THE SECRET LIFE OF US: YOUNG HOMELESS WOMEN WITH COMPLEX NEEDS.

By

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better understanding of the impact of childhood trauma on women can lead to changes in the way society treats them.

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EXECUTIVE SUMMARY

This research project set out to examine the complexities of working with homeless young women, aged 13 to 18 years, in a refuge setting who engage in self harm as a response to childhood trauma. The research also included other risk factors such as drug and alcohol use, support network and sexual assault/domestic violence histories, that have impact on homeless young women's ability to move forward.

The report provides an overview of government responses to homelessness through the Supported Accommodation Assistance Program. This is followed by a literature review, which discusses constructions in which homelessness is framed and an overview of current discourses regarding young homeless women's health. Both areas reveal an emphasis on individual deficits and provide little insight into the impact of structural causes such as sexual assault, domestic violence, family poverty and breakdown, unemployment or affordable and secure family housing and young women becoming homeless.

The report describes theory and practice that have been identified to be useful in this work and suggests that YSAAP workers can provide evidence-based practice that emphasizes strengths without needing to name the problem they perceive they are treating and therefore the expertise they use. The author suggests that the demarcation of expertise to specialist services is in the interests of service providers and not the clients they work with and that this serves to increase the medicalising of social issues.

Using a content analysis approach, records of the service were examined to identify the prevalence of self-harm behaviour as well as other

childhood trauma events (sexual assault, domestic violence) and risk factors (drug and/or alcohol use, parental contact, statutory involvement, multiple issues, medication). The report also documented case studies, to provide a sense of the actual issues faced by young women and YSAAP workers in a residential setting.

The data and case studies provide an overview of the complexities of working with homeless young women in Lowana Young Women's Service and gives examples of the issues. There is the acknowledgement that the primary focus of SAAP is on addressing the symptoms, and not effecting changes in cause so it is imperative that services have staff development that enhances the skills of workers. Sourcing education and training for SAAP workers that is recognised good practice and used within specialist services ultimately enhances the service provided by SAAP and can improve collaborative relationships with those services.

The findings reveal a relatively high proportion of young women engaging in self-harm while homeless, with over one quarter (44) of the sample (156) recording incidents. The findings also indicated that the younger the client was when they first entered the homeless service system, the more likely self-harm was to occur, with nearly two-thirds (64.3%) of clients who were engaging in self-harm having first contact with the service at 15 years old or less. Whether self harm occurred prior to leaving home was unclear and deserves further research.

There was evidence that although young women rarely cite personal space violations in childhood such as sexual assault or domestic violence as reasons for leaving home (most often under NDCA reporting they cite "family/relationship breakdown"), these issues surface as real causes once they have a trust relationship with YSAAP services. In the sample studied,

17.9% of the total cases disclosed sexual assault prior to leaving home and living with domestic violence was an issue for 32%. The research also supports other studies that homeless young women are likely to be vulnerable to sexual exploitation, with 9% disclosing sexual assault once homeless.

In the case of multiple issues, the report highlights concern that where self-harm is an issue, a young woman is more likely to have disclosed sexual assault, come from a domestic violence background and currently be using illicit drugs and/or alcohol (11.3%) than young women not self-harming (1.8%). This evidence supports the literature that describes self-harm as a response to childhood trauma and the need to see the action in context.

The most common medication prescribed for the sample group was SSRI (Serotonin re-uptake inhibitors) antidepressants. The treating of young women with trauma-related problems through the use of SSRI antidepressants presents some worrying results, with 66.6% of young women prescribed antidepressants also engaging in self-harm. This research project did not identify which came first, the self-harm or the treatment. Whether or not there is a direct link, as some research has suggested is an area that requires further study.

Many of these young women have limited or no family support networks, or come from single-parent families with father figures lacking. The report highlights the issues for YSAAP where the average age of young women is 15 when they enter supported accommodation; they are estranged from parental ties and fail to come under the jurisdiction of Child Protection Services. Only 34% of the sample was in any formal relationship with Child Protection, either through voluntary or court orders. It is

acknowledged that Child Protection may not be able to make a meaningful difference, but their involvement does provide for oversight where parental responsibility has been withdrawn or is hostile.

These factors are then further compounded once homeless by illicit drug and/or alcohol use with over one third (37.8%) of the total sample using substances. The research also highlighted that the prevalence of drug and/or alcohol issues increased to almost half (47.7%) where self-harm was an issue. The prevalence of illicit drug use supports the notion that YSAAP should support workers to develop skills in harm minimisation and accepted drug and alcohol practices.

This report provides insight into life within a gender-specific youth refuge. The author advocates for a lessening of emphasis on the deficits and individual characterisation of the causes of homelessness that are perpetuated throughout the discourses of homelessness and mental health. A richer story would include consideration of the context and circumstances under which particular behaviours are formed on the path to homelessness. These stories would account more fully for social causes that cannot be blamed on individuals and therefore re-focus attention away from blaming the victim.

This research raises the following areas that need further consideration for future policy formulation if we are to address the causes of homelessness as well as provide the best possible post-homeless interventions.

- Re-evaluation of publicizing mental health in terms of the medical model is needed. For young people to develop resilience they need to be assisted to accept certain levels of stress, anxiety and

depression as a normal response to trauma that can be utilized to further growth, rather than being pathologised to immobility.

- Emphasis in policy needs to shift from focusing on and describing resulting symptoms of youth homelessness (eg. depression, anxiety, personality disorders) to increasing the rate of prosecution for sexual and violent adult offenders.

- Child Protection across Australia is state-based, poorly coordinated and inadequate. In the ACT there are services available for early intervention that are meant to circumvent statutory intervention, but the failure of oversight by child protection to facilitate these in a timely manner is sadly lacking. Unfortunately, once young people enter YSAAP, it is left to YSAAP to source those services.

- Unless there is a National approach to child protection and youth homelessness and policies that provide concrete solutions to the social justice issues that cause their plight, YSAAP will continue to need to work with self destructive symptoms.

- Centrelink arrangements in relation to financial support for young people in YSAAP should be reviewed, to take into account emotional stability where approving income or breaching is concerned.

- The evidence in this report provides impetus for further research into the efficacy of prescribing psychotic medications to a youth population, particularly anti-depressants, where appropriate monitoring is unavailable.

- Considering the particular age group involved, there should be recognition of the therapeutic work that is carried out either by default or design in YSAAP services. The impact of reporting that expects concrete results from the case management approach and the farming out of emotional distress should be re-evaluated in the light of holistic service provision.

- YSAAP services need the resources to employ supervisors /managers/coordinators, who have certain commitment to life-long learning (consciousness raising, action research, reflective practice). More clinicians, with "expertise" will further polarize homeless young women and healthy society.

- There is a case for shared costs with health to facilitate professional development for YSAAP workers rather than the current idea that specialist services should expand. In light of a strength-based approach, it would be more cost effective to increase the level of expertise in YSAAP services than to increase the number of specialist providers.

- Raising awareness within YSAAP services of the benefits of an action research approach to service provision would assist them to see their work not only as a learning process for the client, but for themselves as well.

- Provision of more transitional semi-independent accommodation for young women whose lives other than their state of homelessness are stable.

Chapter One

PROJECT OVERVIEW

Introduction

Many professionals working in the field of youth homelessness express the belief that risk behaviours exhibited by young women have become more extreme and are more self destructive than ever before. My own experience, having worked as Coordinator of a female, gender specific youth refuge for the past eight years, supports this belief. It seems that through government policy, society is doing little to alleviate the situations that exist prior to homelessness, but instead concentrates on increasing the service system that deals with the aftermath.

The Government's main response to homelessness is through the Supported Accommodation Assistance Program (SAAP). Lowana Young Women's Service is funded through YSAAP (Youth Supported Accommodation Assistance Program) as a supported accommodation option in the Australian Capital Territory (ACT) and operates under a feminist/harm minimisation philosophy. Lowana provides residential, supported accommodation at the one site for up to 8 young women aged between 13 and 18 years within a case management model. The service also operates as a living/social skills program in a non-structured way through daily living experience. There is a rotational roster with a worker present 24 hours a day, 365 days a year.

During my work at Lowana I began to notice that the prevalence of young homeless women engaging in acts of self-harm had increased, or at least become more visible. Many of these young women were being excluded from youth refuges due to their behaviour. We made a commitment

during 2001 that through the experience of accommodating and working with these young women, we could come to understand what role self harm played in their lives. This involved a culture shift by the organisation so that instead of asking what they should do to fit the service system, we began to ask how we could change to better respond to their needs.

Due to the increased prevalence of observable self harm, I was interested in whether there is any relationship between alleged sexual abuse prior to becoming homeless and acts of deliberate self harm, either before or after leaving home. These are contextual issues for being homeless, along with other external factors, that may involve family drug and alcohol use, domestic violence or parental/sibling mental health issues, economic and other social factors that impact on a young person's decision that "home" is no longer a viable accommodation option.

Project Objectives

This project therefore seeks

1. to improve understanding of the difficulties of sustaining accommodation for homeless young women in a group setting where self harm is prevalent and where there is minimal or hostile parental contact and

2. to identify what constitutes good practice in YSAAP based on evidence of working with self harm behaviours.

In achieving this, I intend to define the various behaviours that constitute a notion of self-harm, articulate the specific forms identified for investigation in this research and identify how prevalent acts of self harm are in this particular group. I then intend to identify any preceding

conditions that may have contributed, particularly sexual abuse, by examining commonalities and trends in self-harm behaviour, with a view to contributing to a broader debate on the causes and consequences of youth homelessness.

To achieve these objectives, I have used a content analysis approach using Lowana's records. This approach examines the contents of communications or records to establish if any themes arise (Wilkinson, 2000:53) and was selected due to the amount of information that was available in storage that was serving little other purpose. The research examined what is known about the issues of providing safe accommodation to homeless young women in a specific refuge setting, particularly those who are engaging in self-harm. Background reading on theories of self-harm provided a contextual understanding of the issues and evidence based responses that are useful. The research attempted to identify any common factors that may contribute to the use of self-harm and included components of both qualitative and quantitative data, including case studies.

Structure of Report

This report is structured in the following way:

The next chapter gives a brief overview of homelessness and the SAAP view of complex needs. Included is an analysis of current constructions of homelessness and an examination of the discourse of the causes and prevailing conceptual framework in which policy interventions are formulated.

Chapter Three details the methodology for the project, including data collection technique, method of data analysis and conceptual framework

in which the research is carried out. Included is a review of the literature identifying the current discourses regarding homeless young women's health, current understandings of self-harm, the variety of interpretations of such behaviour and what are considered appropriate interventions?

Chapter Four discusses the evidenced-based interventions employed in practice at Lowana and their perceived impact on service provision and benefits to service users.

In Chapter Five, the results of the data provide a descriptive account of the environment and the possible implications. Of the clients identified to have self-harm behaviours, a case study was written from the existing documents. The case study indicates responses by the service to sustained self-harming and examples where specific interventions are used. A further case study demonstrates the reality of attempts to contain behaviour within the context of a refuge setting and comments on the idea of complex need.

Finally, Chapter Six provides an overview of the findings and their impact on YSAAP services. The report was not intended to make specific recommendations but provides some considerations for the future.

Chapter Two

SAAP AND THE HOMELESS

Counting the Homeless

There are different measurements of homelessness in Australia due to the different reasons for requiring definition. The population size of homeless people is markedly different depending on how broadly or narrowly the definition is set. Chamberlain and MacKenzie (2002) provide the most accepted conceptual definition, the cultural definition, which is used by the Australian Bureau of Statistics and to inform national policy. This definition, with some refinement is used when counting the population and is useful for quantifying the numbers of homeless people but provides no social context to how people became homeless in the first place.

