly Coordinators were frustrated that many women were ambivalent about seeking a VRO or pursuing charges against the violent partner. Police cannot force a victim to take out a VRO or pursue a complaint if she doesn’t want to. However the 1997 Restraining Orders Act does give the Police the power to seek such orders.

**Joint Working Relationship**

The Police Family Violence Coordinators were of the opinion that the joint working relationship between themselves and the DVOR and SAH services worked well for the Police. They indicated that it worked particularly well where there was co-location of the two based in the Police’s office. One of the coordinators commented that they wished that there could be a DVOR worker, a SAH worker or a DCP officer based in all their offices. They cited the co-location of the SAH worker and the Police in the Police’s premises in Peel and in South West metro and the co-location of a DCP officer with Police in the Midwest.

As of Feb 2013 DCP have contracted a number of DV support services across the state (17 districts) to operate in a co-location partnership with Police and DCP. This model is referred to as the Family and Domestic Violence Response Team.

The Coordinators said that that the benefit of the co-location was that it enhanced communication and sped up the referral process. It also allowed the co-located SAH and DCP officers to follow up on some of the administrative details that might otherwise be left to the Police Coordinators, who saw this as quite time consuming taking them away from their primary responsibilities. Additionally the Coordinators

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176 There was no mention made of a DVOR worker being co-located with the Police Family Violence Coordinators.
felt co-location would enhance the capacity of the NPAH service worker to provide material and practical assistance to the woman in a timely manner.

Coordinators felt that since the Police are unable to share incident reports with anyone else that co-location enhanced the sharing of the information contained in these reports. Coordinators also indicated where there was co-location they were able to put all safety and security plans in place on the same day.

One other advantage that was seen with co-location was that it enabled the Police to know the outcome of their referral. They indicated that frequently they were not informed of the outcome of their referral as required by the 48 hour agreement and not knowing was problematic for them. They also felt this lack of feedback impacted on some officers’ motivation to refer. Coordinators mentioned that they found that email referral where Police had consent from a woman to make a referral to the DVOR program worked well and suggested that perhaps email feedback was one way for services to provide feedback to the Police in a more timely manner.

The Police Family Violence Coordinators saw the process of getting consent to refer women\textsuperscript{177} to the DVOR service as difficult. At the point of the Coordinators’ initial attendance many women and men were hesitant to give consent. As a result the Police often needed to go back to the home to try to get that consent. They said this was particularly problematic given the large amount of territory each of their regional responsibilities entailed and thus they spent significant amount of travel time re-contacting the woman or the violent partner.

The Coordinators mentioned it was particularly problematic where the man did not want to or refused to leave the family home. In order to speak with or re-contact the woman, the Coordinators frequently had to go through the man who was in possession of the phone. They felt such contact put the woman in jeopardy. They also referred to the situation where the violent partner had consented to leave the family home, the woman frequently did not have a phone or out of fear that it was the violent partner ringing did not answer the phone.

Some Coordinators were of the opinion that Police were not best placed nor qualified to market the advantages of giving consent for a referral and that this might be better done by someone else like the DVOR or SAH workers.

The Coordinators mentioned follow up depended in part on District staffing limits. At the time of the focus group, it was noted that consent rates by regions were as follows:

\textsuperscript{177} Consent for men involved referral to the Breathing Space Perpetrator Response Program
Table 4: Consent rates for referral to DVOR by Police region\(^{178}\)

<table>
<thead>
<tr>
<th>POLICE REGION</th>
<th>RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Metro</td>
<td>24%</td>
</tr>
<tr>
<td>Se Metro</td>
<td>42%</td>
</tr>
<tr>
<td>Goldfields</td>
<td>24%</td>
</tr>
<tr>
<td>Kimberley</td>
<td>12%</td>
</tr>
<tr>
<td>Pilbara</td>
<td>26%</td>
</tr>
</tbody>
</table>

The Coordinators were of the opinion that some services they referred to were inundated and unable to take all referrals. They mentioned one specific service that would only accept a small number of referrals and that this was problematic. It appears that the service had an internal policy to only make four attempts to contact the victim by phone following a police referral. Following the four unsuccessful attempts no further contact was made with the victim and hence no further support offered despite her initial consent for support.

One issue that the Coordinators saw as significant was the extensive knowledge base the DVOR and SAH workers had in respect to referral sources of services. They saw knowing what was available either through the host agency or other service providers in the area was vital to helping women and their children who require support due to domestic violence.

They saw two major impediments to the collaborative relationship between themselves and the DVOR or SAH worker. The first was the fact that district/regional boundaries for Police, Government and Non-government agencies were not the same. The Police Family Violence Coordinators said this made referral and working together more complex and difficult. They felt that all should have the same boundaries, preferably the boundaries currently used by the WA Police.

The second impediment they raised was the lack of a centralised referral point. The Coordinators were of the opinion that if there was one centralised referral point then it would be a more efficient process for the Police. They suggested that DCP become the centralised referral point. Once the Police had referred to DCP, then DCP could take responsibility for communicating the referral to the appropriate DVOR or SAH service. The Coordinators mentioned that last year 42,000 incidents of DV were attended by Police and 80% had children who were referred to DCP by the Police. They suggested that this results in duplication of some referrals and thus referring all to DCP would streamline the process.

\(^{178}\) These rates were determined from a dip sample of WA Police domestic reports for the month of April 2012. These percentages may increase following the May 2013 enhancement of WA Police’s Incident Management System for the recording of Domestic Violence Incident Reports.
Key lessons

TIMELY RESPONSE
A timely response was seen to be vital to an effective DVOR service – women in domestic violence situations need immediate help. Women who were interviewed commented that the DVOR services provided that prompt and timely response to them.

