INTEGRATED INTENSIVE CASE MANAGEMENT IN PRACTICE

FINAL PROCESS EVALUATION OF THE JOURNEY TO SOCIAL INCLUSION PROGRAM

"…IT'S GONE FAST, BUT I HAVE TO GO HOME NOW".

Sharon Parkinson
and Guy Johnson

RMIT UNIVERSITY
SACRED HEART MISSION

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Author correspondence

Dr. Sharon Parkinson
RMIT University City Campus
School of Global Urban & Social Studies,
Centre for Urban Research, Building 15 Level 4.
Ph +(61 3) 9925 9923
sharon.parkinson@rmit.edu.au

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List of Acronyms

ACT	Assertive Community Treatment
AHURI	Australian Housing and Urban Research Institute
BUDS	Building Up and Developing Skills
CCC	The Salvation Army Crisis Contact Centre
CICH	Collaborative Initiative to Help End Chronic Homelessness
DHS	Department of Human Services
DSS	Australian Government Department of Social Services
EFT	Effective Full-time
FaHCSIA	Families, Housing Community Services & Indigenous Affairs
HEF	Housing Establishment Fund
IAC	Intensive and Assertive Case management
IPS	Individual Placement and Support
ICMI	Intensive Case Management Initiative
IHBOS	Intensive Home Based Outreach Services
ISCHS	Inner South Community Health Service
J2SI	Journey to Social Inclusion
OoH	Office of Housing
SHM	Sacred Heart Mission
MIFV	Mental Illness Fellowship of Victoria
MOU	Memorandum of Understanding
RCT	Randomised Controlled Trial
SAAP	Supported Accommodation Assistance Program
TIC	Trauma-informed Care
VCAT	Victorian Civil and Administrative Tribunal

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EXECUTIVE SUMMARY

This is the final of two process evaluation reports reviewing service practices from the Journey to Social Inclusion (J2SI) pilot program. The J2SI pilot is an integrated intensive case management model delivered over a three year period to 40 participants to end their experience of long-term homelessness. The process evaluation forms part of a longitudinal Randomised Controlled Trial (RCT). The RCT aims to determine the social and economic impact of the J2SI program over a 4 year period. The purpose of the process evaluation is to document the practices and lessons learned as the program was implemented. There are five key components of the J2SI process evaluation:

- Documenting the service model within an evidence informed framework
- Reviewing service model implementation and refinement
- Monitoring the quality of processes, systems and partnerships
- Monitoring the services provided to J2SI participants
- Connecting processes with final outcomes

The first report documented the program and modifications made to the model over the first 18 months of the trial. The purpose of this process evaluation report is to review the quality of the service model within an evidence informed framework, and to identify the lessons learned to inform the policy goal of ending long-term homelessness.

The J2SI program is a relationship based model that aimed to cultivate strong internal and external collaborative partnerships in delivering individualised packages of integrated support. The key elements of the J2SI service model include:

- Building workforce capacity for long-term trauma informed support
- Intensive case management based on a client to staff ratio of 1:4[1]
- Rapid access to permanent housing through formal protocols with housing providers
- Building skills, employment placement and support
- Cultivating linkages to therapeutic and specialist services through proactive and collaborative partnerships

The support process was guided by three service goals:

- Short-term service goal: Building trust, engagement, and stabilisation
- Medium-term service goal: Building self-reliance and healing
- Long-term service goal: Long-term stability in mainstream structures

The first process report identified the promising practices associated with the short-term goal of building and maintaining a trusting relationship and stabilising participants in housing. An organisational culture of client centred practice and high commitment to interagency collaboration was found to be a central precondition for flexible and innovative practices to emerge. In this second report the effectiveness of practices for engaging and sustaining a case management relationship and to connecting to services to sustain housing are reviewed.

CRITICAL AREAS FOR SUCCESS AND FURTHER DEVELOPMENT

The key findings on the critical areas of successful governance and practice, as well as areas requiring further development, are summarised in Table 1.

Effectiveness of practices for engaging & sustaining case management relationships

The review of service activity data combined with consultations with J2SI participants, staff and external partner agencies revealed that the program is a high quality, innovative model of case management and housing support. The program has been delivered in a manner that is consistent with the broader evidence informed practice principles of engaging and supporting people in their transition out of long-term homelessness.

Building workforce capacity

Throughout the three year trial staff had access to an intensive program of training, combined with ongoing generalist, clinical and group supervision. This resulted in significant capacity building within the case management team. The core staff group remained relatively stable throughout the three year period indicating that management and staff had successfully created a culture of strong commitment to the longer-term needs of participants and the overall goals of the program. The program has also been effective in building the capacity of the workforce to respond to individuals with a history of complex trauma.

[1] Although this ratio has fluctuated to 1:6 at different stages of implementation and client needs.

Intensive case management

There is a clear need for long-term intensive integrated models of support to sustain tenancies over time. The service practices reviewed combined with the outcomes identified in the broader trial (Johnson et al., 2014) indicate that a trauma informed and intensive relationship based case management approach is effective in maintaining long-term engagement in the support process and in stabilising housing. Client service activity data collected via the J2SI internal reporting system and management reports revealed that whilst some participants have been more highly engaged in both case management and other elements of support than others, the majority remained engaged throughout the three year period.

Although the model of integrated intensive case management has been critical in the process of engagement in support and in stabilising housing, it has been more limited in its capacity to address entrenched social exclusion, findings similar to those by Tsai & Rosenheck (2012). The process of case management within a harm minimisation framework, as with other therapeutic approaches, was limited in moving participants towards the cessation of drug use but improved their safety and reduced the frequency of use, as discussed in Johnson et al., 2014. Eligibility for the program was not based on a 'readiness' to cease drug use and subsequent programs should not limit access to permanent housing on this basis. However, clarifying the service framework and the realistic outcomes that can be obtained within a harm minimisation framework needs to be further developed across the sector. Similarly, understanding the processes of social recovery and overcoming isolation remains a fundamental challenge for supportive housing services. Further clarifying the role of and approach that support services should play in re-establishing new social networks, remains an area for further service development and research.

EFFECTIVENESS OF PRACTICES FOR CONNECTING TO SERVICES & SUPPORTS

The capacity to cultivate strong inter-agency partnerships across housing, skills building and employment support, mental health, drug and alcohol and other support services to deliver an integrated response to each client's individual needs is a critical success factor of the model. External providers rated the quality of their working relationship with the J2SI service very highly.

Rapid access to and maintenance of housing

The majority of J2SI participants were housed in permanent accommodation, predominately Office of Housing properties, within the first six months of program commencement. The quality of relationships that the J2SI program cultivated with housing providers has been central to the successful housing outcomes attained in the program and provides an exemplary model of interagency collaboration for tenancy management. Having the flexibility to follow clients across different types of accommodation ensured that support was not lost if housing became unstable. The availability of affordable housing stock was critical to the process of rapid rehousing of J2SI participants into permanent dwellings. Being able to provide a range of accommodation options that are affordable for individuals exiting long-term homelessness remains a fundamental challenge for the sector.

Building skills and employment placement

The Building up and Developing Skills (BUDS) and the Mental Illness Fellowship of Victoria (MIFV) components of the program developed into a strong collaborative approach to intensive training and employment support and many success stories have emerged from the program. While both programs were generally well accessed, participants had to overcome significant obstacles in entering mainstream training and employment settings. Participants required a high degree of intensive support to ensure that they were able to access and continue to engage in these opportunities. Individually tailored skills building, employment training and support should be introduced at the beginning of the support process and continue to be offered once individual case management support is withdrawn.

Linkages with therapeutic, medical and specialist services

J2SI participants were provided with funded opportunities to engage in therapy throughout the three year period. However, the uptake of this component of the program was low. The engagement of a clinician to provide regular clinical supervision combined with group supervision to case managers, provided a key avenue for ensuring that the practice of case managers remained trauma informed. While clinical supervision was considered a valuable and innovative enhancement to case management practice, tensions developed within the program as to how far case management should assume a therapeutic focus over practical support. Introducing a clinical component within case management is a key innovation of the model and should be incorporated into any new programs that follow. In particular, a clear framework and set of standards to guide a trauma informed approach within intensive case management should be further developed.

Table 1. J2SI Service elements within an evidence informed framework: Critical areas for success and further development

Service Elements within an Evidence Informed Framework

Practices for engaging & sustaining case management relationships for housing stability				
	Critical areas for success		Critical areas for further development	
	Governance	**Practice**	**Governance**	**Practice**
Building workforce capacity	Management and supervision facilitating a culture of high commitment and reflection. Salaries at advanced practice levels to attract and retain highly skilled staff. Structured training calendar.	Multiple levels of reflection and planning around each client. Training linked directly to client case needs. Staff equipped with a package of practice based frameworks.	Recruitment based on a core set of capacities for long term support identified in the program.	Practice frameworks for staff capacities within a trauma informed model.
Intensive case management	Client-centred individual and flexible model. Proactive planning and reflection through key stages, including matching case managers with clients, monitoring case plans towards outcomes and managing case closure. Data collection systems to document service intensity and monitor progress. Support focused on harm minimisation principles and not conditional on cessation of drug use.	Small case-loads typically 1:4 but not more than 6. Persistent and trusting professional relationship to provide support, challenge behaviour, and model alternative ways of acting. Promoting strengths and building on small successes to build esteem and confidence. Dual worker model to avoid dependency and a joint team approach based on case conferencing. Responsiveness to client preferences & engagement in recreational and arts therapy based activities. Clinical supervision in managing complex trauma and long-term relationships. Harm minimisation focused on maintaining engagement with support. Relationship not conditional on cessation of drug use or participation in drug treatment.	Funding model to allow greater flexibility in staff to client ratios. Capacity to develop model of step up and step down support. Service eligibility and targeting of age specific streams of support. Balancing service objectives for social inclusion through maintaining existing supportive networks versus building new networks. Clearer delineation of the role of clinical supervision and general supervision and its broader integration. Clarification of service goals, indicators of success and protocols of service within a harm minimisation framework.	Greater flexibility in the ratio up to 1:6 depending on need and stage of support. Minimum duration of 2 years but flexible end points depending on need and service engagement. Options for ongoing housing assistance for those unable to maintain housing without support. Establishment of processes for assessment for service entry. Practice based frameworks for how case management goals can be aligned with client driven preferences for social participation and readiness to move on from old social networks. Practice based frameworks on the role of therapeutic case management within a trauma informed approach. Practice based frameworks for case management within a harm minimisation approach, i.e. role in building readiness for change.

Practices for connecting to services and supports for housing stability				
	Critical areas for success		Critical areas for further development	
	Governance	**Practice**	**Governance**	**Practice**
Rapid access to and maintenance of housing	Proactive relationships with permanent housing providers maintained through MOUs and active regular engagement at senior management levels. Flexible funding pool for housing assistance and to purchase household items.	Integrated tenancy management with case managers as first port of call. Support that is able to follow each housing transition allowing clients to avoid homelessness and relocate if housing breaks down.	Greater choice in the availability and location of affordable housing.	Identification of a flexible housing support framework, matching support to needs that range from ongoing to being fully capable of independent living. Developing protocols and ongoing partnerships with other agencies consistent with a step up step down model.
Building skills, employment placement and support	Flexible funding pool to access training needs and job preparation including clothing. Individualised training linked to capacities and interests. Co-location of specialist employment provider such as MIFV and training coordinator role.	Co-location of training and employment specialist to work on an individualised and staged process of transition focusing on intensive practical and emotional support. Building long-term support to assist in the transition to training and work.	Training and employment support embedded in program design from inception. Maintenance of ongoing links with specialist training and employers.	Identifying training and employment goals at beginning of support. Identifying individual capacities and barriers to training and employment.
Linkages with therapeutic, medical and specialist services	Multi-disciplinary management committees and service practice advisory groups with housing, mental health, drug and alcohol specialist focused on building service pathways. Proactive relationships with key providers to cultivate truly collaborative partnerships. Flexible funding pool to purchase therapy and other specialist support as needed.	Detailed client history to provide a conduit role between client & specialist. Proactive and professional networks with specialist providers ensuring appropriate referrals and consultations. Joint case planning to ensure consistent approach to shared clients. Continuity of care at exit points from hospital/prison/ withdrawal & stabilising health through consistent treatment regime.	Further strengthen and build upon formalised pathways between mental health, drug and alcohol at the highest level of decision making. Further development of how generalist service can sit alongside specialist responses.	More streamlined access to mental health and drug and alcohol support.

WORKING TOWARDS REALISTIC CHANGE

The process of moving through the three broad service goals of building trust, engagement, and stabilisation, building self-reliance and healing, and long-term stability in mainstream structures was found to be unique for each individual in the program. This highlights the critical importance and strength of the model in being able to deliver flexible and individualised support to each participant.

Some participants have been able to move through a process of significant change and growth leading to full independence in their housing, reconnecting with family and social activities, as well as engaging in employment. For others the changes are more subtle, but at the same time it has increased their personal safety and provided greater stability that made a critical difference in the quality of their lives and overall functioning. An important intermediate outcome of the program has been its capacity, through the use of positive role modelling, to reduce the presentation of more extreme behaviours. This has been critical in sustaining tenancies and ensuring that individual needs can be more effectively met in the broader system of support.

The findings in this process evaluation have important implications for service delivery into the future, both in terms of identifying realistic aims from the support process and how the success of programs should be monitored and demonstrated over time. The capacity for homelessness support services to tailor the intensity and duration of care, particularly when tenancies are at risk, will be critical to ensuring that the move out of homelessness is a permanent one.

1. INTRODUCTION & BACKGROUND TO THE EVALUATION

The Journey to Social Inclusion (J2SI) program is a three year intensive case management model delivered to 40 participants experiencing long-term homelessness. The program was developed by Sacred Heart Mission in response to the absence of flexible and adequately resourced supportive models that could address the complex needs of those experiencing long-term homelessness. The broad aim of the program was to provide participants with the stability and skills to assist them in making a successful transition out of homelessness into independent housing and mainstream life.

This is the second and final report documenting the quality of service practices and the broader lessons learned from the J2SI program as it has been implemented over the three year trial period. The process evaluation forms part of a larger evaluation incorporating a longitudinal Randomised Controlled Trial (RCT) to determine the social and economic impacts of the J2SI program over a 4 year period. The evaluation is being undertaken jointly by researchers at the Centre for Applied Social Research (CASR) and Centre for Urban Research (CUR) at RMIT University and the Melbourne Institute for Applied Economic and Social Research.

The process evaluation aims to review the quality of the program within an evidence informed framework. A critical aspect of reviewing program quality is to understand the essential elements of the service model and how they are intended to bring about improvements for participants, as well as to understand how the model is distinct from and builds upon existing interventions. This process involves reviewing where J2SI fits within an evidence informed framework of ending long-term homelessness and how the program has been implemented throughout the trial, including the difficulties encountered and how the program has responded. A second critical aspect of the process evaluation is to gain an in-depth understanding of the types of practices that are likely to shape positive outcomes for clients.

There are 5 key components to the J2SI process evaluation:

- Documenting the service model within an evidence-informed framework
- Reviewing service model implementation and refinement
- Monitoring the quality of processes, systems and partnerships
- Monitoring the services provided to J2SI participants
- Connecting processes with outcomes

The main questions guiding the process evaluation are:

1. How does the program model align with current evidence informed practice for people who are long-term homeless?
2. How does the program conform to the initial program design and intentions?
3. What are the elements of the governance of the model and how has this impacted upon service delivery?
4. How well does the program work across key service elements? Does this differ across client groups and service/housing conditions?
5. What are internal and external stakeholders' perceptions of the quality of the program?
6. What are the lessons learned?

The first process evaluation report (Parkinson, 2012) outlined the rationale for the J2SI program as well as the policy and service context establishing the need to develop more innovative solutions in ending long-term homelessness (Sacred Heart Mission, 2009; FaHCSIA, 2008a, 2008b; Victorian State Government, 2011, p.12). The report also documented the practice framework, as well as preliminary findings on what internal and external stakeholders considered to be emerging 'good practices' in the first 18 months of service implementation. The report specifically focused on the practices of building trust and engaging clients in a case management relationship and the processes associated with stabilising them in permanent housing. It identified how the program was modified as it was implemented and the rationale for changes made to the service model.

Drawing on the international and national literature, this report assesses the program model within an evidence informed practice framework as there are yet to be definite evidence based practices in ending long-term homelessness, particularly in the Australian service context[2]. To this end, the report also aims to identify the lessons learned and challenges from the program in order to continue to inform the work of the homeless service sector, as well as other practitioners providing support to those experiencing long-term homelessness. It reviews the practices that support staff and management considered to be most effective in maintaining engagement with participants and the types of intermediate changes that emerged over the course of three years of support focusing on the three main service goals:

- Short term service goal: Building trust, engagement, and stabilisation
- Medium term service goal: Building self-reliance and healing
- Long term service goal: Long-term stability in mainstream structures

1.1 DATA SOURCES AND METHODS

The process evaluation draws on multiple sources of data, including service activity data collected through a special purpose dataset, staff, client and external stakeholder surveys regularly collected throughout the course of the trial, staff focus groups, individual interviews with program management and the J2SI clinician, as well as reflective vignettes prepared by case managers. The key data sources and methods are summarised below.

Service inputs and activity data

The J2SI program was overseen by three governing committees including a Steering Group, a Service Delivery Reference Group, and an Evaluation Reference group. All manager's reports, documentation and minutes circulated to these committees were sent to the program evaluators. This provided a record of significant changes within the program and helped determine whether it was implemented as intended. In terms of 'input' resources, J2SI maintained records on staff qualifications and retention, training and support. A special purpose database was developed to collect and monitor service activity throughout the trial, to document service practices as well as obtain detailed quantitative records of service activity.

The type of client service activity data that has been reviewed in the process evaluation include:

- Number of face to face and phone service contacts
- Duration of support for each face to face and phone contacts
- Extent of engagement in the service as monitored and documented in six monthly managers reports
- Allocation of workers, qualifications, and retention over the trial period
- Type of accommodation lived in, mobility and indicators of risk to tenancies
- Types of services clients accessed internally (such as BUDs and individual therapy)
- Types of services clients have been referred to and accessed externally (such as drug and alcohol support, psychiatric care, and hospitals)

[2] An intervention is considered to be evidence based following repeated randomised controlled trials (RCTs). Evidence based programs require high fidelity with the original model elements, a criteria that is often difficult to attain in social interventions. Evidence informed practice extends to measures of service effectiveness derived from a broader continuum of evidence including practice wisdom and evaluations that are not based on a RCT.