The second most widely accepted definition is formulated under the Australian Government SAAP legislation. In order to support service provision, a homeless person is described as "a person who does not have access to safe, secure and adequate housing" and includes "if he or she is living in accommodation provided by a SAAP agency or some other form of emergency accommodation" (SAAP NDC Annual Report, 2003-04: xiii). The SAAP definition allows services to assist those people without shelter and those who are at risk of becoming homeless. Not only does SAAP assist this population, those assisted provide SAAP with some understanding through research, of the nature and causes of homelessness. Those using YSAAP services are the population examined in this research and are the ones more likely to appear in the literature.

In their Report, *Young Homeless People in Australia, 2001-02,* (2003:xv), the SAAP National Data Collection Agency reported that 36% of homeless people in Australia were in the 12-24 age range and that young females in this age group are more likely to access SAAP than young males. These figures account for young people who are seeking assistance without an accompanying adult. Although there are other young people within the service system of SAAP due to an adult's state of homelessness, this research is concerned with young women who are alone and have come into contact with service providers.

The Supported Accommodation Assistance Program

SAAP is a joint Commonwealth and State/Territory program that aims to alleviate homelessness and has been in effect since 1985. SAAP provides transitional, emergency and supported accommodation and outreach services to homeless people and people at risk of homelessness across all states and territories. The Progam is evaluated every five years and a strategic framework is formulated with aims adjusted to meet emerging trends.

There are layers of responsibility through government that influence service provision through legislation, funding agreements and policy documents (Willis & Craft, 2003). The Program is underpinned by *The SAAP Act, 1994*, with a *Memorandum of Understanding* endorsed by all relevant state or territory Ministers. Along with other policy documents, each state and territory has a *Bilateral Agreement* with the Australian Government that establishes accountability for outcomes that have been articulated in the Memorandum.

One of the main tenets of accountability is the use of a case management approach. This approach has a focus on achieving concrete results within

employment/education/training and transition to independence for homeless people in SAAP. Therapeutic intervention (i.e.; attending to emotional needs) is not considered to be the work of SAAP and these needs are meant to be met by increasing partnerships with other services. The SAAP believes (Complex Needs, 1999) that with co-operative planning, where services reach agreement about the roles and responsibilities of each agency and define them in written protocols for joint service delivery, therapeutic interventions can be carried out by "specialist" services. This fails to account for the regular instances of after-hours crisis that occur within YSAAP services, when no specialist agencies are available and the workers on hand must enact intervention. People suffering from emotional distress are rarely able to delay their responses. This means that a young woman who intends to engage in self-harm at 9pm will be unable to delay until 9am the following day so a specialist can intervene. There are instances where with appropriate training SAAP workers can avoid placing stress on emergency services to resolve such a crisis. So although having partnerships with other services is an essential part of practice, there are instances where carrying out such interventions fall directly to the workers present.

Complex Needs

SAAP acknowledges that there are increasing levels of what is termed complex needs amongst homeless people and the difficulties that may be faced in supporting them. Complexity is identified through analysis of 31 types of need identified through the SAAP data collection agency, The National Data Collection Agency (NDCA), administered by The Australian Institute of Health and Welfare. The categories formulated are useful in identifying the complexity of working with homeless people with multiple support needs but do not categorise self-harming or other behavioural impacts that may be specific to a particular group. The

information collected by the NDCA is broad and provides information about the whole homeless population. It is suggested here that young women in this research would qualify as "Category 1: intensive needs, which may compromise functioning and ability to meet basic needs and which often manifest in difficult behaviours and are more likely to be on-going" (Complex Needs, 1999:vi).

Although SAAP policy acknowledges complex needs through conceptual definitions, there is an assumption that it is "the inadequate level of skill of SAAP workers that defines the inability to cope with a demanding client" (Complex Needs, 1999:8) without an understanding of what that demand requires.

Constructions of Homelessness

The homelessness literature provides copious amounts of information regarding the issues involved in supporting people in SAAP, as well as the complexities of defining and explaining homelessness and its causes. What is clear is that the same issues arise again and again; the real causes for homelessness are social justice issues that are being neglected while under right wing politics, policy is focused on ameliorating the symptoms of those already homeless (Fopp, 2002, White, 2002) rather than addressing structural factors such as, among others, poverty, unemployment, physical healthcare, child care and adequate and affordable housing.

Fopp (2002) asserts that the dominant view of homelessness is that it is caused by deficits within the individual prior to their homelessness, like drug use, unemployment and psychiatric illness. He states that when attempting to describe neutral and objective profile characteristics of homeless people these become deficiencies and are assumed to be the

causes of homelessness. Fopp argues that causes are seen as a "one way street" (p15) in that people have problems and not that structural problems may be inflicted on people. He raises concern that where causes and symptoms are confused, funding is allocated to treating the symptoms and possible causes are not examined.

White (2002) proposes a similar view. White is concerned with the move towards multifactor explanations for social problems and multi-pronged solutions. He believes that with this shift the analysis fails to provide a hierarchy of causes (p19) that have led to the problem and would probably conversely lead to structural issues. He rightly argues that there are always contextual factors that are overlooked that contribute to social problems like homelessness and these are not in the bounds of individual control. Instead there is concentration on immediately identifiable characteristics, which are defined as causes and interventions are instigated to ameliorate those characteristics. White believes that this concentration on multiple factors allows governments to appear to be doing something concrete while the status quo remains unchanged.

The literature provides little insight into the effect of structural issues on the health of young people who become homeless and the impact of factors prior to homelessness. Sociologists believe we are fixated on the struggle with resulting issues that are under the umbrella of mental health rather than attempting to address social problems, social inequality and transformation of structures that may contribute to reducing homelessness in the first place (White, 2002).

The SAAP definition individualises the complexity of working with homeless people without due regard to the environment and context in which that work is carried out. What is not considered is the impact on

holistic service provision of the continuing system of silo funding, where mental health, drug and alcohol and other so called specialist services are to respond to their particular part of the person's problems, separate from SAAP. There also seems to be a lack of understanding that the "complex needs" person does not exist in a vacuum but interacts with others in the environment. Unlike the specialist who is most often working one to one in business hours, the YSAAP worker is trying to juggle group dynamics along with addressing individual crisis, often at night. This means that it is almost crucial that SAAP policy begin to pay more attention to the context component of service provision rather than the individual demographic.

The construction of homelessness suggests that young people are at fault for their state of homelessness and that the symptomatic behaviours and health problems they exhibit are the cause, rather than the result. These symptoms then become the focus of research and intervention and the real causes are left unexamined.

Chapter Three

METHODOLOGY AND CONCEPTUAL FRAMEWORK

Methodology

This project is in keeping with privacy and confidentiality laws and has ethical approval through the Australian Catholic University Human Research Ethics Committee. Although the data is taken from records of minors, consent from parents was not necessary due to their state of homelessness and the fact that they were in an YSAAP service. All young women entering the Service have their name coded on entry and any further reference to them in service records is according to that code. The code used is different to that used in SAAP data.

Literature Review

A literature review was undertaken on two levels. Firstly the review identifies the current discourses regarding homeless young women's health and the conceptual framework in which mental health interventions are formulated. The second part of the literature reviewed relates directly to current understandings of self-harm, interpretations of the behaviour and appropriate interventions.

Data Collection and Analysis

A content analysis examines particular records or communications to identify themes that arise (Wilkinson, 2000). A content analysis approach was used for this project due to the availability of accessible data held at the service. The use of service records came about due to the way in which the service operates on a day-to day basis. Practice at Lowana is grounded in the action research approach of do, reflect and evaluate, adjust and do. This means that over time, the service records show

valuable insight into the way in which practice evolves and how interactions are carried out. The work includes constant critical analysis of what we do and the records provide many instances of the difficulties in providing safe accommodation to a population engaged in risk activities. There are also disclosures made by young women that may never be heard in other clinical venues. In choosing a content analysis approach, the project also took into account the vulnerability of clients and the sensitive nature of the information sought.

The files contain basic information regarding entry assessment, admission details and exit details and some files retain case notes written during the course of the young women's stay. The Log Books are a 24-hour record by workers on shift of day-to-day operations and reflect events occurring within the refuge. Critical Incident Reports are written where the worker on shift considers the event requires specific analysis within the staff team meeting.

The project examined all individual files from previous clients (some having multiple accommodation periods) of Lowana Young Women's Service over a four year period (2001/04) and had no direct contact with any service users. Critical Incident Reports by workers were analysed and all log books over the same period, except for one, which was on subpoena to the ACT Sexual Assault Unit.

A content analysis was undertaken of 156 individual files, 32 log book records, case notes and critical incident reports for references to sexual assault/abuse/violence prior to leaving home, as well as the prevalence of self harm. Other demographic data was taken from referral and admission forms, exit reports and file notes. These were recorded against client

codes and entered into the computer SPSS data program for interpretation/analysis.

The analysis also looked for references within log book records to particular activities that complicate providing safe, supported accommodation, such as prescribed medications, illicit drug use, sexual assault and domestic violence history. A comprehensive case study was taken from critical incident reports, as well as from information found in the Log Books. A further brief case study was taken directly from the Log Book. Examples of other complicating issues were also taken from Log Books.

Quantitative Data gathered included:

- Age on first entry
- Under child protection or youth justice supervision
- Ethnicity
- Consecutive periods of accommodation
- Reference to sexual assault/domestic violence/self harm
- Parents separated/parental contact
- Reference to drug and/or alcohol use
- Any identified prescribed medication
- Incidents of self harm at the service

The data was recorded on tally sheets then entered into SPSS for analysis. Data on those who have self-harmed was cross-tabulated with those who have not. The implications of complexity of issues and any emerging trends are shown in the results in Chapter Five.

Project Limitations

Limited size of sample

The number of client files examined in the study is relatively small (156) and may not be representative of homeless young women in general. The number could be interpreted as a convenience sample of homeless young women due to the use of a specific set of accessible data (service records). However, Rodham et. al., (2005) suggest that studies into self-harm that have community based populations are more likely to provide accurate information compared to hospital or clinical based studies. This is because many instances of self-harm do not present to treatment services such as hospitals and often the clinical settings are unaware of the preceding crisis. Actions of self-harm are unlikely to occur in the presence of the treating mental health professional due to the times they are committed.

The portability of the findings

The research intended to highlight factors that support an action research approach to practice, as well as to identify the complexities of the work. There are criticisms of using an action research approach; that findings are unable to be generalized because they are only valid to the environment in which the research is carried out (Wilkinson, 2000). The findings do however give insight into possibilities for practice for other YSAAP services dealing with similar issues.

Policy on retaining documents

One of the limitations of the research is due to the service policy on retaining client information. Part of the service philosophy is that young women have the right to have the contents of their file shredded, except for basic entry/exit information. Some files have minimal information in them which means some quantitative data is missing and the qualitative data collected has come mostly from the Log Book and critical incident records. It also means that some clients will not be accounted for in sections of the quantitative data and this has been indicated in the results.

Literature Review

Conceptual Framework

This research is underpinned by concern with the way in which the causal factors for social problems are defined in a medical framework. Medicine and particularly psychiatric medicine, takes a major role in explaining a whole range of social issues (Illich, I, 1975, Illich, Zola, et., al., 1977, Roach & Anleu, 1995, DeGrandpre, R, 1999, Fitzpatrick, M, 2001, White, 2002). This is not an issue specific to homelessness but to social problems in general. Pathological language has commandeered a multitude of descriptive words for how one is behaving/feeling and can attribute these to a mental illness, or personal deficit, through common assessment tools. Through the use of psychological assessment, a person's life experience can be reduced to a clinical diagnosis and they then become subject to expert treatment. Illich (1975) discusses how professionals create more illness by steering people away from self-healing into believing in medical magic and so meeting the needs of the professional industry, rather than the needs of those suffering ills.

