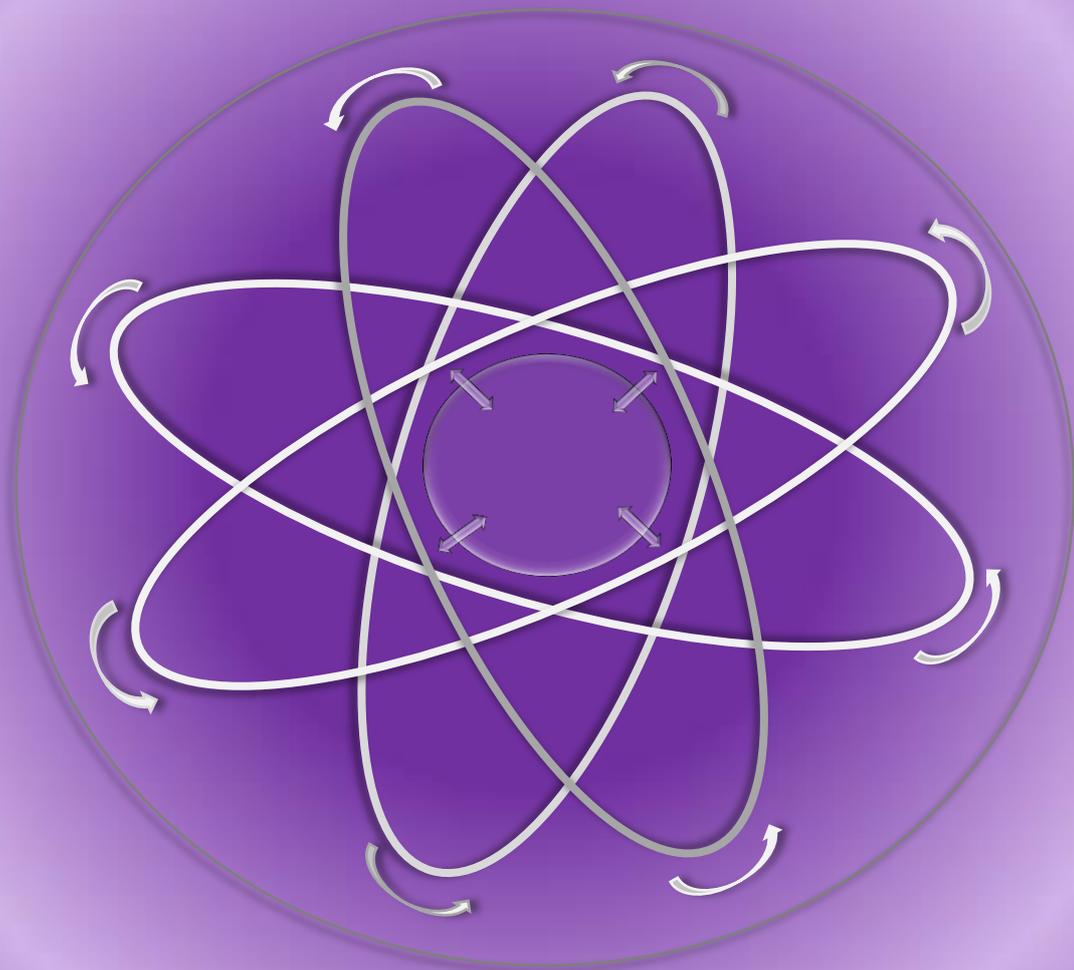


Douglas House, Supported Housing Services, practice model development and evaluation

March, 2017



Research Report

Dr Ann Carrington and Ms Jo Mensinga

James Cook University – Social Work

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Table of contents

Acknowledgements	4
Executive summary	4
Recommendations	8
Context	10
Trauma informed	11
Strengths	11
Recovery	12
Culturally responsive.....	13
Project aims and method	14
Research Aims	14
Method.....	14
Participants.....	15
Limitations.....	15
The Douglas House Practice Model	17
Theoretical approaches	18
Recovery	19
Trauma informed.....	21
Strengths.....	22
Culturally responsive	24
Vision, Values and Experience	25
Vision	25
Values	27
Experience	31
Reflective practice and commitment to the model	32
Implementing the Douglas House Practice Model	34
Understanding the Douglas House Practice Model.....	37
Resident Demographics.....	38
Diagrams - Resident Demographics	40
Mental health	41
Experience of Trauma	42
Diagrams - Mental Health	43

Diagrams – Experience of Trauma.....	43
Institutionalising factors.....	44
Diagrams - Institutionalising factors.....	45
Complexities	46
Diagrams - Complexities.....	47
Redefining outcomes and success	48
Diagrams - Residents of Douglas House	51
Contextualising the practice model.....	55
Concluding thoughts	57

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Executive summary

This report documents the results of a preliminary investigation into the practice model that has been central to the Douglas House Supported Housing Service since its inception in late 2014. Neither the service nor the model had been formally evaluated, however, anecdotal evidence from staff and external agencies suggest that the service is achieving identified outcomes, with staff attributing much of the agency's success to their commitment and implementation of the practice model. This report describes the model currently in use, explores its success in addressing the specific needs of the residents, and provides recommendations for the model's future use in guiding practice within the service and the wider homelessness sector. This report recommends that future projects be initiated to explore and evaluate the service delivery model and its relationship with the practice model.

The principal aim of the project was to capture the practice model implemented by staff. The research also sought to identify:

- how the model being used may be different from the practice framework of trauma based, strengths and recovery approaches, originally identified in the Service Operational Guide (SOG);
- why there may be a difference between the original practice framework and the practice model being implemented;
- if the practice model being implemented is working to achieve the goals of the service and meet the needs of the residents;
- how the practice model being implemented may inform the delivery of other services and fit within the broader practice context with this client population.

A mixed method case study approach (Creswell, 2013) was used to collect both qualitative and quantitative data. The findings from the qualitative data indicated that while the practice model being implemented was informed by the theories identified in the original practice framework (that is, *recovery, strengths and trauma informed*), the practice model as implemented by staff was more sophisticated in order to respond to the complex needs of the residents. This model being implemented, as captured in this project named the Douglas House Practice Model, comprises three core components that occur within the context of working with homeless people who have experienced trauma and have complex needs. The core components are:

1. four, not three, identified theoretical approaches (the fourth being *culturally responsive practice*);
2. staff vision, values, and experience;
3. reflective practice and commitment to the model.

The Douglas House Practice Model can be visualised as four theories that are in constant flux as they orbit the nucleus made up of staff visions, values, and experience. The nucleus and theories are enclosed within a circular boundary that represents the reflective space in which the staff members interact with the residents of Douglas House and other staff, and in which is contained their commitment to the authentic application of the model. Each of the elements of the model are explored in detail in this report.

This report identifies important demographic information about the residents of Douglas House to develop an holistic understanding of the case, Douglas House and its residents. For example, of the 53 residents of Douglas House captured in this sample, 89% identified as Aboriginal or were of Torres Strait Islander descent. Seventy six percent of

The Douglas House Practice Model can be visualised as four theories that are in constant flux as they orbit the nucleus made up of staff visions, values, and experience. The nucleus and theories are enclosed within a circular boundary that represents the reflective space in which...

the residents were identified as rough sleepers before entering the facility, while 18% had been in crisis accommodation, and 6% had been 'couch surfers'. All the residents received a government payment (54% receiving Newstart Allowance, 42% the Disability Pension, and 4% the Aged Pension). Debt was significant for the population, 80.5% of residents carrying one or more debts. While staff noted concern that 50% of the residents had mental health issues, only 19.2% had received a medical diagnosis. Reports of domestic violence were high and primarily reported by women, with 59% of the residents reporting such experiences. Ten per cent of residents reported sexual assault. Further, 18% identified themselves as having been Wards of the State as children. Fifty percent of the residents had physical health issues impacting their wellbeing, 76% had identifiable drinking problems, 62% drug related concerns, and 20% engaged in gambling behaviour.

Despite the complex nature of the client group, the designated outcomes for the program have been achieved. The tenancy rates have been stable with residents welcomed and encouraged to continue their participation in the program. For example, of the resident population included in this sample, 37 people have been residents for more than 91 days and 28 have exited the program overall, with 20 of those former residents securing some form of suitable accommodation. The remaining 8 moved to health and aged care facilities, prison or were not known.

Within the parameters of the Douglas House Practice Model, many more subtle goals were identified as having been achieved. For example, staff report that residents had: an increased ability to seek support to set boundaries; a decrease in the number of attendances at the hospital emergency department; and a decreased need for police intervention. These observations are of significant importance to this population, but are not currently being recorded. This report recommends that observational data be captured to identify in greater detail the benefits of the Douglas House Practice Model.

The Douglas House Practice Model has evolved in response to the specific characteristics of the service's resident population. Features of the model can be used to develop the practice skills of staff and improve service delivery. Elements of the Douglas House Practice Model can also be replicated in the development of other services and

contribute to the broader national and international conversation and knowledge base in the homelessness sector. For example, it is apparent that the:

1. culturally responsive approach of the model can be used where there is a significant representation of Aboriginal and Torres Strait Islander people in the homelessness population, and;
2. complex needs of the long term homeless and the trauma they have experienced demands a responsive approach to practice that includes an holistic understanding of how to facilitate improvements in residents' wellbeing (a pre-recovery stage) before a recovery model of service can be implemented.

Recommendations

1. Staff are employed based on the vision, values, and experience that form the core of the Douglas House Practice Model. The development of an interview tool that allows for these core elements to be explored in the recruitment process is suggested.
2. The culturally responsive approach identified in this report be included as an explicit and formal component of the Douglas House Practice Model.
3. Development of tools and/or training to provide staff with a guide for working within the Douglas House Practice Model is recommended. The tools and training should prepare staff for working within the dynamic model by assisting them to develop critical thinking and decision making skills rather than presenting a step-by-step guide that directs staff on standard procedures.
4. The development of redefined outcomes that will measure the success of the Douglas House Practice Model is needed. This should identify a method or measurement to be used and establish procedures for gathering, analysing and interpreting information relating to the redefined outcomes.
5. Future research is commissioned to:
 - a. encapsulate the perspective of the residents in defining the outcomes and success of the Douglas House Practice Model;
 - b. describe in greater detail the elements that contribute to the success of the Douglas House Practice Model, including how recovery is defined and used within the model, so that they may be replicated with other homeless populations;
 - c. capture and evaluate the service delivery model and its relationship with the Douglas House Practice Model;
 - d. explore if and how the Douglas House Practice Model is implemented at Woree Supported Housing. In particular is the recovery component of the model implemented differently than at the Douglas House site and how do these two sites work together.
6. Tools be developed accurately to record data relating to the complex nature of the residents and their experiences of trauma and mental and physical health.

7. The practice model and complexities of the resident population are demanding. Employment of additional staff to support the implementation of the model to its full potential is recommended.
8. Review of internal and external supervision processes to ensure all staff are supported in their work.

Context

Homelessness has been identified as a major social problem at local, national and international levels as well as a personally traumatic experience for those who experience it (Hopper, Bassuk & Olivet, 2010). A large percentage of those who are homeless are often impacted by additional forms of trauma experienced earlier in their lives such as physical and sexual abuse (Hopper et al., 2010). The presence of a dual diagnosis (that is, both a mental health issue and substance dependence) within this population further compounds the trauma experienced and increases peoples' vulnerability. Within the local Cairns population, the impact of trauma associated with the removal of Aboriginal and Torres Strait Islander people from their traditional lands and the separation of children from their parents as the Stolen Generation is significant. As noted by Home For Good (2014) 405 people experiencing homelessness participated in the registry week, 70.9% of these participants identified as being an Aboriginal or Torres Strait Islander person.

The QCOSS 'Enabling local communities: Homelessness in Cairns - Preliminary site analysis' report (2016) provides a comprehensive overview of the service systems and key stakeholders in the Cairns area, highlighting difficulties in service provision including: the high representation of Aboriginal and Torres Strait Islander peoples; a lack of service coordination for secondary homelessness; and an under-resourced and over-stretched service system.