Staff, client and external stakeholder consultation

Independent surveys focusing on staff satisfaction were undertaken at six monthly intervals from the beginning of the trial. The surveys focused on supervision and training, workload, and morale. The staff surveys also provided space for in-depth information to be collected on what was 'working well' and what was 'not working well' within the case management role and the broader service elements of the program as the trial progressed. The surveys were anonymous and mailed directly to the evaluation team. All staff completed the surveys. This report draws on all rounds of six monthly staff surveys. The surveys and case studies were supplemented with two focus groups with the casework team and individual interviews with the Sacred Heart Mission CEO, the J2SI program manager, and the J2SI clinician.

The report also draws on an external stakeholder survey undertaken at the completion of the trial. The survey collected data on the quality of the relationships with partner agencies including the appropriateness of referrals and professionalism of the J2SI team. External stakeholders were also asked to comment on how, and to what extent the model addressed existing service gaps. The survey is discussed in more detail in section 2.5.

Feedback from participants was gathered every six months using the existing six monthly J2SI outcomes survey. Questions focusing on client satisfaction were added to the outcomes study survey from 6 months onwards. Participants were paid a nominal amount to complete the J2SI survey. Sample numbers in response to each question for each wave are shown in more detail in section 2.6. Many participants only responded to the quantitative questions and the response rate to the qualitative questions was generally lower. The outcomes survey does however have an in-depth element where 20 individuals in both the service and control groups provided detailed qualitative feedback.

Practice based case studies

This report also draws on vignettes that have been prepared by case managers to capture detailed service practices, such as the process of engaging participants, for maintaining housing, and to gaining access to and participating in training and other services. The vignettes have been selected to reflect on the lessons learned in relation to both effective and challenging aspects of the support process and to capture the diversity of individual journeys over the course of the three years.

1.2 STRUCTURE OF THE REPORT

The way we structure the report is as follows. In the next chapter we outline the J2SI model elements and program logic within an evidence informed framework for ending long-term homelessness. Chapter 3 then reviews the quality of the J2SI model within this practice framework drawing on multiple sources of evidence including client service activity data collected over the three years of the program and consultation feedback from J2SI staff and management, clients and external partner agencies. In Chapter 4 we document the reflections of staff and management on progress towards the program's intermediate and longer-term goals of building self-reliance and healing and long-term stability in mainstream structures. This chapter, combined with the preceding chapter, is intended to sit alongside the findings in the outcomes study to provide insight into the practices that were reported to have influenced the outcomes observed over the course of the trial. Finally, Chapter 5 draws together the lessons learned from the program and the implications for future program development.

2. THE J2SI SERVICE MODEL WITHIN AN EVIDENCED INFORMED FRAMEWORK

The J2SI program is a relationship based model of long-term support that ultimately aims to cultivate a strong working alliance with both participants and other providers to end long-term homelessness. The growing policy and practice focus on developing programs seeking to end long-term homelessness has seen an influx of different supportive housing models over the past decade. Programs delivered in Australia aiming to end long-term homelessness draw on a combination of promising practices, some of which may have components of evidence base practices, such as case management. However, as a package of integrated support, there have not been evaluations undertaken using the highest standard of evidence from repeated RCTs. For this reason we consider an evidence informed framework, consistent with the approach adopted by Gronda (2009), to be a more suitable guide for assessing the quality and effectiveness of the J2SI model. In this chapter and subsequent chapters to follow, the J2SI program is reviewed against the 'critical success factors' with respect to engaging and sustaining case management relationships and connecting to services and supports for maintaining housing stability.

The initial J2SI model, including service origins and practice framework, staffing, funding allocated and associated changes to the original design, is documented in the first process report (Parkinson, 2012). A full cost effectiveness study of the program and more detailed costing is being undertaken as part of the economic evaluation (see Johnson et al., 2014). Service eligibility and the method of randomisation of J2SI participants and the comparison control sample for the RCT is detailed in Johnson et al., (2011).

The J2SI service delivery model has five core elements centred on the cultivation of internal and external service relationships:

- **Building workforce capacity for long-term support that is trauma informed:** Provision of ongoing training to build capacity of case managers focusing on a trauma informed approach to service delivery. This includes providing joint case management, regular case conferencing and group supervision, and specialised training. In addition to standard case management supervision, staff also had access to fortnightly sessions of clinical supervision.
- **Intensive case management:** Participants are provided with intensive long-term outreach support (up to three years). The relationship case practice is informed by theoretical frameworks of strengths based approaches to facilitate ongoing trust and engagement as well as motivational interviewing techniques to facilitate behavioural change and progress towards recovery. Support is based on small caseloads with a worker to client ratio of 1:4, although this ratio fluctuated to 1:6 at different stages of implementation.
- **Rapid access to permanent housing:** Access to housing is delivered via a relationship model of shared tenancy management supported by MOUs with housing providers. Tenancies are sustained through strong proactive and collaborative partnerships with case managers being the first port of call for housing needs and issues.
- **Building skills, employment placement and support:** Participants are provided with direct access to personal/work related skills and employment placement support through the internally funded BUDS coordinator role and the co-location of a Mental Illness Fellowship of Victoria employment specialist within the J2SI service site.
- **Linkages with therapeutic and specialist services:** Case managers facilitate linkages with other services as needed including mental health, drug and alcohol services, family and legal services in accordance with case plans. Referral protocols were in place with drug and alcohol and mental health providers. Participants also had access to internally funded therapeutic support for those seeking to resolve underlying trauma.

2.1 CURRENT EVIDENCE INFORMED PRACTICES IN ENDING LONG-TERM HOMELESSNESS

Over the past two decades several comprehensive reviews have provided a synthesis of evidence based or promising programs for individuals with histories of episodic and long-term homelessness, particularly for those with co-occurring mental health and drug and alcohol disorders (see for example McGraw et al., 2009, Leff et al., 2009; Sun, 2012). The clear theme from existing reviews is that there is no one model that provides the definitive solution to ending long-term homelessness. However, there is an emerging consensus that rehousing, preferably within permanent accommodation, must be combined with support that can assist with both the transition and the maintenance of housing over time.

Interventions need to be fully integrated in a way that can link clients into the specialist and generalist supports they require and this can take the form of different service configurations. Services then need to provide the support that can offer greater pathways to independent living through the provision of supported employment, social and civic engagement including volunteering and recreational activities to avoid isolation. Services also need to have a clinical component that can both stabilise and move clients towards healing and recovery.

The types of interventions that have been implemented to address the needs of people experiencing homelessness include a raft of approaches from Assertive Community Treatment (ACT), Assertive outreach, motivational interviewing, clinical case management, intensive case management, harm minimisation, strengths based approaches and so on. A dedicated edition in the Open Health Services and Policy Journal identifies important practice developments for the field of homelessness support into the future, including the need to incorporate trauma informed practices into the organisational culture and support process (Hopper et al., 2010), move towards recovery oriented practices (Gillis et al., 2010), and to build the workforce capacity of the homeless sector to ensure that they are adequately trained and equipped to respond to multiple and complex support needs (Mullen & Leginski, 2010). Below we review the core elements of the J2SI model against the current evidence base and practice wisdom used to inform the development of the original model.

Building workforce capacity for long-term support that is trauma informed

A critical aspect in the development of service models to end long-term homelessness is ensuring that the workforce is equipped to respond to the complexity of needs of the client population. Building capacity of staff through a supportive organisational culture helps to ensure staff are highly engaged and remain committed to the goals of the program over time. This practice is consistent with the approach to building workforce capacity for long-term support advocated by Mullen & Leginski (2010). However, the ability to attract and retain highly skilled management and support workers remains an enduring issue for the homelessness sector in Australia and abroad (Mullen & Leginski, 2010). Within the J2SI program, support workers were paid at advanced practice levels to assist with staff retention.

The 12 months outcomes report for J2SI participants (Johnson et al., 2011) identified significant histories of trauma among J2SI participants highlighting the critical importance of providing a service response that is both 'trauma informed' and 'trauma specific'. From their review of multiple evaluation studies, both quantitative and qualitative, Hopper et al., (2010) find that a trauma informed and specific approach contributes to more effective outcomes across several areas including increased rates of housing stability, and is cost effective to implement. They also identify that there are significant gaps in current knowledge for homelessness specific service models concluding that "…although initial investigations are promising, the research to date is inadequate for evaluating the effectiveness of trauma-informed models within homeless service settings" (Hopper et al., 2010, p.93). Building on the initial program models emerging out of the US a new set of self-assessment standards has been developed to determine whether a program can be considered to be trauma informed in practice (Guarino et al., 2009 for a more detailed overview of the standards). While these are not entirely applicable to the J2SI program model because it is following a small number of participants over a long duration, they do indicate that the program is guided and has been implemented according to the principles and practices consistent with the standards of a trauma informed model. However, the absence of self-assessment standards for the Australian setting suggests the need for a more specific set of indicators to be established for different models of support. This would include intensive case management where most of the support is provided in independent housing, and for more generalist homeless services.

Within the practice literature being trauma informed requires that the whole approach to service delivery is cognisant of the traumatic histories individuals present with by ensuring the process of support provides an increased sense of safety and strives to avoid any re-traumatisation. This includes attending to the physical service appearance, the organisational culture, and the management and staff practices. Moreover, within the field of homelessness, it recognises that the process of being homeless is traumatic in and of itself (Hopper et al., 2010, p.80–81). The first process report documented how the J2SI program had been established and continued to strive towards a trauma informed organisational culture.

The program also implemented a comprehensive training program matched with standard and clinical supervision to ensure that staff were adequately trained at the outset and continued to receive training throughout the three year program in responding to complex trauma. Clinical supervision for case managers providing long-term support has been found to benefit staff by helping them to maintain a positive therapeutic relationship with their clients through being better able to respond to issues of transference and countertransference and to help with the maintenance of professional boundaries (Walsh, 2002). The practices associated with building staff capacity within the J2SI program will be discussed further in chapter 2.

Intensive case management

Although there are mixed findings about the outcomes of intensive case management in terms of reduced service use and changes in non-housing related outcomes, it is generally acknowledged as an evidence based practice with respect to being able to effectively engage high risk populations into the support process (King, 2006; Burns et al., 2007; Gronda, 2009; Olivet et al., 2010). Intensive case management matched with the provision of housing support has been found to be particularly effective in sustaining tenancies (Smith & Newton, 2007; Nelson et al., 2007). The effectiveness of intensive case management as compared to 'standard' case management is generally thought to lie in its capacity for staff to forge a trusting relationship where there is a greater willingness of clients to work towards case management goals, as well as providing staff with a better understanding of the client's history that can assist in matching them to the right kinds of services and supports (Gronda, 2009). Intensive case management is distinguished from standard case management by the intensity and duration of support. However, there is little agreement on acceptable case to client ratios, but it typically ranges from a ratio of 1:5 to 1:10, depending on the types of clients and program of support and should never exceed a case load of 1:20 (Ministry of Health Care, 2005). On this scale the J2SI model, with a case worker to client ratio typically of 1:4 and never higher than 1:6, can be considered to be highly intensive. In this report we examine how the capacity for intensive support through small case-loads influenced the capacity of staff to sustain participants' housing and work towards the program goals of social inclusion.

In reviewing 40 years of research on intensive case management Marshall (2008) cautions what should be realistically expected in terms of its impact on client outcomes. He concludes that intensive case management has the most impact on process related variables such as client satisfaction and service quality rather than being fundamentally able to 'alter the disease process itself'. Specifically, intensive case management is found to generally increase satisfaction with the care provided and therefore willingness of the client to engage in ongoing support. This is likely to be critical in the process of maintaining stable housing by increasing clients' willingness to continue to engage with their case manager once permanent housing has been allocated.

The effectiveness of case management is also determined by how much it differs from the existing level of support offered in the 'standard' case management available to similar clients. In the context of more complex interventions, Marshall's review raises the critical point of what outcomes can be attributed to case management as an intervention and the need to clearly articulate the multiple components of an intervention. In assessing the quality and effectiveness of case management within the J2SI program this means determining how well the case worker-client and worker-external service relationships have been sustained and managed in a way that allows clients to be connected to the service and linked into the supports that are needed over time.

Research undertaken by Chen & Ogden (2012) found that the extent of the therapeutic alliance with a case manager was significantly associated with better outcomes in relation to the 'challenges associated with transition into housing' and reduced homelessness after 12 months. The authors conclude that the case managers' ability to develop trust through a humanistic and non-authoritative working relationship was key to reducing homelessness among those with a mental illness by increasing their motivation to remain in housing (Chen and Ogden 2012). Others have suggested that the formation of a case management relationship that is based on 'doing with' and also 'being with' the client provides the space for them to become more open to confronting longer-term changes. Specifically, intensive therapeutic case management can help to foster positive role modelling, empathy, safety, and provide skills in emotion regulation and self-awareness akin to the role of a positive parenting relationship. A 'friend-like' approach in relating to clients and 'acts of kindness' beyond what is typically provided or expected in service

exchanges were considered to be particularly beneficial in forming trust and longer-term engagement (Angell & Mahoney, 2007 and Padgett et al., 2008). In chapter 2 we examine the quality of the case management relationship drawing on several data sources and from the perspective of different stakeholder groups including participants.

Rapid access to permanent housing

Intensive assistance is generally found to provide the most optimal outcomes when combined with the provision of independent housing or models typically referred to as permanent supportive housing (Rog, 2004; Nelson et al., 2007; Caton et al., 2007; Tabol et al., 2010). Permanent supportive housing, distinguished from transitional housing or step up housing based models, consistently report higher housing retention rates. Whilst programs can differ markedly in how the support is delivered and in the type of housing provided, they are typically considered 'low demand' in that eligibility for housing and support is not dependent on cessation of substance use or abstinence. The key elements include voluntary participation in support, a harm minimisation approach to substance misuse, tenants leasing an independent residence that is considered affordable, and broader service integration into necessary structures of support (Caton et al., 2007). The most noted low demand supportive housing models fall under the umbrella of Housing First approaches (Padgett et al., 2006; Tsemberis, 2010; Johnson et al., 2012).

The J2SI model aligns most closely to the 'permanent supportive housing' approach to resettlement which emphasises direct access to independent and ongoing housing. Whilst the J2SI program shares elements of a Housing First approach, it differs in many respects. Support within the J2SI program was provided by integrating clients into existing services via the long-term case management relationship rather than provided by Assertive Community Treatment teams. Moreover, the J2SI model relied on relationships with housing providers to provide direct access to independent housing rather than sub-leasing private rental properties, as is the approach adopted within the original Housing Pathways Housing First model. Constrained access to affordable housing necessarily limits the speed at which participants can be rehoused and this remains a significant problem in Australia (Johnson et al., 2012). A more detailed discussion of the initial stages of resettlement can be found in the first process evaluation report (Parkinson, 2012).

Service integration and linkages with specialist providers

The importance of service integration in addressing the multiple needs of those experiencing homelessness has long been recognised. Over the years various models have been developed. These range from single agency multi-disciplinary teams comprised of mental health, health, and drug and alcohol practitioners such as Assertive Community Treatment (ACT) through to 'interagency coordination' models involving multiple services who have formalised working relationships with high degrees of 'communication, cooperation and trust' (Rosenheck et al., 2003 p.78; Coldwell & Bender, 2007). While there are benefits and limitations associated with both broad approaches, Rosenheck et al., (2003) study shows that interagency coordination models, if well implemented, can yield similar positive service and client outcomes to single agency multidisciplinary teams.

The effectiveness of a service integration model is highly dependent on the service context in which it is implemented. The practicalities and longer-term sustainability of delivering integrated models is an important consideration. Recent reviews of the projects funded under the US Collaborative Initiative to Help End Chronic Homelessness (CICH) revealed that ACT models, whilst initially producing strong outcomes, can be difficult to sustain in practice due to difficulties finding suitably qualified staff, as well as broader problems that accompany practitioner isolation within teams (McGraw et al., 2009). On the other hand, interagency coordination approaches require intensive management of the relationships of different providers to ensure that clients have seamless access to services. This requires ongoing commitment from all parties involved.

A further critical element of service integration that has been found to prevent recurrent episodes of homelessness is coordinated discharge planning from institutions such as prisons, psychiatric inpatient care, drug and alcohol withdrawal services. Sun (2012, p.24–25) suggests that the critical components of effective discharge include the following: *establishing rules around discharge planning, developing a discharge plan, providing critical time interventions, providing motivational interviewing to assist with outpatient follow up, early engagement with community agencies as a follow on, and access to funds for necessary services*.

The weight of the evidence suggests that long-term supportive housing models that can maintain engagement before, during and after release from institutional and hospital settings will be more effective in preventing a return to homelessness and be able to link clients into necessary supports at the time they are most needed. Chapter 2 examines the quality of external relationships cultivated to promote service integration within the J2SI program.

Building skills, employment placement and support

Programs providing tailored training and employment assistance to individuals who have experienced long-term homelessness need to be delivered in a manner that helps them to overcome significant barriers that relate to issues with self-esteem and efficacy, poor employment histories, criminal records and fears of losing benefits (Becker et al., 2005; Rosenheck et al., 2006, Biegel et al., 2010). Despite the inherent barriers to obtaining competitive employment, Individual Placement and Support (IPS) employment models have been found to be effective in helping formally chronically homeless individuals with multiple needs to become job ready and obtain work. Employment support is considered most effective when it is provided as an integrated package with housing and other interventions including skills development and building in recovery from drug and alcohol misuse into the employment support plan (Becker et al., 2005). Effectiveness of employment support is enhanced when introduced early into the support process (Shaheen & Rio, 2007).

The Individual Placement and Support (IPS) model is considered an evidence based approach that has been effective in assisting those who have significant mental health issues and those experiencing long-term homelessness gain competitive employment. Effectiveness is increased when the support is consistent with fidelity of the original model (Drake et al., 2011). The program model extended to those who have experienced chronic homelessness show promising outcomes. The core elements of IPS include:

- Services focused on competitive employment
- Eligibility based on consumer choice
- Rapid job search
- Integration of rehabilitation and mental health
- Attention to consumer preferences
- Time limited and individualized support

Bond (2004, p.346).