McLellan (1995) challenges the oppression of women particularly, by professionals who take away control from the individual. She states (p45)

that women are encouraged by services to look within themselves for the cause of their unhappiness and to take personal responsibility for their social condition. Young women self-harming are particularly vulnerable to the belief that their own role in their un-wellness is paramount. There are direct links between their own self-deprecating beliefs and the social construction that devalues women and women's experience (Fook, 1993). Most have come out of an environment where their worth was devalued, at an age where their self-identity is being formed. Their personal experience is often not acknowledged which further confirms their worthlessness. It is this focus on symptoms like self harm by the mental health system instead of underlying causes that Miller (1994:67) states is the major failing of treatment for young women who hurt themselves.

Although resilience and protective factors (Garmezy & Rutter, 1983, Garmezy, 1996, Gore & Eckenrode, 1996, White, 2002,) are widely accepted notions for predicting whether young people will be able to overcome adversity, including becoming homeless, the prevailing trend to medicalise behaviour and define disorder within the individual keeps the focus on perceived individual deficits and negatives. This perpetuates a "blame the victim" culture and precludes a wider discourse on external factors, like preceding environment and social context. It has been my observation that because young homeless people in YSAAP are characterized as "at risk", they are more likely to come into contact with other services than their peers, their situation becomes de-personalized and they run the risk of being over analysed, extensively and repeatedly monitored and diagnosed. Their behaviour becomes exaggerated by a medical model that is measuring them against a norm that does not relate to them if put in context with the environment in which they developed coping mechanisms. In short, they are more likely to be pathologised by experts.

When assessing mental health concerns, high levels of depression and anxiety are identified in homeless young women (Horn, 1998; Hodges, 1999; Wilson, 2000; Rossiter, et., al., 2003). Instead of initially accepting and normalising this is as a natural response to the situation, public health policy tends to instigate programs that exaggerate mental ills, while the broader social reasons for being depressed or having anxiety are not acknowledged or addressed.

Testing mental health also has its problems. Mental health is a subjective state and open to interpretation. Rossiter et. al., (2003:17) used the Brief Symptom Inventory (BSI), showing 26% of those tested displaying "psychological distress indicative of a psychiatric disorder". Where researchers use psychiatric scales, there is little room for contextual issues to be accounted for. All that is recorded is the base data against a set of "norms". The fact that these young people are living tenuously and the norms are not is unaccounted for and provides perfect background for medical intervention. Young homeless people are surviving in circumstances that would produce a level of emotional distress in anyone.

White (2002) also argues that the prevailing medical model that is applied to social ills looks to the individual as the cause and therefore the solution to their own problems. Roach Anleu (1995:140) argues: "the individual becomes the location of a disorder's cause and the focus for intervention and treatment, thereby diverting attention from the broader social and economic conditions". Added to this is the neo-conservative politics that accentuate individualism and cost/benefits. Human service organisations have been in a long phase of economic rationalism and the "bottom line" that dictates services need to provide evidence of outcomes for individuals without consideration of social contexts. Community work is

relegated to operate as a business, the same as if the work involved was producing hats or serving meals.

I would argue that the professional treatment of personal issues is further compounded by the power base from which social ills are constructed. The paternalistic nature of professions and government, as the good father who knows best how to fix the problem, leaves little room for accounting for the wider social context. This power base still resides in the white, middle class male ethos. This ethos absolves men from responsibility, even though they collectively contribute most to the domestic violence and sexual abuse histories of many homeless young women. It also allows for a level of acceptance of violence in social interactions, like sport and the media, while expecting that one be responsible first and foremost for their own plight in a violent world.

There is no separation between the personal and political, particularly where a study of a social problem is concerned (Jamerozik, Nocella, 1998). The examination of any social issue is not value-neutral and pathologising social problems by explaining them in terms of behaviour of individuals, rather than social structures, only serves to "suppress the relationship between personal problems and social ills" (Miller, 1976).

White, M (2000) and also McDonald (1999) point out that contemporary social life is increasingly shaped by de-institutionalisation and individualism. McDonald (p217) argues "social policies are increasingly cultural in that they deal with questions of personal identity – from education, employment and urban policy through to youth or health policy". Identity in these discourses is framed as an individual phenomenon, not a community one.

White is concerned that there is a lack of community investment in developing and sustaining institutions generally and McDonald believes that social patterns formed by institutions that socialised young people are disintegrating. Young people are living in an environment of constant change. They no longer have the benefit of a fixed structure formed by stable community, institutions and cultural norms, which once provided initiation into community. Young people are expected to take full responsibility through the cultivation of self-esteem, for their self-actualisation rather than having the benefit of being guided and supported into a social identity (McDonald, 1999). Nowhere is this more pertinent than with homeless young people who have suffered sexual abuse. Even where social roles have existed, the moral internalisation process is severely skewed for a young person who is trying to integrate their own known existence and environment with the socially expected one.

This raises the philosophical concept of the struggle to reconcile "the self" with the "I". Jung (1977) theorised that we are all struggling to become who we were always meant to be and this process is facilitated by what we learn through social interaction. McDonald points to "the decline in models of self, constructed in terms of moral internalisation" (1999:217), to a world that has psychologised social tensions and conflicts. He argues that while we see social issues in these terms, structural problems will continue to be seen as problems of personality and interventions will continue to attempt to program individuals.

It is against this background of individual deficit that young people, who should have the benefit of family and community support, even though considered not to be "full members" of society due to their age, can still be made responsible for their own state of homelessness.

Homeless Young Women and Their Health

The most common themes for health concerns throughout the literature are that young homeless people are more likely to have mental health issues and be mis-using alcohol or drugs than their peers. (Lawson & Perese, 1996, Goldman & La Castra, 1998, Bisset, Campbell and Goodall, 1999, National Crime Prevention, 1999, National Youth Coalition for Housing, 1999, Horn, 1999, Hodges, 1999, SAAP Complex Needs Report, 1999, Huska & Fry, 2000, Veit, 2000, Rossiter, et., al., 2003.)

The most comprehensive study so far regarding health issues for young homeless people is being conducted through the Australian Research Centre in Sex, Health and Society at La Trobe University, Melbourne (Rossiter, et., al., 2003). This is a five-year study into health concerns and the preliminary report provides a detailed understanding of the health risks of homelessness. The research will provide follow up with young people interviewed over the next three years and draw comparisons with a similar demographic in Los Angeles.

This initial part of the study provides information on "how daily practices impact" on young people's long-term health and well-being once they have become homeless (Rossiter, et. al., 2003: 1). The research, although useful for understanding issues that could impact on health once young people are homeless, provides little insight into their state prior to becoming homeless. Most research is concerned with those currently homeless. These are young people separated from their social connections, however tenuous they may have been and are at the mercy of the service system to define their situation and their responses to their situation. They are vulnerable to being influenced by external evaluations

of their lives and to taking on labels and opinions offered by professionals.

Sexual abuse/violence/assault is listed in many of the documents reviewed as an issue and clustered with alcohol and drug use and mental health. Sexual abuse is most widely cited in relation to young women who are already homeless. Young women are said to be more vulnerable to sexual exploitation once homeless. (Goldman & La Castra, 1998; National Crime Prevention, 1999; Rossiter et., al., 2003; Tully, 2003). There is little or no information on the impact of childhood sexual abuse prior to leaving home or whether the use of sex as a bartering tool once homeless (Rossiter et. al., 2003) is a result of earlier sexual abuse.

There is very little relating self harm to incidents of sexual assault. Self-harm is mostly defined as a self esteem issue (National Crime Prevention, 1999), positively correlated with borderline personality disorder (Tyler, Cauce & Whitbeck, 2004), both individual deficits. It is continually linked to suicide or attempted suicide (National Crime Prevention, 1999; Rossiter, et., al., 2003; Mitchell, P, 2000). The concept of self-harm as a separate and discrete coping strategy rather than an attempt to suicide is not explored well in the health or mental health literature.

Most medical research cites self-harm as parasuicide, an attempt at killing oneself that failed. As explored later, although the risk of accidental suicide is higher in young women who self-harm, intent is not necessarily evident. Research into the effects of sexual abuse mostly takes a psychological approach and attempts to define behaviours, including self-harm, as disorders within individuals rather than responses to social milieu. A review of empirical psychological studies (Browne & Finkelor: 1986) confirms that symptoms of childhood sexual abuse include among

other things, depression and self-destructive behaviour. It is not the identifying of the effects that cause the concern about intervention; it is the reframing of these as causes and the subsequent pathologising of the individual without attention to real causes.

Self Harm

There are degrees of behaviour that could be defined as self-harm, in that they ultimately cause harm to quality of life. These would include misuse of drugs and/or alcohol, eating disorders, sexual promiscuity and other risk behaviours that young homeless women may be engaging in. These behaviours are considered as harmful and are examined further in this research in the context of prevailing self-harm. Explored here is the type of self-harm that leaves direct visible evidence, either permanently or temporarily on the body, as well as the misuse of medications. The terms used for such behaviour include self-mutilation, auto-aggression, intentional injury, symbolic wounding, deliberate self-harm, self-abuse, cutting, self-injury, parasuicide or attempted suicide. In this report, the term self-harm will be used consistently to avoid conceptual confusion.

In his book, *Bodies Under Siege,* Favazza (1996) explores "self mutilation" historically across religious, cultural and social contexts and contends that self-harm can be either pathological or culturally sanctioned and that both types share a purpose. He defines culturally sanctioned self-harm practices to be those that are carried out as part of rituals and practices of cultural groups and are used for healing, spirituality or to maintain rites of passage and social order. Pathological self-harm involves individual self-damaging acts that have no particular sanction (p232). He argues that except where cognitive capacity is severely limited, such behaviours serve as an attempt to correct or stabilize a condition that threatens the individual, community or both. This is not to minimize the morbidity and

suffering self-harm causes, nor to invalidate societal or personal explanations of it, but is a belief that "at the deepest irreducible level self-mutilative behaviour is prophylactic and salubrious for groups and individuals threatened by death, disorganization, disease and discomfort "(1996:222).

Miller (1994) describes self-harm as a way to replicate childhood violence. It is a learned way of coping with anxiety about situations over which the actor has no control (p6). Where personal space has been violated in childhood, the one way to gain control in a time of high anxiety is through use of the body – to express emotion through violation of one's own body. Re-enactment of trauma gives the actor a sense of normality, in feeling things are as the actor has always known them and this provides a sense of comfort. Miller points out that where violation and pain in the past have come from the same source as food, shelter and care taking, self-harm reinforces a sense of powerlessness (p8) against the environment.

Karl Menninger (1938) was the first to discuss individual self-harm as an attempt at self healing rather than suicide (in Favazza, 1996). Up until then, there was little exploration of self-harm in psychological literature as a discreet behaviour other than to use the general term of self-mutilation. During the 1970s the recognition that not all self-injury was suicidal in nature led to the classification of three variables. The first is direct/indirect; whether the person is aware of their actions and whether there is conscious intent on harming oneself, second is lethality; the degree to which it may result in death, and thirdly repetition; whether it is a single or repeated act (Favazza, 1996:233). These classifications in turn have given ground for the development of three observable categories described by Favazza.

The first of the categories is major self harms, which are acts that are infrequent and result in significant body damage, such as removing ones eye, limb or sexual castration. These behaviours are most commonly associated with psychotic disorders or acute intoxication and often have connection to delusional influences. The second observable category is described as stereotypic. Stereotypic self-harm is behaviour that is monotonous, repetitive and usually rhythmic, such as head-banging and has a high prevalence in institutionalized "mentally retarded persons" (p238). This category also includes those who gouge their eyes or bite or repeatedly scratch themselves.

The third category of moderate/superficial self harm relates to this research. Moderate/superficial self harm is behaviour that is mostly characterized by cutting, burning, picking or carving the skin. There is support throughout the literature that remedial self-harm of the moderate/superficial type is employed as an emotional regulator where tension and anxiety have created feelings of anger and powerlessness (Miller, 1994, Favazza, 1996, Alderman, 1997, Turner, 2002, Plummer, 2004). This type of self-harm is often episodic and although mostly non-lethal, may indeed cause death due to the risky nature of the act.

