

Homelessness and sexual assault

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This Wrap considers the needs of victim/survivors of sexual assault who are also experiencing homelessness. Reducing homelessness and supporting those without stable, secure accommodation calls for a “trauma-informed” model of service delivery. The characteristics of this model and its implications for accommodation solutions, workforce development and the evidence-base are discussed.

Approximately 100,000 people are homeless in Australia each night, and the number of homeless in Australia is increasing (Australian Government, 2008b). Domestic and family violence are now acknowledged as the largest single cause of homelessness in Australia (Australian Government, 2008a). Existing research has found that sexual assault is also of significance to the homelessness problem, particularly for the most disadvantaged, for whom the situation of homelessness has become entrenched. However, the relationship between homelessness and sexual assault has received little recognition in policy, research or service provision. Being homeless has profound implications for a person’s overall life and wellbeing, but when a homeless person experiences sexual assault(s), before and/or during the experience of homelessness, their lives are made significantly more difficult.

This Wrap looks at the problem of homelessness through the lens of those who have also experienced sexual assault. Doing so suggests different ways of understanding homelessness overall, and different solutions to the homelessness problem. While this paper supports current understandings of solving homelessness through more than “just accommodation and a job”, it argues for an explicit recognition of sexual assault and other violent trauma within these “housing plus” solutions. It describes a model that has “trauma-informed” and “trauma-specific” service systems, said by some to represent a “vital paradigm shift” in the sector. Finally, this paper also addresses how these issues are relevant to the broader issues of social inclusion and human capital agenda, as well as suggesting some topics for future research.



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Contents

Introduction	1
Homelessness solutions from a sexual assault perspective	3
The paradigm of trauma-informed and trauma-specific services for people experiencing homelessness	6
Addressing homelessness from a sexual assault perspective: Implications for policy and service provision	8
Conclusion	10
References	10

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Goodman, Dutton, and Harris (1997) acknowledged that while researchers, policy makers and clinicians had begun to look more extensively at the impact of violence against women:

they have overlooked the very population among whom this problem may be most widespread—those who live in extreme poverty ... And of poor women, perhaps the least researched are episodically homeless women. (Goodman et al., 1997, p. 51)

The dearth of research on sexual assault and homelessness, along with the absence of any explicit mention of sexual assault in contemporary homelessness policy developments, suggests that this oversight still occurs. As Australia develops new approaches to tackling homelessness (Australian Government, 2008a, 2008b, 2008c) this is an excellent time to change that situation.¹ The ideal outcome of this Wrap would be to assist the recognition of sexual trauma within new approaches

1 Addressing homelessness is a key focus of the Australian Government. In May 2008, it released *Which Way Home? A New Approach to Homelessness* the Green Paper on homelessness, which invited public discussion and submissions to inform the development of a long-term strategy to reduce homelessness. The result of this process was the White Paper on homelessness, entitled *The Road Home: A National Approach to Homelessness*, which sets out the national priorities and strategy to 2020. In addition the National Affordable Housing Agreement (NAHA) came into effect January 1, 2009. It provides the framework and measures to facilitate federal, state and territory, and local governments to work together in improving housing affordability for low and moderate income households. The National Partnership Agreement on Homelessness will contribute to NAHA by resourcing and co-ordinating homelessness services across the states and territories. Additional funding of \$1.2 billion has been committed for both these initiatives. The NAHA will be monitored by the Council of Australian Governments.

Box 1. Defining homelessness

The most publicly visible form of homelessness, “sleeping rough”—spending nights in homeless shelters, on the streets, or in other settings “not intended for human habitation” (Goodman, Fels, & Glenn, 2006)—is a significant problem, but it only constitutes 14% of the homeless population in Australia (Australian Government, 2008a). “Rough sleepers” tend to be mostly adult men rather than women or young people. The much larger population of homeless stay at friends’ and neighbours’ places, and on family members’ couches; they return to abusers when emergency shelters are full; they come from rural areas where no shelter is available; and/or they trade sex for a place to sleep (Goodman et al., 2006). The Australian Government (2008b), adopting Chamberlain and Mackenzie’s definition, defines homelessness into three broad categories: sleeping rough—primary homelessness; those in “temporary accommodation” (a crisis service, staying with relatives or friends)—secondary homelessness; and those in boarding houses or caravans with no secure lease or private facilities—tertiary homelessness.

to homelessness in Australia, and to prompt the implementation of practical and effective ways to integrate this recognition into our response to this significant social justice issue.