Within this local context, Douglas House originally identified their practice framework as trauma informed, strengths based and recovery focused reflecting current shifts in the national and international focus and was to be implemented within a supported housing service model. Like recovery, the supported housing model has emerged from within the mental health sector and has been adopted in many housing services (Tabol, Drebing and Rosenheck 2010). As Tabol et al., (2010) explained, this model emerged in

Within the local Cairns population, the impact of trauma associated with the removal of Aboriginal and Torres Strait Islander people from their traditional lands and the separation of children from their parents as the Stolen Generation is significant.

response to service users' desire to live independently, yet still have access to supports and skills development needed to facilitate independent living. Factors relating to these three approaches in the local context of homelessness are explored below, along with an overview of factors relating to Aboriginal and Torres Strait Islander peoples, due to their high representation in the local context.

Trauma informed

Douglas House is not alone in electing to include a trauma informed approach within their practice model. Nationally and internationally, the connection between homelessness and trauma has meant a shift in focus in preferred practice models to those that include an understanding and response to trauma as central to clients' needs (Cash, O'Donnell, Varker, Armstrong, Censo, Zanatta, Murnane, Brophy & Phelp, 2014; Seymour, Dartnall, Beltgens, Poole, Smylie, North, & Schmidt, 2013).

Hopper et al., (2010) argue that homeless individuals are likely to have pre-existing trauma, with homelessness a significant increasing risk factor for re-traumatization and victimization. Factors identified by Hopper et al., (2010) as possible traumatic experiences pre-homelessness include: "...neglect, psychological abuse, physical abuse, and sexual abuse during childhood; community violence; combat-related trauma; domestic violence; accidents; and disasters" (p. 80). In Cairns, trauma is also significant for the homeless population because of the intergenerational trauma (Menzies, 2013) and family violence (Zufferey & Chung, 2015) that are frequently experienced within Aboriginal and Torres Strait Islander communities because of colonisation.

Sweeney, Clement, Filson and Kennedy (2016) outline the following principles as key to a trauma informed approach: recognising trauma; resisting re-traumatisation; understanding cultural, historical and gender context; trustworthiness and transparency; collaboration and mutuality; empowerment; choice and control; safety; survivor partnerships; and pathways to trauma specific care.

Strengths

Strengths is an individual approach as well as a key component of the trauma informed approach (McCashen, 2005). Prestidge (2014) discussed how a strengths approach

could be used to support a trauma informed approach by reframing trauma to enable feelings of resilience and confidence to emerge. Prestidge (2014) presented the positive aspects of adapting such practice for her and the clients as being strengthened engagement and reduced agitation. Hopper et al., (2010) supported the idea that a strengths approach was effective when anchored in an understanding of the impact of trauma. This approach offered physical, psychological, and emotional safety for both workers and service users and created opportunities for service users to rebuild a sense of control and empowerment (Hopper et al., 2010).

Recovery

Recovery originated in the field of psychiatry and mental health (Farkas, 2007) but is now often included in multidisciplinary settings (Cornes, Manthorpe, & Joly, 2014). Recovery is used to understand and respond to intersecting complexities of mental health, substance abuse, experience of care, and the criminal justice system, which present in the lives of those experiencing homelessness (Cornes et al., 2014).

The implementation of the recovery model is contested, largely because researchers are grappling with how to reconcile the differences between the approaches of various disciplines. Cornes et al., (2014) explore the factors contributing to debate with a focus on inflated links to mental illness in the homeless population. Cornes et al., (2014) argue that the overstatement of mental illness in homeless populations is the result of the inclusion of substance dependence as a definition of mental illness.

Despite the debates, there is still some common ground in the recovery model. Commonly, key aspects of recovery include: the promotion of citizenship (seeing beyond 'service user', service user rights, social inclusion, and meaningful occupation); the organizational commitment (to the recovery vision, workplace support structures, quality improvement, care pathways, and workforce planning); supporting personally defined recovery (individuality, informed choice, peer support, strengths focus, and holistic approach); and productive working relationships (partnerships and inspiring hope) (Le Boutillier, Leamy, Bird, Davidson, Williams & Slade, 2011).

In comparison, Farkas' (2007) provided similar guidelines, but with a stronger focus on the person-centred approach that included: person orientated (utilising person centre

practice); person involvement (in planning and delivery of services); self-determination/choice (choosing long term goals to achieve these; and hope (developing and nurturing this in both service user and staff). The idea of hope is further supported by Jacobson and Greenley (2001) who argue that in a recovery oriented service, staff must display a belief that recovery is possible.

Culturally responsive

The local Cairns context necessitates that cultural factors and responses be incorporated in responses to the homelessness in this region. Oelke, Thurston, and Turner (2016) identified numerous factors that needed to be considered for best practice when working with First Nations' peoples. Although Oelke et al., (2016) wrote about Canada's Aboriginal peoples, given the similar experiences of colonisation in Australia and Canada, their best practice recommendations may be transferable to Australia (and other colonized countries worldwide). Best practice approaches include: a focus on cultural safety; developing partnership/relationship; including Aboriginal governance/coordination; ensuring adequate/equitable funding; employing Aboriginal staff; facilitating cultural reconnection; and engagement in research/evaluation on best practices (Oelke et al., 2016).

Project aims and method

Research Aims

The principal aim of the project was to capture the practice model implemented by staff. The research also sought to identify:

- how the model being used may be different from the practice framework of trauma based, strengths and recovery originally identified in the SOG;
- why there may be a difference between the original practice framework and the practice model being implemented;
- if the practice model being implemented is working to achieve the goals of the service and meet the needs of the residents;
- how the practice model being implemented may inform the delivery of other services and fit within the broader practice context with this client population.

Method

To achieve the research aims, a mixed methods case study methodology (Creswell, 2013) was employed. Qualitative data was collected in the form of individual semi-structured interviews and focus groups with workers of the service. Data collected was analysed through the process of thematic analysis using categorical aggregation to establish themes and patterns (Creswell, 2013). Participant quotations from the interviews and focus groups are presented within the report to evidence analysis of the qualitative data. Quantitative data about residents was collected via a Survey Monkey questionnaire. Staff from Douglas House completed the survey using existing data and information extracted from case management files. The survey covered areas such as basic demographics, services provided to the resident whilst at Douglas House, trauma experiences, complexities, and accommodation. The de-identified data was analysed in Survey Monkey and in Statistical Package for the Social Sciences (SPSS), focussing on descriptive analysis to provide a detailed picture of the sample residents. Some open questions were also used, which were coded and analysed in the same method. Some data was not able to be analysed due to errors during the data collection process; however, the impact of this is minimal and only related to five questions. The results of the quantitative analysis have been included in this report

within text and as diagrammatic graphs and charts. A meta-analysis examining results from both the qualitative and quantitative data was conducted and included in the discussion of findings.

Participants

Qualitative participants: Three members of the Douglas House staff took part in both the individual interviews and the focus groups. These participants are members of the management team, identified as Caucasian, and were tertiary qualified in human services. Two participants had experience working in the homelessness sector and the third in mental health support services. Other staff members were not invited to participate in the study. Most of the other members of staff identify as Aboriginal and/or Torres Strait Islander.

To aid in protecting the unique contribution of individuals, quotes used to support findings within this report have not be attributed to individual participants. To ensure the integrity of the analysis and interpretation of the data, the quotes have been drawn from all participants across interviews and focus groups. Quotes have been edited for readability.

Quantitative participants: Staff of the service responded to the survey on behalf of a sample of individual residents. These sample participants included all residents who had stayed in the service for any length of time between 1st July, 2016 and September 2016. A total of 53 surveys were completed. Results note the number of respondents for each question in the title of the diagrams throughout this report. For example 'res n: 51' indicates that 51 out of the 53 participants were accounted for in response to the survey question.

Limitations

General limitations in this study include the small sample of participants in the collection of qualitative data and that quantitative data did not originate directly from residents. Relying on staff to provide the quantitative information based on existing data and case management notes resulted in a high number of 'don't know' responses for many question. Therefore, although such questions can provide a

General limitations in this study include the small sample of participants in the collection of qualitative data and that quantitative data did not originate directly from residents.

potential indicator of significance, the result captured here cannot be considered as wholly representative of the sample population. Considerations for future research are to include the perspective of other staff and management, as well as to gather data directly from residents using a method that would be least likely to re-traumatise residents.

A specific and significant limitation was the size and focus of the study. Although some data relating to the service model (such as staffing structure, the Café 1 Van, and community case coordination) was collected in the qualitative data, analysis of this data was not within the scope of the aims of this research, which focussed on the practice model. Further research evaluating the service model and exploring how it interacts with the practice model is recommended.

The Douglas House Practice Model

Capturing the practice model was the key aim of this project. Although recovery, strengths, and trauma informed theoretical approaches, as identified with the original practice framework were in place, staff noted that perhaps there were areas that were not strictly adhered to because of the needs of the residents of Douglas House. In contrast, this research found that the theoretical approaches of the original practice framework were not only being implemented, but were guiding all practice and decision making within the agency. Nonetheless, the staffs' perceptions were also correct, in that the needs of the residents in Douglas House meant adaptations had been made. The model being implemented, as captured in this project named the Douglas House Practice Model, was more sophisticated in response to residents' complex needs and the experience of trauma.

The Douglas House Practice Model, captured in this study (Figure 1), is an expanded version of the original practice framework outlined in the SOG. As noted above, during the research analysis it became apparent that the Douglas House Practice Model included the initial theoretical approaches, but was more extensive and holistic. The Douglas House Practice Model being implemented was made up of three core components:

1. four, not three, identified theoretical approaches (the fourth being *culturally responsive practice*);
2. staff vision, values, and experience;
3. reflective practice and commitment to the model.

Within the Douglas House Practice Model, the application of the theoretical approaches is in constant flux. No single approach is dominant, with each theory informing the other and moving into focus when needed before fluidly being replaced as the context (resident, agency, or worker need) changes. The figure below shows that it is the nucleus of the model that determines what approach is utilised in specific contexts and how that theory is applied by staff through their vision, values, and experiences. In the Douglas House Practice Model, the theories orbit the nucleus of the visions, values, and experience, with the arrows depicting the dynamic and responsive nature of the model. The theories orbit and move position and direction depending on the context. The theoretical approaches are

enclosed by a circular boundary that represents the reflective space in which the worker interacts with: the residents of Douglas House; the values, vision, and experiences of themselves and the agency; the theories; and other staff and managers. Each component of the model is discussed in more detail in the following sections.

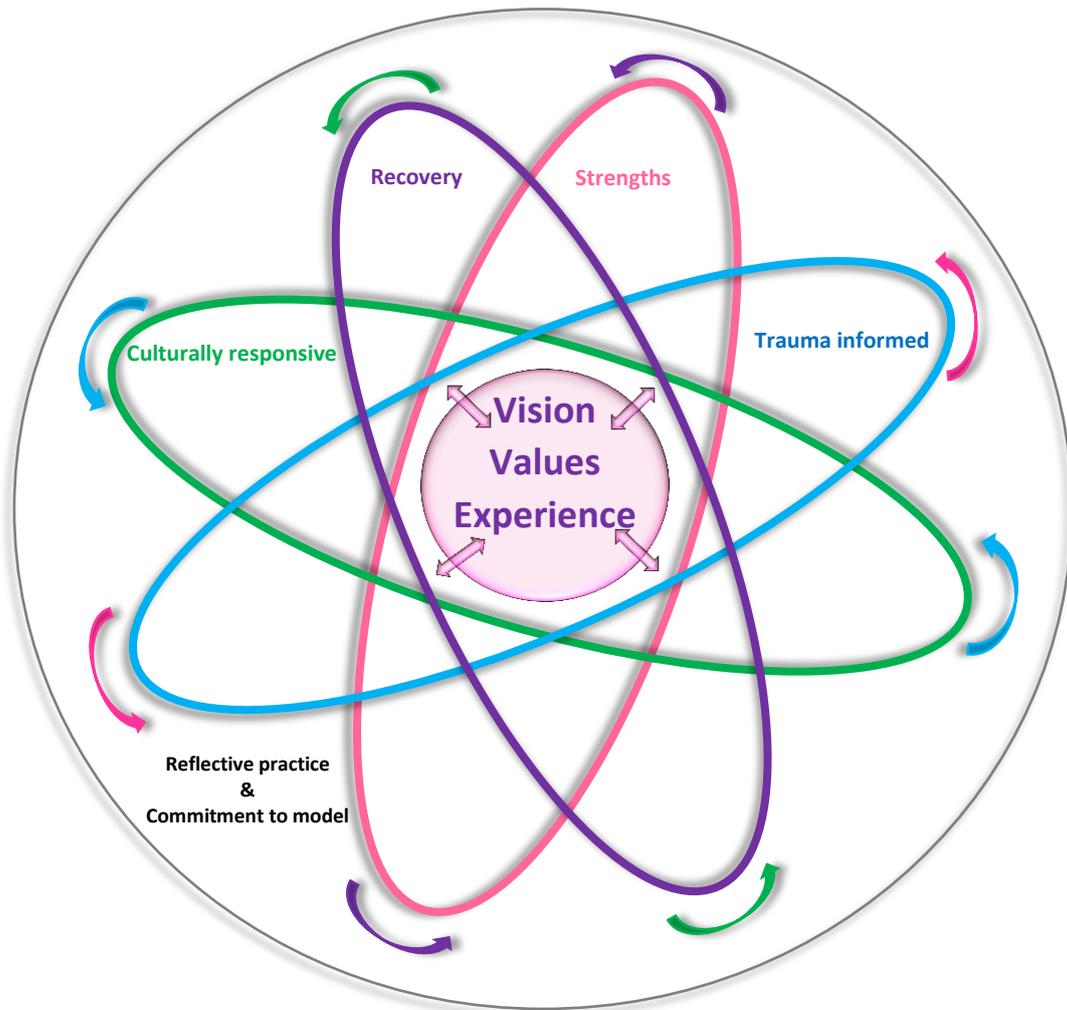


Figure 1 Douglas House Practice Model

Theoretical approaches

The Douglas House Practice Model implemented combines multiple theoretical approaches that individually, and in combination, inform the practice of workers in the service. The initial articulation of the model identified recovery, trauma informed approach,