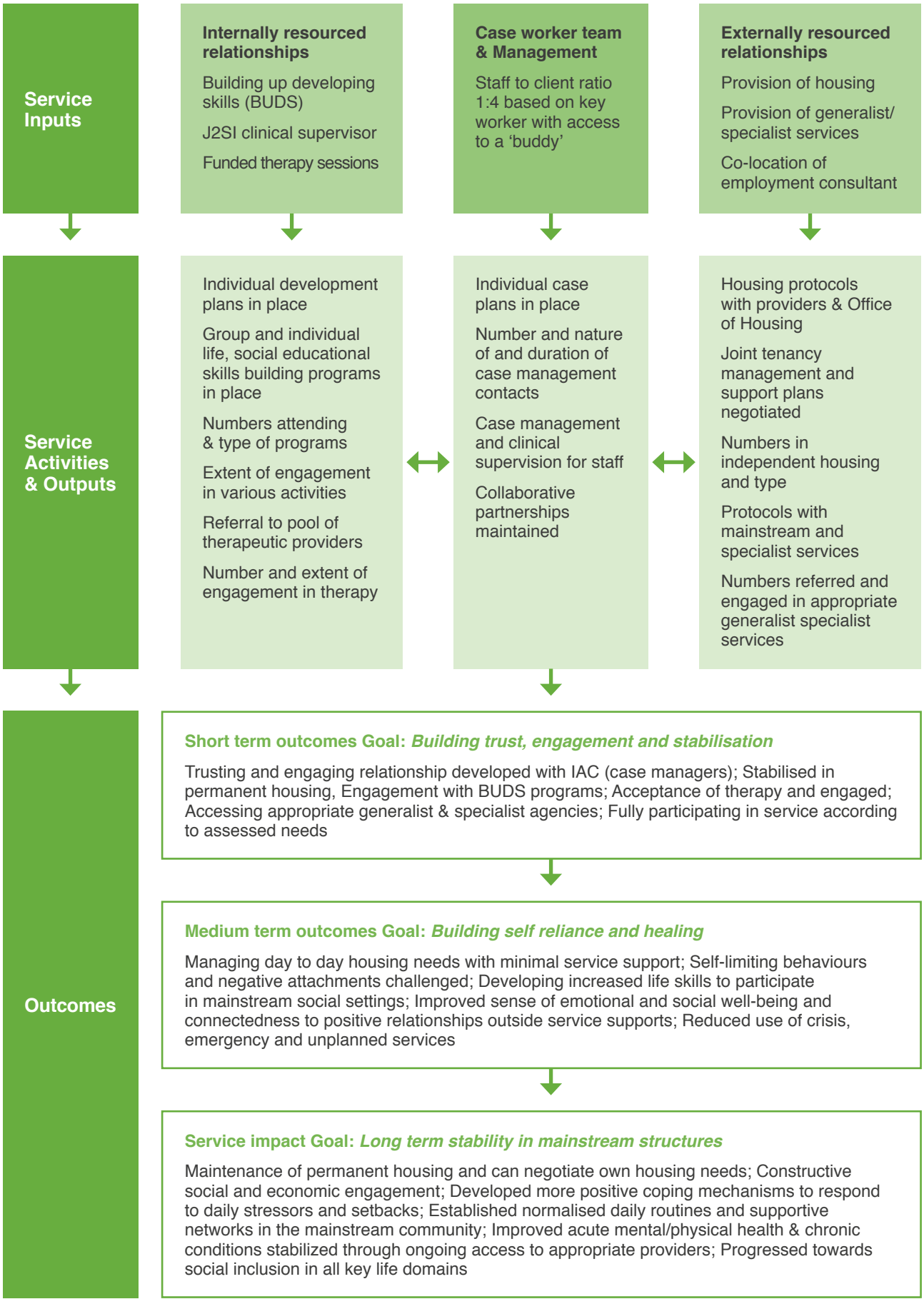
The BUDS/MIFV approach to skills building and employment support share many elements of the IPS approach. The J2SI approach to skills building and employment support is discussed further in Chapter 2.

2.2 THE J2SI MODEL AND ITS PROGRAM LOGIC

The program theory informing the J2SI program is articulated in the logic model shown in Figure 1. The logic model was refined following consultations with program management and staff. This logic model provides a framework for determining individual program elements and how they are expected to contribute to participant outcomes over time. In practice there is considerable overlap between the elements with the case worker being the common link, bridging both internally and externally resourced relationships.

Given that there are many stages of change that participants are likely to progress through, the logic model identifies short-term, intermediate, and long-term goals and the types of indicators that can be expected as each participant progresses through the three year program. It is assumed that the participants will progress through the three stages of change at different rates and that outcomes are likely to depend on each individual's characteristics and experiences. Implicit in the model design is that each participant's journey will be unique and that support must be flexible. To this end, the three goals identified in the logic model are used as a heuristic guide for understanding the different practices employed at different stages of the program, although once again we emphasise that the types of activities and priorities for the participants will shift over time. The process and outcomes evaluation are linked through the program logic model that seeks to collect data through three key stages of program change over time.

Figure 1: J2SI Program Logic Model



3. REVIEWING J2SI PRACTICES WITHIN AN EVIDENCE INFORMED FRAMEWORK

The intensive case management model for the J2SI program, as summarised in figure 1, is underpinned by the cultivation of both internal and external working relationships to achieve individually tailored support goals. A review of the quality of J2SI case management practices must therefore centre on the extent to which the relationship across all parties delivers what is espoused from the perspectives of the different stakeholders involved. The provision of ongoing relationship based case management to people with experience of long-term homelessness requires a consistent and skilled team of support workers who are well supported by a flexible, experienced and engaged management structure. This chapter reviews the case management practices and the organisational prerequisites associated with developing a long-term case management relationship. It draws on client service activity data within the program and consultation feedback from staff, clients and partner agencies.

> J2SI challenges traditional homeless responses of short term crisis and solely task focused by acknowledging the role of trauma both developmentally and as a result of being homeless and that longer term strengths and relationships based work is required *[Staff member]*.
>
> The program has given clients time and space to try out and explore the fundamental roots to where things have fallen down – a new way of looking, acting and coping with everyday issues *[Staff member]*.

In further developing the quality of service responses across the homeless service system there have been recent moves to create a consistent set of standards (See for example DSS website Housing Support – The National Quality Framework for Homelessness Services). These guidelines are intended to build on the existing of set of standards of quality case management, such as Specialist Homeless Service (SHS) case management frameworks, that have informed the broader practice guidelines documented in the policy and procedures within homelessness services. In addition, more generalist service policy frameworks, such as the DHS One Standards Strategy (DHS, 2014), aim to develop a set of unified standards and principles in quality service delivery across welfare and community services. The supervision and practice of case management was reported to follow the J2SI service policy and procedures that have been informed by the principles and standards frameworks of case management practices within Specialist Homelessness Services. In this evaluation the indicators used to assess the quality of the case management relationship and the broader program based on the existing standards of care and evidence informed practice included:

- Clients accepting support and forming a trusting relationship with their case manager
- Staff are well supervised to perform their role in engaging and maintaining the relationship
- The core staff group is retained to maintain consistency in the relationship
- Clients are effectively integrated into the supports they need through strong and proactive relationships with mainstream and specialist providers
- Clients continuing to engage in the program to meet case management goals
- Clients remain satisfied with the case management relationship
- The potential harm from ending the relationship is minimised

The promising practices in the initial engagement and stabilisation of clients in the J2SI program were identified in the first process evaluation report (Parkinson, 2012). The initial process of engagement involved an intensive phase of building a strong working relationship with each participant. Staff adopted various strategies to build trust with their clients. From the first report it was concluded that the initial strategies based around ideas of persistence laid the foundations for a strong working alliance between participants, their case managers and the service for the majority of the participants.

3.1 BUILDING THE WORKFORCE CAPACITY FOR LONG-TERM SUPPORT

The first process report documented the broad governance structure of the J2SI program as well as the framework outlining practice principles that shaped a culture of high commitment amongst both management and staff to ‘stay with the client’ no matter what. Good governance, in terms of the day to day running of the program, required someone with extensive experience in working with people with experience of long-term homelessness and who is able to understand the issues that staff face in the case management process.

According to program management, sustaining clients in a longer-term program of support requires a governance structure that is committed to:

- The proactive maintenance of relationships with key partners at the senior level such as meeting every 6 weeks with the Office of Housing to monitor tenancy management issues with each client
- Good data collection to be able to adequately document the process of long-term support, including adequate writing space for case notes to build a complete history of the client within a purpose built dataset
- Regular planning days to remain on track with each client and keep everyone motivated at different phases of program implementation, including reminding staff and management about the core set of outcomes, how these can be achieved and reviewing progress towards these outcomes
- Ensuring that the program remains accountable and transparent both internally and externally to the sector about what is working well and what is not working well to avoid false expectations for clients, service providers and funders

J2SI required staff to be prepared to commit themselves to the goals of the program over the full three years to ensure consistency in the intensity of support. This commitment has resulted in a high retention rate of staff, producing many benefits for the clients in terms of continuity of care. At the same time, promoting retention required careful management of team dynamics and providing adequate supervision and training to prevent staff burnout. Retention of staff over the three year period was particularly high for a program targeting the long-term homeless. The core staff group were retained, with the exception of one worker, up to the last three months of the program when three staff left the program to seek new employment.

J2SI and Sacred Heart management considered building the capacity of the workforce to be a critical element in ensuring that the program could be successfully delivered. Effective provision of long-term support to a small case load of clients requires certain qualities in a support worker that can allow them to respond positively to interpersonal demands as well as fluctuations in client progress. Staff feedback in the focus groups and surveys also reinforced the importance of the worker being able to understand their own negative triggers, 'where they sit' in their own practice, what they will allow, create and encourage in their client. The following quote illustrates the interface between the worker and the organisational environment in being able to cultivate an effective case management relationship.

> A good worker in a good practice framework makes the difference. A good worker is defined by the level of maturity and resilience they bring to case practice and this does not necessarily correspond with age because some of our younger workers have been particularly skilful and have been able to demonstrate self-reflective practice. You have to be someone who can develop rapport with people and the client has to see that as genuine. The support worker has to be respectful and not be intimidated by behaviour which can be very extreme and threatening. You have to like the clients and have a passion for working with them. You cannot be scared and keeping boundaries is essential. Workers have to create expectations of the relationship and maintaining private space is essential. You have to be able to understand where the behaviour has come from – it has worked for them since they were a young child *[J2SI Management]*.

Building the capacity of the support team in a way that added to the skills base within the homelessness service system was a core goal of the program. Management noted at the time of recruitment that it was difficult to identify a large group within the sector who had experience working with clients in a long-term capacity. Capacity building activities within the J2SI program included:

- A structured training calendar
- Individual case management supervision
- Clinical supervision with a psychoanalyst clinician
- Group supervision and case conferencing

In the early stages of the program J2SI focused on developing an extensive training calendar to ensure that staff were equipped to deal with the complexity of needs and issues they would encounter in supporting their clients (See appendix 1 for the full training calendar). The training calendar was most intensive at the start of the program. Whilst training was typically attended by most of the support team, staff could elect to attend the training that was most relevant to their own professional development needs based on their existing knowledge and previous training. This flexibility ensured that the training remained relevant to those attending.

The training calendar corresponded with the particular challenges emerging throughout the different stages of support. Training sessions were typically run for a day to half a day. The training at the beginning of the program provided the foundations for how to engage individuals with complex needs and with histories of complex trauma as well as the processes for applying for priority housing. There was a strong focus on understanding both the mental health system and how to respond to particular mental health and drug and alcohol issues from a case management perspective, including approaches such as motivational interviewing and trauma and recovery informed practices. The latter half of the program focused on legal advocacy training and how to end therapeutic relationships.

> The training opportunities have been excellent and I have been able to integrate theory into practice. In particular I have got a lot out of training focusing on attachment, trauma and relationships *[J2SI staff member]*.

Staff were asked to rate their satisfaction with the various types of capacity building activities offered to them throughout the program. Satisfaction responses were gathered on the quality of training, staff supervision and case discussions using likert scale questions ranging from 0 to 10 where zero indicates the lowest score and 10 the highest possible score. Staff also provided detailed qualitative feedback for each component of training. Staff perceptions of training were very positive throughout the trial, with a median score remaining at 8 or above. Staff satisfaction with the quality of training peaked at a median of 9 at the 18 month mark. The predominant theme reported in open ended responses to the staff six monthly surveys was that the training was well targeted and highly beneficial. Whilst staff agreed that the type of training was appropriate to their needs, training that was facilitated in a way that could be related back to their own practice was considered to be the most beneficial. Staff gained the most from training that was interactive and drew on case examples from their clients.

> Group supervision has provided a good opportunity to work through shared issues – the facilitator is excellent. I feel as a group we have not utilised this resource to address group dynamic issues that are impacting both staff and clients *[J2SI staff member]*.

A critical component to building staff capacity also included facilitated group case discussions and reflective practice meetings amongst the team. The case discussions provided a forum for practice issues to be discussed and for all staff to become familiar with all clients in the program to allow staff to respond to their needs in a consistent manner. The feedback relating to case discussions was very similar to that of training. Staff responding to the six monthly staff surveys felt that the case discussions helped them to gain more understanding of different perspectives on how to resolve issues with their particular clients.

In addition to specialised training, staff were provided with regular supervision throughout the program. Regular group supervision, facilitated by an external provider, was also made available for joint case discussions and to ensure that all team members were familiar with the needs of each client in the program. Group supervision and case discussions were introduced at different time intervals on an as needs basis including at the end of the program to support staff with the closure of the working relationship. Generally, group supervision was seen as a useful space to explore the impact of the work and review different perspectives. However, some staff felt that group dynamics could hinder the potential benefits of group supervision due to different perspectives on how to address particular issues.

Individual supervision included both general supervision by the case management team coordinator and program manager and fortnightly clinical supervision by a trained psychoanalyst. Generally staff reported that they were well supported, reporting a median satisfaction score of 7 or above throughout the three year pilot period. However, satisfaction with supervision depended on the individual staff needs and whether these matched the style of supervision provided. Some staff were highly independent and directed their own supervision goals whilst others required more intensive support and validation of issues encountered with clients. Tensions were evident in relation to the roles of general case management and clinical supervision with some staff blurring the functions of individual and clinical supervision, expecting individual supervision to be more like clinical supervision.

I enjoy my job immensely and the work I do with clients. I try to remain separate to issues that are not client focused and refuse to let any other issues affect my morale or the work I do *[Staff member]*.

I feel as though there is a tension within the team and that some people are more reflective and open about the impact of the work whereas others prefer not to talk about and sometimes minimise or deny that there is an impact *[Staff member]*.

The risks of staff burnout are high in long-term support. Questions relating to staff morale and satisfaction with the workload were also monitored throughout the three years to follow the impact of long-term support. Staff morale showed the most variation across time periods, suggesting that the impact of long-term support will differ according to the ebbs and flows of the support process. Overall morale was particularly high in the beginning of the program starting at a median of 9. By 30 months morale dropped to a median of 7 and then rose again to a median of 9 at the completion of the trial.

In the beginning of the trial, qualitative responses indicated that staff were highly positive about the possibilities that lay ahead for the client and the program as a whole. As the program reached the final six month mark, the general impact of long-term support or 'compassion fatigue' set in amongst some staff contributing to a dip in morale. These findings, combined with discussions in the focus groups, reinforce the challenges associated with long-term support and the central role of both staff and management in cultivating a supportive environment that can sustain morale over the longer-term. Overall, staff satisfaction with workload remained consistently high, at or above a median of 8. Most respondents acknowledged that the workload fluctuated from time to time but overall remained manageable throughout the three year period. Some staff highlighted the capacity to work across clients during busy times was critical in managing workload.

3.2 BUILDING AND SUSTAINING A CASE MANAGEMENT RELATIONSHIP

The focus of this section is to identify the practices that staff and management reported to be effective in building a long-term case management relationship. The capacity to maintain a long-term relationship is a critical success factor in being able to support people with experience of long-term homelessness, in both the transition into independent housing and to maintain stability over time. Consistent with the first process evaluation report, both staff and management considered the length, intensity, and flexibility of support as being fundamental to being able to form an ongoing therapeutic relationship with J2SI participants. Staff feedback from the focus groups and survey responses indicated that the approach to maintaining relationships has continued to be individually based and primarily client centred, an approach that is consistently reinforced in service standards frameworks (Department of Human Services, 2014). This included elements of strengths based approaches, trauma informed and recovery oriented practices, and at times, ideas informed by motivational interviewing techniques focused on challenging and moving the client towards change. The elements that staff considered as being critical in how they continued to sustain ongoing professional relationships with their clients are summarised below:

Having high commitment with boundaries

- Being 100% committed to building and maintaining the relationship by following through on what is said will be done is delivered.
- Getting to know the clients really well to understand their patterns of behaving to advance case management goals and provide a bridge to other services – i.e. by being able to let others know that this is how you engage this client "if you do this they will be ok".
- Placing clear boundaries on the nature of the professional relationship, not colluding or becoming over involved yet still being a key support person that they can turn to.
- Being patient and accepting in order to create a safe space for trusting and ongoing engagement.
- Being prepared to accept the choices people make and accept them for who they are.

The clients have learnt the value of commitment and consistency. It is such a big responsibility of not letting the relationship down and sticking to what you said you would do – keeping to your word. Quite a lot of small things – if the clients expects you to be there at 10.30 – if you're sick there are consequences for you as a worker for not following up. 100% commitment and reliability at all times – this client would never allow me to slip up they would call me on everything *[Staff member]*.

Creating opportunities for reflection and growth

- Not responding immediately to crisis rather stepping back and allowing the client to take responsibility for their problems.
- Being able to 'sit' with clients, encouraging reflection (particularly after a crisis) and focusing on what is said to help them to develop the insight necessary to assist and sustain change.
- Looking beyond the presentation of each client to work in a way that is respectful but challenging of behaviours. This means knowing when to hold back and when to push and when to ask questions and when to challenge.
- Building greater self-awareness and introspection amongst clients through emotional support linked to therapeutic discussion in clinical supervision. Engaging in further therapeutic work where the client is ready and able to confront past experiences.
- Working in a way that enables greater self-reflection about behaviours by being able to draw on incidents in the past and being able to name the behaviour – i.e. "look what happens when you act this way or that way" or, "six months ago you acted this way and now your response is different".

Promoting strengths

- Engaging clients in activities that they are skilled at to foster a sense of competency. This includes allowing them to lose themselves in activity through groups and other recreational activities such as horse riding, sporting activities, and art therapy.
- Fostering independence in choices and goals by taking small steps that allows the client to achieve success – i.e. supporting a client through a staged transition of being accompanied on public transport to being able to use it independently when previously they have been afraid to use it.
- Allowing the participant to do things rather than doing everything for them. It is critical not to carry people by giving them the opportunity to succeed without support.
- Having appointments that are not task focused, allowing clients to articulate needs and work towards tasks. A program where there is an emphasis on meeting appointments and being rigid around contact would not have worked in the same way.