It is important to stress that self-harm is rarely a conscious attempt at suicide (Miller, 1994, Favazza, 1996, Alderman, 1997, Turner, 2002, Plummer, 2004) even though the common belief that it is still lingers. The person may state that they want to die but in fact the act of self-harm is a way of delaying that end. There are common themes for the use of self harm, among others articulated, the following: tension release, return to reality, establishing control, security and uniqueness, influencing others, negative perceptions, venting anger, relief from alienation, anxiety and depression (Miller, 1994, Favazza,1989b). Self-harm is also commonly

linked with psychological disorders (Favazza, 1996, Plummer, 2004), particularly Borderline Personality Disorder (BPD). There are a high percentage of young women who self harm being diagnosed with BPD as the behaviour is seen as attention seeking/manipulation, one of the characteristics of BPD (Miller, 1994:156). A full discussion of whether BPD is a valid assessment is not possible here. Considered from the perspective taken, such diagnosis feeds into the notion of individualizing social ills and provides little value other than to label the individual so as to explain the behaviour to others.

Skin cutting is the most common form of self-harm enacted by young people (Favazza, 1996). Along with overdose of antidepressants and Panadol, cutting is also the most common to work with in a refuge setting. Miller (1994) and Favazza, (1996) both suggest there is evidence of the risk of self-harm having a contagious nature in institutional settings. Whether self-harm is contagious or the actors have a previous hidden history that comes to light together is not clear.

Although some authors (Miller, 1994, Alderman, 1997, Turner, 2002) include other behaviours, such as eating disorders and substance misuse as self-harm, Favazza only notes a link between self-harm and eating disorders but does not include drug overdoses. His rationale for this is due to the invisible nature of overdose, where common self harm leaves, albeit often temporary and superficial, visible sign and in eating disorders dramatic weight loss. The use of medications will be included in this research, as many homeless young women who are typically self-harming as defined in the literature, also have used medication over dose to achieve the same effect. Many are also using illicit drugs and/or alcohol in conjunction with prescribed medications, most notably antidepressants. Often it is also noted that medication is not taken as prescribed.

Regarding illicit drug use, Rossiter et. al., (2003) cite numerous studies that have found that young homeless people use drugs and alcohol at much higher rates than their home-based peers (pp17-23) and their own study so far confirms this. There is however evidence that although they use more as homeless people, most left home due to domestic violence, family breakdown and conflict, not because of their drug use (SAAP, 2002: 25). Young people who have become homeless may be using drugs and alcohol at higher rates, but is this because of their homeless state, or is it a manifestation of the causes of their homelessness? Langeland and Hartgers (1997) study in Amsterdam provided evidence that there is a higher likelihood of alcohol problems for women if they were sexually or physically abused as children and this has implications for young homeless people in YSAAP.

Noted in the literature is the connection between self-harm and childhood trauma (Miller, 1994, Favazza, 1996, Alderman, 1997, Langeland and Hartgers 1997, Browne & Finkelor 1986, Turner, 2002, Plummer, 2004). Sexual abuse is not noted anywhere as a primary factor, but is considered along with other forms of abuse; physical abuse, lack of childhood attachment and domestic violence. Childhood context contributes to self-perception and supports the notion that self harm is formed in the context of social environment.

If self-harm is considered as representative of childhood abuse, (Miller 1994), there are several characteristics that are evident. The actor demonstrates control of the body (p9) by inflicting her own wounds, much as the abuser inflicted wounds in childhood. She has grown up in the habit of secrecy (p29). Abuse is a secret activity and much of self-harm occurs in secret and on parts of the body that can be covered. She has an inability to protect herself (p31) and often puts the needs of others before

her own (p129), as has been the case in abuse. She also has an inability to form healthy relationships (p32) and sees them as unpredictable (the course of abuse was somewhat predictable) and therefore unsafe. Because abuse is not talked about, there is manipulation of reality that habituates repression (p76) and the actor needs to find some other way of expressing the truth.

For the young woman engaging in self harm, "the search for intensity of experience, to the point of violent bodily sensation……..must be understood as replacing the connection of emotion, leading to a desensualisation and de-eroticisation of the body" (McDonald, 1999:209). It is the struggle to still be visible and heard, in the face of unspoken experience for which society has often excluded her for disclosing in the first place.

The literature reviewed here highlights the deficit framework in which some young people come to terms with their history. Due to being powerless in the situation, many resort to self-destructive behaviour as a coping mechanism. This serves to draw negative attention and provides the grounds for medical (mental health) intervention that concentrates on alleviating the behaviour as the immediate issue, leaving the causes unaddressed.

Chapter Four

LOWANA AND EVIDENCE-BASED PRACTICE

Miller (1994) and Favazza (1996) give the most comprehensive practice advice for working with self-harm behaviour, with both taking into account and using research by others. Both confirm the need to understand self harm as symptomatic rather than causal.

There is wide support in the medical model for biological treatment to enhance serotonin levels in the brain (Favazza, 1996:290). Prescription of medication follows a similar regime to treatment for eating problems, depression, obsessive-compulsive behaviour and anxiety. Young women at Lowana who are prone to self-harming are regularly prescribed antidepressants such as SSRI's (selective serotonin reuptake inhibitors) Medicating is expected to affect impulsive behaviour, stabilize mood and decrease the likelihood of self harm. These drugs are also popular because unlike the former use of benzodiazepines, the risk of death by overdose is minimal (McLellan, 1995).

Favazza (1996:319) questions the efficacy of the use of SSRI's over a long period and believes they fail to maintain their effect. Personally, I question the efficacy of any prescribed psychoactive medication in a youth population from an ethical point of view, as well as a practical one. In our drug-using culture, is it useful for young women to be encouraged to see a cure for their ills with pills at an early age and is it useful if they are possibly using other substances such as cannabis, ecstasy and alcohol to add a prescription to the mix? In any case, biological treatment is not a decision of YSAAP services and interventions within accommodation

services should rely on psychosocial models even where medication is being prescribed.

Using an action research approach with evidenced-based practice is valuable in YSAAP services. Where interventions are used, this approach provides opportunity to evaluate service effectiveness and to adjust approaches to meet individual needs through appropriate operational guidelines, policy and procedure and team meetings.

Authors reviewed recommend a variety of psychosocial interventions including Dialectical Behaviour Therapy (Favazza, 1996:296 Plummer, 2002), Cognitive Behaviour Therapy (Favazza, 1996:308, Turner, 2002:149) and also include administrative changes (Favazza, 1996:313). Miller (1994) is much less formal in intervention advice but makes reference to Narrative Therapy (p250) and the Family Therapy perspective (p176-178). Although Alderman (1997) discusses self-harm from an addictions perspective, she suggests 12 Step Programs as a preferred intervention. Ultimately, the literature points to interventions based in client-centered approaches that are non-judgmental, supportive and give the client autonomy to make their own decisions.

According to the literature, the goal of any intervention for self-harm should be to assist the young woman to:

- Understand the antecedents that lead to behaviour and delay action
- Give up the symptomatic behaviour
- Create a new set of responses

- Let go of the past

The environment needs to demonstrate safety and be supportive, regardless of behaviour (Miller, 1994:39, 182, Favazza, 1996:294). Firm boundaries should be established at the beginning of the relationship, explaining the service's attitudes and expected responses to any acts of self-harm. Favazza (1996:294) emphasizes the need to trust the client and not try to save them from their own behaviour. If an abuse history is likely, disclosure may expose raw emotions of fear, rage, anger, shame or grief and these will need to be dealt with in the environment and may result in further self harm (Miller, 1994:236).

Even where past abuse is known the worker should not encourage the young woman to disclose or discuss this early in the relationship. The worker should however, listen for the unusual, unexpected and incomprehensible (Miller, 1994:183). Power and responsibility for the direction of any conversation should lie with the young woman, not the worker.

Lowana Young Women's Service Practice Base

Experience is not what happens to you. It is what you do with what happens to you.
Epston, 1997

Lowana Young Women's Service has developed a practice base over the last four years that incorporates many of the interventions described in the literature. The service generally utilizes strength-based, solution-focused models of practice which have been found to be effective in working with young people with complex needs (Szirom, et. al., 2004). Strength-based approaches shift focus from examining deficits to validating skills and talents acquired during adversity. The eclectic range of interventions

employed validates a young woman's unique place in the world and her potential for positive contribution to society. The following range of intervention models used by Lowana workers is in keeping with the feminist philosophy of empowerment, with the client as the expert in her own life. They also serve the intention of assisting young women to do something with what has happened to them that will enhance their lives and for them to choose what that may be.

This variety of techniques and philosophies is underpinned by several assumptions, when working with complex issues (Miller, 1994). The first assumption to draw on is that the actor's behaviour is symptomatic of broader issues and is not personal. The worker also needs to assume the behaviour to be an attempt to cope with life stressors that occur in multiple contexts, both historical and present and that it serves a purpose currently valid to that individual.

Team work without key workers

Favazza (1996:296) advises not to have key workers when working with self-harm in a residential setting. In my experience not allocating a client an individual worker helps reduce any worker burnout that can occur from intense contact. Due to the isolation from family and community, homeless young women also have an increased likelihood of developing dependency with workers in a refuge setting. The young women have such close and constant interaction with workers that there is a real danger of one on one relationships developing into something counter-productive to their progress through "splitting" the worker from the team or manipulation.

All young women using the service form their relationship with the service as a whole. All information is shared within the staff team so all

workers are aware of current levels of crisis in the service when they come on shift. This enhances opportunities for workers to debrief and draw on each other for support when dealing with complex issues. With this in mind, workers are not rostered on consecutive night shifts and always have at least two nights off between shifts.

Living/social skills Program

Lowana practices in a way that models living/social skills on a daily basis. This is not a formal program but links the personal to the political through consistent modelling of the service philosophy. The tenets of this are:

- Atmosphere of equity, fairness and respect
- Be mindful of individual need
- Target the behaviour not the person
- Foster negotiation skills
- Use of direct, open and honest communication
- Incorporate world view from a non-violent perspective
- Mindful of developmental stage as one of reasoning

For the client who self harms, this includes fostering problem-solving ability, enhancing capability and self-responsibility. They are taught to care for and dress their own wounds wherever possible (Favazza, 1996:296). Workers facilitate self-soothing activities such as having a spa, aromatherapy and playing music. Young women are encouraged to talk through problems (not self harm) develop their own solutions and evaluate the solution's effectiveness.

Workers encourage young women to explore their artistic ability through drawing and painting, as well as writing poetry, doing puzzles and keeping journals. The living/social skills program also places high value on physical activities. These are all simple techniques intended to change the young woman's focus from self-harm (Favazza, 1996:296) to other activities.

Client Centered Counseling

Client centered counseling is mentioned in most literature regarding human services as the most effective way of working with clients, including SAAP documents. The work of Carl Rogers has had a major impact on the way in which client centered counseling is carried out (Ivey, et., al., 1993) and has as its main tenet a respect and empathy for the client. The three main stages of conversation in Roger's process are:

- Non-directive: where the relationship between the therapist and client is firmly established through non-judgmental acceptance of and trust in the client.

- Client centered: reflecting feelings and resolving incongruities between the constructed self and the real self

- Person centered: expanding on an understanding of the self in relationship to others rather than individual, including a broader understanding of the impact of social, cultural and power issues.

Within the context of Lowana, client centered work is based in the existential-humanistic world-view (Ivey, et., al., 1993). This view supposes we are in the world and acting on that world while it simultaneously acts on us (p285). We come to know ourselves through our relationships with other people and construct our view through those relationships of

ourselves and the world. Anxiety or disharmony can result from a distorted view of relationship. The goal of the worker is to understand the construction of the client's world and assist them to realise that they have power to alter that view through the decisions they make. Rather than seeing the situation as problematic, the client is encouraged to see opportunity to act and change. There is however, limited opportunity to follow this process in the orderly way in which it can be theorized. The culture of the service does encourage this philosophy as a way of communicating with young women.