and the strengths approach as the theoretical framework for practice. Culturally sensitive practice had been identified in the SOG as a set of principles to guide service delivery but was not included as an explicit part of the theoretical framework. Through the analysis phase of the research it became apparent that culturally sensitive practice was informally playing a significant role in the practice model by guiding daily practice and service decisions. Therefore, a key finding of this project is that culturally sensitive practice is integral to the model and should be included as a theoretical approach. It has been included here as part of the Douglas House Practice Model.

Each theoretical approach of the model will now be discussed, briefly highlighting aspects of the theoretical approach that was identified as being significant within the Douglas House Practice Model.

Recovery

The Recovery approach as originally outlined in the SOG was drawn from the National Standards for Mental Health Services (NSMHS) (2010). Recovery in the mental health sector means “...gaining and retaining hope, understanding of ones abilities and disabilities, engagement in an active life, personal autonomy, social identity, meaning and purpose in life, and a positive sense of self” (NSMHS, 2010, p. 42). The NSMHS (2010) standards outline a set of principles to guide recovery practice that cover six key areas: uniqueness of the individual; real choices; attitudes and rights; dignity and respect; partnership and communication; and evaluating recovery.

Evidence of a recovery approach informed by the NSMHS (2010) key principles was evident in all interviews and focus groups; however, some adaptations were made, which are discussed in more detail in the following section of this report (Implementing the Douglas House Practice Model). Although the aforementioned principles of a recovery approach were used within the Douglas House Practice Model, particular elements of the recovery approach were more significant. These included positive risks, trust, relationships, the capacity of residents, hope, independent decision making, resident defined outcomes and ‘buy in’ or self-determination as identified below in Figure 2.

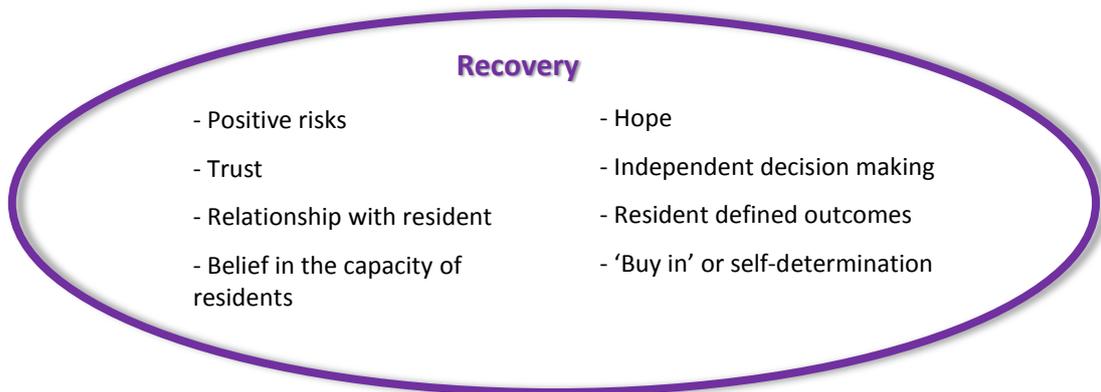


Figure 2 Elements of a recovery approach significant to the Douglas House Practice Model

The following excerpt of a conversation within a focus group illustrates the commitment to the recovery aspect of the Douglas House Practice Model and the aspects of positive risk, relationship, and trust:

First speaker: ...arguably it's actually why we have less risk, going back to the model... it's actually because there's...all these elements of freedom and because we're coming from a good space, the residents know it and they're not fighting with us... Like, it's almost like it's all linked and is why it's such a safe space to work in every day of the week. It is because of the integrity that is given.

Second speaker: Yeah...and if you could see the confidence in those people, because some of the stuff we're doing is outside of the box. And some of that [is] ...we're trying not to say, "well, let's go fishing". You know, we were struggling at first, fishing trip every week, where's the knife [laughs]? You know, where's the knife? But if you don't trust people to have a knife and cut their own bait, well, you say, when do you need the knife? You know, so, you've got to have that – yes, we need to know that the knife has come back and, yes, we need to know that knife is going to sit in the box and staff may check but we don't need to be saying to residents, you know, unless there's a fight occurs in the middle and they're going to stab and someone verbalises they're going to use the knife, but that's what it's about. It's about trusting, you know, and some staff struggle with that because they're not used to that autonomy themselves, they're not.

The following comment identifies hope in the model:

Having hope for somebody - yeah, 'cause that has to be genuine but the staff or the team need to have hope that this can work...and the residents need to be able to feel that.

Trauma informed

Trauma informed as originally outlined in the SOG included the following five domains: adapting policies (with understanding of trauma); assessing and planning services (strengths based assessments, person centred, exploration, working together, and celebrating achievements); involving consumers (in planning and implementation and resident given meaning roles and responsibilities); creating a safe supportive atmosphere (consideration of physical environment, safety, privacy and confidentiality, consideration of triggers, acceptance for personal, cultural and religious beliefs, client rights and grievance processes, and open and respectful communication); and supporting staff development (supervision, self-care plans, awareness of vicarious trauma, and training).

Evidence of a trauma informed approach as outlined in the SOG was evident in all interviews and focus groups. In analysis, it became apparent that some elements of the trauma informed approach were used more significantly within the Douglas House Practice Model. These included appreciation of trauma, resisting re-traumatisation, safety, management of space, self identification of trauma, resident led empowerment, understanding each resident, and recognition of cultural trauma and colonisation as identified below in Figure 3.

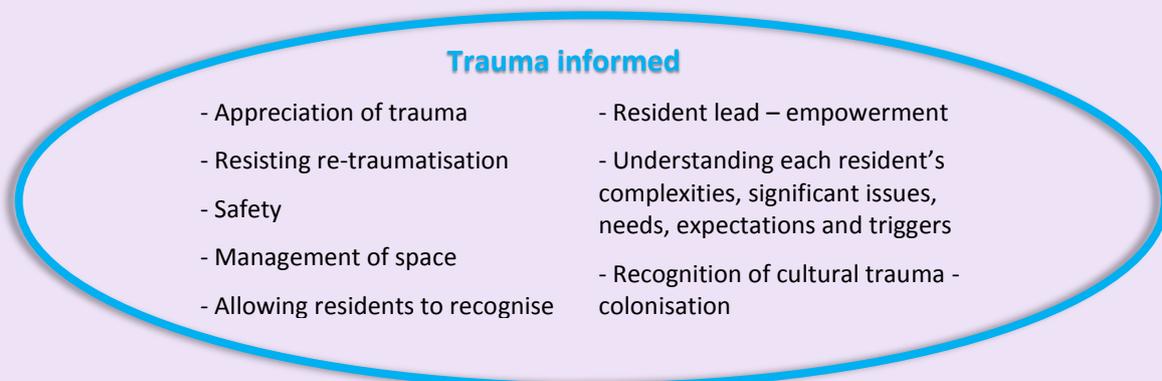


Figure 3 Elements of a trauma informed approach significant to the Douglas House Practice Model

The following participant comments illustrate core principles of the trauma informed approach of the Douglas House Practice Model:

So we can't get the people here to even identify what trauma is or has been in their life. And yet, they are the most trauma affected individuals I've ever worked with.

Their behaviours, their triggers, their physical [reactions], so if we've got, so we've got 26 people in the one complex and somebody might yell at somebody "Clean that mess up, you're always fucking leaving that mess around." That person there might have a traumatic response. So you could even see it physically where they'll go, put their hands up to their head and "Oh, I can't, I can't, I can't, I can't," you know, and then they'll start rocking.

So you're almost using, like...by giving them some integrity in their space and some rights and some responsibilities, that we are removing risk for ourselves and managing space and making it - not only is it - if they're calm, their neighbour is calm their, their things aren't being triggered so much. So it's quite complex.

So, I think the trauma around just recognising that so many of the residents have been through trauma and loss and are still grieving or haven't processed that kind of emotion and context...

Strengths

The strengths approach is described within the SOG as having three key principles: all people have strengths and capacities and can learn and change; people are experts in their own lives; and all information is inclusive and transparent. As with the recovery and trauma informed approaches, the strengths approach was evident in all interviews and focus groups. This is not surprising considering that a strengths approach is also an explicit component of the trauma informed approach. A strengths approach appeared to form the foundations of the entire practice model. Evidence of the strengths approach was difficult to

identify in isolation from other theoretical approaches in the model precisely because it was so embedded in the Douglas House Practice Model. Figure 4 identifies elements of the strengths approach that are significant within the Douglas House Practice Model.



Figure 4 Elements of the strengths approach significant within the Douglas House Practice Model

The following participant comments illustrate the application of the strengths approach within the Douglas House Practice Model:

So... their resilience, they've survived this length of time not knowing where Centrelink is. And yet he still had his payment. So what has he done to be able to keep achieving that? So why, why would that be? That would be something I would look at.

Yeah. So, fishing's a really big one and it's something that we offer, and we're about to start regular weekly again, but it has been on, you know, ongoing, for the last couple of years, hey? It's been something...they've identified, and something they miss from their lives as well.

We use [the] strengths based perspective, we like to think when we give a breach, again, it's coming from somewhere that, "Okay. How can we assist you to remedy that breach so that that doesn't lead to you being evicted?" So it's still all very focused on, yes, it's a breach, but let's use that as a positive, "Okay. You've been breach[ed] because of this, what can we do?"

Culturally responsive

Although a culturally responsive approach was not included in the original practice framework as outlined in the SOG, a statement of principles for working with Aboriginal and Torres Strait Islander people was included. Throughout the research, being culturally responsive to the needs of Aboriginal and Torres Strait Islander people was constant and necessary (at the individual and organisational levels) and informed and challenged aspects of the Douglas House Practice Model. Some of the significant elements of a culturally responsive approach within the Douglas House Practice Model include; empowerment, learning from cultural expertise, up skill, working to cultural requirements, recognition of trauma, appreciation of different communities, and supporting culturally enriching activities. However, although aspects of Oelke et al., (2016) principles of culturally responsive practice were clearly being implemented, along with the guiding principles set out in the SOG., the culturally responsive practice approach in the Douglas House Practice Model could be further enhanced by a focus on: cultural safety; partnership/relationship; Aboriginal and Torres Strait Islander governance/coordination; adequate/equitable funding; employment of Aboriginal and Torres Strait Islander staff; cultural reconnection; and research/evaluation of best practices.



Figure 5 Elements of a culturally responsive approach significant to the Douglas House Practice Model

The following participant comments illustrate the application of a culturally responsive approach within the model.

Well, it's around language...so, we want recovery because we believe in it, but, when we have rolled out training in recovery, Indigenous workers have sat there, and gone, "oh, can't use that language, that's not okay for what we say". For us,

then, it's about [asking] "well, what is okay? Because we still want that model and we still want that approach, but what language can we use? What tools can we use?"

We've got a lot of Indigenous workers.