Offering tangible and practical support

- Remaining focused on meeting individual needs – every client's needs are different and the program was resourced in a way that allowed them to respond individually.
- Having something to offer the client – i.e. housing, advocacy, transport.

An across team approach

- All staff being aware of the client's needs through joint case work and reflective planning across the team.
- Having a duty system at the office where clients can drop into when they need a safe space or someone to talk to.
- The introduction of a buddy system where the primary support worker worked closely with another staff member to provide mutual support or a 'second ear' to deal with different aspects of case management. This ensured that intensive work could continue when staff were on leave with a second worker who also had a relationship with the client.

The case study below illustrates the complexities that can be encountered in forming a therapeutic relationship and the gains that can be achieved by developing a unified approach across a number of professionals involved in the shared care of one client. The case study also reveals the importance of persistence and how critical moments can culminate into a turning point in building a trusting relationship and helping the client to overcome defences associated with the fear of rejection that can hinder effective engagement.

When Veronica and the caseworker commenced working together so much attention and energy was being placed in the conflict between the services providing assistance. It became clear to the caseworker that each person involved with Veronica had very different experiences and stories. It was important that the care team come together and the case plan meetings over time became a place of reflection.

Veronica's experiences of trauma at an early age and her experiences of being homeless taught her that she was not worthy of connection to another. Her experiences with care givers have been abusive. She had expected that her worker would abuse her too. It soon became clear that what Veronica was communicating strongly, that it is not practical support she requires, she needs responses to her fear and acceptance of where she is at. She was not asking her worker to fix her problems, she was asking the worker to connect with her and listen, to "get it".

On one occasion when her case worker went to visit she was acting out extreme aggression. Whilst on the surface this looked to be threatening, the worker spoke softly and acknowledged her anger and fear. Veronica and her worker now reflect on this as a pivotal point in the relationship. This was the point where her worker understood that there was a lot more to intensive support than providing abundant practical assistance and utilizing basic counselling skills. It involved the worker's presence in the relationship. From this point Veronica realized her worker was listening and could be relied upon. Her worker was not going to reject her.

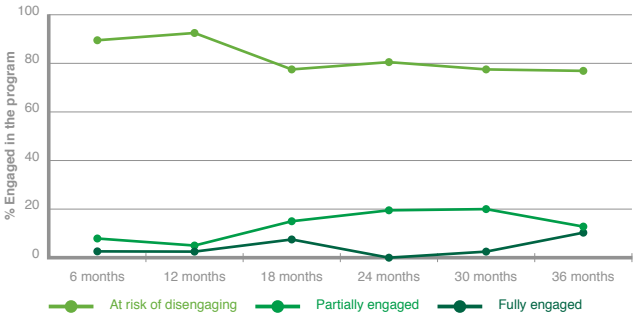
From this the relationship grew. As the trust developed in the relationship, Veronica was able to open up, turbulent times have been reflected upon and new insights into triggers for acting out behaviour have been developed. Each time Veronica presented with intense emotion (which can look like aggression), her worker acknowledged this. Over time her presentations with extreme emotions lessened. Veronica has used these insights and new relationship skills to begin to develop relationships within her community.

3.3 CLIENT RETENTION IN THE PROGRAM

Whilst clients can exit programs for both positive and negative reasons, a crude measure of the quality of the relationship can be obtained from the extent to which clients continued to want to engage in the program over time. Overall, the majority of clients remained fully engaged in the program indicating the effectiveness of a relationship based approach in engaging those with experience of long-term homelessness. Figure 2 shows the extent of engagement in the program from its inception in November 2009 to the program ending in October 2012. Since commencement of the program in November 2009, five cases were closed, primarily due to problems with the initial referral. Two people were unable to be located, two people repeatedly informed the program that they no longer wanted to participate and one person did not require the level of support available from J2SI. In addition, four people have been made inactive. Of these, two people moved interstate, one person was incarcerated for 18 months and one person withdrew participation when J2SI involved the police in response to activities which posed a significant risk to the community. One of the clients who moved interstate returned to Victoria within six months and re-commenced with the program. A further client had a planned exit at 2 years whilst 1 participant passed away in the third year.

Participation data for those who were appropriately referred and considered to be an 'active' client reveals a high degree of retention in the program over the three year period. The number of clients fully engaged in the program peaked at 93 per cent by twelve months before subsequently declining to around 80 per cent by 18 months where it continued to hover around that level until the end of the trial. A further 20 per cent of clients were considered to be partially engaging until the final six months where the proportion fell to 13 per cent and those deemed at risk of disengaging prematurely increased to 10 per cent.

Figure 2: Extent of engagement in the J2SI program, 6–36 months



Source: J2SI client dataset

A further indicator of the quality of the relationship with case managers and the service is the number of contacts and duration of support. Table 2 compares the average (and median) number of contacts and duration of support. The data on the number of contacts and duration of support is extracted from the client service activity dataset that has been merged to the client outcomes survey and is based on a pooled sample of client observations (or episodes) over the three year period. The final sample therefore represents the number of total observations for clients not the numbers of clients. As shown, those who were considered to be fully engaging in the program had an average of 83 contacts in the previous six months. For the fully engaged this equated to an average of approximately 62 hours of direct care support over a six month period. Participants who were either partially engaging or at risk of disengaging had on average a respective 65 and 48 contacts in a six month period equating to an average of 38 hours and 14 hours of support.

Table 2. Extent of engagement in case management, pooled episodes, 6–36 months

	Number of contacts with J2SI services in previous 6 months	Duration (in hours) of contact with J2SI services in previous 6 months
Fully engaged		
Mean (Average)	83.28	61.5
Median	74.36	52.7
Partially engaged		
Mean	64.68	38.4
Median	54.07	30.7
At risk of disengaging?		
Mean	47.76	13.9
Median	29.41	10.1
Total		
Mean	79.86	57.2
Median	71.74	48.5
N	248	

Source: J2SI client dataset merged to client outcomes survey responses

The intensity of case management was also measured according to different types of support provided by case managers. Table 3 shows the total number of contacts recorded by type of support. The total number of client contacts in a 6 month period peaked at 5712 by the 24 month period indicating the intensity of support provided to participants remained high throughout the trial. As to be expected the highest number of contacts by type of support (1408) in the first six months related to housing and declined steadily thereafter to 555 in the final six months, suggesting that participants gained more independence in their housing over time. Client contacts for general engagement (2222) was highest at the 24 month period before declining to (1550) in the final year. Engagement in BUDS, employment and other social inclusion activities also peaked at the 24 month period. This reveals that the intensity of case management and involvement in other parts of the program steadily built to a peak at the two year period and then declined as participants were linked into other types of support and gained greater independence. This also indicates that stabilising participants in housing and linking them into the supports they need can take time.

The percentage of time (in hours) case managers spent on participants according to the broad types of service activity throughout the trial period is shown in Table 4. Addressing support needs relating to housing access and settlement consumed over a third (35%) of case management time in the first 6 months of support. The need for housing specific support declined to around 11 per cent of case management time by the final six months. This indicates that a significant amount of case management activity in the initial stages of the program was focused on housing resettlement and issues of tenancy management. A decline in the amount of time spent directly on housing related assistance suggests that housing became more stable over time. However, it also indicates that tenancy management forms an ongoing component of case management time despite being rehoused for long periods of time.

As housing stabilised case managers were able to devote their attention to the continued engagement in the relationship where other goals became the focus of support. Time devoted to health related activities generally remained consistent throughout the program consuming up to 21 per cent of direct case management time at 12 months and generally remained above 17 per cent of time throughout the trial. The need for ongoing support with health issues is consistent with the high proportion reporting chronic health conditions (see Johnson et al., 2011). Support activity relating to BUDS and employment increased to 11 per cent by the 18 month mark, remaining at around 10 per cent of case management time thereafter. In the final 6 months around 8 per cent of time was devoted to issues of 'transitioning' participants from the program at completion of the three year trial.

In all, the client service activity data reveal that the intensity of support has remained relatively consistent throughout the trial period and indicates that the program has been successful in its aim of providing a highly intensive response to stabilise housing. The data also reveal that the process of support has mainly centred on engagement or maintaining a one on one supportive relationship between the case manager/s and clients.

Table 3. Number of contacts by type of support, 6–36 months

	Engagement	Housing	BUDS/ Employment	Family/ social inclusion	Health	Clinic/ Therapy	Legal	Income	Transition	Total case contacts
6 months	1008	1408	70	454	552	91	238	157	0	3978
12 months	1550	878	453	399	871	166	298	140	0	4755
18 months	1801	735	558	475	774	140	276	116	0	4875
24 months	2222	719	670	598	817	84	493	99	10	5712
30 months	1883	622	453	526	714	48	309	99	7	4661
36 months	1550	555	565	389	644	75	277	109	220	4384

Source: J2SI client service activity dataset

Table 4. Percentage of time spent on support areas, 6–36 months (Row %)

	Engagement	Housing	BUDS/ Employment	Family/ social inclusion	Health	Clinic/ Therapy	Legal	Income	Transition	Total case contacts
6 months	21.3	34.9	1.93	13.4	15.9	1.32	8.0	3.05		100
12 months	27.3	18.5	9.08	10.9	21.1	2.29	8.10	2.64		100
18 months	30.2	16.4	11.04	11.52	18.9	2.01	8.67	1.35		100
24 months	35.3	11.35	9.4	11.8	17.93	0.84	11.9	1.1	0.4	100
30 months	37.0	9.2	7.8	13.6	18.13	1.19	11.20	1.49	0.3	100
36 months	30.9	10.85	9.54	11.92	16.8	0.9	9.46	1.36	0.3	100

Source: J2SI client service activity dataset

3.4 INTEGRATING CASE MANAGEMENT WITH HOUSING AND OTHER SUPPORTS

> There is a need to challenge assumptions that once you get housing it is all suddenly fixed. It takes a good committed team to sustain progress of the case management plans over a 3 year period. It takes a solid commitment from the case managers and other services/housing providers involved. It is critical to have a good clinician who is committed to the goals of the program, and strong collaboration between the BUDS training element and MIFV employment placement. There has to be ongoing work at both case management and management level to ensure that all the elements are integrated for the client on the ground as they are needed. The model worked best when all the elements came together for a client *[J2SI management]*.

The provision of integrated support forms the cornerstone of good case management practice, especially for those who have multiple and complex needs. Over the years, integrated support for those experiencing long-term homelessness has assumed many different forms. These include the co-location of multidisciplinary teams through to collaborative models that seek to link clients into existing mainstream and specialist services. The J2SI model reflects the latter approach where collaborative partnerships are cultivated from the level of service governance through to individualised case plans.

Engagement with Housing providers

The first process evaluation documented how the establishment of partnerships with housing providers, particularly the Office of Housing, enabled rapid access to permanent housing. Case management activity in the first six months predominately focused on gaining access to and establishing structures around the client to help stabilise them in their housing. A review of service administration data shows that the majority of participants were housed in Office of Housing properties by six months. The numbers housed in public housing properties peaked at 32 by 18 months and then fell slightly to 29 participants by the end of the trial. While there have been a small number of housing losses, as shown in Table 5, the majority have remained housed. The J2SI outcomes reports continue to document superior housing outcomes of J2SI participants compared with the 'service as usual' group over the time of the trial. Trends in housing stability with a comparison service group are examined in more detail in the 12, 24, and 36 months J2SI outcomes reports (See Johnson et al., 2011; 2012; 2014).

Table 5. J2SI participant housing status, 6–36 months

	6 months	12 months	18 months	24 months	30 months	36 months
Office of Housing	20	28	32	31	30	29
Private rental	0	0	0	1	1	0
Supportive housing/SRS	5	5	5	4	5	2
Transitional housing	7	1	1	1	0	0
Private/community rooming house	2	2	1	2	3	3
Primary/secondary homeless	5	4	0	2	1	3
Prison	1	1	1	0	1	1
Unknown	0	0	0	0	0	2
TOTAL	40	41	40	41	41	40

Source: J2SI client service activity dataset

The core activities of the case workers throughout the trial continued to focus on building a system of support around each client to help them maintain their housing over time, which included:

- Proactively maintaining the relationship with the Office of Housing and other housing providers at both management and support staff levels.
- Encouraging other services to also share responsibility for the client's housing needs – keeping all services informed e.g. state trustees, health services and housing groups.
- Working through practical tenancy management concerns as they arise to identify flexible solutions to help the client maintain their housing.
- Using the support process and the relationship formed with the client to provide positive role modelling in building a sense of pride and connectedness to the home.
- Challenging and creating change in behaviour and reflecting upon crisis points that have led housing to break down in the past and using this background to assist clients to build up skills to resolve housing problems as they arise.

Skills building and employment

In addition to individual case management, J2SI participants had ongoing access to an internally resourced Building up and Developing Skills (BUDS) coordinator position and a Mental Illness Fellowship employment support coordinator collocated at the service. The MIFV worker came later in the program in November 2010, following the signing of a joint Memorandum of Understanding between Sacred Heart Mission and the Mental Illness Fellowship. The two coordinators forged a strong collaborative working relationship to closely align participants' identified training needs with access to employment opportunities. Both BUDS and MIFV roles mirrored the approach to intensive case management within J2SI by providing individualised work placement and training support that aimed to help participants focus on areas of interest to them and how this might be linked to possible training and employment pathways commencing from the strengths they already possess.

The BUDS component of the program provided both group and individually based activities. The core aim of the BUDS program, as detailed in the first process report, was to provide participants with essential life skills that can assist in their move to independent living as they move from being homeless to housed and then to provide broader opportunities to pursue personal development goals, whether by increasing voluntary engagement in community organisations to build confidence, through to participation in structured accredited training programs. Initially BUDS involved group activities with J2SI participants to assist in the transition into housing. These activities included living skills training and sewing classes to make curtains and cushions for their new home. The latter half of the program has concentrated on providing individualised training access to accredited programs through to one to one mentoring around study, computer skills, or other individualised skills development needs.

Figure 3 shows that 33 clients accessed the BUDS component of the program since commencement. The number of clients ever accessing the program peaked by 30 months. Whilst the majority of participants have accessed the program at some stage during their three years of support, there is a smaller group that engaged in a more ongoing way progressing through formalised and accredited training programs and into employment. A core part of the BUDS and MIFV roles have been to provide both practical and emotional support in the preparation for employment. This has ranged from ensuring that participants have adequate clothes and are able to present themselves well, to accompanying participants to their place of training or employment through to direct liaison and management of relationships with training providers and employers.

Figure 3. BUDS service contacts 6–36 months

Source: J2SI Managers reports

Participation in the BUDS and MIFV components of the program were voluntary. A question asking J2SI participants to state the main reasons for not accessing the BUDS component of the program was included in the client outcomes survey from 18 months onwards. With the exception of survey 4 (18 months) when the majority reported 'other' reasons for not engaging with BUDS, the most frequently reported reasons at the respective 24 and 30 months survey periods was that they were not ready (31% and 35%), whilst at the 36 month period the largest group reported that they did not need to access this component of the program (42%).

The MIFV employment coordinator commenced with the J2SI program in November 2010. Data collection on client contacts is from the end of the first 18 month mark through to the end of the trial. The "ever referred/engaged" provides a cumulative count over the trial. The "point in time" counts refer to actual numbers at each six month mark.

As shown in Table 6 there were 28 participants who were ever referred to the MIFV program by the end of the trial. Of those, a maximum of 18 participants had engaged in employment support. By the end of the trial there were 15 employment placements and eight education placements.

Table 6. Number of clients accessing MIFV employment support, 18–36 months

	18 months	24 months	30 months	36 months
Ever referred/engaged				
MIF Referrals	19	25	28	28
MIF Met	17	23	27	27
MIF Engaged	14	17	18	18
MIF Employment Placements	3	5	14	15
MIF Education Placements		0	8	8
Point in time				
Total number of people working	5	4	5	6
Total number doing training/studying	3	0	5	1
MIF Voluntary work		1	3	3

Source: Management Reports

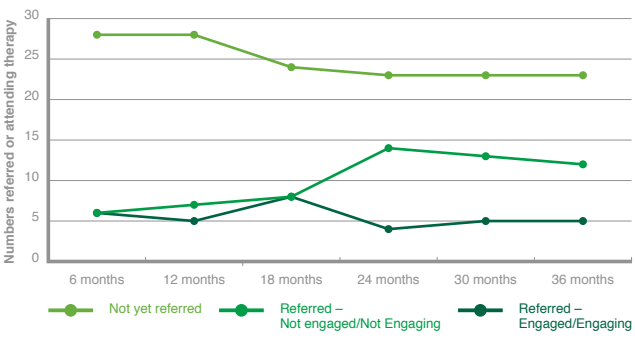
Therapeutic support and trauma informed practice

The first report outlined the evolution of the therapeutic component of the program and the modifications made to it as it was implemented. At program inception, funding was set aside to provide access to therapeutic support for those who needed it or were willing to engage in ongoing therapy. The numbers engaging in therapy remained low throughout the program (Figure 4). While the highest number accessing therapy peaked at 10 clients, there were typically around 5 clients who were actively engaging in therapy throughout the trial period.

> It is not an easy task to be present to the clients. What can happen in a clinical relationship is that client/patient works through something. The client is not going to sit in therapy. What is beneficial is the effect of a period of time in a relationship with someone else where there has not been an imposition on them and they are important themselves as a human being. It's really orienting the relationship around the central question of what it is you want to do with your life – it is a very confronting question. For some it is a question of life and death *[External stakeholder]*.

Following an internal review of the therapeutic component of the program, a clinician was funded to provide clinical supervision to case management staff who would then act as the conduit for therapeutic support (See Parkinson, 2012 for first process evaluation report). The approach to clinical supervision remained consistent throughout the trial following its implementation. Staff attended clinical supervision on a fortnightly basis. Within each session staff would discuss practice issues around one client. The goal of each clinical supervision session was to arrive at a key question that could be taken back to the support process.

Figure 4. Therapy referrals and attendance, 6–36 months



Linkages with other support services

A clear strength of J2SI is its internal resources (BUDS, employment, clinical), its use of secondary consult and its partnerships with the wider service systems (MH, D&A, housing) – this allows for a holistic and integrated response to the client which is more likely to address the issues underlying a person's homelessness. The case management role services as a co-ordination point to ensure services are holistic and appropriate *[J2SI staff member]*.

The ability of the J2SI program to effectively collaborate with mainstream and specialist providers in connecting participants to necessary services was considered a core strength of the model and where it contributed most in filling a crucial service gap. The first process evaluation report documented how the service governance structure, comprised of service development and advisory committees with representation of key experts from mental health, drug and alcohol and housing services, was central to facilitating shared ownership of the broader goals of the program and for promoting effective inter-agency collaboration on the ground.