Homelessness solutions from a sexual assault perspective

Looking at the problem of homelessness through the lens of those who have also suffered sexual assault suggests different ways of understanding homelessness overall, and different solutions to the homelessness problem.

Crisis and shelter accommodation

Shelter accommodation will often be problematic for people who are homeless and have experienced sexual assault. Many shelters are neither “culturally sensitive nor trauma informed” (Goodman et al., 2006), so are unable to deal with clients who have experienced sexual and other trauma. Young people who are homeless and have been sexually assaulted report feeling constantly unsafe, and unable to trust adults. They may experience intrusive thoughts and imagery, nightmares, and have difficulty sleeping (see Morrison, Quadara, & Boyd (2007) for impacts of sexual assault).

All of these issues raise major concerns within a supported accommodation environment and often lead to young people being evicted from services or having difficult relationships with youth workers. (Tully, 2003, p. 3)

Shelters that are not trauma-informed may be unable to deal with victim/survivor’s angry outbursts, or recognise the difference between (trauma-related) flash-backs and (general) psychosis: “a woman whose trauma-related nightmares wake up an entire dorm may be asked to leave” (Goodman et.al., 2006, p. 7).

Some shelter services and systems may create an environment that actually worsens a traumatised person’s distress. Often, people in authority control access to basic resources such as food, clothing and shelter; there is little privacy; and entering many programs requires subjecting the private details of one’s life to regulation and/or scrutiny. The very process of accessing the variety of programs necessary to escape homelessness may itself create a chaotic situation. This combination of chaos, power dynamics and power differentials can mirror and exacerbate the experience of violence many homeless people have survived (Goodman et al.,

Box 2. Prevalence of sexual assault among people who experience homelessness

International studies show a high prevalence of the experience of abuse, particularly for women, both before, during and after episodes of homelessness. Homeless women often report multiple experiences of violent victimisation at the hands of multiple perpetrators, beginning in childhood and extending into adulthood. One of the largest studies in the US found that 92% of homeless mothers had experienced severe physical and/or sexual violence at some point in their lives; 43% reported sexual abuse in childhood; and 63% reported intimate partner violence in adulthood (Browne & Bassuk, 1997). Another US study found that 13% of homeless women had been raped in the past 12 months, and half of these women were raped at least twice (Wenzel et al., 2004). In another study, 9% of homeless women reported sexual victimisation at least once in the past month (Wenzel, Koegel, & Gelberg, 2000).

Australian research

A study of women and men who were homeless in Sydney (Buhrich, Hodder, & Teeson, 2000) found that half of all the women and 10% of the men had been raped in their lifetime (for men, the experience of rape usually occurred in an institutional setting). In another study, domestic violence was the primary cause of homelessness for 21% of women, while

36% had experienced “lifetime violence”—that is, “a lifetime punctuated by violence and abuse”, including sexual assault and abuse (Grigg & Johnson, 2007). In a small, qualitative study in Melbourne (Casey, 2002), three of the 11 women interviewed described childhood sexual assault as a key contributing factor in becoming homeless, and three women reported being sexually assaulted while homeless. The researcher stated that this was probably “under-reporting”, which is consistent with most data on rates of sexual assault (Lievore, 2003).

Young people

In a study by Alder (1991), 70% of young women and 20% of young men had been sexually assaulted while homeless—only 20% had discussed it with any service provider. When asked about victimisation in the preceding 12-month period, 52% of young women who were homeless reported that they had been sexually assaulted and 65% had been physically assaulted (Alder, 1991). The Human Rights and Equal Opportunities Commission (1989) found that 50–75% of young people in SAAP services (Supported Accommodation Assistance Program) had experienced sexual assault.