It's hard to get skilled Indigenous staff because if they're out there, they will go to the jobs that are paid more. So we employ, giving staff a go and recognise the importance of having Indigenous staff, but it's a bit sad that there's no senior positions with that.

The cultural knowledge, I said it earlier, and probably looking at knowledge around the services and the remoteness and how the Cairns region is sometimes, you have a lot of people coming into Cairns from other regions and acknowledging that, and then looking at how housing, I think, is just grouping people based on no real assessment about placing different cultures in the same region or a street or something like that, whereas...this is a very open and transparent process here as well, but having that knowledge of, maybe, those relationships and taking that into consideration, and there are a lot at the moment. I think there's five who are all interrelated and the staff are very aware that having that local knowledge is very crucial, so, informing ourselves of others, you know, around their life history is really crucial.

Vision, Values and Experience

It is apparent that the individual and shared vision and values and experience of the staff are at the core of the Douglas House Practice Model. The staff members' vision and values guide them in what theories to adopt within the model and their vision, values, and experience informs the application of the model in practice.

Vision

Staff members' vision was a key theme in the interviews and focus groups. Each participant held a vision of what the service could do and what they themselves could do. The belief in the altruism of the service for the resident population motivates staff to best

practice and to achieve the best possible outcome for residents. This goes beyond meeting funding criteria and required outcomes to focus on the humanity of the residents and the hope they hold for each individual resident. While staff members may carry a personalised vision, there were commonalities across the participants that suggested a shared vision. Following is an attempt to articulate the common themes as a vision statement for the Douglas House Practice Model.

*An holistic approach to
achieve the best life possible
for the individual in
community, as determined
by the individual.*

An holistic approach to achieve the best life possible for the individual in community, as
determined by the individual.

One participant expressed their vision of the service in the following way:

Here's the opportunity to stand on your own two feet, and, you know, recovery is a process, you're not going to fix everything, you're not going to - everything is not going to be great in three months - but it's going to be a process, you know, and we'd love to walk alongside of you while you're on this process.

To achieve this vision there was a desire to affect change beyond the individual and include stakeholders, services, funding bodies, hospitals, police, mental health, and other homelessness services. While change is sought beyond the individual, the underlying intent was to change the lived experience of the individuals and communities with whom staff work:

You know, are we doing our job? Absolutely. Is the funding body happy? Absolutely. Are we wanting more for the people were working with? Yes!

I had a recent realisation that, that there has been intent, we haven't been just making it up as we go, and that there can be change. And there's even, arguably could be small, systemic changes...what it's allowed me to do, I think

could be, yeah, create some real change for the cohort, whether they're in our service or not, over the long-term. So, look, I guess it's not giving up on anyone.

[Residents] who are successfully sustaining a tenancy. So they could say they're ticking all the boxes...the focus and what I think they want to achieve, is that whole of community, support. Like, external support, so they can recognise a Douglas House has value in the community. Plus while the residents are here, that they can, make some proactive changes. Come from being homeless, really struggling, hitting lots of barriers, lots of discrimination, and then make those little changes to hopefully go on and have a stronger, better, you know, more wellbeing.

Values

The values held by the staff team are the foundation of how the Douglas House Practice Model is applied in practice. While other components of the model are dynamic and responsive values are constant, even during turbulent or challenging times. As with the vision, each individual staff member holds their own set of values, but as a collective they also subscribe to a shared set of values. These values are aligned with those of Mission Australia, but their application is unique to the Douglas House context.

Mission Australia requires that all staff work within a Christian-informed value base. This value base can be captured in the following bible quote:

I was hungry and you gave me food, I was thirsty and you gave me drink, I was a stranger and you made me welcome, naked and you clothed me, sick and you visited me, in prison and you came to see me...whenever you did this to one of the least of my brothers and sisters, you did it to me (Matthew 25:35).

The values of compassion, justice, integrity, respect, perseverance, and celebration are presented as central to embodying this Mission Australia value base. Throughout the research these Mission Australia values were evident within the implementation of the Douglas House Practice Model as evidenced in participant comments.

...it's our kindness that - or firmness as well. Firm, kind, firm, kind.

So the trauma being trying anger recovery, trying to continually plant the seed with the person [or] people we're working with, asking them "Do they want to start identifying some of the underlying issues?" So it's a not a pressure driven.

We would say: "Let's try something for three months and if it doesn't work, change it. Three months, doesn't work, change it, give it a good go." Now, that's part of our practice, where staff will come to us and say that kitchen's not working...can we change it? Yep, yeah, you change it. So, they're actually doing stuff that I can't even catch up on...that's become now, part of the culture, I think.

Douglas House is very much an open door for them in the future, but they didn't get it this shot, but what are we doing in the meantime?

If it's to sit down, assist them to find a book, or assist them on the Internet to login into something; if it's, you know, to try and track down your mum in Bamaga; if it's, you know, but they're the things we have to work on, all of those... it's saying to them, that's your job. Same as Woree, the Indigenous housing mentors, it's about, okay, how do I link back into my community? How do I - you know, find out what it is, start planting those seeds? So for every worker in this building it's about planting seeds...whenever, planting seeds to try and get them to engage in something in Douglas House. I don't care whether it's cooking, I don't care whether it's cleaning, I don't care whether it's fishing, whether it's art therapy, whatever it is.

I really believe that in the end, ultimately, if you – if your heart is in it, that's what you should be focused on.

There were some distinct points of difference or an expansion of Mission Australia values that were identified which were self-determination and structural change (as discussed under vision). Although self-determination is an implied value within the Mission Australia ethos, it is not explicitly identified; however, self-determination is core to the Douglas House Practice Model. Where the values subscribed to by Mission Australia

encourage 'doing for', the Douglas House values can be better described as 'walking with' and 'actively seeking to ignite the self-determination' of the residents. Self-determination is also a value that aligns with the theories of the Douglas House Practice Model and can be applied equally to staff and residents. Self-determination is an action and an objective that directly feeds into the vision, which reflects not the staffs' idea of the best life possible, but the best life possible determined by the individual.

...the Douglas House values can be better described as 'walking with' and 'actively seeking to ignite the self-determination' of the residents.

Trying to get them to make decisions on their own, trying to get them to make appointments on their own, not being that service that does everything for, but does everything with, until we can take that step back. So it would be, you know, when they move in, it's quite intensive, and we'll do the work that needs doing, you know, because sometimes they'll come in and then their physical health mightn't be very good, you know, so, and their mental health, and, so it might take a couple of months where we'll do the intensive work, we still won't do for...but, you know...it's about walking alongside.

It's the way to go for anything. Because it's around, you know, self-determination and someone's own goals and what they want to achieve. I mean, trying to install your values or goals on anyone. You're only ever hitting barriers.

So we try not to do that. If people are coming here - if people are coming here to see them, we're trying to get them to come down and say "Actually, you know, I don't want to go out drinking with you" instead...because what was happening, they'd leave messages with staff and say, "You know, if my aunty and uncle come around I don't feel like drinking today, tell them," and so as - as easy as what it would be for us to do that, we've learned actually "Well, in the real world, you're going to have to get up off your couch and tell your aunty and uncle."

If your ultimate goal is to have a service that's got a model that allows people to feel safe in their own lives and they get - you know, they're able to make -

understand what their wants are and what their needs are, help themselves, all of that. If that's your goal up there, and you're always focused on that, that's – like, it's just – [laughs] – it's actually about the focus. So, you might go – you might strain, you might be failing but then you go, oh, what do we really need? So, reassessing what the service needs.

Your normal resident always ensuring that the clients involved in all the, you know, stakeholder-type meetings, any - every part of the process, because they are their own being. So it's basically anyone who feels like they've recovered don't - don't feel like it was the services that recovered them, it was themselves and they needed to be on that journey. And that's pretty much the guts of it that - that everyone can recover...and that - that - that hope that sits behind that and the inclusiveness in the sense that they're, they are the driver, they are like the CEO of their own case.

Staff noted that valuing self-determination within the Douglas House Practice Model is markedly different from other services that do 'for' clients, rather than 'with' them. This difference in values is noted in participant comments below.

Yeah. Yeah. Yeah. But there's services such as – and I always use this as an example... where they'll go, they'll get a free meal, they'll get a bed – and this is any night and every night if they're in, you know, if they're, if they're not banned - but they'll get their clothes washed, cleaned, clean set of sheets, like – and these are free services, so, when they come into a service like this and have to pay, it's a struggle for people.

Really, really positive. I think the part that they struggle with is, because there's so many – this is a really important component - and people are probably sick of hearing me say this - but there are so many services out there that provide a meal and it's free. They were, there's you know, around the corner they can access free bread and milk and, you know, so, we're trying to teach them to shop and cook for themselves. There's a van that was in town, I think it's now at the CRC, Cairns Regional Council but, you know, where they'll provide a free meal, and we're trying to get people off that.

The vision and values demonstrated by staff as important to the Douglas House Practice Model also demonstrate a strong alignment with those identified by Farkas (2007), specifically the belief in empowerment and citizenship, the constant renewal of hope and meaning, and gaining a sense of control in one's life.

Experience

In addition to the vision and values held by the staff, their professional and lived experience is also critical to the implementation of the model. Because the model includes multiple approaches, staff members need to be able to distinguish where, when, and how to implement interventions and which theoretical approach will inform their actions in any given practice situation. In the Douglas House Practice Model, the experience of the worker is not only highly valued in this process, but necessary to its success. Although seen as a strength of the model, the research also highlighted that some staff experienced discomfort with the professional freedom the model provides them:

They just want to know – some staff that come here just want to know black and white, what's my job, when that happens, what is my response, what do I follow up with? That's it.

Overall, the freedom offered staff to utilise their own training and discipline-specific knowledge within the Douglas House Practice Model enables a broader understanding of homelessness and client needs, as well as encouraging transferable learning. The model and practice become dynamic and responsive to the complex needs associated with each individual resident, based on a fluid process of assessment that is informed by each component of the model (the theories, vision, values, staff experience, and reflective practice and commitment to the authentic application of the model).

It's - you've got - there's still got to be an ongoing immediate assessment. You know, keep all that stuff at the back but you've got to be constantly assessing what's - and kindness tends to be one part of that.

Reflective practice and commitment to the model

The final component of the model guiding staff members' assessment and interventions with each resident has been depicted as a circle on the outside acting as a boundary for the other components that lie within. This circle represents a commitment to reflective practice and authentic application to the model. The commitment to the authentic application of each aspect of the model was something shared by each participant and is the principle that informs all other decisions they make. Staff are constantly questioning and challenging themselves and each other in relation to their practice, exploring what works and if what they are doing reflects the model. This desire authentically to apply the theoretical approaches of the model, has contributed to the development of a culture of daily individual and shared reflective practice.

Just almost drilling that into ourselves as a team or if I - there's a lot of honesty that needs to come forth. So, like, there's one resident - and I think I'm pretty good at stepping back with things - but there was one resident that I took really personally, and he'd come up and he would, sort of, be aggressive and I needed to fade in the background rather than, "Something needs to be done about this," you know, in my, sort of, senior role. And it's, like, no, no, no, no, I'll fade back and let somebody else.

It does take a deliberate intent, like, that, like, methodical debating how much to do for or not do for, when it's appropriate to do less. That can be cruel in itself, to do less at times because people are used to services doing it for them. It's not you [it's] the system that's failed you. Sometimes, you know, it sounds like we're talking about them as if they're, they're incapable but, like it's, I believe, it's a system that's, that has bred that incapacity in and is - if we're going to be in the system, I mean, we've got to, we've got to be the ones that help deconstruct.

You do have to argue, but then, but then that's our model, and that's where we've gotten to, to get staff to understand, and all of us on the one page.

The reflective approach to practice not only informs work with residents, but is also used to encourage staff development. The strengths approach was evident in relation to building the capacity of staff by encouraging their autonomy and the use of their professional and lived experiences. The recovery approach underpinned their maintaining

hope through a shared vision. The trauma informed approach facilitated the recognition that many staff may have experienced trauma themselves, so it was important to be aware of possible triggers and to reduce the re-traumatisation of staff. Finally, a culturally responsive approach was evident in the need to employ Aboriginal and Torres Strait Islander staff and how to support their participation in the program. Given the high percentage of Aboriginal and Torres Strait Islander residents, the cultural knowledge Aboriginal and Torres Strait Islander staff members contributed to the model is highly valued and contributed to a desire to build their capacity:

Why are we still fighting to get recovery really to work in here, because, I think, it's one of the only models that actually believes in actually these people. They've got the capacity, most of them, and they can actually stand on their own two feet, and that would lead me then into the institutionalisation of what I think is happening. But, yeah, so that the trauma - very, very ingrained and very sadly part of life.