The governance structure was also a key strength. Having various experts in mental health, housing etc meant that they had a buy into the program which paved the way for work on the ground, helping to overcome road blocks and contributing to more collaborative relationship based practice. People were really committed to the pilot and invested time in the beginning of the program design to set up those relationships was critical. It is critical to have them established beforehand *[J2SI management]*.

J2SI played a key coordination role on a range of services involved in participants this ensured clear /effective case plans, minimised duplication of work. J2SI was able to have clear oversight as it was not focused on one area i.e. mental health, D&A etc so we were able to take a more holistic view *[J2SI staff member]*.

Both internal and external stakeholders reported that the J2SI program has been able to work with some of the most 'difficult to engage' clients who have had a long history of chaotic service use. Staff and management of the J2SI program attributed this to the formation of a trusting relationship. This was possible due to the program's capacity to work in a long-term and planned manner which enabled them to 'carry the history of the client' in referring to services and advocating for their needs. Using the relationship to help motivate clients towards acknowledging the need for and accessing support, particularly ongoing management of mental health and substance misuse, was considered critical. Having the time to physically assist clients to access and accompany them to appointments meant the difference of attending versus not attending at all.

Table 7 shows the number of services that J2SI participants were engaged with at the time of referral to the program and referred to/engaging with in the final year of support. Overall, the numbers of services clients accessed significantly increased over time indicating that clients were linked into the mainstream and specialist services required. The services listed are those that have been identified through the individual case planning process. This does not include emergency services or other high cost unplanned responses. It should be noted that the numbers reflect services engaged in and not numbers of individuals as many clients accessed multiple programs.

Referral and engagement in all service types increased with the exception of crisis drop in and food programs. This is consistent with the broader program goal to build supports outside of the homelessness service system. The need to identify a stable and suitable general practitioner was identified early on in the program and all clients had been linked in with a regular doctor by the final year. There have also been noted increases in the number accessing drug and alcohol support including pharmacology/methadone treatments, psychiatric services, community/allied health and dental programs, and legal services.

You have to have everyone on board. Where there are issues of splitting amongst services you have to work with services to resolve this and build up what is around the client – it took a long time to build this up about a year – one client had 18 professionals around them and you need strong support from the service system to achieve a coordinated response *[J2SI staff member]*.

Spending the time to work out the right medication for the client has been critical – one client is 52 years old and no one has sat down in detail to work through it with him. They have had their diagnoses confirmed and the medication regime sorted out and pysch services can see the differences in the client *[J2SI staff member]*.

Table 7: Engagement and Referral to Other Services Before and After J2SI Support

Service Type	No. of services at referral	No. of services engaged with following referral in the final year of support
Mental Health		
Counselling/therapy/psychologist	2	23
Psych services – Private/Hospital Psychiatrist/ Outreach/Assessment	11	35
Dual diagnosis	0	4
Specialist trauma, sexual assault, personality disorder	0	5
Drug and Alcohol		
Detox/specialist services/outreach/ Pharmacology/methadone	2	22
D&A Counselling/peer support	5	8
Family support	1	11
Neighbourhood/community centre – including homelessness specific drop in/Crisis Centre/ Meals program	19	10
ICMI – General support	3	1
Good/suitable GP	8	41
Community Health/Allied/Dental Programs	18	26
PARC psychiatric disability support	0	3
Other health	0	10
Legal services/legal aid/state trustees*	0	20
Others Services	0	5

Note – does not include BUDS. Numbers reflect total numbers of referral episodes across individuals as some participants have had multiple referrals. Does not include employment and education. Does not include corrections

3.5 PERCEPTIONS OF THE QUALITY OF THE MODEL FROM PARTNER SERVICES

Developing and maintaining strong and effective partnerships with external agencies is critical to ensuring that case management goals can be met. In monitoring key relationships, two surveys were mailed out to external providers and partner organisations throughout the course of the trial. The results of the first survey mailed out at the half way mark of the program appeared in the first process report. The second survey was mailed in September 2012 before the final end date of the program. There were a total of 11 responses to the second survey. The findings of this second survey reveal consistently high satisfaction with the nature of the working relationship from the perspective of external providers. Providers responding to the survey included staff and management from drug and alcohol, mental health including homeless outreach and area mental health services and well as private counsellors. There were also responses from community housing providers and OoH and other drop in services including the Women's House and Family support workers.

The nature of the working relationship varied amongst these providers from being a regular source of secondary consultation, to having MoU'S (such as those with housing providers) in place around a shared client/tenant, to providing joint and complimentary support to the same client. The intensity of the contact for shared clients ranged from weekly for services providing ongoing counselling, mental health and family support, to monthly contact with legal providers or on an as needs basis for those providing secondary consultation. Some services were also more intensively involved towards the end of the program, such as New Horizons in Home Based Outreach Service (IHBOS).

Partner agencies rated the provision of support highly across all areas (in Table 8). In general, providers reported that the J2SI model provided a significant addition to the broader homeless service system. The qualitative feedback from providers is themed according to perceptions of staff qualities, gains made with respect to joint clients, and the impact on housing stability. External providers typically reported that the working relationship was strong and positive. The J2SI team were described as being highly professional and responsive, making appropriate referrals to their agencies and dealing promptly with risks to shared clients. The collaborative and 'lateral' approach was valued by partner organisations, particularly amongst those who provided a joint response to a shared client. Partner agencies saw a clear complimentary role for the program and the gap that J2SI filled in being able to work so intensively with the clients. The capacity to work holistically with the clients was considered a further strength. Secondary consultation was considered to be used appropriately by program staff.

The capacity to provide ongoing support to assist with the transition and ongoing stability of housing was considered essential for J2SI and other programs in being able to meet the broader needs of their shared client. Generally housing providers responding to the survey believed that all clients were referred appropriately to the type of housing provided, despite the fact that some tenancies could not be sustained. There was a view that some clients may not have been 'ready' to live in independent housing. Maintaining regular contact with housing providers by keeping them up to date with any housing concern or needs was considered very beneficial. The example excerpts below from the external partners illustrate these sentiments.

Table 8. External provider self-rated satisfaction with the J2SI working relationship

	Satisfaction with……						
	Referrals	Quality of support	Responsiveness	Professional relationship	Approachability	Collaboration	Client relationship
Mean	9.6	9.6	9.6	9.8	9.7	9.7	9.2
Median	10.0	10.0	10.0	10.0	10.0	10.0	10.0
N	9	11	11	11	11	11	10

Source: Partner agency survey

Quotes from partner agencies

Very professional service, meeting the client's needs effectively, providing the intense support that the client requires due to the complexities of the issues. Being able to build long-term trust relationships with clients. Supporting the client to access services such as therapy, supported playgroup, medical services that the client would not be able to attend without support. Connection with above mentioned programs has meant stability for the client through community connections and intensive service support to assist the client to work through the complex and entrenched issues they face *[Family Support Worker]*.

J2SI has established excellent therapeutic relationships with difficult to engage clients. Always provided the clinical service with regular updates and feedback… Amazing results with very challenging clients *[Area Mental Health Service]*.

While a few of the tenancies failed we would still argue that they were appropriate referrals. There has been a mixed result. Some J2SI clients were simply not ready to live independently in our houses. Others have however fared well. From a community housing perspective J2SI has worked very hard to maintain the tenancies but for some clients it was too early *[Community Housing Provider]*.

J2SI has made an incredible difference in the case of my client because of the efforts of this J2SI worker, the client has stable housing for the first time in decades. Because of this stability, he is now in a position to work on his other issues such as drug addiction. The involvement of J2SI has been crucial for this person *[Therapist]*.

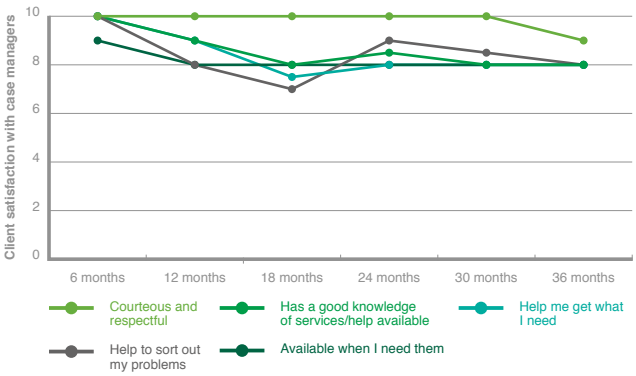
J2SI clients that we worked with were well housed and supported to remain in these properties workers supported clients to engage in study and paid work. Clients were also supported to re-establish links with family, support with legal matters and address D&A issues and spend time and re-engage within their local areas *[D&A Service]*.

Housing provider – J2SI have taken the 'frequent fliers' of our service and made considerable change to their lives *[Housing Provider]*.

3.6 PERCEPTIONS OF THE PROCESS OF SUPPORT FROM CLIENTS

Data focusing on the quality of the working relationship from the perspective of J2SI participants was routinely collected every six months throughout the trial. Clients were asked to assess their overall satisfaction with the relationship with their case manager, drawing on five main indicators (figure 5). These indicators are based on a likert scale ranging from 0 to 10 where 0 represents the lowest score and 10 the highest score. Satisfaction with the program remained high throughout the trial. Clients reported the highest satisfaction for their "case workers being courteous and respectful", which remained at a median of 10 before dropping to 9 in the final six months. The slight drop could be explained by the anticipation of the program coming to an end, as some of the qualitative responses indicate that clients became concerned about the options for ongoing support once J2SI had ended. Satisfaction for the remaining four indicators tended to fluctuate more throughout the trial but in general was lower at the end of the program than in the first six months. High satisfaction in the beginning could stem from gaining, or the anticipation of gaining, access to housing. Declining satisfaction could have resulted from the familiarity with the program and a potential mismatch between their expectations of the program and what was delivered.

Figure 5. Client satisfaction with case management, 6–36 months[a.]



a. Median Score

Source: Six monthly clients outcome survey 2–7, 6 months N=36; 12 months N=37; 18 months N=33; 24 months N=35; 30 months N=29; 36 months N=33.

It is a good thing that I can come here and have a cuppa and talk to someone *[J2SI participant]*.

It is the first time I've had a bunch of people not giving up on me *[J2SI participant]*.

Response rates to the qualitative questions amongst clients were generally much lower than the likert scales, with a range of 7 to 10 people providing responses across different time periods. The qualitative responses focused on what participants liked best and least about J2SI and the support they received throughout their time with the program. In the beginning, the provision of permanent housing and being supported to keep it was considered to be one of the best components of the program. As the program progressed, positive comments typically focused on the nature of the activities that participants found to be particularly enjoyable and engaging because they were seen as an extension or outside the typical case management role. These included participating in sporting, recreational and art based activities, going to the library to use the internet with their case worker, and being able to access the BUDS and MIFV programs offering skills and employment training. Having a range of activities that was available to them if needed was a valued component of the program.

I think the program should work on one thing at a time. It bowls me over sometimes *[J2SI participant]*.

Sometimes the needs of the program haven't been what I need. I understand but it's been frustrating at times *[J2SI participant]*.

I'm not utilising the resources that are there. That's up to me. I haven't been well enough to take advantage of what's on offer. I feel a lot of guilt for not taking advantage of it *[J2SI participant]*.

Other participants commented on the nature of the relationship with their case manager and valued having someone to talk to. Being able to communicate with more than one worker was also considered beneficial especially when their main support worker was away. Having flexibility in the service response, such as being able to drop into the service 'for a coffee' and also the outreach component of the program was considered helpful in meeting support needs. The fact that the program had not 'given up on them' was highly valued by some participants. Participants were appreciative when their case worker was able to advocate on their behalf to resolve issues such as parking infringements and legal issues.

When participants provided negative feedback about the program they typically centred on perceived problems emerging within the case worker–participant relationship or a mismatch between what they perceived the expectations of the program to be and what they wanted from the program. These issues included feeling that there were breaches to their privacy and confidentiality at times when the case worker had to intervene to prevent tenancies from breaking down and contacting other professionals or management to assist or resolve problems. Some participants felt that the program put too much pressure on them, while others suggested that the program did not push them enough. The multiple aims of the program and the provision of different components of support was reported to be a little overwhelming for some. There was a view that case workers did not have enough knowledge of the particular services that were available to them in the new local areas that the clients had moved to or that their support worker was unable to resolve all their needs. Finally clients became frustrated when they could not make contact with the case worker and needing to leave messages or that their case managers tried to contact them at times when they were unavailable.

In the last two surveys there was a common view amongst those providing qualitative responses that they did not want the program to end. There was also a view that the program should be extended so that others had the opportunity that they had. Some felt that extending the BUDS and MIFV components of the program would be a good way to stay engaged and to build on what they had gained over the three years. This included having access to courses that were of interest not just those aimed at getting a job.

The general perception among staff and management is that BUDS and MIFV programs have evolved into an effective and integrated package support that is able to provide a continuum of individualised training and employment support. Clients who accessed the BUDS and MIFV components of the program were generally highly satisfied with the support they received. Figure 6 shows that satisfaction with the BUDS component was typically higher following the first 12 months, potentially reflecting the shift towards more individualised training and a move away from group based activities.

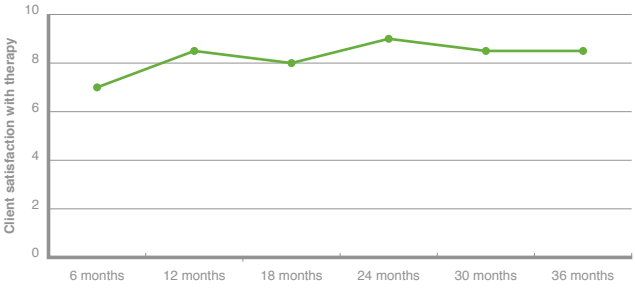
Figure 6. Client satisfaction with BUDS training, 6–36 months[a.]

[a.] Median Score

Source: Outcomes survey waves 2–7, 6 months N=14; 12 months N=15; 18 months N=14; 24 months N=15; 30 months N=8; 36 months N=9.

Although the uptake of paid therapy sessions was low, Figure 7 illustrates that those who continued to attend therapy were generally satisfied with the service they received, particularly in the latter 12 months of the program. In the first six months the highest proportion of clients reported that they were not ready to access therapy. As the program progressed the majority reported that they did not need to attend or that therapy was not relevant to them.

Figure 7. Client Satisfaction with therapy, 6–36 months[a.]



[a.] Median Score

Source: Outcomes survey waves 2–7, 6 months N=15; 12 months N=17; 18 months N=14; 24 months N=16; 30 months N=8; 36 months N=9.

3.7 ENDING THE CASE MANAGEMENT RELATIONSHIP WELL

> One client would always mention the date from the start and would know how long was left. He was also concerned about the ending and given he has a learning disability he had more insight and understanding that it would come to an end and seemed to be preparing himself for it. I have known that this part of the program would be a challenge, not in me as such, but with clients demonstrating their sadness in the end of intense relationships. One client has asked "Will you still say hello if I see you in the street?", this is hard as they are sort of asking will you still remember me *[J2SI staff member]*.

The potential for further trauma is a real risk in long-term intensive case management if the process of client closure is not managed with respect and care. The time limited nature of the J2SI program, up to three years of support, meant that staff and management had to plan for how best to manage the ending of the worker-client relationship from the beginning to ensure that any gains made over the course of the program could be sustained. Management, staff, and clients all reported many challenges associated with this aspect of the program.

Generally, from a review of case notes, external consultations and staff feedback, this process was managed in a way that remained client focused. The practices reported by staff and management demonstrated a high degree of integrity and care for the wellbeing of the participants and for the staff involved. Whilst staff and management reported that planning for and managing the closure of the program had always been present in the goals of case management, the final 12 months in particular focused on putting in place the necessary supports and building independent structures that could sustain the work of the program once the service was folded back.

The procedures that were put in place included the following:

- Case plans oriented towards what participants hoped to achieve in the final year, linked to social participation, skills training, employment or other needs they wanted to have addressed in the program.
- Detailed exit plans including supports required and which services would take on the lead case management role if this was still required.
- Tenancy plans with housing providers.
- Bringing in an external training facilitator for case workers to equip them with the skills in how to manage the end of the client relationship in a professional manner.
- Beginning conversations with participants early in the year to prepare them for the end of the working relationship including focusing on how to end a relationship in a positive way.
- Building connections with family members and other ongoing support where these were positive including attending informal family meetings with the client and case worker.
- Retaining a small pool of the initial J2SI case work staff and the BUDS coordinator at Sacred Heart Mission. Their role was to serve as a general contact point for former J2SI program and to provide a way for clients to build on the skills and employment development needs.
- Working jointly with new services with the clients before withdrawing J2SI support.
- Preparing detailed case notes that could be forwarded onto relevant providers to ensure that the in-depth histories of the clients that were built up over the three period were documented.

A review of case notes from support workers revealed that participants reported coping with the end of the J2SI program in different ways. Some wanted to make a clean break from the program feeling that they were ready to go it alone. Others expressed strong feelings of sadness and of being scared about how they would cope in their housing alone. Some reported that they were worried about working with a different service because 'they would not understand them' or show them the same patience. Some showed fears of abandonment. Others became concerned about the employment of their case workers and whether they had jobs to go onto.

Excerpts from case notes of the conversations on closing the relationship reveal the depth of the working alliance formed with many of the clients, not just with the individual workers but with the broader program. They also reveal that the process that each client goes through is unique. Support staff encouraged participants to reflect on their own growth through the program and the importance of ending the relationship on a positive note taking what has been learnt with their support worker into forming new working relationships with other providers. The conversations reveal the mixed feelings of leaving behind an old life but happiness for the opportunities that were opening as a result of the program. The final outcomes report one year on from the program will provide more insights into how participants have fared over the longer term.

William thanked writer for everything and that he has gained so much out of it. He thanked writer for the commitment, patience and consistency. Writer had taught him about purpose in life.

Mel spoke about feeling confused although also feeling confident. Discussion re transition stage – old ways of doing things not feeling right anymore, and getting ready to do things differently but not sure what that will look like. Discussion re Mel's progression over J2SI – growing confidence, being direct, growing understanding, sticking up for herself, feeling very different from her old friends. Mel stated 'you can't do all this work and not grow.'

Deb – "The program gave me confidence, structure, a routine to my life, and stability…" "I'm turning 35 this year but I'm not like a real 35 year old, I was like a 15 year old when I started (J2SI) and now I'm like a 20 year old, if that makes sense." Deb thanked the writer for being different to her other workers and sticking by her despite her sometimes "bad" behaviour and giving her structure and boundaries….Deb phoned the duty line and informed the writer that she will "miss worker to pieces."