2006). Without an understanding of the experience of trauma and its manifestations, the behaviour of people who are homeless and have experienced sexual assault and other violence will not be recognised as the effects of abuse, and as the best way they know how to cope with these effects.

Long-term accommodation

A greater focus on achieving long-term housing outcomes for people who are homeless is a critical feature of the Council of Australian Governments' (COAG) National Affordable Housing Agreement (Australian Government, 2008c). For some women who are experiencing homelessness and adult survivors of child sexual abuse, the prospect of long-term accommodation can be experienced as threatening because they have never had a stable home—they don't know what to expect, whether they can handle it, and whether they "deserve it" (Jacobs, 2004).

Most women distrust offers of long term stable housing as it does not relate to their

world view. We view this as a direct result of the training these women received in childhood from the perpetrators of their abuse. For a lot of women moving or fleeing a situation is the only way they have of dealing with conflict. (Jacobs, 2004, p. 4)

Preferring not to stay in one place can subsequently become a key issue if long-term housing is to be maintained. For one group of women who had experienced long-term homelessness, none could describe a place they thought of as home except for very short-term experiences (Casey, 2002). This went as far as the women identifying difficulties in having a home, compared to being homeless.

The living skills needed when a person is homeless, such as living in the present and having a survivalist orientation, may clash with those needed for maintaining long-term accommodation and achieving longer-term goals. Focusing on these women's strengths (rather than deficits) recognises the skills they have developed to survive homelessness, trauma and other severe hardship.

Box 3. Common risk factors for sexual assault in the context of homelessness

Homelessness itself

The experience of homelessness dramatically increases the risk of being sexually assaulted. Sleeping rough offers little protection from sexual assault. Homeless women and young people also report being sexually assaulted in shelters. In particular, young people who are homeless have little power to negotiate their safety (Tschirren, Hammet, & Saunders, 1996): "loneliness, hunger, and material needs forced these young people into situations that made them extremely vulnerable" (Joy & Hall, 1998, p. 26). Many young people are forced to leave home before they are emotionally, physically and economically able to fend for themselves. Perpetrators exploit these situational vulnerabilities to perpetrate sexual assault(s), and also to employ an array of tactics or psychological mechanisms causing the young person to blame themselves, creating debilitating feelings of self-hatred and shame (D. Tully, 2008, personal communication).

Living with a serious mental illness

In a large-scale survey of men and women in the USA who are homeless and have a mental illness, 15.3% of female participants and 1.3% of the men had been raped in the past 2 months (Lam & Rosenheck, 1998). In one study of women with a serious mental illness and histories of homelessness (Goodman et al., 2006), the chance of re-victimisation for those who had experienced child physical or sexual abuse was close to 100%, leading the authors to comment that for women who are homeless and who experience a

mental illness, "rape appears to be a shockingly normative experience" (p. 5).

Experience of child sexual abuse

A study of women seeking help from a sexual assault crisis centre found that childhood sexual abuse was reported by 43% of participants who were homeless, compared to 24.6% of housed participations (Dunlap, Brazeau, Stermac, & Addison, 2004).

Substance abuse and addiction

A study found that women who are homeless and who had experienced either physical or sexual victimisation in the last month were three times more likely to report both drug and alcohol abuse or dependence than homeless women who had not experienced violence (Wenzel et al., 2000).

Sex work and "sex for favours"

For some women who are homeless, survival is contingent on trading sex for money, goods, services, transportation, and protection, leading some to argue that sex in these circumstances is "never really a choice" (Goodman et al., 2006) and that safety is difficult to maintain. Young people who are homeless and had engaged in "sex for favours" were more likely to have been sexually abused than those who had not (Tschirren et al., 1996).