Speaker 1: Having a collective of Indigenous staff is really different to having one or two, because they become experts as opposed to a collective thinking approach, which I think has been really huge, which I think is important for the for the human side of running a model.

Speaker 2: Absolutely...there's not a day that goes past where we're not getting advice from those [Aboriginal and Torres Strait Islander] workers because of their background, because of their culture.

Implementing the Douglas House Practice Model

The Douglas House Practice Model identified in the previous section of this report was captured during this research and in response to addressing the principle research aim. This section of the report presents the merged findings and discussion addressing the first subsequent aim of the research that explored if and how the original practice framework may differ from the Douglas House Practice Model captured in this research.

The description of the Douglas House Practice Model highlights points of difference against the original practice framework. The first point of difference is that there is a need to expand the understanding of the original practice framework. The original practice framework as described in the Douglas House SOG is a list of the theoretical approaches. This research identified that through implementation it expanded to an holistic model rather than a practice framework. The components of the Douglas House Practice Model, included the influence of staff through their vision, values, and experience in conjunction with reflective practice and a commitment to the authentic application of the model. The influence of staff that is what brings the different theoretical approaches to life and makes the whole, the Douglas House Practice Model. The combination of the theoretical approaches and how they are implemented would vary if they were applied by different staff or if another vision, set of values and/or experiences were in place. In other words, it is the influence of staff that makes the model unique.

The second point of difference between the original practice framework and the Douglas House Practice Model is a culturally responsive approach. Although not an identified theory of the original practice framework, the recommendation is that this needs to change. The culturally responsive approach was integral to practice and informed decision making of staff, organisational staff structure, engagement with residents and informed changes to the implementation of particular theoretical approaches within the model.

With the inclusion of the staff vision, values, and experience as central to the Douglas House Practice Model, the expectation for staff to navigate the different components of the model can be both a strength (as already discussed) and a concern. Given the dynamic nature of the model, and the expectation that staff can move between

the different theoretical approaches as the situation demands, there is a potential burden of responsibility on individual staff members. This was highlighted as a concern with the acknowledgement that some staff cannot cope with this approach. It is a recommendation of this research that supporting staff in their decision making and interventions is further developed through the production of tools and training that will provide staff with a guide for working within the dynamic Douglas House Practice Model. These tools and training would need to capture the uniqueness of the Douglas House Practice Model and ensure the authentic application of the theoretical approaches of the model and its vision and values. Tools and training would need to prepare staff for working within a dynamic model and focus on developing critical thinking and decision making skills, rather than providing a step-by-step guide directing staff what to do.

The final point of difference is an adaptation to the recovery approach with a shift in focus that leads to an adapted phase within the Douglas House Practice Model of pre-recovery. Throughout the interviews and focus groups, concern was expressed in relation not fully following the principles of the recovery approach. The concerns outlined included the amount of intensive support that was being provided to residents, the limited level of resident input into their case management goals, the rules residents were expected to live by, services being delivered in-house, and the design and functionality of the building. These concerns are reasonable when reviewing practice only from the recovery approach. However, when reviewed from the perspective of the model as a whole, including all theoretical approaches, support for such an adaptation is present. The pre-recovery adaptation aligns with the values held and is firmly supported

The final point of difference is an adaptation to the recovery approach with a shift in focus that leads to an adapted phase within the Douglas House Practice Model of pre-recovery.

by the trauma informed approach with a focus on supporting residents to create safe spaces and resisting re-traumatisation. Further the individual and team reflection and challenging that surrounded the decision and implementation of what has now be labelled as the pre-recovery phase, further concretises this approach within the Douglas House Practice Model. It is not simply the trauma informed approach that supports these practical responses: the

commitment to implementing the full recovery approach motivates staff to work with residents to assist them to reach a point where a full recovery approach could be implemented. This research identifies this as a unique process/phase of pre-recovery that has emerged from the implementation of the trauma informed, strengths, and recovery approaches in combination with the vision, and values and experience of the staff through the reflective process as they respond to clients' complex situations. This is significant when understood in the context of the resident population. For example although the recovery model is being applied to 82% of residents (see page 50), only 19.2% of the resident population within this sample had a diagnosed mental health condition (see page 41). Moreover, although data indicates staff believe that 50% of the population have an undiagnosed mental health condition (see page 41), this is still a large gap between the number of residents with a mental illness and the number of residents who have the recovery approach applied by staff in their work with them.

Understanding the Douglas House Practice Model

The preceding sections of this report have considered the enacted practice model and explored how it differs from the agency-defined model. This report will now focus on responding to the second sub-aim by drawing initial conclusions as to why there may be a difference between the original practice framework, outlined in the SOG and the Douglas House Practice Model captured within the research.

In the previous section of this report, there is an acknowledgement that some difference in focus and adaptations to the theoretical approaches has occurred in the implementation of the Douglas House Practice Model. In reviewing the data, it became clear that the refining of and adaptations to the model were driven by the shared vision, values and experience and the context of applying the model within Douglas House, particularly in response to the complex needs of the residents. As identified previously, the residents present with a range of issues from 'not being able to cook' through to serious physical and mental health issues. This range of needs compounds the complexities of working with residents and provides challenges in achieving resident goals and providing appropriate support services.

The complex issues faced by the residents and staff are noted in participant comments:

So – so that's that level of complexity. You know, if someone can't change their sheets or know how to mop their floor, how are they thinking to sustain their tenancy? Or to fill out a bond loan? Or you know, save and budget for two weeks' rent or anything like that.

Quantitative data was collected on a variety of issues to capture a broad picture of the residents of Douglas House, the issues that may be impacting their lives, and to establish if the factors identified in the qualitative data are present within the population and do influence how the Douglas House Practice Model is implemented. The quantitative data presented in this section of the report provides data relating to potential challenges and complexities experienced by the residents of Douglas House. The data examined in this section is presented in five different categories including:

1. General demographics
2. Mental health
3. Experience of trauma
4. Complexities
5. Institutionalising factors

It is noted that while these categories generally informed the design of the survey, the allocation of specific categories was assigned retrospectively to present the findings and was informed by the meta-analysis of the qualitative and quantitative data.

Resident Demographics

The basic demographics explored included gender, age, identify as, duration of homelessness prior to entering Douglas House, accommodation prior to entering Douglas House, annual income, sources of income, debt, and debtors.

The mean age was 44.5 years with the median age of 45 years and a standard deviation of 9.79. The minimum age was 25 years and the maximum age 66 years. As illustrated on page 40 89.3% of the sample population identifies as Aboriginal and or Torres Strait Islander, with 66.7% identifying as Aboriginal, 11.8% identifying as Torres Strait Islander, and 9.8% identifying as both Aboriginal and Torres Strait Islander. There was an equal representation of gender with 50% male and 50% female. The high proportion of participants identifying as Aboriginal and/or Torres Strait Islander considered within the context of Australian colonial history could be a potential indicator of individual and intergenerational trauma (Menzies, 2013).

Another general demographic factor that is considered as trauma is the experience of homelessness itself (Hopper et al., 2010). With the service delivery criteria for Douglas House being that services are provided to the long term homeless, it could be expected that all those accessing Douglas House have experienced trauma based on their homelessness status. The experience of long-term homelessness within the sample population was reflective of the service intake criteria with 36% of participants homeless for 4-6 years and 20% homeless for 16 years or more with only 4% being homeless for a period 6-12 months. Their housing situation prior to entering Douglas House included the clear majority of

residents rough sleeping (76%), crisis accommodation was the next highest representation (18%), with the least represented being couch surfing (6%).

Participants annual income is extremely low. Almost 53% of participants had an income less than \$19,999.00 and were therefore living below the poverty line as determined by the Australian Council Of Social Services (ACOSS). The ACOSS guidelines identify the poverty line being less than \$423.60 per week (which calculates to \$22,167.6 annually) for single adults. The single adult calculation was used. Although some residents were living as part of a couple (14%), the ACOSS guidelines did not provide a calculation for couples without children. Therefore, although some were living as a couple it was more accurate to calculate as a single adult using ACOSS calculations.

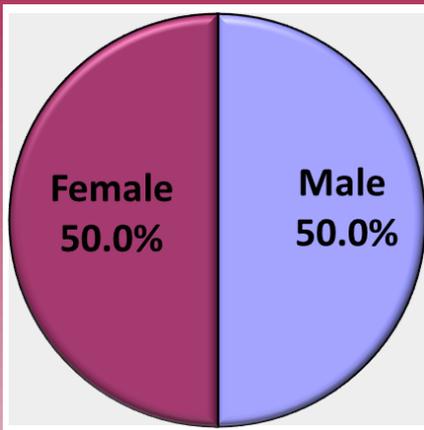
All 50 residents that responded to the question on income source received an income from a government payment with 54% receiving Newstart Allowance, 42% receiving the Disability Pension and 4% receiving the Aged Pension.

Residents also have difficult financial situations with 8% of residents carrying one or more debts. Three key debts emerged with at least 50% carrying a Bond Loan, 55.5% carrying a State Penalties Enforcement Registry (SPER) debt and 55.8% carrying a Centrelink debt. This question allowed for multiple answers and results indicate that some residents are carrying multiple debts. Of those carrying debt the majority at 73.2% are carrying debt less than \$10,000.00, with 12.2% carrying debt between \$10,000.00- \$19,999.00 while 7.3% are carrying debt between \$20,000.00- \$29,999.00. It is of interest, that while the residents in this sample rely entirely on government payments, the majority of their debt is also to government entities in the form of SPER debts, Bond Loans, or Centrelink debt, with only private debt of retail (9.6%) or banks and other financial institutions (3.8%).

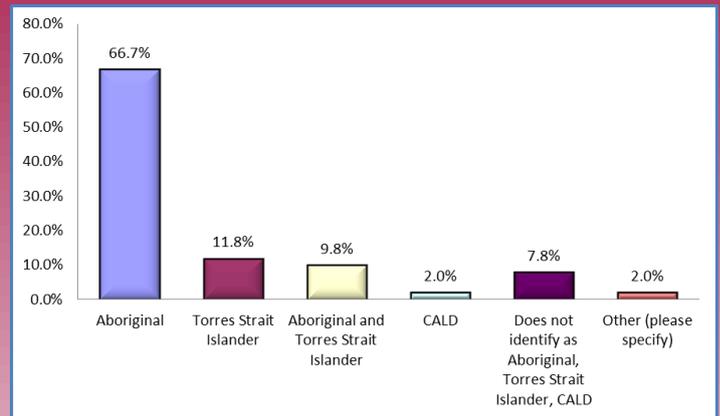
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Resident demographics

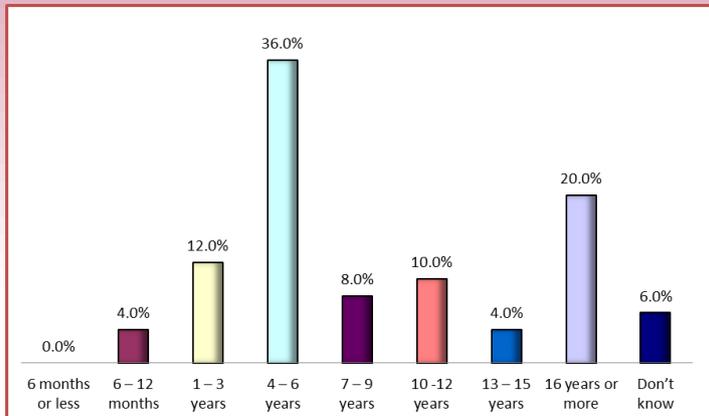
Gender (res n: 52)



Identify as.... (res n: 51)

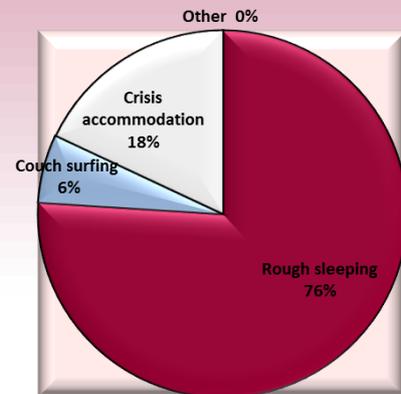


Duration of homelessness (res n: 50)