Ellen asked if writer could buy her some milk and a lighter rather than take her for lunch, as she'd rather make coffee at home. Writer bought these things then took Ellen for a milkshake. Ellen drank it really quickly, and said of the program "its gone fast, but I have to go home now".

Writer explained that it was time to let go and Mick repeated it and said "yes it is time to let go of our relationship and also of this....my ideas of being famous and in movies and what else is in my head..."

Rachel commented a couple of times that she would miss J2SI. She stated that she never thought she could work and now she knows she can. Rachel stated that her life has turned around thanks to J2SI and how much the program has helped her achieve.

Mat began to speak about how much he has changed in being able to speak to others and how J2SI had made a difference to him. Mat added that we wanted to know him and genuinely cared for him. Mat went on to say that he has managed to 'flip the record and hear the other side'. Mat said that his life has changed around, now he has a car, dog and home.

Carol came into the office to see me on my last day. She wanted to say good bye and wished me well. We reflected on the last 3 years together and Carol said "it went way too quick". Carol giggled about our up and downs and remembered our first day we met. She wished schuppi (my dog) and me all the best and stated that she guessed I won't attend her wedding.

Message left on white board – Thank you for everything you've done for me over the past 3 years. I know it's been frustrating as well as good. Everything I've learnt I will take with me on my journey to a better life. A, you've been the best worker I could have hoped for, and I'll always remember you, also including [managers] and the rest of J2SI workers. Always and forever ++++

4. STAFF REFLECTIONS ON PROGRESS TOWARDS PROGRAM GOALS

The first process evaluation report documented the promising practices associated with building trust, engagement and stabilising clients in housing in the early stages of the support process. The client service activity data reviewed in this report suggests that the model of an intensive and integrated relationship based approach to case management has been effective in engaging clients over the longer-term and connecting them to the necessary supports to sustain their housing. In this chapter we document staff and management's reflections on the links between their practices and the client outcomes that have been observed over the trial, focusing on progress towards the intermediate goal of building self-reliance, healing and social inclusion and ultimately the longer-term impact of maintaining stability in mainstream structures. The J2SI outcomes reports (Johnson et al., 2011; 2012; 2014) have been tracking the broad outcomes of J2SI participants over the 3 year trial and will continue to follow outcomes for a further 12 months after the program has ceased. In this chapter we focus on the types of indicators that staff and management considered to be important 'shifts' in their client that have not been captured in the outcomes study. The chapter draws on a series of case study vignettes to illustrate how case management practices and service integration have contributed to observed outcomes over time. Whilst the findings are interpretative and based on the perceptions and meanings attributed by staff, their qualitative accounts provide additional insight into the types of intermediary outcomes that can expand upon observations in the outcomes study. These findings should be considered in tandem with the outcomes reports.

4.1 BUILDING SELF-RELIANCE, HEALING AND SOCIAL INCLUSION

> Healing and self-reliance will be observed in the acknowledgement that they no longer need a worker to help with day to day survival and coping. They will cope with life events and struggles without catastrophizing and allowing everything to crumble. The relationship based practices of the therapeutic response have afforded clients the space to try out and make advances towards these changes *[J2SI staff member]*.
>
> A shift occurs when they start to take responsibility for their life and becoming more in control and empowered, that is the preconditions – the soft outcomes that don't show in the hard outcomes but are critical in sustaining them *[J2SI management]*.

A core goal of case management within the J2SI program was to provide participants with the intensity of support that could assist them to begin to confront some of the deep seated traumas underpinning their experience of long-term homelessness and move towards greater stability, self-reliance and social inclusion. Whilst the longer-term outcomes of the trial are still being followed, the 36 month report (see Johnson et al., 2014[3]) revealed that many participants had made progress towards these goals by the end of the trial, particularly with respect to housing. There were also noted improvements in emotional health including depression, stress and anxiety as well as physical health. The use of more costly emergency physical and mental health services as well as the duration of inpatient care reduced over the three year period. However, the report also identified that progress towards stability, recovery, and inclusion is a long and slow process that varies for each individual. In particular, there was less change in substance use and the extent to which J2SI participants felt connected and supported by the community beyond their support workers. Whilst there were many successes in obtaining employment, securing longer-term ongoing work has proven difficult for the majority of participants.

The most profound gains in moving towards self-reliance, healing and social inclusion were identified in terms of a reduction in self-limiting behaviours including acting out and self-sabotaging behaviour. Staff and management identified that one of the most fundamental changes they observed in their clients over the course of the three year trial was the shift in extreme behaviours that either threatened tenancies or made it difficult for them to be linked into necessary supports. Whilst some of the underlying difficulties for clients remained, and will remain in the longer-term, changes in interpersonal presentation of participants were often described in terms of intangible outcomes but ones that were believed to have hugely profound consequences for how they were able to relate to others and therefore remain in their housing and have their needs met in mainstream settings.

The shift in self-limiting behaviour was mainly believed to occur through staff role modelling more positive ways of relating to others and by not reinforcing previously learnt negative patterns of engaging. Some support staff described this growth in terms of developing a more mature way of relating to others, not being aggressive or acting inappropriately towards staff as well as learning how to reduce conflict with neighbours and housing officers. Helping clients to learn better ways of having their needs met is a significant outcome in and of itself and can be considered a vital first step for how the sector as a whole will be able to resolve long-term homelessness.

> Changing behaviour is incredibly hard and there are reasons why behaviours become entrenched…, it has been their way of surviving and getting the response they need from services – and it works for them so the behaviours continue. Some people will use confronting and intimidating behaviour to get attention and that has stopped when they present with their case managers through the use of appropriate boundaries, and reinforcing acceptable behaviour *[J2SI management]*.

The types of qualitative indicators that staff believed were important markers of change in their client's presentation towards a reduction in self-limiting behaviours included:

- Gaining an understanding of the limits of the support with less focus on 'I want' and 'I need' in the way the client relates in case management interactions.
- Clients showing acceptance of the relationship with less abuse and aggression directed at the case worker.
- The client not ringing all the time demanding to have their requests met instantly.
- Greater understanding of the source of behaviour and gaining acceptance for past behaviours.
- Better at communicating with other external services through modelling a more appropriate response.
- Being able to talk about painful issues and reporting feeling worthy of being listened to.
- Being able to look back and reflect on where they have come from or developing insight into their experiences and behaviour.
- Developing more positive coping mechanisms to respond to daily stressors and setbacks.
- The client recognising that they do not need this service any more.

> Some clients are constantly on the go and trying to numb a sense of self through drugs and medications – they are always doing something so they don't have time to stop and reflect – in their mind they are always on a mission *[J2SI staff member]*.
>
> Most clients are survivors and so are self-reliant in their own space but they have difficulty in being self-reliant in a mainstream sense in those structures of paying bills etc. They are survivors of their own space. Some can drive and get themselves around but they straddle the trench – there are still all these distractions in their lives *[J2SI staff member]*.

[3] Progress on longer-term outcomes will be documented at the 48th month mark corresponding with one year after the program has ceased.

There was a view by staff that many clients have not fully worked through the depth of their trauma. While some have been able to confront past experiences, especially those who have been actively engaged in therapy, for many, the past is too painful to 'work through' and some remain caught up in the 'chaos of the present'. This sentiment from staff is reinforced in the outcomes data, which shows that changes in enduring issues including drug misuse have been difficult to resolve.

There was a view by staff that some clients are only now ready to start to work through past traumas three years into the program and at the point where it was close to ending. In contrast there are others who are ready to move on from having support workers in their lives and who want to regain greater independence and take responsibility for their day to day living. A further group that staff identified were those who are likely to need practical and emotional support in a more ongoing way or even access to permanent support in some capacity or another.

Staff reported that those who continued to misuse substances, or who remained in a pre-contemplative state in the stage of change (Prochaska et al., 1992), were not ready to "take the journey far and stuck in the behaviour and patterns that they identify as needing". Age was considered an important factor in how clients were able to progress towards a significant change in their life style, particularly with respect to problematic substance misuse. Older clients were more prepared to make the break from their past networks and former lifestyle. Building self-reliance and healing is thus a fundamentally individual journey that does not have a set time sequence nor necessary predictability. This raises significant implications for how outcomes for services targeting those with experience of long-term homelessness can and should be measured.

It is incredibly difficult to overcome the feeling of being different from others. Some have dropped out of courses because of this but still want to give it a go. Despite the difficulties many have persevered and gone on to complete the courses, which is an incredible achievement! For many, it has been the first time in their lives that they've ever attempted something like this *[J2SI Staff member]*.

While there has been strong interest in being involved in the program there are still significant barriers for clients around issues of mental health and histories of criminal records. It is incredibly hard to place people in work who have criminal records and the majority of the clients who have accessed the programs have a strong long/ extensive history of offences. The program has had to seek out employers who are prepared to give the clients a go following police checks *[J2SI staff member]*.

Support staff reported that social inclusion has remained a fundamental challenge for the majority of clients. The greatest gains towards this goal have been for those who have been able to work or link into sporting or other voluntary activities. The increased income for those gaining employment was considered a significant boost to esteem and enabled clients to engage in more activities that interested them, such as going to the football. The capacity for clients to move towards this goal was also considered dependent on the life they had before becoming homeless. Those with more recent and longer experiences of being attached to 'mainstream' structures 'wanted this life back'. For others who have had protracted experiences of disadvantage from a young age or who had significant mental health issues, the observed gains towards the goal of social inclusion are more subtle. There was a view amongst some staff that their clients have continued to want to maintain connections with their former life – the friendships and routines that they know – and it is incredibly difficult to break this cycle and exist in a 'new space' because old networks provide structure to their lives. Qualitative feedback from staff revealed the inherent difficulties of undoing years of trauma and disadvantage and the emotional importance of existing networks. These insights raise important implications for future service delivery about how to work within existing relationships whilst at the same time orienting clients towards new opportunities.

Social inclusion is one of the hardest things to address – many still sit outside and there is a strong pull back to their known world. Some people feel so visible in the community and that makes them feel really isolated – it is easier to retreat to older circles *[J2SI staff member]*.

Many have no friends – one client graduated from a course and said it would be good if I had some friends and not just workers to see this *[J2SI staff member]*.

Staff reported that the evidence of moving towards the skills that can foster greater inclusion can be seen "in the little things that for the client represent a major cultural shift". Examples included taking greater responsibility for their own actions, keeping appointments, paying for bills and understanding the value of money, graduating from always wanting to eat out at McDonalds to feeling more comfortable in a coffee shop, or no longer wanting to eat their meals at the Mission rather going out or cooking for themselves in their own home. The capacity to use public transport on their own was considered a fundamental leap forward for some clients who had anxieties about travelling independently. Others were able to move towards social inclusion in many areas of their lives and no longer needed support.

The three case studies presented below highlight the successes and the challenges that staff sought to overcome in assisting their clients to remain in their housing whilst also working towards self-reliance, healing and inclusion. The case study of Maddie, in the excerpt below, reveals the practises and intensity of support required to move her through intense anxieties around her health, gaining self-awareness of her defences in response to feelings of isolation and loneliness, overcoming fears of using public transport on her own and developing a self-belief in her ability to cope and take greater control of her own future. Maddie's story also reveals the underlying complexity of presenting conditions that can only be uncovered over an extended period of engagement built upon a trusting therapeutic case management relationship. Providing a safe space and devoting the time that Maddie needed to work through her fears by building on small successes at a pace she was comfortable with was critical to her gaining greater self-belief and independence.

J2SI began working with Maddie in November 2009 and she moved into public housing in early 2010. Maddie has complex health and mental health conditions. She has a history of long-term homelessness that is largely due to repeated experiences of extreme physical and sexual violence. Maddie experienced anxiety on a daily basis which was exacerbated by social isolation and her feelings of loneliness.

The focus of the work has been on assisting Maddie to build self-reliance to overcome her intense anxiety that would often manifest in physical symptoms. The key to assisting Maddie move through her intense anxiety was building a relationship in which she felt safe and connected. The caseworker listened to her without judgment and transported her to weekly appointments with doctors, specialists and with her therapist. Over time, Maddie's physical complaints lessened and in times of high stress she began to identify what was going on for her. The memory of this period became a useful tool for reflection that assisted Maddie to build a sense of self-awareness.

During the second year of the program the caseworker began to consistently encourage Maddie to do the things she said she couldn't and challenge her negative self-talk. The caseworker offered a combination of practical and emotional support to encourage her independence. The caseworker expressed belief in Maddie when she expressed little belief in herself. The caseworker started to attend appointments with Maddie on public transport before slowly withdrawing this practical support. Withdrawal of practical support was a long and at times painful process for Maddie. Firstly, the caseworker did not tell Maddie when they arrived at her tram stop to demonstrate that Maddie did know where the correct stop was. The caseworker then started to meet Maddie at the doctor's surgery so that she completed the first part of the journey on her own. Eventually the caseworker didn't meet her at all and Maddie independently managed transport and doctors appointments. The caseworker continued to provide emotional support via phone calls afterwards. During this process, the caseworker provided positive encouragement and consistently focused on Maddie's strengths.

In the third year of the program Maddie began to internalise the self-belief the caseworker had been holding for her. She started to say "I believe I can do this". Her new found confidence has had a flow on effect to other aspects of her life. For example Maddie is now taking steps towards slowly reducing her methadone dose after being on the program for ten years and is working with the BUDS worker towards voluntary work.

Ellen's story illustrates the cumulative gains that can be made when all of the elements of an integrated program come together. Ellen's story also reveals the personal courage required to embark on further training and confront her underlying trauma in a therapeutic setting. The role of the case worker has been to provide a point of reference and safety that has incrementally built Ellen's confidence to confront new challenges and allow her to move towards greater self-reliance moving on from the need for case management and feeling ready to engage in therapy.

Ellen has resided in her current Office of Housing flat for over 18 months, which is the longest period of maintaining housing since her youth. As in most of her past tenancies, Ellen's tenancies became threatened due to her vulnerability to exploitative and abusive relationships. While Ellen is often tempted to leave her property to get away from this issue, she has worked extremely hard to reflect upon her role in this ongoing pattern and how she can combat it to maintain her home rather than running away from the problem. To assist Ellen to maintain her housing, discussions with her caseworker have included: reflections on the function of these relationships, flagging people who may be unsafe, identifying ways she can protect herself and identifying the times when she is more vulnerable. Discussions have also included the role of domestic violence in her life, self-confidence, self-worth, identity, and grief and loss. Through this process, Ellen's confidence and capacity for self-reliance has grown, and she has begun the process of healing, which has assisted her to reduce some of the patterns which have historically contributed to her transience.

In 2012, Ellen completed Levels 1 and 2 Certificate based courses through the help of the BUDS program. Ellen has stated that she has never completed anything before J2SI, and that the ending of J2SI prompted her to gain formal qualifications. The caseworker and the BUDS Coordinator were able to discuss the difficulties that Ellen had experienced in completing formal training and provided emotional support and encouragement to build up her low confidence. The BUDS Coordinator was able to help Ellen with her homework to practically assist her to complete the courses. Ellen was extremely proud of herself when she completed these certificates. Ellen is now looking forward to working with the BUDS Coordinator and MIFV Employment worker in regards to gaining employment.

Ellen was highly dependent on case management support prior to J2SI, but has now decided that she does not need an ongoing support worker. Ellen has currently been linked with a J2SI therapist for several months, and is keen to continue this relationship post J2SI. Ellen has spoken of the difficulties in engaging with another person whilst still working with the case manager, and splitting behaviours have been evident. Ellen has however, been keen to develop a transparent rapport between herself, the case manager and the therapist, and thus many important insights about Ellen have been shared between the group. This has meant that many of the important reflections/learnings shared by Ellen with J2SI have been effectively passed onto her ongoing support.

In the 36 month outcomes report noticeable differences were revealed in the service use patterns among the J2SI and the control group (See Johnson et al., 2014). Specifically, those in the J2SI group reported a reduction in the use of crisis, emergency and unplanned services, particularly for mental health and other homelessness services. Moreover, it was found that when the J2SI group were admitted to general hospital or accessed health care settings they stayed for a shorter period of time.

In the focus group discussions staff identified several practices that are likely to underlie shorter stays in health care settings. Being able to provide flexible support meant that the J2SI team were able to become the crisis response. Staff also reported that they were able to provide a more coordinated crisis response because of the knowledge of the client's history. A key role of J2SI workers has been to ensure that clients are receiving the medication they need, reviewing and managing its use over time by linking clients into and accompanying them to appointments with the same medical practitioner has been critical in stabilising both physical and mental health conditions.

The capacity for staff to know the history of the clients, accompanying them to hospital when in need and being a part of the discharge planning were all considered critical in having their health care needs addressed more rapidly. Staff reported that through the process of case management support, clients have been able to start to self-identify the early signs of a decline in physical and mental health. When clients did seek specialist help, the process was able to be managed in a planned way rather than responding to crisis. This was a factor that staff believed assisted in the overall management and, potentially, in the duration of inpatient stays. Staff also believed that having a home to go to following discharge was central in decisions about the final length of inpatient stays.

The story of Donna in the excerpt below shows that despite significant childhood trauma and multiple support needs, she was not only stabilized in her housing, significantly reduced her use of costly hospital and psychiatric services but proceeded to complete a certificate II level course. Her success in completing the course was facilitated by a stable relationship with her case manager combined with intensive collaborative support with the BUDS coordinator. The story also highlights the extent of the exclusion faced by those within the J2SI program and the significant obstacles they need to overcome in their journey out of homelessness and towards greater social participation.

Donna has a long history of homelessness and of involvement with the service system. She has been a client of a number of intensive support programs and her money is managed by state trustees. She was placed in foster care at 13. From 1991 – Nov 2009 Donna had 45 psychiatric admissions. She has had three admissions since November 2009 and the last admission was over one year ago. Donna is currently on a CTO and is case managed by a psychiatric outreach team. Donna has been on the methadone maintenance program for nine years and continues to smoke cannabis on a daily basis and occasionally uses amphetamines. Donna has undergone drug and alcohol treatment regimes in the past including residential withdrawal programs & individual counselling. Donna has significant chronic health issues including liver dysfunction (Hep C), pelvic inflammatory disease, and chronic obstructive pulmonary disease.

Donna engages in street based sex work. Although she is keen to stop engaging in street based sex work her identity is very much entwined in this. She has very limited social networks and often describes herself as isolated and lonely. Donna's friendships are often intense and short lived, she then feels unsafe that these people know where she lives and fears that they will enter her house and contaminate her food.