COMPREHENSIVE SERVICE DELIVERY
In order to be effective, any service to women and their children who have experienced domestic violence needs to provide a broad approach to service delivery that addresses the root causes and on-going consequences of violence towards women and their children. The women interviewed affirmed that the DVOR service’s philosophy and model of service delivery provides a comprehensive service that addresses material and practical intervention but also emotional support, advice, and advocacy in respect to their experience of Domestic Violence. This position was also specifically affirmed by three out of the five managers interviewed.

VIOLENCE RESTRAINING ORDERS
VROs are indicated as being problematic and appear not to provide women the safety they had expected. Until VROs actually result in women and their children feeling and being safe from the perpetrator of violence, then housing accommodation is likely to be a lower priority for the woman and thus impact both on housing sustainability and on-going safety for the woman and her children.

The availability of security cameras appears important as they provide the concrete evidence that is required that a violent partner is violating the VRO. To provide cameras is quite costly but is reported by women and the Police Family Violence Coordinators as an effective protective mechanism.

Key to resolving many of the issues would appear to be greater collaboration and communication between the DVOR services and Police Family Violence Coordinators. There seems to be significant disparity between the understanding and perspective of each party.

REGIONAL AND REMOTE ISSUES
A number of issues arose specific to the DVOR services being located in regional and remote areas.

Paucity of services
Managers and workers reported that services in regional areas are scarcer than in the metropolitan area. They highlighted the lack of counselling and therapeutic (mental health) services for women and their children, particularly in respect to children who are traumatised as a result of witnessing the domestic violence. Where services did exist in the regional centre, for those who resided outside of the centre, there was a lack of public transport that prevented many clients from accessing these services or that required the workers to travel great distances to transport the clients. While there is a paucity of services in regional areas, this absence is
exacerbated in remote areas. Workers suggested that there really were few options for referral in remote areas thus leaving women and their children more vulnerable to the consequences of domestic violence.

**Services to perpetrators**

In the Police Family Violence Coordinators’ focus group the comment was made that a residential treatment service for perpetrators of domestic violence like the service provided by Communicare in the metropolitan area would be desirable.

A recent Progress Report identified the absence of services to work with perpetrators of domestic violence as an impediment to securing sustainable housing for women. It was noted that concomitant with providing women a temporary place of safety is the need to help violent men change their behaviour. The Progress Report indicated that there was no service in their regional area that worked with perpetrators of domestic violence. It is likely that this is the situation in many if not most of the regional areas served by the DVOR service.

**Timely access to duress alarms and security cameras**

Another Progress Report indicated that a significant impediment was lack of timely access to duress alarms and security cameras. The process of obtaining these to enhance the safety of the premises women resided in requires contact with the regional Police Family Violence Coordinator to make an application for such equipment. While the Coordinator was said to be quite helpful the application process itself was seen as cumbersome. Once the application was approved, then the equipment had to be flown from Perth. The service indicated that at times this caused long delays, placing the woman and her children at risk.

**Fly in/Fly out**

In at least one area fly in/fly out (FIFO) workers may have increased the number of referrals to DVOR. Many of the FIFO workers were on 457 visas and the Progress Report indicated that there were cultural issues that contributed to the incidents of domestic violence coupled with the fact that the women involved had limited social supports. The Progress Report suggested the situation was exasperated by the use of drugs and alcohol and that women were concerned that disclosing and taking any action about the violence would result in their violent partner losing his job.

**INDIGENOUS SERVICE PROVISION**

Reference has been made in interviews with workers and managers and in Progress Reports to the complexity of service delivery to Aboriginal women. The overlay of cultural issues makes service delivery more intricate and at times less successful. These issues can include:

- cultural obligations to family and to country which make it difficult for Aboriginal women and their children to relocate to a place of safety
- pressure from the perpetrator’s family which can pose a threat to the woman’s safety and that of her children
- retribution against the woman by the perpetrator’s family should the perpetrator face negative consequences for which the woman’s action are perceived as responsible like the sanction of the VRO or serving time in goal
as a result of the violent incident.

Mention was made of a woman who was so severely assaulted by her partner that she was hospitalised. The perpetrator’s family believed that as a result of the woman seeking and receiving a VRO the man committed suicide. The partner’s family was said to have ‘camped’ outside of the hospital the woman was in and was seen to be a threat to the woman’s safety. The woman had to be relocated for her own protection which resulted in her being deprived of support from her own family as well as separation from country.

A worker spoke of Aboriginal women needing to sort things out in the ‘Aboriginal way’. The worker said that her job was to ‘walk alongside of the woman’ and provide her with the help and support and (the cultural) understanding that she could.

Given the high level of Aboriginal clients (30%) in the DVOR service, it would appear vital to find culturally appropriate, effective, and relevant ways of working with Aboriginal women and their children.

Summary and conclusions

The Domestic Violence Outreach services are meeting their quantitative targets. In addition they appear to be achieving a range of qualitative outcomes to the women and their children though one to one support and referral.

Of significant note is the issue of suitable and sustainable accommodation coupled with the unique issues associated with being a victim of domestic violence. This dual relationship of accommodation and domestic violence contributes to the complexity of achieving suitable and sustainable accommodation, particularly in the context of the current housing market.