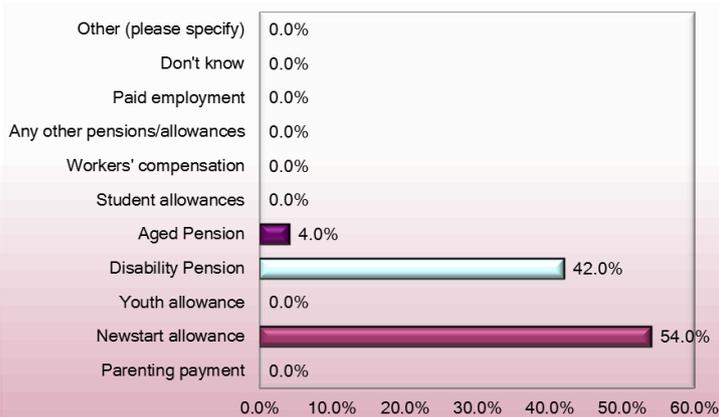


Accommodation on entering Douglas House

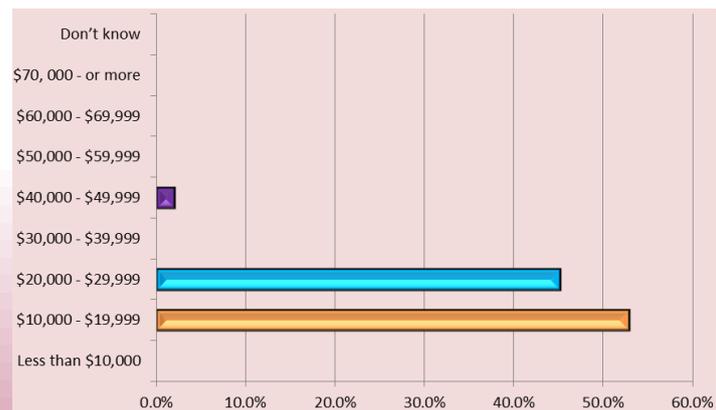
(res n: 50)



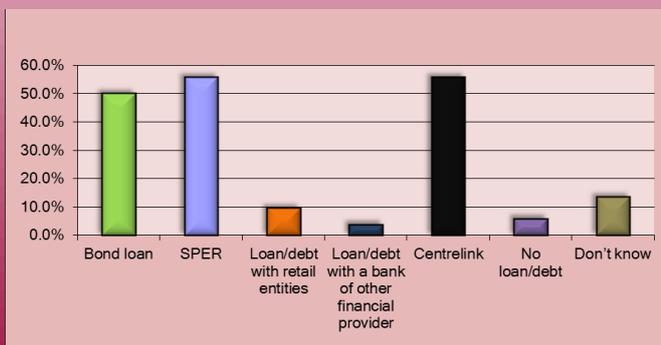
Main source of income (res n: 50)



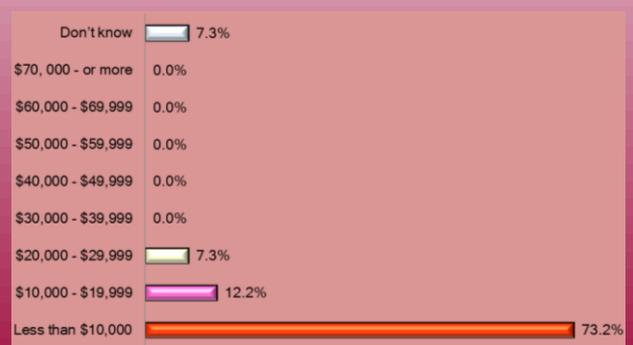
Annual Income (res n: 51)



Debtors (res n: 52)



Debt amounts



The basic demographics show a level of trauma and complexity that impacts the residents of Douglas House. In addition to the most basic components of their lives, the residents lives are further complicated by the direct experience of trauma, mental factors, a broad range of complexities, and institutionalising factors.

Mental health

The quantitative data reveals that only 19.2% of the population have a mental health diagnosis; however, that data also indicates that the staff at Douglas House believe that these statistics do not accurately represent the rate of mental illness, with staff noting concerns that 50% of the residents appear to have an undiagnosed mental health condition. Given that only 19.2% of the residents have an official mental health diagnosis and that the recovery approach is one of the core theoretical approaches of the practice model, this figure does raise questions about the relevance of the model as an intervention in this context. However, the low level of diagnosis is consistent with the literature in which claims that mental health occurs at higher rates in homeless populations in comparison with homed populations is contested (Johnson & Chamberlain, 2011). Johnson and Chamberlin (2011) also point out that much of the discrepancy depends on how and if substance dependency is included, as substance dependency can inflate the proportion of people classified as having a mental health condition. In this study, if substance dependency (alcohol 76% and drugs 62%, see page 46) had been included in the mental health category, it seems likely that this would have greatly increased the percentage of the population identified as having a diagnosed mental health condition.

It is recommended that a clearer articulation and understanding of how recovery is being defined and included in the model would be useful in the future development of the practice model. The expanded model of recovery outlined by Cornes et al., (2014) may be of assistance in this process. Consideration should address questions such as: What are the residents recovering from? Is it mental health, homelessness, trauma, institutionalisation, or compounding complexities? Recovery was often spoken by staff as the process for self-determination, so it is possible the model is being adapted as a model of empowerment rather than directly dealing with issues of mental health.

Experience of Trauma

Data was collected on experiences associated with trauma and the results demonstrate that trauma, (excluding homelessness and colonisation), is experienced by residents as domestic violence, sexual assault, or being a ward of the state. Being a ward of the state was identified as traumatic due to the experience of removal and its associated impacts.

In relation to domestic violence, 58.8% of the population have experienced domestic violence. This is not surprising and is also representative of the gendered nature of domestic violence and intergenerational family violence (Zufferey & Chung, 2015) with those who reported domestic violence, 76% were female and 24% were male. A much lower percentage was recorded as having experienced sexual assault at 9.8%; however it is important to note that sexual assault is often unreported.

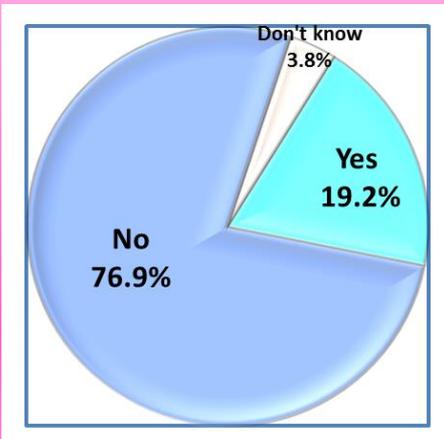
The final experience categorised as trauma was being a ward of the state and this study identified 17.6% of this population as having been a ward of the state; however, 41.2% of respondents did not know if they had been a ward of the state. Therefore, the results for this question may not accurately represent residents which was supported by staff who noted that this was difficult to answer with many residents having been on missions rather than being 'wards of the state'. This lack of clarity in this data represents an opportunity for future research.

The experiences of trauma by the participants that has been identified in this study provides support for the inclusion of the trauma informed theoretical approach within the practice model. The reporting by all residents of trauma resulting from their experiences of homelessness may explain why some of the changes to the model have occurred in the development of the intensive support of pre-recovery phase.

Mental Health

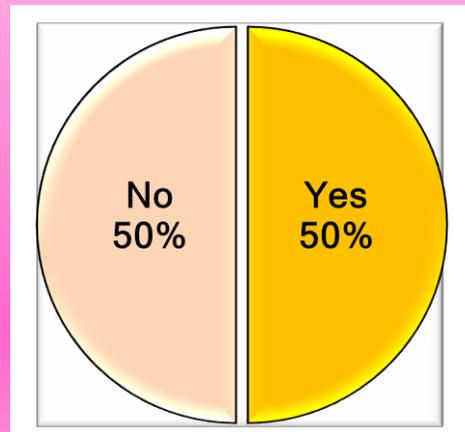
Has a Mental Health Diagnosis

(res n: 52)



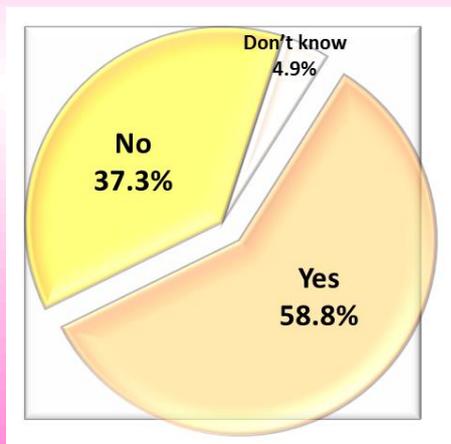
Staff concerns re undiagnosed Mental Health

(res n: 50)

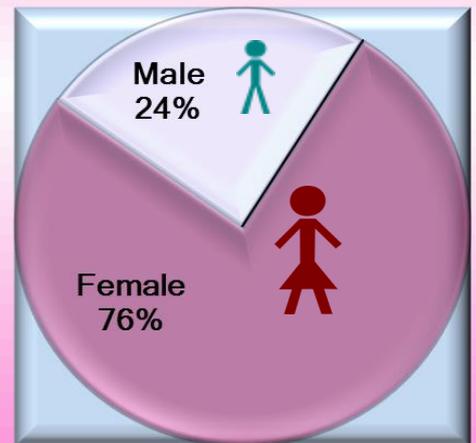


Experience of Trauma

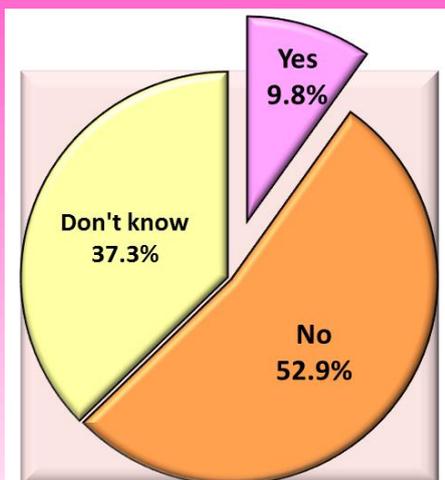
Victim of Domestic Violence (res n: 51)



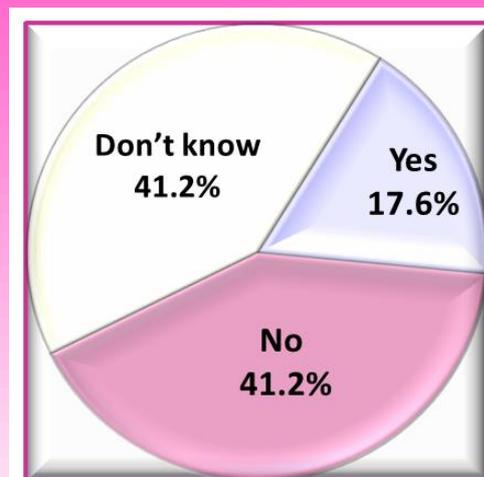
Victims of DV and Gender



Victims of Sexual Assault (res n: 51)



Was a ward of the State (res n: 51)



Institutionalising factors

Institutionalisation was a further factor identified in the qualitative analysis as contributing to the adaptation of the Douglas House Practice Model in relation to the pre-recovery phase. Due to experiences of institutionalisation, many of the residents did not know how to do basic things for themselves. This was viewed as a barrier to residents wanting to subscribe to the self-determining vision that the staff held for them.

Well, again, there's masses of institutionalisation happening... It does sound like you're blaming the person for that, you know, the institutions have done it.

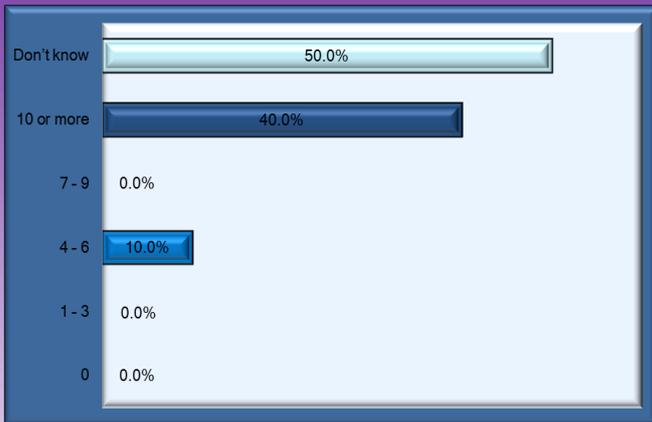
The clients are going to drive this. And it was so disheartening for me, because I never actually realised how institutionalised the people that we work with are.