Despite the complexity of her needs, ongoing struggle to stay well and chaotic housing history in the past, Donna has sustained her OoH property since April 2010. She has developed and maintains a garden and is caring for her pet cat. Through the stability of the relationship with her support worker Donna now has greater ability to identify patterns of behaviour and is willing to engage in dialogue about these patterns and the repercussions of her actions. Donna is keen to work towards changing her behaviours particularly "acting out" behaviour. There has been a marked decrease in "acting out behaviour" since commencing support. She has developed appropriate boundaries within the relationship. With intensive case management and skill building support from her case manager and the BUDS coordinator Donna has gone onto complete a certificate II level training whilst in the J2SI program. There has also been a marked reduction in psychiatric hospital admissions since commencing the program.

Daniel's story highlights the flexibility of the J2SI model to follow him into prison and provide a vital source of support upon release. This flexibility ultimately prevented a return to street homelessness. At the same time, it shows the revolving door of drug treatment and difficulties adjusting to a new housing environment combined with volatile relationships and the barriers he faced in finding and engaging in ongoing work that perpetually placed his housing at risk. A range of services involved in Daniel's post release settlement, were coordinated through the relationship with his J2SI case worker and as a result he has been able to become more stable in the community – but his journey towards greater social inclusion still continues.

When J2SI began working with Daniel he was sleeping rough. J2SI was able to engage and develop a relationship with Daniel by providing him with practical assistance, specifically in the form of housing support and linking him with a drug and alcohol worker. In early 2010 Daniel was arrested and remanded in custody. J2SI continued to engage with Daniel during his period of incarceration, this was achieved by carrying out regular visits to the prison, and developing a relationship based on trust and consistency. As Daniel was no longer in contact with his family J2SI served as his only link to the community.

While in custody Daniel engaged with a number of prison based programs including; a drug and alcohol support program and further education. Prior to Daniel's release J2SI developed a post release support plan. This included resubmitting Daniel's segment 1 Office of Housing (OoH) application and negotiating housing options with a Community Housing service. Additionally both the Building up and Developing Skills (BUDS) Coordinator and Mental Illness Fellowship Victoria (MIFV) worker met with Daniel while he was incarcerated and began looking at training and employment options.

When Daniel was released on parole J2SI helped him to gain community housing. J2SI worked closely with Daniel to ensure that he was able to engage in meaningful use of his time. J2SI funded a sports club membership, provided transport to his parole appointments and MIFV assisted him to complete a resume and begin looking for paid employment. Daniel was offered permanent housing via the OoH in September 2011. J2SI supported Daniel to develop an attachment to his property by assisting him to purchase furniture and household items. Daniel was very happy with his property offer as it was a spot purchase in a nice suburb away from his old networks. Daniel was assisted by MIFV to attend a job interview, this included; purchasing appropriate clothing, providing transport and pre and post interview support, unfortunately he did not obtain employment as a result of this interview. During this period Daniel was non compliant with his parole and was ordered D&A counselling and community work. This resulted in him being served with a breach and being re-referred to D&A counselling. Although he attended these mandated sessions he was not fully engaged in the process.

Daniel's lifestyle and drug use became quite chaotic with increased police presence. A number of complaints were made to the OoH which put his tenancy at risk. During this period Daniel was charged with theft and issued with an intervention order. He was granted bail and required to sign on at the local police station. At that time he disclosed that in addition to regular methamphetamine use he was also using heroin. J2SI assisted Daniel to engage with a D&A service and commence pharmacotherapy treatment. J2SI funded this treatment for a six week period to ensure that he reached a therapeutic dose.

In early 2012 the OoH applied for a compliance order via Victorian Civil and Administrative Tribunal (VCAT) due to ongoing neighborhood issues. Although Daniel did not attend the hearing J2SI was able to advocate on his behalf. He was issued with a three month compliance order. Shortly after the hearing Daniel's relationship ended, he requested assistance to address his substance misuse issues and to ensure that he maintained his housing. J2SI followed up with referrals for residential withdrawal and D&A outreach program for ongoing support. Although attending an initial appointment with ISCHS Daniel did not engage with this service. He did however enter a residential withdrawal facility in mid 2012 and participated in that program for three and a half days. Daniel has expressed an interest in being re referred for residential withdrawal and a residential rehabilitation program. Daniel has yet to follow up on these options.

Despite his continued chaotic lifestyle Daniel has managed to maintain a strong relationship with J2SI, his housing and continue pharmacotherapy treatment. Daniel continues to participate in dialogue about engaging in further drug and alcohol treatment. Daniel has independently managed to obtain a few days casual employment. In August 2012 Daniel celebrated his one year anniversary of being released from custody. He reports that in the last seven years this is the longest period of time he has managed to remain in the community.

4.2 LONG-TERM STABILITY IN MAINSTREAM STRUCTURES

The final 48 months outcomes report will determine the extent to which participants have been able to maintain longer-term stability in housing and increased economic and social participation beyond the J2SI program. It will also determine whether the gains in physical and mental health can be sustained over time. This section examines staff and management reflections on the foundations that have been built towards this goal and the potential obstacles that participants will need to overcome.

Long-term stability in permanent housing for the majority of participants is the strongest indicator of success of the program. Staff attributed their success in sustaining housing throughout the program to the proactive management of tenancies based on strong collaborative partnerships with housing providers. Through the case management relationship support staff were able to provide a mediation and advocacy role between the housing provider and client when tenancy issues arose. The capacity for long-term tenancy management was considered critical in preventing clients from sliding back into homelessness. When tenancies were at risk or fell down, staff were able to respond quickly to find alternative accommodation thus avoiding a return to homelessness.

Staff feedback revealed that the capacity to provide ongoing outreach to housing beyond the life of the program will be critical in ensuring that participant housing is maintained in the longer-term. While the program has laid down the foundation for greater independence and self-reliance, the needs for some were reported to be so high, particularly those with chronic physical and mental health conditions, that they will require ongoing support to monitor their tenancies. Stabilising mental health was considered critical in being able to stabilise housing. Likewise mental health was more likely to become better stabilised once housing was in place. External stakeholders, including mental health practitioners, considered this to be a key role of where the J2SI model added to the service system.

> It is very difficult to house in spot purchase…. It can set that person up to fail because they don't fit in with the expectations of the neighbourhood. Some are not ready for the quiet retiring life style. But at the same time not liking the high density housing either *[J2SI staff member]*.
>
> The outreach and intensive support model has meant that my client who is intellectually disabled and illiterate has been able to maintain his housing. Prior to J2SI involvement this person was constantly being evicted due to his inability to respond to issues with his tenancy *[J2SI staff member]*.

Staff reported the ongoing tension they faced with the right to self-determination versus the need for ongoing intervention and assessment of whether the client was able to manage their housing. The capacity for participants to cope with the responsibilities for housing varied at different times depending on how well they were functioning. There was a view that support workers have been propping up housing and that staff need to always be mindful of not creating a dependency by ensuring that the role of support strives to constantly reinforce personal responsibility for managing housing. However, the need for support staff to keep a check on arrears, tenancy issues, concerns with neighbours, particularly in spot purchased properties, persisted to the end of the program. Staff identified a small group that have and will in the future lose their housing no matter what supports are put around them. This included examples of clients who did not feel they could cope in housing on their own and who sought to return to a rooming housing structure to overcome feelings of isolation and pressures associated with the full responsibility for the house.

Being able to support clients in their home is not just a housing issue or support but has built skills and modelling for the clients to maintain a home that was previously out of their reach. Feedback from OoH and psychiatric supports has been positive and the relationships for the last 3 years has helped to provide and in some cases change their opinions of the clients trauma not being a 'problem' person but a valued human *[J2SI staff member]*.

The workers role has been to discover why keeping a home is difficult. So the worker's role is to provide the mechanisms or the tools "here this is what you do", which then helps the client to resolve the issue the next time round *[J2SI staff member]*.

It is an ongoing process with clients managing the housing is always there *[J2SI staff member]*.

Developing an attachment to the house 'as a home' was considered a critical marker for whether housing would be able to be maintained in the longer-term. Those who had made this shift towards viewing their house as a 'home' were more prepared to try and save their housing by keeping on top of bills and daily maintenance. Older clients were reported to be more willing to settle into their housing and make it their home. For some younger clients the 'pull of the homeless' subculture was more alluring. There was also a view that several clients did not like the housing or the area they have been placed in, which is likely to affect stability down the track. Staff reported that some clients have needed to experience different types of housing before they could settle and gain a sense of attachment to their house as a home. Staff also reported that some clients had a high sense of entitlement to be transferred to different housing when things were not working out for them – an issue that required careful management. Housing choice thus remains fundamental to ongoing housing retention and reinforces the importance of being able to access a range of different types of accommodation.

The story of Michael reveals that through the support of his case worker he was able to realise his full goals of finding housing, employment and competing in a triathlon before moving onto full independence. Michael's story reveals the importance of persistence and being present without judgement in order to build a trusting case management relationship. The capacity for flexible and less conventional means of providing support through the joint participation in recreational activities was central to being able to effectively engage Michael.

When Michael was referred to J2SI he was sleeping rough and without income as he is ineligible for Centrelink. Over the first six to twelve months Michael was very difficult to engage. Our initial meetings would only last for 5 minutes and it was clear that it was not working. We needed to try something different, so we started a volunteering activity together, which we participated in consistently every Friday for over 6 months. Michael eventually would share a sentence every now and then, and a sentence would turn into a full conversation.

When a close person to him died he allowed me to support him. As the trust grew Michael started opening up and over the next eighteen months he slowly began to identify his goals. These were obtaining employment, housing and focusing on health and fitness. By Jan 2012, Michael had been working part-time for over 12 months and had moved into transitional housing, participated in regular fitness activities and lost weight. His final goal was to participate in a Triathlon in January 2012 but was having difficulties committing to this goal as he struggled with self-belief, low confidence and doubt in his level of fitness to be able to compete in this Triathlon. To help motivate Michael to achieve this goal I helped him by training with him. We established the routine of having in – depth challenging discussions while warming up for the training session. These conversations were crucial and had a significant impact on Michaels's values, beliefs and views. For instance, through conversation and experience he now understands the value of money and the value of housing. He knows he needs to work to get money and to pay rent.

Michael felt that the triathlon was a journey in itself and represented the whole J2SI Journey. Michael stated that he won't continue with J2SI until the end of the program and that he thought to see it through until mid March 2012. Michael showed great insight into why he was leaving the program, that he no longer needed support and that he wanted to practice his independence. As there were still several months until the program would officially end I offered to write Michael a letter once a month, to keep the door open in case he needed some support. Michael responded very strongly to this, explaining that March was it for him.

Due to the complex issues many long-term homeless people face, the J2SI model will make a difference as it is not just finding a house that is the issue, continuance of tenancy and the ability to manage a tenancy is just as important and the J2SI model has the capacity to assist here *[External stakeholder]*.

Office of housing – We have succeeded in sustaining up to 16 tenancies supported by the J2SI program. This contains the success of the program *[External stakeholder]*.

While the majority of J2SI participants have retained their housing, there were some who found it difficult to hold down their tenancies despite the support that was offered to them or different types of housing arrangements. Helen's story below reveals the extent of the challenges associated with assisting clients who remained substance dependent and highly embedded in the homelessness sub culture towards significant change and growth. It reinforces the potential limits of the support process in facilitating wide reaching change when the client is unable or not ready to commit to a process of change. In this instance, steps forward in the case management process have been slow and at times frustrating. Working within a harm minimization framework has been critical in keeping Helen engaged in the process of support that has aimed to build on small but incremental successes. While Helen has not reached the point of living within mainstream structures she has been stabilized in the local system of support that continues to provide a point of safety for her amongst the daily chaos.

Helen was unable to maintain her public housing beyond 12 months because of continued substance misuse and vulnerability to the influence of older males. Helen was linked to a therapist but was only able to commit to a couple of sessions. Her drug use holds her back but at another level has also kept her afloat and given her some purpose and focus. She sees that she has been “on her own” since leaving home in her teens. In fact she has been reliant on herself, her wits, her extremely good luck, her youth and her resilience to get her through to date. She has had ongoing trauma as a result of the violent relationships and her dependence on males to provide stability for her.

The external support services (The Sacred Heart Mission, The Women’s House, J2SI and The Salvation Army Crisis Contact Centre) give her a sense of stability and anchor her. The relationship she has formed with the J2SI Team functions to keep her safe by offering and modelling consistency, reliability and honesty. Helen no longer acts inappropriately in her dealings with J2SI as she realizes that we will not buy into this behaviour and we have modelled the importance of an authentic and honest relationship to her. We have modelled consistency in response to Helen and this has helped her mature.

It is difficult to know whether Helen has benefited therapeutically from the J2SI relationship or what she has taken from this. She is very well defended emotionally and has great difficulty talking about her feelings. She can easily act out her behaviours but not talk about feelings. We have tried to get her to talk about how she feels and to put words to her pain. She can only do this in little bits but even this has been a huge breakthrough in terms of her healing.

Helen will continue to be part of the homeless service system. She is not at the point of being included into more mainstream structures but is becoming slightly more stable within this system. Her resilience gets her through but she continues to place herself at risk and be at risk through her “street” associations and “street drug use”.

The BUDS and MIFV programs were an important channel for building capacity to increase economic and social participation in employment and social engagement beyond the homeless support system and to build social connections beyond established networks. The role of BUDS and MIFV has been to build up the confidence of each individual to help them address feelings and to persist with their goals by focusing on and building upon small successes. As documented in more detail in the first process evaluation report (Parkinson, 2012), the two programs were able to build on small success because they had the capacity to work so intensively and to try different alternatives when the first attempts at placement did not work out. This individualised approach is consistent with the IPS employment support model. Despite the many successes within the BUDS and MIFV components of the program, J2SI participants continued to face significant barriers in accessing both training and employment opportunities. Reported barriers related to feelings of inadequacy and being ‘judged’ when they entered into mainstream training and employment settings. Records of prior convictions proved to be a significant obstacle in gaining access to mainstream or ‘competitive’ employment for many clients.

The case study of Patrick reveals that the goal of employment can be realised despite an ongoing struggle with mental illness. Patrick’s success in obtaining and maintaining his employment was facilitated by a staged process beginning with intensive support that was incrementally wound back as he became more independent and stable in his workplace. Patrick’s story also illustrates that it may often take a few attempts at different roles before a suitable job match is found and to not give up on the first attempt.

Patrick has a long history of instability that includes a succession of tenancy breakdowns, moving from one rooming house to another, voluntary and involuntary stays in psychiatric services. In addition to noncompliance with his psychiatric medication and a transient lifestyle, Patrick also has a history of illicit drug use and gambling. Patrick has a long history with mental health services going back to his late teens. His records show that he has been admitted on 32 occasions.

When he was referred to J2SI Patrick had little insight into his illness. Throughout the last 3 years the J2SI program has created the space for Patrick to find himself, adjust to a different way of living and thinking and created safe boundaries around him that he has agreed to. The relationship building with Patrick started with linking him into social activities, golf, bike riding, tennis and support to maintain his home – a newly established tenancy in supportive housing. Each activity required Patrick to concentrate and learn new skills. Patrick's stamina and verbal capacity was limited at the beginning and he found it hard to be motivated and to interact appropriately with others. It was also noted that during the first year Patrick would sleep a lot and complain that he felt tired. He would also opt out of activities half way through.

Patrick early on had a drive to find employment and was referred to the employment consultant. The first job he found did not work out as it quickly became clear that it was too much for Patrick to handle – especially unsupervised. Consequently the employment consultant worked with Patrick to secure supported employment at an organisation that employs and supports people who have a diagnosed mental health condition. Patrick has been working there two days a week for over two years. Initially Patrick was assisted with transport and wake up calls but he now takes full responsibility for his employment. He is a valued employee and loves his work.

Patrick maintained his tenancy in supportive housing for over two years but the tenancy was often at risk as he was unable to comply with the no smoking house rule. J2SI worked collaboratively with the tenancy manager and, over a period of nine months, Patrick was able to significantly reduce his smoking and the associated room damage. Despite a significant reduction it was clear, however, that the tenancy would remain at risk so J2SI worked with Patrick to find an alternative supportive housing facility where smoking is allowed. Patrick has moved in and is happy in his new property.

At the end of 2011 Patrick was transferred from the Mobile Support and Treatment Services to the Continuing Care Team. Patrick was also transferred to oral medication. Over a long period Patrick has been able to explain what his mental health means to him and started to develop his own phrases such as "my Schizophrenia", "my vertigo", "scattered thoughts", "my disability". Patrick has been able to attach these words to how he is feeling, especially when he is unwell at golf or work. This has been a big change as it meant that the subject of his mental illness can be discussed and over the last year he has shown more insight, been able to speak to others about his diagnosis and what it means to him. He is also able to see the signs before they become acute and has developed a number of strategies to help manage them.

The social and work activities have created a focal point where Patrick has been able to develop his communication skills (especially around his mental health), mental and physical stamina and responsibility. Work has been an essential element in Patrick's rehabilitation combined with the case management. Patrick has expressed that he likes his life and wants to make it work for him.

Two meetings with Patrick's mother capture the changes in him.

– "This is the best I have seen Patrick since he was 17."

– "It's like my son is back for the first time since he was a teenager, he is now helpful, considers others and you can have a conversation with him."

5. BUILDING ON THE LESSONS LEARNED FROM J2SI IN ENDING LONG-TERM HOMELESSNESS

J2SI has shown that a long-term, intensive relationship based model is key to making a difference to long-term homelessness and shows that the service system should focus on this. Short-term support and crisis intervention will never change homelessness for individuals who have been in the system for years. The strength of the model is that it got beyond the big ticket items of housing and was able to address the depth of issues *[J2SI Management]*.

The service data, combined with feedback and case studies from staff, management and partner agencies, illustrate the practices that have helped clients maintain their housing and move towards addressing the underlying causes of their homelessness. It is clear that the J2SI program has made a significant impact on housing outcomes that exceeds those observed within the 'standard' approach to service delivery. At the same time, increasing social inclusion and overcoming trauma has remained a fundamental challenge for many in the program. Whilst the initial aims of the program were ambitious, much has been learnt over the course of the trial about just how far formerly long-term homeless persons can move towards greater social inclusion and what this might represent for different clients. This final chapter identifies the key lessons learned and the implications for the replication of the J2SI model and future evaluations.