Many of these skills are no longer needed or appropriate when safe long-term accommodation is available; therefore, different skills are required at this stage (Jacobs, 2004). Dealing with complex mental health issues can make such adaptation more complex. For example:

Our tenants often have nuisance complaints which follow them from tenancy to tenancy, regular difficulties in paying rent due to the interruption from drug and alcohol misuse or mental health issues ... Due to the lack of opportunity [to develop these skills from childhood] our tenants often find themselves lacking basic living skills which can lead to [other] problems in their tenancies; such as eviction, rent arrears, nuisance and annoyance complaints, and/or failure to adequately maintain the property. (Jacobs, 2004, p. 4)

It is important that the approach to homelessness takes into account the issues faced by people who have experienced sexual and other trauma and recognises that “people are doing the best they can at any given time to cope with the life-altering and frequently catastrophic effects of trauma” (Prescott, Soares, Konnath, & Bassuk, 2008). This has implications for homelessness solutions overall:

Taking trauma seriously as a driver of persistent homelessness ... would entail a serious challenge to current welfare policy discourse around “independence” and “full social and economic participation”. (Robinson, 2006, p. 4)

For many people who are homeless, “the road home” will need to involve explicitly recognising their experience of trauma, including sexual assault, and building a response informed by this perspective. For some, this will surely lead to greater social and economic participation in the future.

Recognising sexual assault: Screening and supporting disclosure

Explicit recognition of the experience of sexual assault and other trauma facing many homeless people is necessary in policy and service provision. Without doing so, we contribute to a culture of silence—silencing the people who need to speak about it most. We minimise the impact of abuse, and prevent it from having a presence in homelessness priorities. Finally, without recognising sexual assault and abuse, service delivery is “often likely

to be ineffectual or limited and may have dire consequences” (Tully, 2003, p.4).

When service providers fail to recognize abuse histories and their potential relationship to symptom severity, their intervention strategies have little chance of success. Too great a part of these women’s everyday lives are left out. (Goodman et al., 1997, p. 67)

Some literature discusses recognising sexual assault and other violent trauma through “screening” people who are homeless (Browne, 1993), or ensuring a detailed victimisation history is taken (Wenzel et al., 2000). Browne (1993) argued that if the behaviour of victim/survivors is to be recognised as an appropriate reaction to trauma, the trauma must be known: “in many assessments of homeless women, a detailed victimization history is never obtained and effects are interpreted in isolation” (p. 377). Rather than simple screening to solve this problem, others discuss how to create the conditions and willingness to recognise sexual assault and abuse to enable and support disclosure:

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The common story is that people wanted to speak out, but they felt no one provided them with the opportunity, or responded to them in a way that inspired trust ... Most people who have been subjected to sexual abuse wish they had the opportunity to disclose at a younger age. (Tully, 2003, p. 4)

The recommendation is that not all workers provide a therapeutic role, but at a minimum they need to acknowledge the impact of the abuse:

In the experience at SideStreet, when youth agencies give young people appropriate opportunities and information, many young people will choose to talk to a youth worker. (Tully, 2003, p. 4)

What can a service do to create opportunities for people to discuss their experiences of sexual abuse, to “open doors” around this issue? At SideStreet, they say to the young people with whom they work:

Many young people who we see at this service have experienced sexual abuse or violence. We understand this can be very difficult for people. But if you want

to talk to us about anything like that you can or we can help refer you to another service that can assist you. (D. Tully, 2008, personal communication)

Of course, a system that screens for sexual assault or encourages disclosure will also need to be able to follow up with providing (or referring to) an expert response.

The paradigm of trauma-informed and trauma-specific services for people experiencing homelessness

Trauma-informed services for people experiencing homelessness are argued by some to be the “vital paradigm shift” that is needed (Hodas, 2006) (see Table 1). It is seen as a “profound cultural shift in which consumers and their conditions and behaviours are viewed differently, staff respond differently, and the day-to-day delivery of services is conducted differently” (Jennings, 2004). Trauma-informed and trauma-specific services were initially applied in the USA in the early 2000s in public mental health and substance abuse service system settings (Harris & Fallot, 2001a, 2001b). See Box 4 for a description of these terms. By 2004, approximately 12 US states had established an

informal network to support the development of trauma-informed systems of care:

As awareness and the prevalence and impacts of trauma increases, the individuals for whom the trauma-informed and trauma-specific services ... were designed are increasingly viewed not as a subgroup or an anomalous or special population of clients, but as encompassing nearly all persons served by public mental health and substance abuse services. This increasing knowledge is reflected in the rising number of [US] States taking significant steps toward integrating knowledge about trauma into existing services and developing and/or implement new “trauma specific” services. (Jennings, 2004, p. 8)

Most recently, these ideas have been applied to the homelessness problem—modified and refined to meet the needs of women and children who are homeless (see Prescott et al., 2008). This work is based on the recognition that “despite all our knowledge about trauma and its prevalence, there remains a dearth of practical guidance about how to best support individuals and families in the healing process” (Jennings, 2004, p. 8).

Table 1: Comparison of traditional models and trauma-informed service models

Traditional services and systems	Trauma-informed services and systems
Traumatic stress is not viewed as a primary event in defining people's lives.	Traumatic and violent events are central, primary events impacting everything else in the lives of victim/survivors. Assumes the impact of trauma is all-encompassing.
Problems/symptoms are discrete/separate, and require a separate source of support and/or intervention.	Problems/symptoms are inter-related responses or coping mechanisms to deal with trauma.
A hierarchical approach: clinical staff and administrators are trained to respond to trauma survivors in a specific way. Clinical personnel are seen as the experts who assign diagnoses to treat a condition. The focus is on being objective and distant. This approach is based on power imbalances.	Shared power/decreased hierarchy: everyone is trained to respond to individuals in distress, and about the impact of trauma in the lives of clients. This approach emphasises the importance of viewing clients' responses through the lens of trauma and attempts to equalise power imbalances in relationships.
People providing shelter and other services are the experts. People who are homeless are passive recipients of services provided by people who are more knowledgeable about what is best for them.	People who are homeless are active experts and partners with people who provide services. Homeless clients are viewed and treated as the experts in knowing what is best for them and what will help the most.
Primary goals are defined by service providers and focus on symptom reduction.	Primary goals are defined by the person or family who is homeless and focus on recovery, self-efficacy and healing.
Reactive: Services and systems are crisis-driven and focused on maintaining high liability.	Proactive: Services and systems focus on preventing further crises and avoiding retraumatisation. At the individual level, providers assist families create crisis prevention plans. At the systemic level, policies and practices are adjusted to avoid re-traumatising.
Sees clients as broken, vulnerable, damaged and needing protection from themselves. Agencies and providers are responsible for fixing the problem.	Understanding that providing clients with the maximum level of choices, autonomy, self-determination, dignity, and respect is central to healing—based on a philosophy of holistic healing and resilience. The agency is responsible for creating an environment conducive to healing and becoming a partner in a process defined by the individual/family who is homeless.

Source: Adapted from Prescott et al., 2008, pp. 9–10.

According to Jennings (2004), a trauma-informed system is characterised by:

- safety from physical harm and re-traumatisation;
- an understanding of clients and their symptoms in the context of their life experiences and history, cultures and their society;
- open and genuine collaboration between provider and consumer at all phases of the service delivery;
- an emphasis on skill building and acquisition rather than symptom management;
- an understanding of symptoms as attempts to cope;
- a view of trauma as a defining and organising experience that forms the core of an individual's identity rather than a single discrete event; and
- a focus on what has happened to a person rather than what is wrong with a person.

This has substantial ramifications for workforce development. In a trauma-informed model all staff members—including grounds-keepers through to administrators—are trained to respond to individuals in distress (Prescott et al., 2008). However, these ramifications have been found to be “cost effective” in the US.

Research has found that trauma-informed services with trauma-specific services available have better outcomes than “treatment as usual”. For example, adults have been found to experience a decrease in psychiatric symptoms and substance abuse; improved daily functioning; and a decrease in trauma symptoms, substance abuse, and mental health symptoms (Hopper, Bassuk, & Olivet, 2007). Research has also found trauma-informed services may have a positive effect on housing stability. For example, a multi-site study of trauma-informed

services for homeless families found that 88% of participants had remained in provided housing or moved to permanent housing at 18 months (Rog, Holupka, & McCombs-Thornton, 1995). Trauma-informed services also appear to be cost effective (Domino et al., 2005), and both providers and consumers report positive outcomes (National Centre for Family Homelessness, n.d.).