Factors of institutionalisation for this category were identified as being institutionalised for mental health conditions, being incarcerated (prison, not watch house), and being a ward of the state (see page 45). Being a ward of the state has been categorised as an experience of institutionalisation, as being a child in care results in decision being removed from the individual and family. It has been included in this category as well as the trauma category as it has the potential to impact both as trauma and as institutionalisation.

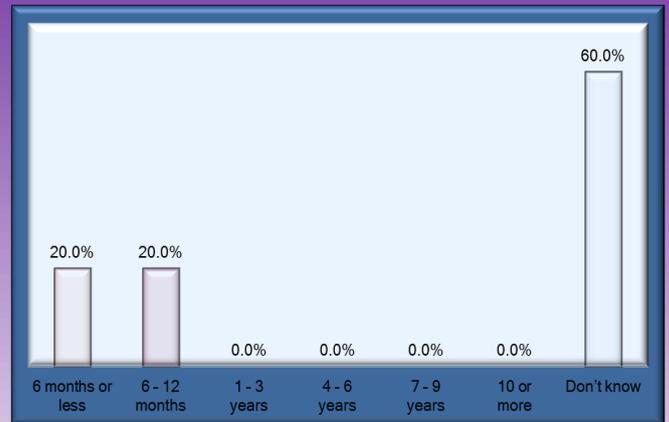
For residents with diagnosed mental health conditions (19.2 %), 50% had been institutionalised, with 40% of these being institutionalised 10 or more times. The longest duration of institutionalisation for mental health conditions shows an even split of 20% between 6 months or less and 6-12 months. A more significant number of residents (42.4%) have been incarcerated and although 33.3% were incarcerated for six months or less, with representation in most other timeframes, 4.8% had been incarcerated for over ten years. As mentioned previously, 17.6% of the population had been a ward of the state, with 33.3% wards for 10 years or more and all others known as wards of state for between 4-6 years. However, as already noted, accurate representation of ward of the state status for residents is problematic.

Institutionalising factors

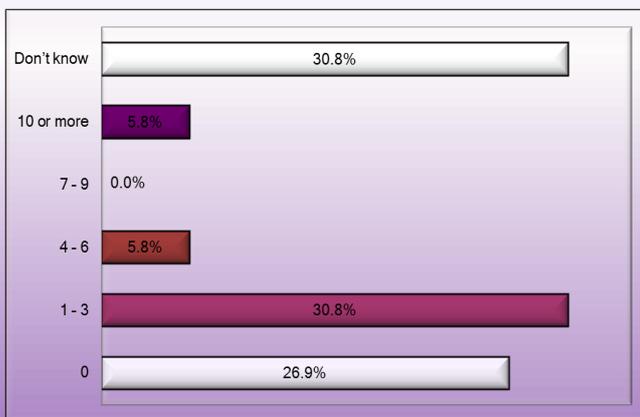
Times a resident with a mental health diagnosis has been institutionalised



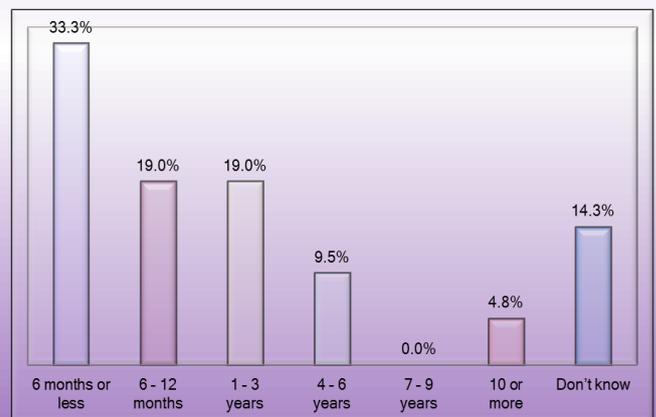
Longest period of institutionalisation



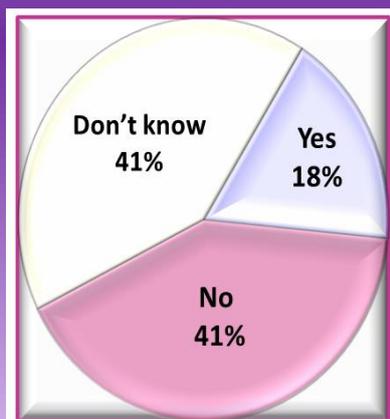
Times a resident has been incarcerated (res n: 52)



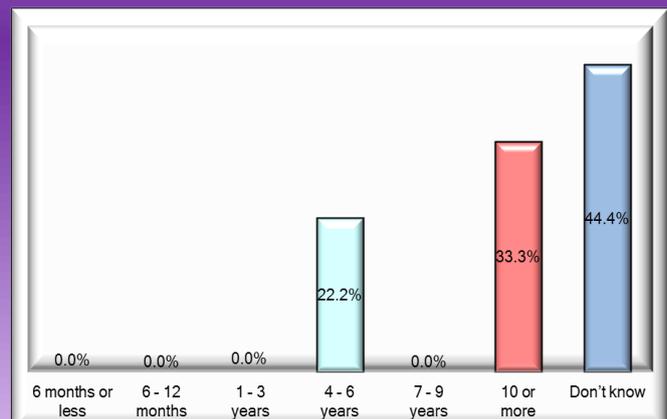
Longest period of incarceration



Was a ward of the State (res n: 51)



Length of State care



Complexities

In addition to the difficulties that residents experience in relation to general demographics, mental health, trauma, and institutionalisation, there are additional factors that add to the complexity of residents' lives and to the service as it responds to the residents' needs.

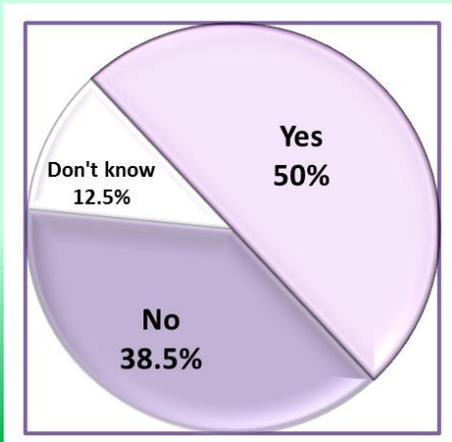
Factors that contribute to client complexities include: (see page 47):

- A physical health diagnosis (50%)
- An identified drinking problem (76%)
- An identified drug problem (62%)
- Identified gambling problem (20%)
- Have a current child protection order in place (17.6%)
- On parole while at Douglas House (16%)
- Charges pending while at Douglas House (41.2%)
- Family law matters pending (5.9%)

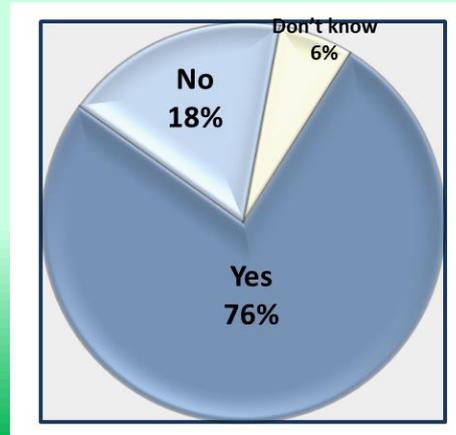
The literature (Chamberlain et al., 2014) supports these findings for long term homeless populations. Further, it is recognised by the trauma and mental health (Cornes et al, 2014; Hopper et al., 2010) that those who have experienced trauma and mental health often present with co-morbidities including substance abuse, chronic health conditions, and some/all of the factors identified above. It is therefore consistent that these complexities do indeed influence the Douglas House Practice Model and service delivery as staff attempt to meet the goals of the service and the residents' needs.

Complexities

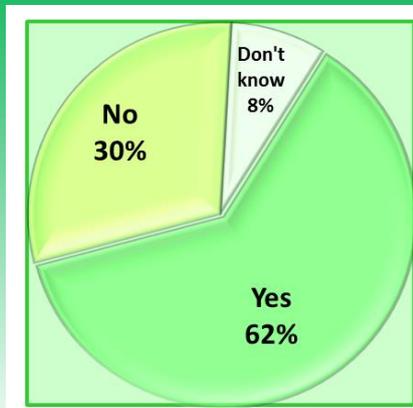
Has a Physical Health Diagnosis (res n: 52)



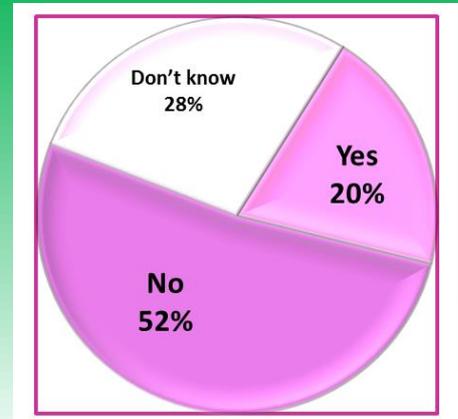
Has a Drinking Problem (res n: 50)



Has a Drug Problem (res n: 50)



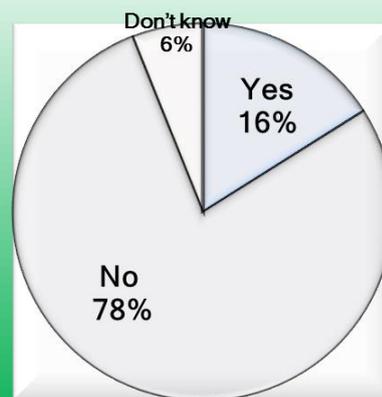
Has a Gambling Problem (res n: 50)



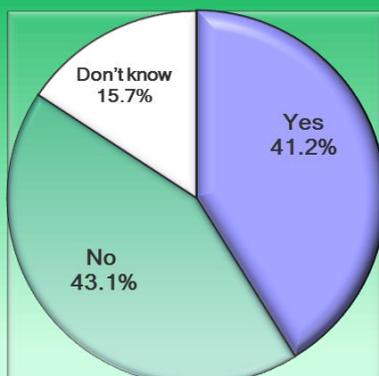
Child protection order in place (res n: 51)



On parole while at Douglas House (res n: 50)



Charges pending while at Douglas House (res n: 51)



Family law matters pending (res n: 51)



Redefining outcomes and success

Through the examination of the residents' demographics, experience of trauma, mental health, institutionalisation, and impacting complexities, an understanding of why adaptations such as the pre-recovery phase have been integrated into the model becomes clear. In acknowledging these adaptations, sub-aim three becomes an important consideration to establish if the Douglas House Practice Model is achieving the formal goals of the service and the needs of the residents, and this is discussed in this section of the report.

Throughout the interviews and focus groups, participants clearly articulated that the service is meeting the funding requirements for housing and supported accommodation. Additionally, they provided clear evidence that they were meeting the aims and objectives set out in the SOG and that the Douglas House Practice Model was assisting in this process. There is a clear alignment between the aims and objectives outlined in the SOG and the principles and practice of the theoretical approaches of the Douglas House Practice Model and the shared vision and values and experiences of staff. The aims and objectives extracted from the SOG as detailed below, provide an example of this alignment in relation to the concept of self-determination, culturally responsive practice, and an acknowledgement of the trauma and complexities affecting the residents:

Aims

- To assist Residents to achieve the self-reliance and independence to maintain permanent accommodation
- To provide a culturally appropriate response and environment for Indigenous people

Objectives

- To provide a full residential support facility for people experiencing homelessness with complex needs for the duration of need
- To conduct assessments to identify appropriate responses for clients within a trauma informed approach to Resident recovery planning (SOG, pp. 12-13)

The following participant comment confirms that the formal goals of the services are being achieved and that local services recognise the impact of the service's work with residents:

We've had comments from the hospital, they say, "Oh, I thought they'd passed away, we haven't seen them for six months," or "I haven't seen [the resident] for 12 months," "No. That's because they've been here."