Finally the issues around VROs have a major impact on the on-going the safety of women and their children and on whether they can remain in the family home. While the factors are broader than just DVOR or other funded programs and beyond the scope of the individual funded programs, the need to address these is critical to ensuring the safety and well-being of women and their children escaping domestic violence.

Suggestions for improvement

Given the high proportion of Aboriginal clients in the DVOR program it is suggested that DCP consider whether there are further ways in which services can be assisted to develop culturally appropriate, effective and relevant ways of working with Aboriginal women and their children who have experienced family violence.
KEEPING KIDS SAFE—CHILDREN IN DOMESTIC AND FAMILY VIOLENCE REFUGES

The Fact Sheet\textsuperscript{179} on NPAH lists two distinctly different projects under the Keeping Kids Safe program: the Keeping Kids Safe (KKS) Project itself hosted by the Women’s Council for Domestic and Family Violence Services (WA) and which provides funding for the Children’s Policy Officer and secondly, funding for Child Support workers in two country services. To reflect this, the Keeping Kids Safe Project report is presented in two sections and for this reason the layout of this sub-report differs from others in the document.

The NPAH Fact Sheet states that the KKS program ‘strengthens the responses for children in domestic violence accommodation services to improve integration with mainstream services including schools, child care and health professionals’.

Section One: Keeping Kids Safe Project

The Keeping Kids Safe project aims to provide support, training and resources to Women’s Refuge staff to enable them to best support children and young people escaping family and domestic violence with their mother/caregiver.

Description

The project includes professional development and training; best practice guidelines and case management approaches; and developing partnerships with other agencies and services. These activities are based on the following objectives:

- mothers and children in women’s refuges are supported to ensure children’s needs are met
- children are engaged in education, health and community recreation
- local protocols are developed with women’s refuges, schools and health professionals to ensure the needs of children are met
- staff in women’s refuges are provided with training and resources to ensure good practice and optimum outcomes for children.

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>Staffing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keeping Kids Safe Project, Children’s Policy Officer</td>
<td>Women’s Council for Domestic and Family Violence Services (WA)</td>
<td>Statewide</td>
<td>1 FTE</td>
</tr>
</tbody>
</table>

Key features

The Children’s Policy Officer indicated that her role and responsibilities are as

\textsuperscript{179} Department for Child Protection n.d., Fact Sheet: Homelessness National Partnership Agreement Western Australian Initiatives Information Update.
follows:

- work with Child Support workers and Child Advocacy workers in refuges to provide support to them, make resources available to them, and offer training
- support to agencies to overhaul their process for referral to the Children’s Counselling Service
- advocate for the needs of Child Support workers
- contribute yearly to WACOSS pre budget submission process for identify funding priorities for services to children, and to keep the need for appropriate levels of funding for children escaping domestic and family violence on the agenda politically
- advocate on behalf of the staff who work with children to ensure children’s voices are heard in the provision of domestic and family violence services
- advocate for an increase to the role of working with children through increased staff hours and numbers and increased funding to deliver vital programs to ensure better outcomes for children
- state-wide scoping of how clients enter the domestic and family violence system, and how they travel through that system
- raising awareness in the community regarding the impact of violence on children
- professional development and training with schools to sensitisise students to the issues of domestic violence
- lectures to TAFE students regarding the impact on children of living in a violent home.

The ‘clients’ for the Children’s Policy Officer are the Child Support Workers and Child Advocates state-wide. It would appear that this includes approximately 33 workers the majority of whom are part time.

**Evaluation data sources**

As KKS project and the Children’s Policy Officer role is completely different to the other NPAH programs the general evaluation approach used for other program areas was not suitable.

Data sources included:

- interviews with the Children’s Policy Office and the Chief Executive Officer of the Women’s Council for Domestic and Family Violence Services (WA)
- progress and other reports provided by the agency to DCP.

**How much has the program done?**

The Project Officer indicated that the following has been achieved:
developed Good Practice Guidelines for working with children in refuges
• quarterly training for Child Support workers
• established a Child Support workers’ network which meets every two months.
  o The network shares information, resources, key education opportunities, established a mentoring/contact list, and provides debrief opportunities
• provided group supervision for metropolitan Child Support workers in recognition of the isolation of the role
• provided support to various refuges to develop individualised protocols with schools and community health services
• many training and development opportunities at low or no cost were provided over the past 3 years, including regional and remote training, international speakers, and provision for regional and remote staff to attend larger Perth based trainings when appropriate through travel subsidies.
• contributed to the pre-budget process for WACOSS for funding for services to children
• assisted Children’s Counselling Service on re-framing the service and streamlining the referral service
• provided a number of presentations to TAFE and other relevant organizations, schools, and agencies regarding the impact of violence on children
• facilitated planning days for three Child support Worker services and two for Children’s Counselling Services.

With what results?
It would appear that the policy officer has provided substantial support to the Child Support and Child Advocate workers.

Guidelines
A major task of the Children’s Policy Officer has been the development of the Good Practice Guidelines for Working with Children in Refuges. These are now complete and are awaiting sign-off prior to their launch. When endorsed these guidelines should provide significant support to the Child Support and Child Advocacy workers.

An initiative that is planned for near future is the development of broad guidelines for refuges for protocols with local schools, health and community services where those are not already in place.

Training
Ongoing training is a key to development of quality service delivery and worker support. The children’s policy officer reports that she has established quarterly
training for Child Support workers.