A critical lesson learned from the trial has been the uniqueness of each participant's journey, reinforcing the fundamental importance of support remaining focused on what is realistically achievable for each individual. However, the 'complexity' of the J2SI service response, comprising a myriad of services that all combine to produce observed and unobserved outcomes, poses a major challenge for the evaluation of practices and broader replication of the model across the sector. The difficulties associated with program replication and maintaining the fidelity of the original program elements for models aiming to end long-term homelessness is evident in the modifications made to Housing First approaches implemented in different settings (Johnson et al., 2012). However, the combined process/outcomes evaluation has identified that there are core elements within the J2SI model that, if implemented in other settings, would greatly enhance the service system response to ending long-term homelessness.

These include:

1. Ensuring that staff have access to a comprehensive training program and ongoing supervision that is trauma informed.

2. Providing intensive individualised support that can follow clients into different types of housing situations over the longer-term, which is a primary strength of the J2SI model.

3. Providing a service that the clients can trust is essential to maintaining longer term engagement and for reducing unnecessary service duplication.

4. The necessity of small caseloads that have sufficient flexibility to respond with greater or lesser intensity, depending on the stage of support, is vital to effective long-term engagement.

5. A strong governance structure that ensures accountability, transparency and a willingness to disclose both successes and failures is vital if the sector is to progress towards real change and ultimately make gains towards ending the cycle of long-term homelessness.

Despite the successes within the program, there have been many day to day challenges that staff and management reported throughout all stages of service delivery. These challenges can be broadly conceived of in terms of those that are organisational or program specific and those which are likely to be shared across the sector as a whole. Specific to J2SI, both staff and management reflected on the difficulties of the trial component of the program. Whilst increasing research rigor, there was a general perception that it introduced a degree of inflexibility to the model that would not normally occur in 'real life practice'. Strict adherence to the case loads and random assignment of clients into the program meant that the service did not openly select who was eligible. Nonetheless, the service took up the challenge in being able to provide a program to a broad group of people with experiences of long-term homelessness regardless of their presenting issues. Moreover, the program had to maintain the initial staff load and clients whether they were actively engaging in the service or not. Being under the microscope with such intensity also provided its own set of stresses for staff, particularly when clients were not progressing in a manner consistent with an outcomes focus.

Service staff and management reported that the model worked best when all the elements came together for the individual. However, despite the best efforts of staff, some participants were not at a stage where they were able to engage in all aspects of the program. Whilst this reinforces the importance of individual flexibility in the type of services on offer, it remains a challenge for how J2SI and other services configure the necessary services internally and externally to augment the central case management relationship in providing the right mix and intensity of services at any given point. It also suggests that the outcomes are not going to be uniform. As one staff member reflected 'people will only take the journey they are prepared to take'. Ensuring the right mix of supports across the various elements of the program was not an easy task and at times staff reported that there were tensions between broader therapeutic goals and more practical support. Some staff preferred a more therapeutic approach whilst others emphasised the need for support to remain practical thus creating divisions in professional practice at times. A clearer and consistent agreed upon framework with a set of standards for the role of therapeutic case management within a trauma informed approach that all staff work to will go some way in overcoming these practice tensions.

Some participants responded more favourably to being involved in the BUDS component of the program whilst others were not ready or able to pursue training and employment. It is vital that there be choice in the types of activities that clients engage in. This means that the worth of programs should be judged, not only on the individual client outcomes but also on process outcomes relating to how the service is delivered. For instance, does the model assist other services to provide a service to the client group? Is the support provided in a way that will foster the cultivation of a relationship with a case manager or broader service system? Is the service adequately resourced to deliver intensive and flexible support? Process outcomes cultivated through strong partnerships have been critical in sustaining housing and the importance of this in and of itself needs to be recognised.

5.1 THE NEED TO BUILD CAPACITY FOR LONG-TERM SUPPORT

Long-term case work requires a different set of skills to keep clients engaged and motivated whilst at the same time having the resources to prevent staff burnout or 'compassion fatigue'. Issues of vicarious trauma and 'parallel processing' amongst the staff need to be recognised and managed to ensure that staff are adequately supported to cope with extreme behaviours and past experiences of trauma that their clients present with.

Effective capacity building also requires staff and management to take a long-term view of positives and negatives and be reflective about their practice. This includes ensuring that the case management relationship is managed in a way that seeks to avoid creating a dependency with the client. To this end, the establishment of a dual worker role or introducing new workers in the support process when the client-worker relationship was not working, has been beneficial for some clients. Whilst the notion of a key worker remained central it was not always the preferred model of support by J2SI participants. Persisting with an experimental focus and pushing into new terrain has resulted in innovative practices to emerge with respect to building long-term relationships with individual workers and the service as a whole. For most part, the general and clinical supervision and training provided to staff has been highly effective in building their capacity to respond to the diversity of needs emerging throughout the three year period. An intensive program with more ongoing funding will require increased flexibility in the way training is delivered to cater for new staff coming into the program at different times.

5.2 ENTRENCHMENT OF DISADVANTAGE AND TRAUMA IS HARD TO UNDO

The process of engaging J2SI participants in the three year trial has provided Sacred Heart, and the sector more generally, with a greater sense of what change is realistic given the difficulties of achieving the goal of social inclusion more broadly and of undoing years of cumulative trauma. The trial has reinforced the need to develop a greater understanding of what progress should and could look like for the client group at different stages of their lives. This has implications for the types of outcomes that services are expected to achieve and what might be considered valuable outcomes in future models, an issue that housing first models in the US have also had to grapple with (Kertesz et al., 2009, Kertesz & Weiner, 2009). For instance, some clients will need ongoing support to fully move into independent structures whilst others will be able to progress to a state of complete independence and become integrated into mainstream structures. Future service models need to be sufficiently flexible to move people through the process of support across different time periods. Assessment of a program's overall success or 'worth' has to be based on what best possible outcomes can be attained for the client's quality of life given the complexity of their needs, readiness and capacity to move through a process of change and growth.

The history and profile of the J2SI participants, particularly with respect to criminal records remained a significant challenge for the BUDS and MIFV component of the program in being able to place participants in suitable jobs. The program and others that follow will have to overcome significant hurdles in this respect. In many instances the J2SI program has been successful for some individuals but such outcomes (universally) will be difficult to obtain because a program cannot undo the structural constraints that impede access to training and work, the quality of employment available and the security of working conditions in contemporary labour markets. A considerable amount of effort is required to help those with experience of long-term homelessness to be accepted and feel accepted in the workplace and other mainstream training settings. Moreover, some have not been ready to make the necessary changes. The move away from old networks can be extremely isolating and perhaps counter to ideas of social inclusion. The recognition that you can fix the housing but can't do anything about the loneliness weighed heavy on staff morale and served to undermine their efforts to foster change at times. Understanding how to reconcile this issue remains a fundamental challenge for the sector as a whole.

> We need to think through the whole social network issue and how we develop that as a part of the long-term strategy. We really need to understand more about the point of separation from the homeless sub culture. In some respects I think the bar was set a little too high in respect of addressing social exclusion, how far people could move out of that space. The cycle will be forever hard to break for significant and complex mental health issues. The system is failing those people. Something else is needed so it doesn't all have to break down before they can get the treatment they need. *[J2SI management]*.
>
> The client has long term complex issues. He remains chaotic despite the best efforts of his J2SI worker. *[External provider]*.
>
> Time and readiness are the challenges. Are the clients ready to let go, is the attachment too strong/weak. Have we created dependency thus leading to abandonment? Are the clients ready to go it alone? Will they ever be ready, is three years long enough? *[J2SI staff member]*.

5.3 THE NEED FOR FURTHER SERVICE INTEGRATION

The J2SI program has been effective in creating strong working inter-agency partnerships from the level of governance structures through to direct service delivery. However, service integration remains a fundamental challenge beyond the J2SI program. Service integration encompasses how an intensive model sits alongside shorter-term crisis work within the internal organisational structure as well as the ongoing engagement of specialist agencies in addressing case plan goals. This raises the perennial question of the optimal service configuration to promote service integration. Assertive Community Treatment has been promoted as one potential model for integrating support however, the broader implementation of ACT models pose their own set of difficulties. There needs to be much greater recognition of service integration at the level of funding to bring different service providers together with a common client and purpose. The working relationships cultivated with housing providers have proven to be highly effective. Similar partnerships could be further strengthened through the areas of drug treatment services and mental health. Staff reported that the generalist focus of the model was a core strength and that there needed to be greater recognition of how

this approach can sit alongside specialist services. The need for a more streamlined process to access detox and drug and alcohol, direct psychiatric secondary consultation, and medical support was considered vital in sustaining tenancies.

A trauma informed approach to service delivery was considered essential in being able to effectively engage individuals with experience of long-term homelessness. The take up of therapy was typically low amongst this client group. Access to therapy should be considered a voluntary component through a more flexible funding pool that enables clients to access different types of interventions and programs as needed and requested. Access to clinical supervision for case management staff was considered a significant component in being able to continue to work with participants in a trauma informed way by assisting staff to better understand how to respond to their clients and manage the relationship over the longer term. Future models engaging those with experience of long-term homelessness would be significantly enhanced through a structured and ongoing clinical component including case conferencing and group supervision that provides a forum for training and reflection for case managers to be equipped to respond to complex trauma.

5.4 STRENGTHENING THE LINKS BETWEEN PERMANENT HOUSING AND LONG-TERM SUPPORT

> Firstly, you need to get good solid outcomes around housing and health and then have a system around how they can access specialist services when they have to. Clients need to get to a point of stability, stabilising, and then equipping them with the skills about how to manage crisis – to know the signs of when things are unravelling and be able to act on these crises promptly. Be more aware of the signs of crisis so it doesn't get to the point where everything breaks down again. The goal of support should be to build resilience so they can break the pattern themselves and then build a spider web of support around them. It is critical to work in the beginning with the end in mind. Moreover, clients still need to have a sense that they have somewhere to go when things go wrong and not get into a mess again. It is really hard to break the behavioural cycles that keep contributing to crisis amongst the long-term homeless. And it is difficult for them to get out until they can learn to do that *[J2SI management]*.

The J2SI model demonstrated that for most, housing can be sustained over the longer-term. More rapid access to housing must be the primary goal in breaking the cycle of long-term homelessness. However, access to affordable housing remains the primary challenge in replicating a model such as J2SI. There needs to be a flexible range of housing stock and ultimately choice in the type of housing provided and its location. The private rental sector in most part does not guarantee that housing will remain affordable and remains a problematic tenure offering very little longer-term security for those whose needs remain high. The strength of the J2SI model is that it is able to provide support and follow clients through different living arrangements rather than being tied to a single site specific or congregate housing model. However, this relies on strong partnerships and good will of housing providers to share the same goals of support. The relationships developed with housing providers and the collaborative approaches to tenancy management clearly prevented at risk tenancies from breaking down and provided the means to minimise the impact for those who could not remain in their housing.

The links between housing and support need to be further formalised through recognised funding models for collaborative tenancy management. Moreover, there was a view that crisis support staff need to increase their focus on segment one applications for Office of Housing properties and other community housing programs. There was a strong view amongst staff and management within the J2SI program that the capacity to continue to support people in their own home needs to be flexible. Some will require two years whilst others may need to have ongoing support to be able to live in mainstream housing. Moreover, the intensity of this support will vary over time with some suggesting that a step up step down type of approach to supportive housing could be beneficial. At which point the homeless support system steps out and other agencies step in to provide this care needs to be clarified recognising the strengths of what different sectors bring in the resettlement process.

5.5 SMALL CASE-LOADS WITH FLEXIBILITY

The need for an intensive response based on low caseloads was considered paramount to being able to effectively engage and respond to the needs of the long-term homeless. However, there was a general consensus across staff and management that there should be greater flexibility within the maximum number who were supported at any given time. The optimal caseload was considered to be 1:6 depending on the stage of support. Over the course of the program, the key worker model developed into dual worker or team approach providing back up for the primary workers. Some J2SI participants reported preferring more than one worker whilst others felt more comfortable with a single worker. Clients of intensive supportive models also need to have a relationship with the broader organisation so that they have a way back into support if needed. Building a relationship with the organisation was generally done well through group case conferencing, drop in support, and the duty system. The option of changing workers half way through the case plan was proposed as one way of preventing negative patterns from forming and to prevent staff burnout. There was a strong view that the case management relationship needs to be responsive to the preferences of clients with management being supportive of different approaches as needed. The duration of case management also needed to be flexible depending on the client's progress and willingness to continue to engage in support however there was a strong view amongst staff and management consulted that support should not be less than two years to allow the time to resettle and develop capacity to manage housing independently.

5.6 SERVICE ELIGIBILITY REMAINING FOCUSED ON LONG-TERM HOMELESSNESS

Staff and management generally considered that to break the cycle of long-term homelessness the sector needs to continue to strive towards engaging the most vulnerable and high needs clients. It was considered critical to leave the eligibility criteria open to those who have experienced long-term homelessness because the full extent of needs and trauma only become apparent through the support process. Thus long-term homelessness in and of itself signifies the need for more intensive forms of support to stabilise housing. There was a view that an important source of referral and service continuity could follow on from where the Intensive Case Management Initiative (ICMI) ends at six months of support. A model such as J2SI can intervene to stabilise and maintain housing then step down to an intensive home based outreach service. It was also expressed by staff and management that participation in the program has to be voluntary – clients have to want to take part in the process of support. Staff expressed that age was a key determinant in how the client wanted to engage in the program and move on from former networks and create new opportunities. There was a view amongst staff consulted that the ability to offer distinct adult and youth streams within the program could help to better tailor case plans towards age consistent goals.

5.7 BUILDING NEW SKILLS AND OPPORTUNITIES FOR A DIFFERENT FUTURE

The process of support must be directed towards creating opportunities that help to build a new future through employment placement support, training, and personal skill development initiatives. What is needed and possible will be different for each client but a strengths based approach that builds on existing skills and interests was considered the foundational starting point. Consistent with the current evidence based approach within the IPS model, employment and skills training elements need to be built into the support process from the very beginning. Moreover, the employment component must continue beyond support so that clients have a way of continuing to build on the gains achieved through their individual case management. Employment support must be delivered in a manner that is also intensive with low case loads. This will allow services to devote the time required in preparing their clients to re-enter mainstream training and employment settings, foster relationships with training providers and employers and have the capacity to provide one to one tutoring within the program such as assisting with computer skills. Moreover, partnerships need to be developed with social employment enterprises that are more supportive of the histories of the clients.

We see the best results when clients are engaged in both work and training at the same time because it helps build a greater sense of self-worth that they can be earning some money at the same time as building up skills in something that they are interested in pursuing. Training needs pathways into employment etc to make it relevant and something to work toward. It might take clients a few go's until they find what fits best for them but each experience helps build confidence and new skills and is seen as a positive step forward rather than a failure when it doesn't work *[J2SI staff member]*.

Training and employment is used as a vehicle to gain new connections. It is very difficult to facilitate new social networks for clients, so training and work is one of the best ways to do that. It is focussed on the future and is forward thinking, solution focused and strengths based. Support for clients can be built around what can be done and that is different from a lot of models that sit within a crisis/welfare response *[J2SI staff member]*.

5.8 CONCLUDING COMMENTS

The J2SI program is a high quality innovative intensive case management model that has been delivered in a manner that is consistent with the broader evidence informed practice principles of engaging and supporting those with experience of long-term homelessness. The program has made a novel contribution to the homelessness sector in delivering support that is trauma informed and this remains a key legacy of the model. The J2SI program has been well resourced allowing it to make a significant investment in building the capacity of the homelessness sector workforce in providing long-term support. The governance structure has been transparent and committed to identifying and advancing the practices and preconditions for ending long-term homelessness. In the main, the original staff team have been well supported, supervised and retained throughout the trial ensuring continuity in the process of support over time. Moreover, staff, participants, and external partner agencies have typically reported a high degree of satisfaction with the quality of care and the relationships throughout the three year period.

The J2SI program has demonstrated that 'taking responsibility' to end long-term homelessness requires long-term support to maintain housing and meet complex support needs. Having the flexibility to follow clients across different types of accommodation ensured that support was not lost if housing became unstable. However, the challenge in gaining timely access to affordable housing remains.

Whilst participants were provided with access to an integrated package of support, case managers have remained the core form of support for the majority in the program. This can be considered both a strength and challenge of the model. Case management with individual workers and the broader service has been critical in the process of engagement and stabilising housing but it has been more limited in its capacity to move clients from a place of entrenched social exclusion, findings similar to those by Tsai & Rosenheck (2012).

While programs such as BUDS and MIF remain critical in providing opportunities to access training and employment, they also demonstrate that success must be viewed in accordance with an individual's capacity to move towards greater participation as a goal. This has important implications for service delivery into the future in terms of identifying realistic aims from the support process and how the success of programs should be monitored and demonstrated over time. The capacity for homeless services to tailor the intensity and duration of care, as well as providing the capacity for those who have previously been supported to reengage when they are at risk of losing their housing, will be critical to ensuring that the move out of homelessness is a permanent one.

APPENDIX

Table A1. J2SI Training calendar

Date	Topic
October 2009	Dealing with Challenging Behaviours
October 2009	Trauma Informed Service Delivery
November 2009	Completing applications for recurring homelessness
November 2009	Working with Men who use family violence
December 2009	Family violence common risk assessment
January 2010	Self Care
February 2010	Case Management and complexity
March 2010	Suicide intervention and prevention
April 2010	Negotiating the Mental Health system
May 2010	Homelessness research
July 2010	Responding appropriately to Self Harm
August 2010	From Chaos to Control
September 2010	Supporting people with Personality Disorders
October 2010	Shame Shifting – supporting people who have been sexually abused
November 2010	J2SI database
January 2011	Motivational Interviewing
February	Anxiety
March 2011	Depression
May 2011	Writing Court Reports
May 2011	Brain development
June 2011	Vicarious Trauma
July 2011	Infringements
July 2011	Drug & Alcohol training
September 2011	No Bullshit Therapy
November 2011	Problem Sexual behaviours
January 2012	From Trauma to Recovery
February 2012	Managing the Transition from J2SI
May 2012	Schizophrenia Neuro pathways
June 2012	DMT training
July 2012	Ending relationships therapeutically
July 2012	Ending relationships therapeutically – part two

Table A2 Joint case discussions with external experts

Date	Case Discussions
20-Sep-10	Private consultant (ex-Spectrum) (Attachment)
20-Oct-10	Director of Clinical Services, Spectrum (Personality Disorders)
01-Dec-10	Centre for Excellence in Eating Disorders
17-Jan-10	Director of Clinical Services, The Lighthouse Foundation
01-Mar-11	Private consultant (ex Berry Street Victoria) (Trauma)
11-May-11	Gamblers Help Southern

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