The quantitative data examining factors relating to the residents' stay at Douglas House (see page 51) provided further support to demonstrate that the service aims, objectives, and resident needs were being met, with 75% of residents having stayed for more than 91 days. This data suggests that Douglas House is successfully meeting its service objective to be welcoming and to encourage residents to stay. However, because the data included both current and exited residents, the duration of stay of those who have not yet exited could be higher. The data examining the number of interruptions to the tenancy of residents shows that eight residents were identified as having an interruption to their tenancy. The reason for interruptions were provided as an open response, which was then coded to themes which identified that interruptions were as a result of domestic violence, health issues, violent behaviours, and incarceration. Importantly, these were interruptions (with residents returning to stay) rather than terminations, which further supports the premise that Douglas House is welcoming and encourages service users to stay. Furthermore, that Douglas House is willing to have these residents return to the facility demonstrates their commitment to their vision and the objective to provide residential support for the duration of need.

The data also showed that 56.9% of the population had a termination of tenancy. Data relating to the type of exit revealed that 68% of these exited as part of a planned and assisted transition or as a voluntarily exit and 25% were evicted. The remaining 7.1% exited under circumstances that included incarceration and hospitalisation. Data describing residents' housing situation upon exiting was also collected as an open response, which was then coded into themes. This data demonstrated that of the 28 that exited, seven exited to homelessness, three went back to country, five to live with family, and five moved to

supported or independent accommodation. The remaining eight moved to health and aged care facilities, prison, or was unknown.

Information about the types of services accessed by residents while living at Douglas House was collected. This question allowed for more than one service to be identified and it was found that residents accessed a wide variety of services (see page 51). Other than accommodation, which 100% of residents accessed, the top six services accessed by residents were:

- Transport (92%)
- Individual recovery work (82%)
- Advocacy and support with Centrelink (78%)
- Developing practical skills (72%)
- Living skills (70%)
- Support and advocacy relating to alcohol use (misuse) (68%)

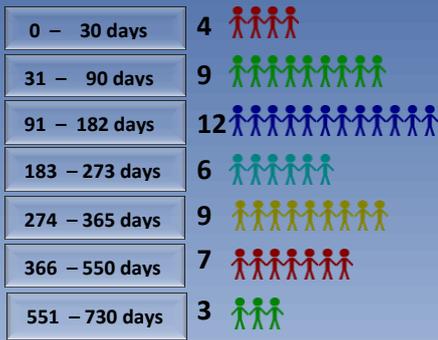
The mean or average number of services accessed by residents was 12.8, with a median of 13, and a standard deviation of 4.65. Of the 23 services, including the option of other, the minimum services accessed was one and the maximum was 20. These results support staffs' feedback regarding the provision of intensive support during the pre-recovery phase. It also illustrates that the recovery approach is being used with residents, irrespective of their mental health diagnosis.

In meeting the service's aims and objectives, it was evident in the qualitative data that there was a distinction made between outcomes required for the funding body, and the outcomes as defined from the perspective of the Douglas House Practice Model. There is recognition that within the model,

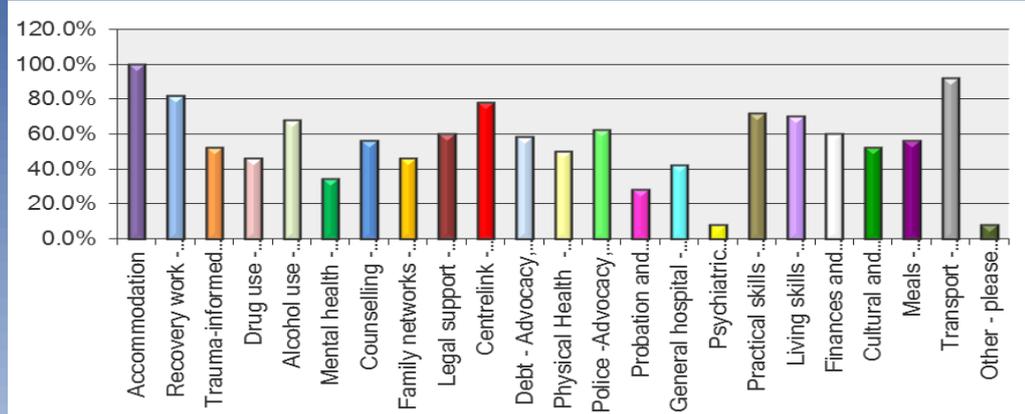
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Residents at Douglas House

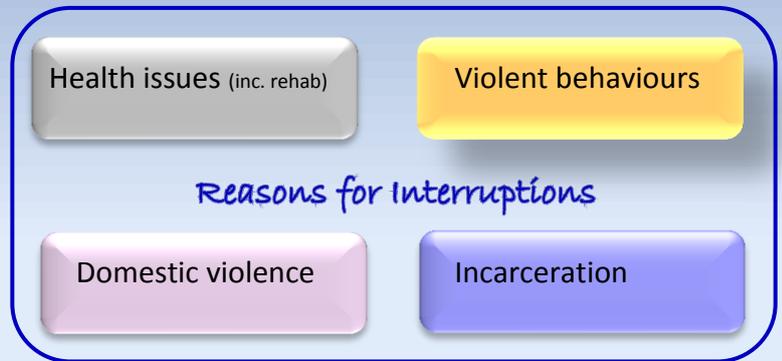
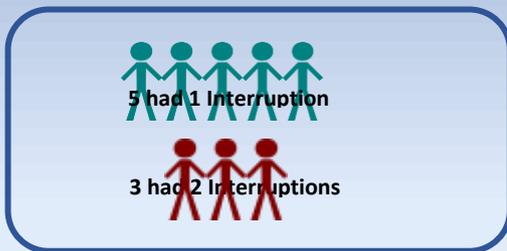
Days as a resident (res n: 50)



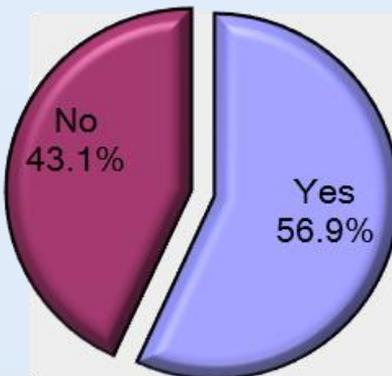
Services accessed during tenancy (res n: 50)



8 Residents had interruptions to their tenancy



Terminated tenancy (res n:51)



Reason for termination



Accommodation after leaving



recovery from trauma, dealing with compounded complexities, and navigating long term homelessness takes time, space and some periods of intensive support in the pre-recovery, stage which produces different outcomes as indicators of successful or effective intervention. These outcomes are subtler and appear to be stronger indicators of change by participants than the more simplistic outcome measurement of housing provision. This was also true when discussing the value of self-determination. Therefore, existing outcome measurements require redefining and should include factors in the Douglas House Practice Model more accurately to represent the achievements of clients, staff, and the agency. Future projects are recommended to identify these redefined outcomes and to develop appropriate measurement tools. This should include the perspectives of residents and how they define success.

Some possible areas of outcomes and measurements that have been identified in this project include:

1. Ability to self soothe
2. Ability to set boundaries
3. Increased ability to seek support
4. Increased independence and self-determination
5. Identify and develop strengths and capacity
6. Not drinking for a day
7. Not causing a disturbance for a day
8. Decreased attendance at emergency
9. Decreased police intervention
10. Development of practical skills. For example, cooking
11. Development of living skills. For example, independently accessing Centrelink

There are two incidents that are paraphrased from the qualitative data that illustrate the difficulties in defining outcomes and success:

Incident 1: Ambulance officers attended a female resident. During the visit the paramedic stated that they had not seen the woman for some time and that the service had done well in supporting her. Staff acknowledged that although they themselves thought they had worked well with this resident, they found it ironic

that this was being said in the context of attending to her as she lay amongst broken glass.

Incident 2: A male resident who was encouraged to give a performance at a 'gig' organised by one of the staff but had been taken into police custody for intoxication. On his release, the resident arrived as agreed and delivered a great performance. Staff also described how showing up to the 'gig' had led to other opportunities including visiting his community and having his story documented in film.

These stories highlight that the impacts of the service on residents are being acknowledged by external service providers and that, while 'problem' behaviour may continue for residents, the service is still able to be hopeful and celebrate small achievements, consistent with the Douglas House Practice Model.

This report recommends the development of outcome measures and appropriate tools capable of capturing the value of incidents such as those noted above, are needed to develop a more realistic and authentic picture of the effectiveness of the model within the context of Douglas House and the complexities associated with the residents.

In addition, given the complexities of the resident population, their unique needs, and the time it takes to implement the Douglas House Practice Model, it is recommended that consideration be given to employing additional staff to aid in the implementation of the model to its full potential and to achieve effective outcomes with a higher percentage of the cohort. Additional staff would assist in implementing the Douglas House Practice Model as standard practice, achieving outcomes with a higher percentage of the cohort, meeting the self-care needs of staff (also an occupational health and safety obligation), strengthen reflective practice, and support authentic application of the Douglas House Practice Model.

A further recommendation of this report is that internal and external supervision processes be reviewed to ensure there is an adequate supervision program for all staff members in place. The range of services offered at Douglas House, the intensive nature of these services, and staff's own identification of the need for supervision, supports this recommendation. For example, one participant noted:

Debrief was the third thing, if that was needed, so, that was triggered every day, to realise there's a lot of stress in this workplace and sometimes we don't realise it, because we're not here late at night with people coming back drunk...

Contextualising the practice model

The final sub-aim to be addressed in this research is the exploration of how the model may inform the delivery of other services and fit within the broader context of practice with this client population.

The described service model of supported accommodation appears to work well with the Douglas House Practice Model to meet the service's goals and needs of the residents. Hopper et al., (2010) note that trauma informed care is successful when working with homeless populations because of the prevalence of trauma among this group and because it encourages workers to develop strategies to both anticipate and respond to the complex needs that may arise during their daily work. The culturally responsive focus and the pre-recovery phase of the model may prove helpful for others who are working with people experiencing long term homelessness.

The Home for Good (2014) report showed that in Cairns, 70.9% of the sample identified as Aboriginal or Torres Strait Islander, which is more than double the rate Queensland wide. Although Cairns' rates for Aboriginal and Torres Strait Islander homelessness are high, arguably there are many other regions across Australia where Aboriginal and Torres Strait Islander peoples would be over represented in the homelessness population. Therefore, it is suggested that the service and practice models of Douglas House could contribute valuable information to other local and national homelessness services that work with Aboriginal and Torres Strait Islander peoples. While the elements of the model that support Aboriginal and Torres Strait Islander people may not be required in all homelessness agencies, the recovery, strength and trauma informed approaches are likely to be transferable to other services working with long term homeless because of the compounding complexities and trauma experienced by this cohort irrespective of culture (Hopper et al., 2010).

Therefore, it is suggested that the service and practice models of Douglas House could contribute valuable information to other local and national homelessness services that work with Aboriginal and Torres Strait Islander peoples.

The identification of the pre-recovery phase provides an extended understanding and intervention of the trauma informed and recovery approaches used when working with this cohort. The potential importance of the pre-recovery phase is further highlighted for the development of the new Woree site. Although Woree was initially to be an extension of Douglas House, it has rolled out as a more consistent iteration of the recovery approach, with a much greater focus on the independence and self-determination of the residents and lower levels of support from staff. The potential, then, is for Woree to provide a secondary phase to Douglas House, with Douglas House having an intense focus on pre-recovery and trauma and Woree focused on full recovery. Although these services can work together as stepping stones in an individual's journey to recovery and independent tenancy, they also have distinct identities that will provide different services to individuals. For example, not all residents will access transition between the services. The pre-recovery phase may provide some beginning guidance as to what aspects of the practice and service models will be emphasised in each service and may be crucial in identifying the appropriate intake of individuals between the two services.

Concluding thoughts

This report has presented an early snapshot of an evolving model that could provide other services with a road map of how to implement such an approach. Further research is recommended to capture a more detailed blueprint of the model and enable a greater opportunity for replication and more in-depth evaluation of outcomes. As mentioned earlier, a key focus for future research would also include evaluation of the service model and an exploration of how the service model and Douglas House Practice Model interact and inform each other.

If us three left tomorrow – I don't know how we'd keep it in the building. There's nothing at the moment, what would keep it here, anchored here other than hope that some staff by the end of it, or whoever Mission employs, has a concept of the model that we've got here.

This process of further evaluation and consolidation of the models is of importance, as one participant noted:

If us three left tomorrow – I don't know how we'd keep it in the building. There's nothing at the moment, what would keep it here, anchored here other than hope that some staff by the end of it, or whoever Mission employs, has a concept of the model that we've got here.

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