Training held in partnership with the Women’s Council in September 2012 featured Allison Cunningham, Director of Research and Planning at the Centre for Children and Families in the Justice System in Ontario, Canada. Her publications focus on the area of violence within families and intimate relationship and on adolescents and intimate partnership violence. The two day workshop she presented in September 2012 called *Best Evidence to Inform Interventions for Families and Children Affected by Domestic and Family Violence* was attended by 168 participants.

A further training workshop held in November 2012 was presented by Dr Allan Wade. Dr Wade is an expert in the relationship between trauma and violence. The workshop, *Lessons from Pippi Longstocking: How Children and Young People Resist Violence and Oppression* had an attendance of approximately 50 participants.

A DV Legal Training Workshop was held in March 2012 with 35 participants in attendance and a Protective Behaviours Training Level 2 was provided by the Children’s Policy Officer in June 2012 for 15 workers.

Approximately 15 workers were funded to attend the *Reframing Practice: Domestic and Family Violence Conference* in 2011. Sand and Play and Symbol Work training was provided to Child Support Workers and Children’s Counselling Service workers in September 2010.

**Presentations**

The Keeping Kids Safe project presented at two Conferences in 2012. The first, *Workshopping Resistance Based Practice*, was in partnership with the Women’s Council. This presentation was very well received, and was mentioned as a highlight on the second day of the conference.

The Children’s Policy Officer also presented at the DCP *Leading the Road Home Conference* in May. The workshop focused on best practice for working with children in specialist homelessness settings. The presentation was also reported to be well received and provided valuable feedback which was incorporated in the Good Practice Guidelines.

The Children’s Policy Officer provided presentations to the Department of Housing as well as at Central TAFE on the *Impacts of Domestic and Family Violence on Children*.

**Supervision**

Of particular note is the provision of group supervision to metropolitan workers. The literature consistently affirms the vital role supervision plays in both delivery of quality services and worker retention.\(^{180}\) Group supervision should enhance worker skills, allow for sharing of experience and practice wisdom as well as reduce isolation of, for the most part, being sole workers in their particular service.

Concomitant with the group supervision initiative is the Child Support workers

network which should provide similar opportunities. The metropolitan based network including Mandurah and Rockingham meets bi-monthly. The goal of that network is to share information, resources, to provide key education opportunities, establish a mentoring/contact list and opportunity for support and debrief. Of particular note is the mentoring and contact list as the Child Support positions are isolated. The KKS Progress Report March to September 2012 indicates a desire to expand these network opportunities to regional areas via the use of technology as face to face meetings are not seen as feasible. Prior to the establishment of the network, a workshop was held in May 2010 which provided workers with an opportunity to talk to and share with other workers, particularly those from rural and remote areas.

**CHILDREN’S COUNSELLING SERVICE RE-FRAMED**

In respect to the reframing the service and streamlining the referrals service for the Children’s Counselling Service, these streamlined referral processes were rolled out on July 1, 2012. They were developed in partnership with Children’s Advocates and Refuge Managers. The streamlined process includes a schematic flowchart for ease of use. Refuges are being provided training on a rolling basis during the implementation of the new process as well as specific training for children’s workers on ways to work with children and how to identify need, case management, and safety planning.

Also as part of the *Children’s Counselling Service Project*, generic training for all refuge staff on the impact of domestic and family violence on children, as well as specific training for children’s workers on ways to work with children and how to identify case management and safety training was piloted in five refuges.

**STAFF RETENTION**

The Children’s Policy Officer has reported that her current worker survey indicates staff retention has increased and more vacant positions have been filled. Given that support and supervision such as that provided by the Children’s Policy Officer has frequently been found to address staff turnover and staff retention\(^{181}\) the input provided by the Children’s Policy Officer may be one of the factors that contributed to this result.

**SATISFACTION WITH THE SERVICE**

From the feedback available it would appear that the role of the Children’s Policy Officer is a valued one. Reference was made in the Progress Reports of March – September 2010, September 2010 – March 2011, March 2011 – September 2011 and March 2012 - September 2012 of the to the Children’s Policy Officer advocating for child support staff around unnamed issues to do with the role. Also feedback from the bi-monthly child support meetings were said to have been ‘invaluable in supporting new workers in the field, providing support to new staff, with more experienced workers helping them to develop programs, problem solve etc’.

\(^{181}\) Austin, M. J. Op cit, p. 224.
Key lessons

It would appear that the Children’s Policy Officer has met the main aim of the role, that is, to provide support, training and resources to women’s refuge staff (such as Child Support workers and Child Advocacy workers) to enable them in turn to better support children and young people escaping family and domestic violence with their mother/caregiver.

Different strategies needed to support metropolitan and country services

One of the key lessons about such support, i.e. training and resources, has been that different strategies are needed depending upon whether the worker is in a metro or country area. For example, it was possible to provide face to face group supervision for metro staff but not so for regional or remote staff.

There was recognition that a creative approach to providing similar support for those in regional and remote areas is needed. It has been indicated that a future focus will be on determining how technology and technological advances can support the expansion of the Child Support Network to these areas. While ideally face to face support and supervision would be preferable, thinking outside the square as to what is possible and what can be effective in light of the constraints is a beginning. If this approach is applied to the Child Support Network Project there is no reason to believe that it will not also be applicable to supervision. Of course to expand in this manner will be a significant resource issue for the Children’s Policy Officer position.

Policy and practice support

In addition to funding direct service positions like the Child Support Workers, the service require the provision of policy and practice support through a role such as the Children’s Policy Officer. That role has provided not only direct support to the workers but also advocacy for Child Support workers and their clients as well as operational policy development and the development of documents that can be used across the various services.