Motivational Interviewing and Brief Intervention

Lowana has a commitment to the principles of harm minimization, which have been in place in national drug and alcohol policy since 1985. The aim of harm minimization is to prevent the uptake of drugs and to reduce the harm caused by the use of drugs and alcohol on individuals and society. The principles of harm minimization in practice are not restricted to drug and alcohol use but can be extended across a range of behaviours that are harmful, including self-harm.

Motivational Interviewing (Miller & Rollnick, 2002) utilizes a client-centered approach and initially attempts to provide factual information and personal feedback about the short term consequences of a particular behaviour, commonly risk use of substances. Motivational interviewing uses a non-judgemental/non-confrontational style of open-ended questions (p328). The conversation avoids labeling the problem and talks in terms of choices and behaviour (p330).

Brief intervention, using a motivational interviewing style, does not attempt to change behaviour directly, but to build up personal understanding of why behaviour may be seen as troublesome. This brief

intervention is intended to motivate the client towards a change in behaviour by developing a discrepancy between the current behaviour and broader goals and values. The principles of motivational interviewing (Miller & Rollnick, 2002:33-42) are:

- Display empathy and acceptance of the individual's right to autonomy and to act as they choose.

- Develop discrepancy between "how it is and how I want it to be" without outside coercion. Do not include impact of behaviour on others, only on self.

- Roll with resistance and don't force your point of view. Offer new information and allow the client to take it or leave it

- Encourage self efficacy by enhancing confidence to change through validating skills the client has already demonstrated in overcoming adversity

Although Miller and Rollnick concede there is little evidence of the efficacy of motivational interviewing with a youth population (p331), they point out that ambivalence is common in young people and they often have greater resistance to pressure to change their behaviour, so the non-confrontational style should prove useful (p322). They also believe that motivational interviewing is particularly useful for those already engaged in risk behaviour.

Narrative Therapy

Lowana workers engage in a basic strategy of Narrative therapy and I acknowledge that there is much more to the practice than described here. Narrative therapy is underpinned by poststructuralist thought and White

(1997) describes this way of working as engaging "us in terms of description that are not the taken-for-granted terms when it comes to matters of life and to human action – terms of description that are unfamiliar" (*ix*). The use of different descriptions for dis-ease replaces commonly understood notions in contemporary life that carry preformed solutions. This provides opportunity to deconstruct preconceived notions and provide new meaning.

The basis of Narrative therapy supposes that a dominant problem story is fabricated to describe a life through professional discourse (p119). For example, the dominant stories of young women self-harming are that they are maladaptive, acting out, manipulating, attention seeking and borderline or have low self esteem. The practice of narrative is to make a thicker description (p122) by drawing on other events in her life that contradict the problem-saturated story. This thicker description provides dimension to a situation that has often been narrowed to problematic issues and can provide new meaning to the storied life (p133). The principles of working in a Narrative way are expected to undermine the power status of the expert and include:

- Avoiding the use of mental health language/descriptions/labels
- Acknowledging that the worker does not and can never take the detached, observer status in conversation with the other.
- Acknowledging the trust that has been invested in the service.
- Acknowledging the existence of power relations and where and how they exist.

- Being constantly mindful of positions of privilege held by those more advantaged.

- Being transparent in communication with the other.

- To continually question whether the other is finding the conversation relevant.

White also points out that when conversing with young people, it is important to check that the vocabulary is being understood and to avoid the use of adult jargon (p133).

Behavioural Therapies

Dialectical Behaviour Therapy (DBT)

DBT was first developed by Marsha Linehan (1987) and focuses on self-harming individuals (in Favazza, 1996:296) who are undertaking one to one therapy. Self-harm behaviour is viewed as a response to stressors by people with poor problem-solving skills, who exhibit a low distress tolerance and inadequate coping skills.

Lowana workers do not use a formal approach of DBT, but utilize this understanding in the daily living/social skills acquisition progam described previously.

Cognitive Behaviour Therapy

Cognitive behaviour therapy aims to highlight the connection between thoughts and behaviour (Favazza, 1996, Alderman, 1997) with a focus on

personal choice and collaboration (Ivey, et., al., 1993). Workers are trained to assist young women to reframe negative thoughts of "I can't" and construct small steps towards "I can" (Ivey, et., al., 1993:269) using the following:

- Recognising and identifying all or nothing thoughts
- Highlighting repeated patterns that are self-defeating (i.e., automatic thoughts)
- Using humour to highlight discrepancies in thought and reality
- Using logic to underline irrationality of automatic thoughts

Both Motivational interviewing and Narrative therapy are compatible with Cognitive therapy. All aim to promote connection between thoughts and behaviour to change a constructed reality into something different. None of these methods needs to have a specific focus, like mental health or drug and alcohol. They only need to be applied appropriately to the presenting situation.

Effect on Practice

Action research is defined by Carr and Kemmis as a "form of self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practices, their understanding of these practices and the situations in which these practices are carried out" (in Wilkinson, 2000). Action research is an ongoing process, like social activism, community action and feminism, it is a practice that is fluid and evolving. In this framework, action is the operative word, in that it is difficult to be static long enough to look at one aspect of a situation. Action research professes no answers but rather continuous exploration

and understanding of a situation; an attempt to change things and to describe what is learnt from the change process (Winters & Munn-Giddings, 2002).

In the spirit of an action research environment, Lowana Young Women's Service has provided workers with professional development that is targeted and has a background of theory. In practice this provides them with confidence to work with the most difficult of behaviours in an environment of high client: worker ratio. Crisis services generally have a high turnover of workers. Worker retention rates at Lowana have increased from an average of two years to 50% of the current workforce being employed four years or more. As well as increasing retention rates, targeted professional development enhances future employment opportunities for workers.

These theories have moved workers from reacting to a crisis in an uninformed way, to being able to name what they do and to identify what is the most appropriate intervention for the situation. Where a particular issue presents problems, rather than blame individual clients, current policy and procedure is reviewed and changed where possible. The first change occurred regarding drug and alcohol use. Just using rhetoric of harm minimization is not enough. Prior to articulating what harm minimization is intended to do and educating workers in some basic practices, responses to drug and alcohol use usually came from a punitive position, i.e., stop use or exit. The service now attempts to continue to accommodate and works with young women currently using drugs and/or alcohol to steer them towards understanding the effects and decreasing use through self-monitoring and access to appropriate services. There has been an increase of young women entering a

detoxification facility directly from Lowana, through negotiation with the service for a return at completion.

Following on from this was to develop a better understanding of self-harm. Where workers knowledge was limited, responses were similar to attempted suicide, to discuss the act or attempt in detail and to provide nurture and attention. This proved counter-productive and usually increased self-harm behaviour. Once an understanding of the need to help young women to nurture themselves and to receive benefit from self-care was understood, workers were able to decrease their own feelings of responsibility for not stopping the behaviour.

As is the way of action research practice, Lowana is now grappling with how best to respond to young women who have learned that violence, either verbal or physical as a coping mechanism in their communications, produces an outcome. We are in the process of understanding the context in which these young women have learned to get their needs met in the past and that a change in environment won't immediately create an immediate change in behaviour.

One of the main benefits for workers is the understanding that mental health and drug and alcohol workers do not have mystifying magic that SAAP workers cannot expect to have. They often use the same interventions described in this report. This sharing of knowledge greatly reduced the reliance on and expectation of what "specialist" workers could actually achieve that SAAP workers could not. This helped for a better relationship with emergency services as workers became confident to seek their support rather than wanting them to take the "problem" over.

In the past, return rate to SAAP has not been viewed as a successful outcome. I would argue that where clients are chronically homeless, with an average age of 15 years and issues that are considered complex, returning to a service repeatedly could be seen as an indication that a healthy relationship has been established. The return rate to Lowana for clients engaging in risk behaviours is relatively high and indicates a move towards a sense of connectedness to the service, a protective factor in resilience.

Chapter Five

FINDINGS AND DISCUSSION

The following was written by a 14 year old in response to our request for her perspective of why she was seeking YSAAP support. It is indicative of the ostracism experienced by young women where sexual assault in childhood is disclosed. This client has returned to Lowana on four occasions and has a history of drug misuse and chronic homelessness.

"It all started when I was sexually abused by one of my mother's ex-boyfriends. Mum tried to shut out what was happening to me because this man had money. After that she just shut me out and we didn't know how to talk to each other to this day the subject is still avoided. I have 3 sisters and 1 brother and it was as though I was constantly being grounded or punished. I started becoming really depressed about school and my home life! It was like I was an outcast, and mum would always be impatient and nasty to me it got to the stage that if she even raised her voice at me I would be in tears Because I couldn't handle it anymore! I became suicidal and just couldn't sleep so I used to steel (sic) tablets out of the cubourd (sic) to make me sleep. I ran away one night when mum had yelled at me and she didn't talk to me much at all and I was always the one having to make the effort and when I would go up to see her she would just shut me out all over again. I can't stay (here) anymore because not only could she (the woman she was staying with) not cope But I was being blamed for bringing down her daughter with me!"

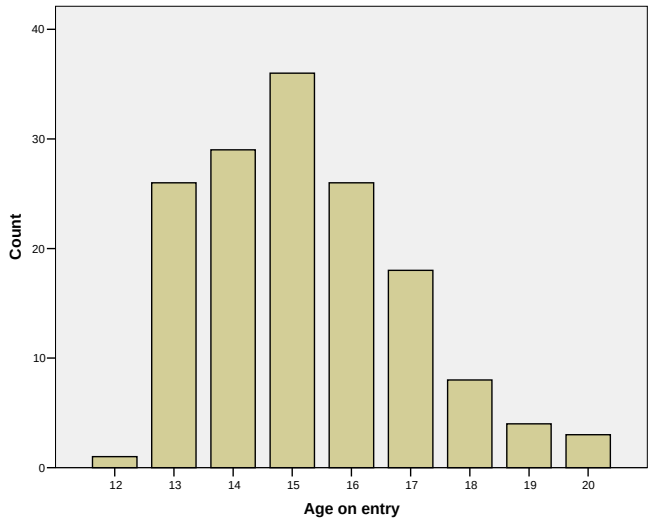
This chapter provides an overview of the findings from the content analysis. The sample consists of a total 156 files, case notes, Log Book entries and Critical Incident Reports. Some data is incomplete due to missing information and this has been accounted for.

Age Range

Data collected by Lowana for SAAP through the SMART program over the same period of all clients accommodated indicated most clients were aged

between 15 and 19 years. SAAP data does not separate by age but records age brackets. Of 151 cases where actual age on first entry age was identified for this project, 60.9% were between 12 and 15 years old when they first made contact with Lowana. (Mean 15.22, median 15.00 and mode 15)).

Figure 1 ***Age Range***



Ethnicity

Information on ethnicity was not recorded for 53.8% of the cases. Of the remaining, 26.3% identified as Anglo-Australian, 11.5% as Indigenous and the remainder were of non-English speaking background. SAAP data from Lowana for the same period of all clients recorded 75% as "other", 21% "Indigenous Australians" and 4% as "people from non-English speaking background". This indicates that the majority of young women identify as coming from an Anglo-Australian background but the Indigenous rate of homelessness is high given the size of the ACT Indigenous population, around 3%.