Support and supervision for the policy officer

Another key lesson is the need for greater partnership between the Children’s Policy Officer and her management or management team. The scope of the position makes prioritizing critical. It is difficult for a position like the Children’s Policy Officer’s to do that independently. Just as above discussion has focused on the fact that many of the support workers and advocates are sole operators in their position, so too is the Children’s Policy Officer. This makes support and help with prioritizing vital to achieving outcomes in a timely and comprehensive manner. Without support and supervision there is concern that such position may be subject to burnout and as a result worker turnover.

Being hosted by a larger agency, in this instance the Women’s Council for Domestic and Family Violence, enhances the work of the Children’s Policy Officer and the outcomes the position can achieve. For example, the capacity to bring international trainers/speakers is made possible by the collaboration with the host agency and its facilities.
Summary and conclusions

There is no doubt that Keeping Kids Safe’s Children’s Policy Officer has made major and important contributions to the KKS program in supporting Child Support and Child Advocacy workers. The various initiatives undertaken by the Children’s Policy Officer have made a vital difference to staff and as a result to the children for whom they provide support to and advocacy.

It appears to be that the brief of the Policy Officer has expanded incrementally over the life of the KKS project. Furthermore, because of the nature of the work, the Policy Officer has also taken on responsibilities that are broader than the initial goals established for the KKS project. For example, she has supported various refuges to develop individualised protocols between themselves and schools and health. Although likely to be valuable to the refuges this may have contributed to an over extended workload for the Policy Officer. As a result it appears likely that the Policy Officer will be spread thinly across the various initiatives that are now part of her responsibilities.\(^\text{182}\)

Section Two: Child Support Workers

The following services were funded to employ Child Support Workers to strengthen responses for children in domestic violence accommodation services. The role of these Child Support Workers is the same as Child Support Workers employed in other family and domestic violence accommodation services around the State.

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Provider</th>
<th>Coverage</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anglicare’s Albany Family Violence Service</td>
<td>Anglicare WA, Inc</td>
<td>Great Southern</td>
<td>.5 fte</td>
</tr>
<tr>
<td>Child Support Worker, Domestic Violence</td>
<td>Share and Care Community Services</td>
<td>Wheatbelt</td>
<td>.5 fte</td>
</tr>
</tbody>
</table>

The service agreement commenced on 1\(^{st}\) July 2010.

**Key features**

This section discusses key aspects of the Child Support Worker component of KKS and how the services are provided.

The services have in general the following features:

- a case management plan developed for all clients
- a focus on making children/young people feel welcome, supported and safe
- linkages established to provide age appropriate activities

\(^{182}\) At the time this report was being written the project team was informed by the host agency, The Women’s Council for Domestic and Family Violence Services WA, that the Children Policy Officer had resigned from the position.
• linkages with services such as school, child care, child health and health a priority
• priority is to support children within their current school where possible
• provision of ‘low key’ parenting services to parents
• reliance on host agency auxiliary services

Evaluation data sources

The data sources for the evaluation were:

• Progress Reports and tracking sheets provided to DCP by the agencies
• interviews with managers
• three client interviews
• three responses to the on-line worker surveys (two in 2011 and one in 2012)

How much has the program done

The caseload for each worker is 30 children a year. Over two years this equates to 120 children assisted. From Table 1 which shows the number of new and existing clients worked with by agencies in each six month period it is evident that more than double the number of children has in fact been assisted.

Table 1: Children worked with in a period

<table>
<thead>
<tr>
<th>Period</th>
<th>New Clients</th>
<th>Ongoing Or Repeat Clients</th>
<th>All Clients In Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>July – Dec 2010</td>
<td>23</td>
<td>4</td>
<td>27</td>
</tr>
<tr>
<td>Jan – June 2011</td>
<td>105</td>
<td>6</td>
<td>111</td>
</tr>
<tr>
<td>July – Dec 2011</td>
<td>91</td>
<td>25</td>
<td>116</td>
</tr>
<tr>
<td>Jan – June 2012</td>
<td>66</td>
<td>25</td>
<td>91</td>
</tr>
<tr>
<td>Total individuals</td>
<td>285</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The clients

There were slightly more boys (56%) than girls (44%) assisted the child support workers. As Figure 1 shows the program greatly exceeded the target of 11% Aboriginal clients. The average age of the children was six years (median five years, range 0-17). Forty-five percent of the children were aged under five years.
Figure 1: Cultural background of the children

Most of the children (73%) had no identified disabilities, 20% had a medical, intellectual, physical or sensory disability and 7% has some ‘other’ disability.

The largest number of children were from single parent households headed by a woman. Household composition is shown in Table 2.

Table 2: Household composition

<table>
<thead>
<tr>
<th>Household Type</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Couple with children</td>
<td>97</td>
<td>34%</td>
</tr>
<tr>
<td>Extended family</td>
<td>19</td>
<td>7%</td>
</tr>
<tr>
<td>Single female &amp; children</td>
<td>167</td>
<td>59%</td>
</tr>
<tr>
<td>Unknown</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>285</td>
<td>100%</td>
</tr>
</tbody>
</table>

Referral source is shown in Table 3. The most common referral source was ‘other’ of which 49% were ‘self’ – presumed to be the child’s parent.

Table 3: Referral source

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other</td>
<td>131</td>
<td>46%</td>
</tr>
<tr>
<td>NAHA Service</td>
<td>98</td>
<td>34%</td>
</tr>
<tr>
<td>DCP</td>
<td>33</td>
<td>12%</td>
</tr>
<tr>
<td>Police</td>
<td>11</td>
<td>4%</td>
</tr>
<tr>
<td>Unknown</td>
<td>9</td>
<td>3%</td>
</tr>
<tr>
<td>other</td>
<td>3</td>
<td>1%</td>
</tr>
<tr>
<td>Total</td>
<td>285</td>
<td>100%</td>
</tr>
</tbody>
</table>
How well has the program done its job?

This section covers clients’ engagement with the program and whether clients found the program helpful.

By 30th June 2012 240 cases (84%) were closed. The average length of time children remained engaged with their Child Support Worker was 47 days or one and a half months (median 20 days and range 0-364 days). It is evident that 50% of cases remained open for less than a month presumably reflective, at least in part, of the length of time their mothers stay in the refuge.

It is interesting that the worker who responded to the 2012 worker survey considered that the program should be for 24 months when in fact only 3% of cases remained open for nine months or more and none for over 12 months.

One agency specifically identified in its service agreement that its worker would be a part of a team that included other staff members from the host agency in order to provide a more comprehensive and inclusive service delivery. The manager went on to say that because the host agency had a ‘suite’ of relevant agencies already in place there was the opportunity for quicker, easier and more accessible referrals for the Child Support Workers. The worker survey also affirmed this perspective.

With what results?

Results for Child Support Workers are about linking children to the services they need, ensuring that the children feel welcomed, safe and secure in the refuge, supporting them to attend school and linking them to age appropriate activities. The case study, which was taken from one of the agencies’ January – June 2012 Progress Reports, is indicative the results a Child Support Worker can achieve.

Linking to services

Workers responding to the 2011 on-line worker survey indicated that their clients’ most important needs were counselling/therapeutic services for the adult client or their children. One worker apiece identified counselling services, parenting services, and access to public housing as being important.

All children or their families were linked with at least one service while one the program. General and family support were the most common services provided. The women interviewed spoke of referral for their children for protective behaviours work and general therapeutic work.

Workers responding to the 2011 and 2012 on-line worker surveys indicated that services such as access to public housing, community mental health services for children and young people and counselling/therapeutic services for children all had inordinately long waiting lists and difficult to access for their clients.
Table 4: Links to services while on the program

<table>
<thead>
<tr>
<th>Service</th>
<th>Percentage Linked</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentoring</td>
<td>66%</td>
</tr>
<tr>
<td>Health Service</td>
<td>58%</td>
</tr>
<tr>
<td>Education Services</td>
<td>48%</td>
</tr>
<tr>
<td>Transport</td>
<td>46%</td>
</tr>
<tr>
<td>School</td>
<td>41%</td>
</tr>
<tr>
<td>Other services</td>
<td>31%</td>
</tr>
<tr>
<td>Recreation services</td>
<td>20%</td>
</tr>
<tr>
<td>Connected to social networks/sport</td>
<td>15%</td>
</tr>
<tr>
<td>Individual Protective Behaviours</td>
<td>13%</td>
</tr>
<tr>
<td>Group Protective Behaviours</td>
<td>8%</td>
</tr>
<tr>
<td>Group</td>
<td>5%</td>
</tr>
<tr>
<td>Counselling sessions</td>
<td>5%</td>
</tr>
<tr>
<td>Disability Services</td>
<td>3%</td>
</tr>
<tr>
<td>Support</td>
<td>Percentage Linked</td>
</tr>
<tr>
<td>General support</td>
<td>95%</td>
</tr>
<tr>
<td>Family support</td>
<td>94%</td>
</tr>
<tr>
<td>Recreation support</td>
<td>50%</td>
</tr>
<tr>
<td>Education support</td>
<td>34%</td>
</tr>
<tr>
<td>Health support</td>
<td>31%</td>
</tr>
<tr>
<td>Court/justice support</td>
<td>10%</td>
</tr>
</tbody>
</table>

One of the notable aspects of the three client interviews was recognition of the importance of the one to one work the Child Support Worker herself provided to the children. One mother commented that her child had really bonded well with the worker, to the point of passing by a social opportunity in order to keep her appointment with the worker.

**WELCOMING, SAFE, SUPPORTED ENVIRONMENT FOR CHILDREN**

Making children/young people feel welcome, supported and safe in the refuge is an important role for the Child Support Worker. Clients interviewed spoke with great praise of the worker they were assigned and said how important the worker was in their children’s lives and their own. Their comments illustrated that the Child Support Workers were providing a service that was true to stated service model.
The women specifically said\(^{183}\)

\[I \text{ don’t know where I’d be without the girls [Child Support Workers] and the [agency]. They were wonderful.}\]

\[We \text{ felt safe.}\]

\[They [the workers] always made sure we felt safe no matter what.\]

\[They encouraged us to maintain a normal life and a routine.\]

\[It enhanced my and my children’s confidence.\]

The women also observed that having staff on site around the clock was very beneficial. This staffing (which probably was a part of the refuge program and not just Child Support Workers) provided on-going support to the mothers and their children, especially in respect to child behaviour management issues.

**Support for children in school**

Managers spoke of the fact that linking with the school was a key focus of the service. The data confirm this – 75% of children over the age of four were provided with an education service and 67% were linked to school. Managers saw the Child Support Worker as an advocate for the child in respect to their education and at times the link person for the child/young person. They indicated this was because of a perception that for a number of reasons the children’s mothers were not able to carry out that linkage role at least during the initial stages of service involvement.