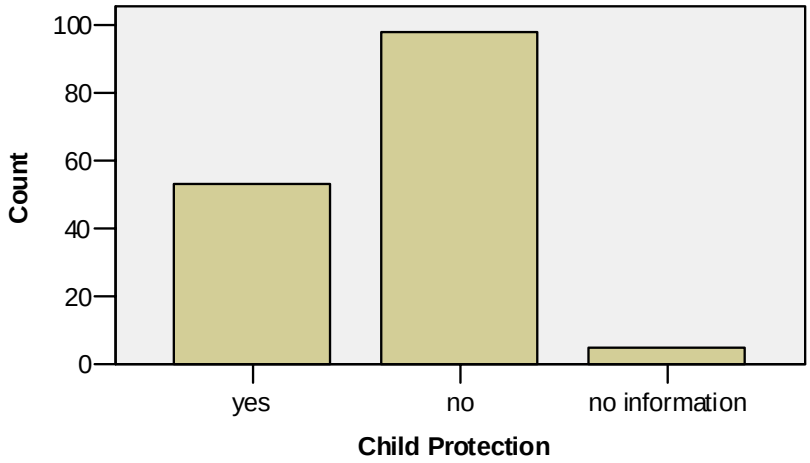
Parental Contact

Of the 132 cases where parental contact was recorded, 27 came from a two-parent family and 66 cited a single-parent home. A further 13 had no ongoing contact with either parent and 15 either did not know their father or did not have any contact with him. This confirms other research through SAAP; that the majority of young people using SAAP services come from single parent homes. It also indicates that breakdown of family relationships is common even where the nuclear family is still intact. There is also a lack of appropriate male adult figures in homeless young women's lives and parents often cease to have any involvement once homelessness occurs. This also makes financial support an issue.

Statutory Involvement

Child protection was cited as having involvement in only 34% of cases and Youth Justice with 12.8%. Of the total under Youth Justice Supervision, 15% were also under Child Protection.

Figure 2. ***Statutory Involvement***



There should be cause for concern that with a mean age range of 15 years and limited contact with guardians, that child protection is not taking a more pro-active role. Although Lowana reports all young women who enter the service under 15years old to Child Protection, as "at risk", very few are taken up as cases for early intervention. This means that "parental responsibility" falls to YSAAP workers, particularly where parental contact is non-existent or hostile. It is also a situation that is specific to SAAP youth refuges, when compared to other SAAP services and has implications for duty of care. There is further impact on ability to carry out case management as an advocate in regards to income and education/training, where the role of some YSAAP services becomes that of coercive parent for young people on no income and out of school, in order to comply with Centrelink requirements to provide financial support.

Accommodation Periods

Most young women (63.5%) had only one accommodation period and did not return to the service. Although single return rates for those not

identifying self harm (66%) were higher than for those who did identify (56.8%), returns more than three times were more likely where self harm occurs (20.5%) than where it doesn't (15.2%). Return is not unusual in the geographic area, where chronic homelessness is an issue, regardless of self harm behaviour, but young women engaging in self harm are more likely to have multiple stays (more than 3).

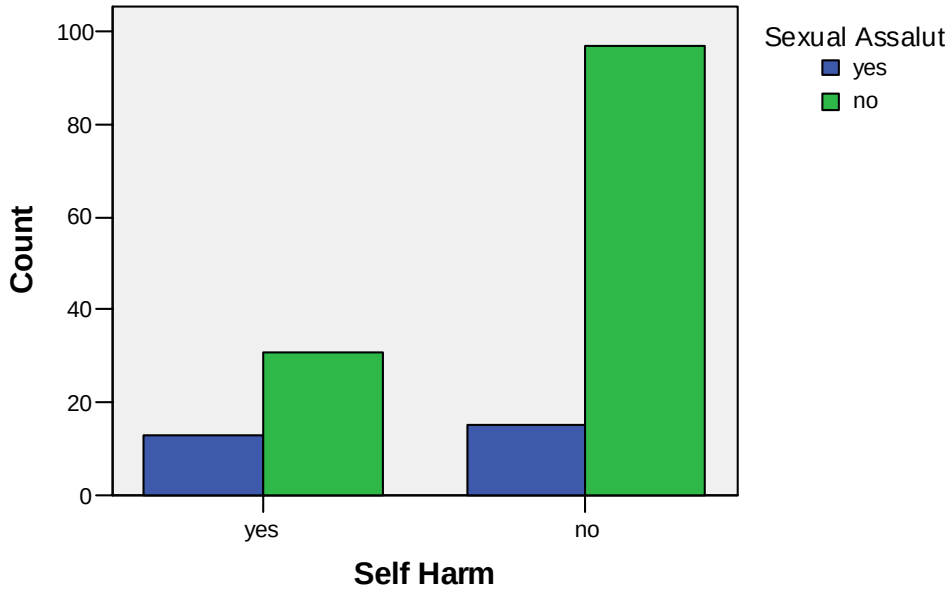
Sexual Assault/Drug and Alcohol/Domestic Violence

The results in the following tables compare the population identified to be self-harming with those who don't, and is cross tabulated with the issues of disclosure of sexual assault or domestic violence and current drug and/or alcohol use.

Sexual Assault

Disclosure of sexual assault prior to leaving home was recorded for 17.9% of the total cases (156), with 9% having disclosed sexual assault occurring once homeless, several reported to workers on shift as having occurred while the young women were out from the Service. This supports notions of vulnerability described in the research on health. Of those who self harm (44), 29.5% have disclosed a history of sexual assault prior to becoming homeless. This rate is considered to be relatively high, considering that not all clients will disclose sexual assault due to previous experiences of disclosure.

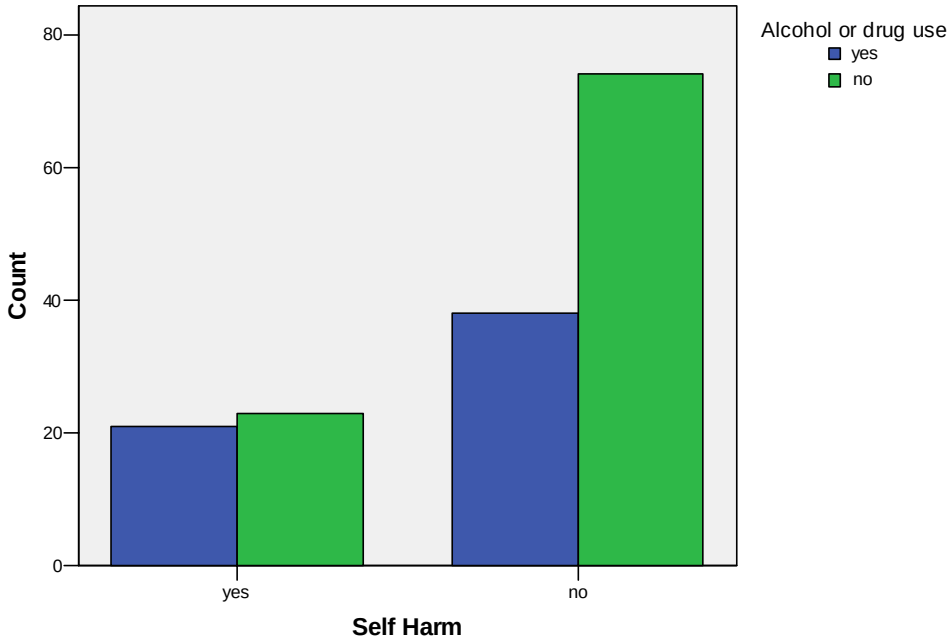
Figure 3 ***Sexual Assault***



Drug and alcohol use.

Drug and/or alcohol use while at Lowana was recorded for 37.8% of the total cases, with 47.7% for young women engaging in self-harm. This suggests that young women engaging in self-harm are more likely to also be using drugs and/or alcohol. The research did not identify whether drug and/or alcohol use commenced prior to becoming homeless, only whether use was recorded while homeless.

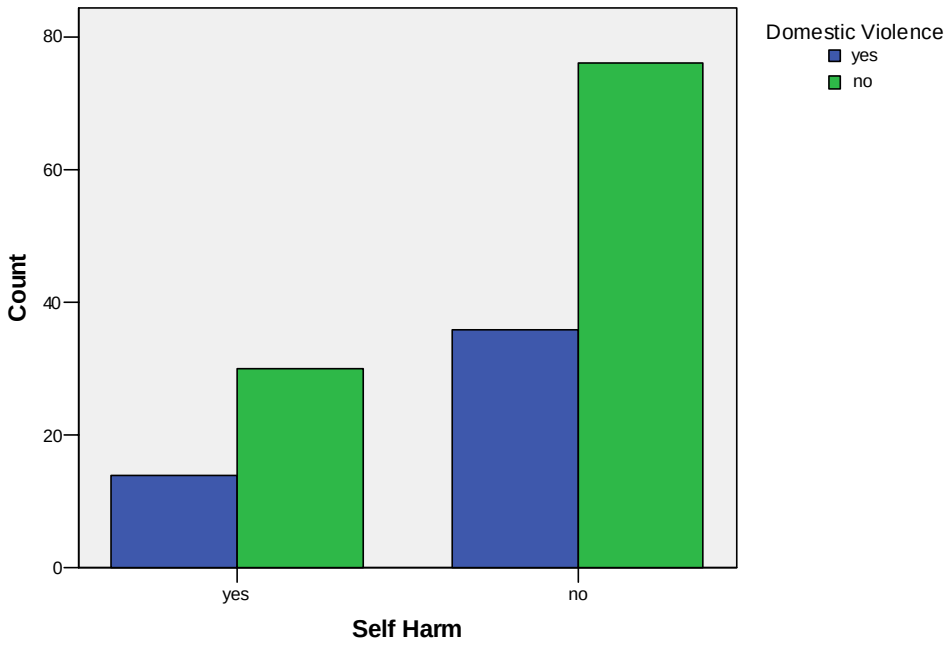
Figure 4 ***Drug and Alcohol***



Domestic Violence

Domestic violence was mentioned for 32.1% as an issue prior to leaving home. This has implications for YSAAP services in that young women from domestic violence backgrounds have often developed inappropriate ways of dealing with conflict within a group setting. For young women identified to be self-harming domestic violence was recorded for 31.8% as an issue prior to leaving home.

Figure 5 ***Domestic Violence***

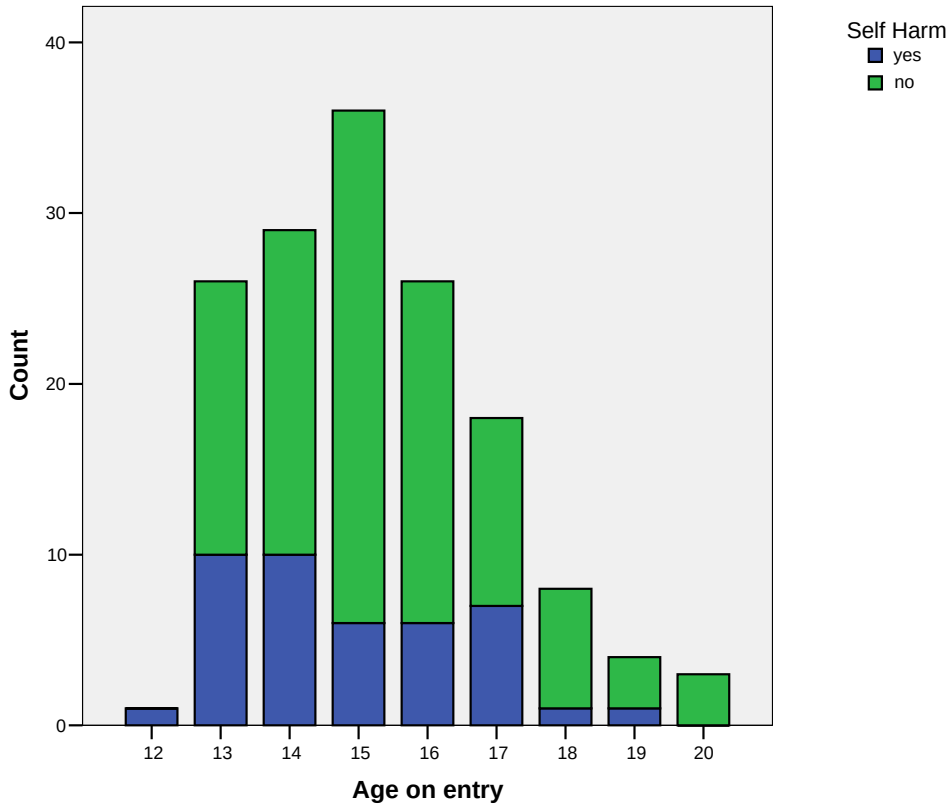


Self Harm

Incidents of self-harm were recorded for 28.2% of the total population. Although age of first incident was not recorded, in a cross tabulation of 42 of the 44 clients where incidents of self harm were recorded, 64.3% were 15 years or under when they first came into contact with Lowana. This indicates that the earlier young women become homeless, the more likely

self-harm behaviour occurs. Whether self-harm commences prior to leaving home is an issue for further study.