A critical part of Child Support Worker’s role is to get the child enrolled in school and to have them attend regularly. Both managers and workers confirmed that this outcome was achieved. Unfortunately what was not generally able to be achieved was linking the child with the school they had attended prior to entering the refuge. Such result obviously would have contributed to a sense of loss and likely dislocation for the child/young person.

**Age appropriate activities**

The women interviewed spoke of their children being provided with activities such as painting and crafts. Their children also were able to participate in after school activities at the refuge.\(^{184}\) Older children were able to participate in activities such as footy training and other sporting activities.

**Parenting support**

Much of the service provided to the mother was supporting her to more effectively and appropriately parent her children. Services were also provided to the mother in respect to her own development and employment skill development.

Two of the three women interviewed in terms of the services and supports provided for their children said that the Child Support Worker gave them (the children’s

\(^{183}\) All the comments below are direct quotes from the women who participated in the KKS client interviews

\(^{184}\) It appears these were part of the host agency’s service program
mothers) the skills to deal with their children’s anger issues especially through learning effective parenting techniques. They also referred to skill development in managing other behaviours such as acting out, engaging in violent or aggressive behaviours. All three of the women interviewed expressed the value to them of learning the 123 Magic techniques. One mother commented that:

*My worker helped me deal with my daughter’s anger – it turned it (her anger) around.*

Another mother spoke of the Child Support Worker helping her deal with her child’s eating problems.

Managers observed that mothers were more engaged both with their children in respect to working towards meeting their children’s needs but also more engaged themselves with appropriate services.

One unanticipated outcome that one of the managers identified was an enhanced capacity to break the intergenerational cycle of domestic and family violence, presumably though better managing their children’s/young person’s inappropriate, violent, or aggressive behaviours.

**CHILD CARE**

The women interviewed spoke about the value of having the Child Support Worker provide child care for their children so that the women were able to attend employment interviews, look for accommodation, attend parenting or self-help groups, attend to legal matters and regularly participate in counselling sessions (apparently as part of the refuge program). This service was seen as invaluable to the mother but also as giving the children the opportunity to participate in activities they might otherwise not be able to do. It is difficult to ascertain if such child care was provided by the host agency’s crèche program or by the Child Support Worker. Irrespective of who technically provided the child care services, this illustrates that the KKS service is meeting one of its important priorities – that of providing child care.

**CASE STUDY**

*Elizabeth was referred to the [agency] by the Department for Child Protection. DCP had become involved in Elizabeth’s case after an incident involving abuse by her mentally unstable partner. DCP had grave concerns for the welfare of Elizabeth’s four year old daughter Mollie and contacted [agency] to arrange safe accommodation for Elizabeth and her child.*

*Elizabeth and her partner had been living a very transient lifestyle exacerbated by John’s paranoid beliefs. Elizabeth herself had been diagnosed with schizophrenia, however during her period of accommodation at [agency] there were minimal behavioural indicators of her condition.*

*Elizabeth and her daughter were accommodated at the [agency] for approximately four months. This gave the Child Support Worker and other support workers many opportunities to observe Elizabeth’s parenting style and interactions with her daughter. Mollie was a very bright and intelligent child however was also very willful. Elizabeth was very loving and caring towards Mollie however needed consistent guidance and assistance to take control of situations as a parent.*
At the commencement of the accommodation period, Elizabeth’s four year old daughter had had very little contact with children her own age and was still drinking from a bottle and was not toilet trained. Elizabeth’s lack of contact with other parents in social settings was very apparent as she was not aware of these two issues being beyond the range of normal development. It was imperative to assist Elizabeth to prepare Mollie for schooling.

Mollie was linked in to health services such as the Child Health Nurse, doctors and private FDV counselling due to the waitlist for Victim’s FDV counselling.

Mollie commenced attending day care to provide Elizabeth with some respite and to assist Mollie with her socialisation. The Child Support Worker also provided information and encouragement to attend activities within the community such as Library Rhyme Time. The presence of Elizabeth’s partner John in the community was still a concern; hence Elizabeth’s anxiety prevented her from attending these events often. The Child Support Worker also encouraged activities that would prepare Mollie for kindergarten such as educational activity books for her cognitive development and crafts to develop fine motor skills.

Elizabeth required intensive support and suggestions of multiple strategies to enable her to help Mollie make the transition to drinking from a cup and using the toilet. Mollie also would wake regularly at night screaming and demanding food and drink. Again, the Child Support Worker and other support workers were constantly providing Elizabeth with encouragement and support to overcome these behavioural challenges of Mollie’s and eventually the desired outcomes were achieved.

Towards the end of the accommodation period, Elizabeth was also taking Mollie to see a private psychologist. Mollie had been referred to a Children’s Family Violence Counselling Service, however that service has an approximately six month waitlist and attention to Mollie’s issues were needed immediately.

The Child Support Worker hosted the ‘Magic 1, 2, 3’ Emotion Coaching Parenting Course and the ‘Protective Behaviours’ Course, with Elizabeth attending both. Elizabeth bonded well with some of the other parents and also attended regular Coffee Mornings until case closure.

With advocacy from Child Support Worker and [agency], Elizabeth and her daughter were successful in obtaining housing through the [a homeless support service]. Elizabeth has been able to access brokerage funding from the Domestic Violence Outreach Program to upgrade the security and provide a visual barrier to her home and car from people passing. Mollie is doing very well and is now attending kindergarten within walking distance of her new home and Mollie is attending mainstream services in the community. The family is a classic example of the ability of the Child Support Worker role as well as the importance of multiple agencies working together to support clients in a mutually beneficial way to alter the impact of FDV on women and children.

Key lessons

KKS CONSIDERED UNDER-RESOURCED

Although the service is achieving intended results, both service delivery managers indicated that they felt the KKS program was under resourced and that the need for child support was significantly greater than could be accommodated. This was affirmed in the 2011 on-line worker survey when one of the workers indicated that they felt their case load was too high and that when the clients exited from the service that she had not been able to work as intensively with the women and their
children as was needed by the clients. It should be noted that these two positions were added to country areas that did not have Child Support Workers previously. Whether managers’ comments on need outstripping the capacity of the Child Support Workers to provide apply to Child Support Workers in other areas is unknown.

**Summary and conclusions**

The results of the evaluation indicate that the Child Support Worker component of KKS is achieving the intended result of supporting children accompanying their mother or primary caregiver to a refuge and linking them to mainstream services, including schools.

The service is valued by mothers in terms of making their children feel welcome, supported and safe in the refuge, engaging the children in age appropriate activities and supporting them in their schools. Mothers have been assisted to parent their children effectively.
Appendix One: WA implementation Plan budget for 2009-10 to 2012-13 and expenditure to 30 June 2012

<table>
<thead>
<tr>
<th>services</th>
<th>budget (services only)</th>
<th>expenditure to 30 June 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commonwealth $</td>
<td>state $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Place to Call Home (Foyer Project)</td>
<td>2 469 000</td>
<td></td>
</tr>
<tr>
<td>Street to Home for Chronic Homeless People (3 programs)</td>
<td>12 811 073</td>
<td>8 157 952</td>
</tr>
<tr>
<td>Support for Private and Public Tenants (2 programs)</td>
<td>9 335 186</td>
<td>5 747 191</td>
</tr>
<tr>
<td>HUGS and Financial Counselling Services (2 programs)</td>
<td>16 380 000</td>
<td>12 570 000</td>
</tr>
<tr>
<td>Assistance for People leaving Child Protection Services, Correctional and Health Facilities (3 programs)</td>
<td>6 432 396</td>
<td>4 936 760</td>
</tr>
<tr>
<td>Services to Assist People with Substance Abuse (1 program)</td>
<td>5 037 947</td>
<td>3 267 056</td>
</tr>
<tr>
<td>Improvements in Service Coordination and Provision (1 program)</td>
<td>150 000</td>
<td>157 698</td>
</tr>
<tr>
<td>Support for Women and Children experiencing Domestic and Family Violence</td>
<td>6 894 157</td>
<td>4 809 433</td>
</tr>
<tr>
<td>Assistance for Homeless People, including Families with Children (1 program)</td>
<td>8 208 057</td>
<td>5 176 383</td>
</tr>
<tr>
<td>Outreach Program for Rough Sleepers (1 program)</td>
<td>2 415 032</td>
<td>1 472 177</td>
</tr>
<tr>
<td>Support for Children to Maintain Contact with the Education System (1 program)</td>
<td>3 215 973</td>
<td>2 320 456</td>
</tr>
<tr>
<td><strong>Total Services</strong></td>
<td><strong>49 671 753</strong></td>
<td><strong>72 725 821</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capital Projects</th>
<th>budget (capital only)</th>
<th>expenditure to 30 June 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Commonwealth $</td>
<td>state $</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Place to Call Home (33 Dwellings and Foyer Project)</td>
<td>31 689 000</td>
<td>18 154 903</td>
</tr>
<tr>
<td>Street to Home (St Bartholomew’s House – lime Street)</td>
<td>23 700 000</td>
<td>21 038 835</td>
</tr>
<tr>
<td>Street to Home (State land contribution)</td>
<td>7 000 000</td>
<td>7 000 000</td>
</tr>
<tr>
<td><strong>Total Capital</strong></td>
<td><strong>62 389 000</strong></td>
<td><strong>46 193 738</strong></td>
</tr>
</tbody>
</table>

1 The expenditure of $12.6 million for the Hardship Utilities Grant Scheme and Financial Counselling Services is an estimate.

Source: OAG, DCP and the Housing Authority

### Appendix Two: Hierarchy of intended outcomes – National Partnership Agreement on Homelessness

<table>
<thead>
<tr>
<th>Ultimate Outcome</th>
<th>Homelessness reduced by 7%</th>
<th>Indigenous homelessness reduced by 33%</th>
<th>Former homeless people integrated into the community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intermediate Outcomes</td>
<td>Clients are stably accommodated</td>
<td>Clients are coping with mainstream support</td>
<td>Clients are engaged in education, training or employment</td>
</tr>
<tr>
<td>Immediate Impact</td>
<td>Clients suitably accommodated</td>
<td>Clients suitably supported to deal with personal and tenancy issues</td>
<td>Clients engaged in education, training or employment or actively looking for work</td>
</tr>
<tr>
<td>Outputs</td>
<td>Housing/accommodation sourced as required</td>
<td>Clients engaged</td>
<td>Clients linked to specialist and mainstream services related to tenancy management issues</td>
</tr>
<tr>
<td>Activities</td>
<td>Public and Private Tenancy Support Services operating in selected areas of metropolitan, rural and remote WA</td>
<td>Foyer model operating for at risk young people and young people leaving child protection</td>
<td>Program for young women leaving child protection services operating in the metropolitan area</td>
</tr>
<tr>
<td>Inputs / enablers</td>
<td>33 Social Housing properties purchased or constructed by Dept of Housing</td>
<td>Foyer development by Dept of Housing</td>
<td>Contracts let and monitored by Dept for Child Protection</td>
</tr>
</tbody>
</table>