Figure 6 ***Self Harm***



The evidence provided does suggest a link between self-harm and sexual assault but further research would need to be carried out to confirm any relationship effect.

Figure 7 ***Self Harm and Sexual Assault***

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)

Pearson Chi-Square	5.596(b)	1	.018		
Continuity Correction(a)	4.553	1	.033		
Likelihood Ratio	5.211	1	.022		
Fisher's Exact Test				.035	.019
Linear-by-Linear Association	5.561	1	.018		
N of Valid Cases	156				

a Computed only for a 2x2 table
b 0 cells (.0%) have expected count less than 5. The minimum expected count is 7.90.

Of the Critical Incidents recorded (15), the majority of self harm involved cutting, predominantly of the arms, abdomen or legs (9). The remaining records were for overdoses of Panadol or antidepressants.

Multiple Issues

There is no indication that identifying clusters of individual issues such as sexual assault, drug and alcohol use and domestic violence has a direct link to whether or not young women will self harm, except to say that a higher percentage of those who self harm identify all three. Of the 44 self-harming clients, 29.5% did not identify any of these issues, 43.2% identified one, 16% identified two and 11.3% identified all three.

Of the 112 not self-harming, 41% didn't identify for any of the issues, 42% identified one, 15.2% identified two and 1.8% for all three.

The relevance for multiple issues in youth SAAP services is not necessarily whether one client has multiple issues but that these issues are more likely to complicate service provision where multiple clients identify having at least one.

Medication

There were 34 separate cases of the possible 156 recording medication of various kinds, excluding the contraceptive pill. Apart from antibiotics, the

most common medications recorded were antidepressants. Four of those on SSRI's (selective serotonin re-uptake inhibitors) recorded no self harm. Of those with recorded incidents of self-harm, 7 were prescribed SSRI's, and 3 were prescribed other antidepressants. Combined, they totaled 66.6% of medication and self-harm. Two young women on methadone, one on antibiotics and one on insulin for diabetes also recorded self-harm.

Figure 8 ***Medications***

Medication Type	No of S.H.	Total	S.H % of medication.	% of Total 156
SSRI antidepressants	7	11	63.6%	
Other antidepressants	3	3	100%	
Antibiotics	1	15	6.6%	
Methadone	2	2	100%	
Insulin	1	2	50%	
Other	nil	2	nil	
TOTAL on medication	15	34	44.1%	21.8%

On the surface, it appears that the efficacy of medicating young women prone to self harming with antidepressants is questionable, given that 10 of the 14 prescribed antidepressants still recorded self harm incidents. Whether or not these young women are taking medications as prescribed would impact on this finding, as would the use of other drugs along with

medication. Of the clients using drugs and/or alcohol, 32% were also on prescribed medication. Anecdotal evidence suggests that prescribed medications may be useful for those who take self responsibility for dosage but not so for young women engaging in other risk behaviour.

As well as looking across the files and log books for patterns, I also looked for a couple of case studies which highlight the complexity of issues for YSAAP services looking after young women. The first provides insight into the perceived contagious nature of young women self-harming in an YSAAP service. The young woman "Julie" was involved in several group attempts, some with young women with their own histories. The second demonstrates that complex issues do not necessarily arise from an individual but come from a combination of issues arising for a number of young women at the same time.

CASE STUDIES

Questions have been raised regarding whether services should separate self-harming clients out and provide specific accommodation for them. Favazza (1996) recommends that services accommodate no more then two clients exhibiting self-harm behaviour at any one time. Given the secret nature of the behaviour, it is often hard to know prior to offering accommodation and in any case knowledge by the service of possible behaviour is not something Lowana believes should warrant exclusion. Although the work is challenging, deliberately targeting these young women would be counter-productive. In keeping with not individualising ills, accommodating them with other young women with other issues reduces the stigma of their own behaviour and sometimes provides productive peer judgement by non self-harming residents. In the following case study, the client "Julie" appears to incite other young

women into enacting self-harm with her. This behaviour confirms the view of self-harm having an "attention-seeking" component.

CLIENT 104 ("Julie") – TYPICAL SELF HARM

Julie was just turning 16 when first accommodated by Lowana. She was referred by the Child and Adolescent Mental Health Service (CAMHS) and came directly from her mother's home with a history of self-harm involving cutting her arms or legs, mostly with razor blades, as well as having been treated for an eating disorder in the past. Her family, including grandparents, was refusing to associate with her unless she stopped this behaviour. Her inability to do so led to her being made homeless. Even though she had an existing relationship with Child and Adolescent Health, a mandated reporting agency, for reasons not evident, Child Protection was never involved.

Over the next 18 months, Julie had six periods of accommodation with Lowana, which totalled around ten months and recorded ten separate critical incidents involving self-harm on the premises, mostly at night. Nine of those involved cutting herself with razors and one of overdose of medication. There were other superficial attempts that did not require an incident report, including overdose of Panadol and constant threats of suicide.

Julie was on several medications over this period, including several different anti-depressants, anti-psychotics, asthma medication and antibiotics. Due to refusal to take and in accordance with Lowana policy, Julie was responsible for her own medication. Workers indicated in the Log regularly that Julie failed to take medications as prescribed, sometimes not taking any for days. She was regularly observed to be under the influence of a variety of other drugs she claimed were alcohol,

cannabis and ecstasy. Workers regularly engaged Julie in brief intervention (p44) to highlight the pros and cons of not taking medications as per prescription and the possible side effects, both physical and psychological, of using other drugs.

During the course of her stays, Julie disclosed sexual assault by a family friend when she was a child that her parents were unaware of. She alleged sexual assault by a young man whilst on a night out from Lowana and she claimed her father had done "something" to her for whom she wanted him to answer but she did not disclose what that was. Her relationship with her mother was conditional and contact often triggered feelings of inadequacy.

Three self-harm injuries occurred in the first period of two months and were in the company of other young women who also self harmed using the same method with her. These occurred over an eight-day period. There were few indications that self-harm was likely other than a constant need for attention (as opposed to seeking attention). Whenever the worker on shift failed to attend, Julie articulated a feeling of being unsafe/not well.

Critical Incidents

Day shift with one worker and Coordinator present.

Julie and another resident came to workers to disclose they had taken Zoloft. Julie stated she took 20 and the other young woman took 10. The worker contacted Poisons Information and was advised to contact the Hospital who advised bringing them to Emergency for observation. Julie was admitted for the night and returned the following day, the other young woman returned to the service stating she had broken up with her

boyfriend and was feeling “down” when she took the medication, which belonged to Julie. She stated she was not influenced by Julie and admitted to “taking pills on a regular basis”.

Weekend Day with one worker rostered on shift with five residents.

Julie returned to Lowana in the company of two other residents, one of whom believed she was pregnant and currently having a miscarriage. While the worker was attending to her, Julie and the other young woman went to the backyard. Shortly afterwards the worker was drawn to the yard where both young women had used broken glass to cut their arms. After discussion with the on-call worker, an ambulance was called. Julie’s injuries were considered more severe and she was taken to the hospital, with the young woman suspected of miscarriage. Both returned later that day.

Overnight shift with one worker rostered on with five residents.

During a critical incident (self harm by cutting) with another young woman, the worker over heard Julie and a third young woman discussing their own self harm. She realized they were becoming agitated and discouraged them from this conversation. Julie stated that the incident had triggered her and asked to go out for a walk with the other young woman. The worker agreed they could go while she was organizing an ambulance for the first incident. On return, a fourth young woman came to the worker saying she was angry because both Julie and the third young woman had returned with cuts to their forearms. This young woman had already debriefed with the worker over the first incident and felt unsafe. A second ambulance took them to Hospital and they returned at 1am. Both required stitches.

Taking such issues into consideration workers felt that Lowana was becoming unsafe for other young women not engaging in self harm and requested Julie and the third young woman exit for a period. Julie went to another refuge and returned to Lowana after one month.

After the first accommodation period, workers agreed that to work with Julie we needed to keep her behaviour separated from other young women. The team also agreed that we would not accept more than two young women with histories of self-harm at any one time (Favazza, 1996). This could only apply to those who were already identified and did not account for those young women self harming in secret.

Along with this strategy we targeted professional development for workers. This involved all workers attending workshops on Dialectical Behaviour Therapy (DBT, p47). With a greater understanding of the particular skills these young women needed to cultivate, workers were able to provide strategies through the living skills program for de-escalating self harm opportunities and assist them to employ self-soothing and distraction techniques.

The next time Julie stayed at Lowana workers put into practice what we had learned about working with self-harm and she was able to refrain for several months but regularly disclosed to workers that she was using cannabis and alcohol in lieu of harming herself. Although our use of motivational interviewing (p44) was successful and she had several attempts to enter a detox facility, due to disclosing in assessment her use of pills and the risk of self-harm, no-one would take her.

During this period, Julie had external support from her CAMHS case-worker and attended an alternative school program. Lowana worked closely with CAMHS and the Mental Health Crisis Team to intervene with distraction prior to any acts, which was intense but worked well. Workers at Lowana however observed that she was constantly "not feeling well" and talked readily of a need to self-harm. She also became quite focused on eating, or not eating to be more precise. The use of narrative therapy (p46) attempted to juxtapose these issues against the more positive aspects of her life in that she had resisted the urge to hurt herself and was attending school and maintaining her stay at the service and Julie acknowledged there was more to her life.

The catalyst for escalating her behaviour came when we accommodated another young woman with similar behaviours, known well to Julie through the mental health system. Julie began to talk more regularly about harming herself so workers put in place a contract that she would not do this on the premises. We rationalized with her that Lowana was a safe house and if she harmed on the premises it meant Lowana was not safe for her, other residents or workers.

1. Day shift and Overnight shift, one worker rostered on with six residents.

   The worker had a call from Julie's mental health case-worker to say she had left their meeting threatening to kill herself. The mental health worker had called the police to have her taken to the Canberra Hospital Psychiatric Secure Unit (PSU). Julie called Lowana and was advised to return there but she refused stating the police would get her. Later a call came from the police to say she was being admitted to PSU on a three-day order. Then at 5pm during worker handover she

arrived at Lowana with her mental health worker to say that she was not being admitted. The mental health worker informed the worker that she had told Julie in their meeting she was leaving her position today.

Later that evening Julie came to the office and stated she had cut herself and would the worker call the police to take her away. Instead the worker called the mental health crisis team who came and medicated her. The next day Julie was warned that any further harm on the premises would result in her exit. That night, she became highly agitated in the house, with the worker observing her to oscillate between being potentially violent and upset, slamming doors and yelling. The worker also observed that her arm was bleeding through the bandage from the previous night's incident. The worker recorded the following:

> While I was on the phone to on-call another resident (C) came into the office and asked me to lock Julie's door. I asked her why and she said Julie had just told her she was going to her room to kill herself. When I went upstairs C had closed Julie's door and Julie was repeatedly kicking the door really hard. When I asked her to stop she started crying. She was yelling at me to open her room. I said I didn't think she was safe at that moment and said I wanted to call on-call. Julie refused to come to the office with me.
>
> After speaking with on-call and being unable to get through to Mental Health, I called the police. Julie was quite hysterical. She went outside to have a cigarette. I heard her ask C for a glass of water. Then I heard the glass smash. By the time I was outside Julie was going to cut her arm with a piece of glass. I asked her not to cut her arm in front of me. She refused to give me the glass. Julie was agitated, stating she felt out of control and talking of suicide. She was also questioning my decision to call the police. Julie went inside, I found her as she had turned all the hotplates on. I started turning them off but she held one on for quite a while. She left the hotplates and walked to the office. I turned the hotplates off and when I went to the office she had sat down and was waiting for the police.

During this time she called her mother. The police arrived at about 9:15pm. The police took Julie to the hospital.

Following this Julie had three more periods with Lowana. The final period she self harmed the day she was admitted while four others were present. The other residents expressed their anger at her to the worker for making Lowana unsafe for them but through a group meeting (living/social skills, p42) agreed to give her another chance. Unfortunately she harmed again and we had to exit her. Before she left, in conversation with the worker, she identified for herself that instead of feeling safe at Lowana, she believed that the environment now somehow triggered her feelings to self-harm. She could not articulate how except to say that when with Lowana she had more contact with her mother than when not at Lowana. She was turning 18 and had already spent some time in an adult women's SAAP service. We had brief contact when she referred herself some months later but was advised she was out of our target group and assisted to contact the adult women's service with whom she had previous contact.

The following case study demonstrates that complex issues do not necessarily arise from an individual but come from a combination of issues arising for a number of young women at the same time.

CLIENT 106 ("Helen") – USE OF MEDICATION

Helen was a 16 year old insulin-dependent diabetic under Child Protection from the substitute care system. She came to Lowana from another facility with a "suicide watch" warning. She was accommodated for three weeks until another substitute care facility could be arranged. She had a childhood story of domestic violence and sexual assault perpetrated by her father and articulated well the impact this had on her

ability to function in relationship with adults. Helen was being accommodated with four other residents exhibiting the following issues:

- A) Was using amphetamines daily and workers were assisting her to consider a detoxification using motivational interviewing (p44)

- B) Was using amphetamines but not yet acknowledging their impact on her life. By providing educational information about the effects of the drug using brief intervention techniques (p44), workers were moving her towards some positive action.

- C) Was continually ill and eventually identified to be suffering from ovarian cysts and ultimately required emergency surgery, for which Lowana had to give permission as her parents could not be contacted

- D) Was dealing with anger management issues. Mother was refusing to have her home yet continually contacting the service after hours with complaints, even though she had been asked repeatedly to speak with the Coordinator during business hours about her concerns.

In sessions using a client-centred counselling approach (p43) Helen identified that she was not suicidal but used threats of harming herself to manipulate workers, because she stated it had worked for her in the past. Although she constantly threatened to hang herself, pour petrol on herself and sniff aerosol, in fact she happily reported at the end of her stay she had not carried out any of these threats while at Lowana.

What was more significant was workers attention to her manipulation of her diet. Helen regularly admitted to eating junk food so that her blood

sugar levels (BGL) fluctuated to a dangerous degree, a physical state she claimed to enjoy. It was identified that through promoting healthy living skills (p42) workers needed to be diligent with her testing her own BGL prior to behavioural indicators which commonly included threats to self harm. She returned to a substitute care facility and has had two respite stays with Lowana since for alleged attempted suicide, none of which was exhibited at Lowana.

OTHER ISSUES REFUGES FACE

It became clear through the Log Books the intensity and multiplicity of issues workers faced working with all clients and the role stress plays in self-harm and other risk behaviours. Refuges accommodate young people with various levels of need and there are issues in the house dynamic that impact on individual behaviour, not only of those who engage in self-harm. Some of those identified in the Log Books included:

- The high percentage of young women less than 16 years where income and parental supervision are still a real requirement, yet parents and/or Child Protection were not and on occasion, refused to become involved.
- Parents who are unwilling to have the young woman at home but who constantly have contact with complaints about how the service operates.
- Difficulties with the night time curfew and young women regularly "going missing" so that we need to follow a duty of care and inform the appropriate authorities. Sometimes this would be parents, or the police or statutory body.
- Young women going out at night and unable to get transport back. Where one worker is on shift overnight it is impossible to go out and pick them up.

- The accommodating of young women with mild mental disabilities who are not assessed as disabled and where transition is unlikely, because of the lack of services for these clients.
- Constant contact with police over incidents out in the shopping malls and bus interchanges, like assaults, causing disturbance, intoxication and shop-lifting.
- Factions that develop in the house where young women are excluded from a group and are subject to bullying. There were also regular instances of young women stealing each other's belongings if they were left in the common areas of the house.
- Young women seeking support from each other by sharing their problems. There is a tendency to form attachments in very short periods between each other that may be detrimental to well being and there is a tendency to want to rescue each other.
- There were several incidences of young men phoning the refuge to speak with "whoever is there". Workers identified that often homeless young women are preyed upon by men due to their vulnerability and easy attachment tendencies.
- Particularly for those who self harm, there were issues regarding stability of outside "specialist" support, such as Julie's mental health worker, leaving her position and failing to properly put in place transition to a new worker.
- Also in the geographic area, young women who are chronically homeless get to know each other and often Lowana was accommodating young women who had already lived together in refuge before. This had particular implications for Julie, who had engaged in group self harm.

- Accommodating two young women in early pregnancy, one wanting to terminate and the other have the baby. The moral conflict between the two impacted on the whole house.
- Accommodating young women exploring their sexuality and facing homophobic attitudes from their peers in the house.
- The lack of affordable transition housing for young women who do not have complex issues and could move to semi-independence. Even though their own lives have become relatively stable, they are forced to remain in refuges with young women in crisis.

COMPLEX NEEDS

Complex needs that are defined in the individual context do not really provide a complete understanding of the issues facing homeless young women and those who work with them. The findings here indicate that the complexity comes from working with a variety of issues in the one environment with a high client: worker ratio. It is the work that is complex, not the individual.

The case studies demonstrate the ongoing nature of crisis that affects both the service and the young women. While managing the complex nature of self-harm, workers are also addressing a multitude of other youth issues that occur in the process of growing up. Many of the issues I have identified as peripheral to self-harm would be occurring for young women regardless of their present accommodation. I would still maintain that refuges play a vital role in therapeutic intervention, particularly if there was more recognition and professional development resources given to this area of our work. The environment provides opportunity to assist young women to gain skills in communication that are foreign to them through the group living/social skills program. It also

provides opportunity for changing behaviour in an environment that is non-judgmental and that does not label them as "the problem". Where traditional institutions and community/family networks have failed them, young homeless women can find those supports through YSAAP.

Chapter Five

CONCLUSION

As suggested at the beginning of this report, through government policy, society is doing little to alleviate the situations that exist prior to homelessness, but instead concentrates on increasing the service system that deals with the aftermath. The report explored whether there is any relationship between alleged sexual abuse prior to becoming homeless and acts of deliberate self-harm, either before or after leaving home.

The data reveals a link between sexual assault and self-harm but further study is required to identify any direct relationship. What is clear is that the effects of childhood trauma such as sexual assault and domestic violence affected one third of homeless young women in the study and can be identified as causes for homelessness. With 28% of the research sample enacting self-harm, 29% of those disclosing sexual assault prior to becoming homeless and 47% using drugs and/or alcohol once homeless, these are powerful indicators of the breakdown in social structures that should protect and nurture children.

YSAAP services are charged with working with these symptoms of homelessness while ever the social causes are not addressed. This should not mean that the work that is done cannot be grounded in evidence based practice. There are distinct differences between working in a residential setting with symptomatic behaviour of a group of young women and their state of homelessness and working in a clinical setting where one young woman and her symptomatic behaviour is the focus. An understanding of and the use of, a range of approaches to complex issues is required for the work.

In a refuge environment focus cannot be on providing accommodation and practical case management support only. The prevalence of self-harm and the impact this has, demonstrates the need to be skilled enough to provide a therapeutic response to emotional issues. Untimely issues arise in a refuge and they require a broad knowledge of therapeutic interventions that can be enacted immediately. With an average age of 15 years on first entry and a lack of involvement by family or Child Protection, YSAAP services need to be able to provide support for emotional distress.

Mental health and drug and alcohol services do not have professional title over therapeutic intervention. Because these services are based in the medical model of disease, they often provide no hope for the autonomy of the individual. The silo of funding perpetuates the ideal that only mental health workers can have the expertise for alleviating emotional distress, only drug and alcohol workers can assist drug users and SAAP services can only provide accommodation. The way in which these services are titled and compartmentalized perpetuates the ideas of deficit. In fact this sends a message to SAAP workers of their own deficit, rather than building on their strengths as one would with a client. With a sharing of knowledge, SAAP services can provide the same interventions without calling themselves mental health/drug and alcohol workers and without emphasizing mental ill-health or substance abuse. Collaboration with specialist services through cross sector training and skill sharing is a way to improve overall service to clients.

Part of the intention of this research was to provide insight into the realities of working in a SAAP youth refuge. The case for SAAP services to have an action-research approach (reflective practice) to their work is clear. Where services are able to properly provide for professional

development, develop policy and procedures that move with changing situations and have a workplace that is open to self criticism and improvement, both workers and service users benefit.

The results in this report indicate that the complexity of working in YSAAP services cannot be confined to individuals and their perceived deficits. There is a high level of stress and anxiety that contributes, resulting from a failure of social structures and institutions to protect young people, which is the cause of many to become homeless. An individual deficit view, of both client and YSAAP workers, rather then a structural view and strength-based practices, keeps the focus on symptoms rather than causes.

As demonstrated by this report, YSAAP services can provide holistic and therapeutic interventions if encouraged and supported to develop evidence-based practice in a reflective environment. The silo system of funding to mental health and drug and alcohol services is clearly not addressing the causes, but continues to grow in attempts to address symptoms.

This research raises the following areas that need further consideration for future policy formulation if we are to address the causes of homelessness as well as provide the best possible post-homeless interventions.

- Re-evaluation of publicizing mental health in terms of the medical model is needed. For young people to develop resilience they need to be assisted to accept certain levels of stress, anxiety and depression as a normal response to trauma that can be utilized to further growth, rather than being pathologised to immobility.

- Emphasis in policy needs to shift from focusing on and describing resulting symptoms of youth homelessness (eg. depression, anxiety, personality disorders) to increasing the rate of prosecution for sexual and violent adult offenders.

- Child Protection across Australia is state-based, poorly coordinated and inadequate. In the ACT there are services available for early intervention that are meant to circumvent statutory intervention, but the failure of oversight by child protection to facilitate these in a timely manner is sadly lacking. Unfortunately, once young people enter YSAAP, it is left to YSAAP to source those services.

- Unless there is a National approach to child protection and youth homelessness and policies that provide concrete solutions to the social justice issues that cause their plight, YSAAP will continue to need to work with self destructive symptoms.

- Centrelink arrangements in relation to financial support for young people in YSAAP should be reviewed, to take into account emotional stability where approving income or breaching is concerned.

- The evidence in this report provides impetus for further research into the efficacy of prescribing psychotic medications to a youth population, particularly anti-depressants, where appropriate monitoring is unavailable.

- Considering the particular age group involved, there should be recognition of the therapeutic work that is carried out either by default or design in YSAAP services. The impact of reporting that expects concrete results from the case management approach and

the farming out of emotional distress should be re-evaluated in the light of holistic service provision.

- YSAAP services need the resources to employ supervisors /managers/coordinators, who have certain commitment to life-long learning (consciousness raising, action research, reflective practice). More clinicians, with "expertise" will further polarize homeless young women and healthy society.

- There is a case for shared costs with health to facilitate professional development for YSAAP workers rather than the current idea that specialist services should expand. In light of a strength-based approach, it would be more cost effective to increase the level of expertise in YSAAP services than to increase the number of specialist providers.

- Raising awareness within YSAAP services of the benefits of an action research approach to service provision would assist them to see their work not only as a learning process for the client, but for themselves as well.

- Provision of more transitional semi-independent accommodation for young women whose lives other than their state of homelessness are stable.

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