Without the labels “trauma-informed” or “trauma-specialist”, some providers will already be incorporating this sort of work into their practice in Australia. This work needs to be documented, and these concepts promoted. In an integrated services system, one option would be for existing trauma-specialist services, for instance sexual assault counselling providers, to be included into the integrated homelessness partnerships. However, existing capacity would need to be greatly increased for such services to meet the needs of people experiencing homelessness, and appropriate models would need to be developed for working with homeless clients (e.g., Jacobs, 2004), similar to the models that have been developed for other diverse service users (e.g., Cox, 2008).

Very few trauma-specialist services, specifically for people who are homeless, currently exist in Australia—neither the homelessness Green Paper or White Paper (Australian Government, 2008b, 2008c) mention specialist services for homeless victim/survivors of sexual assault. One existing service is the SAAP-funded SideStreet Counselling Service by UnitingCare Wesley Adelaide. This

In a trauma-informed model all staff members—including grounds-keepers through to administrators—are trained to respond to individuals in distress.

Box 4. Defining trauma-specific and trauma-informed services

Trauma-specific services

Trauma-specific services are designed to treat the actual consequences of sexual or physical abuse trauma. They include a variety of therapies and techniques (such as grounding techniques, desensitisation therapy, and behavioural therapies) in a way that is consistent with the need for respect, information, connection, and hope for clients. It is important to recognise the adaptive function of “symptoms” and the need to work in a collaborative, empowering way with survivors. All trauma-specific service models need to be delivered in a context of a relational approach that is based upon the empowerment of the survivor and the creation of new connections (Jennings, 2004).

Trauma-informed services

Trauma-informed services are not specifically designed to treat symptoms or syndromes related to sexual or physical abuse or other trauma, but they are informed about, and sensitive to, trauma-related issues present in survivors. A trauma-informed system is one in which all components of a given service system have been reconsidered and evaluated in the light of a basic understanding of the role that violence place in the lives of people seeking services. Trauma-informed services work in tandem with trauma-specific services.

service works with young women and men who are homeless, or at risk of homelessness, and who have experienced sexual and/or physical abuse. It provides a counselling service that has the flexibility and responsiveness to engage young people dealing with the effects of abuse and homelessness, employing an active outreach model. It is unique in Australia and was developed because of an explicit recognition in South Australia that sexual abuse is a significant contributing cause and a factor in the continuation of youth homelessness (ACSSA, 2004). Services such as SideStreet work in a complex space,

Trauma-informed services work in a complex space, shaped by the therapeutic priority of establishing safety ... for clients who have experienced trauma, and the difficulty of doing this when working with people experiencing homelessness.

shaped by the therapeutic priority of establishing safety (both psychologically and physically) for clients who have experienced trauma (e.g., Connor & Higgins, 2008; Sanders & McNaughton, 2007), and the difficulty of doing this when working with people experiencing homelessness.

Addressing homelessness from a sexual assault perspective: Implications for policy and service provision

Integrated services, workforce development and a specialist approach

Housing is fundamental to solving homelessness, including for people who are homeless and have experienced sexual assault: “without a secure place to live it is impossible to rest and to begin the arduous process of healing from the long term effects of childhood sexual assault” (Jacobs, 2004, p. 10). But housing is just the beginning.

The Australian Government Green Paper suggested that the new national effort on homelessness needs to provide “housing plus”—a support package for homeless people in which “support needs [are] tailored to each individual and focused on the outcomes that will make the greatest long-term difference to their lives” (Australian Government, 2008b). Suggested reforms across the service sector included the delivery of services that “wrap-around” the individual—tailored services brought to the person for however long they need assistance.

There is strong evidence that linking short- and long-term accommodation with clinical support for people with severe or ongoing disability caused by mental illness would enable early intervention at points

of crisis and instability, and would prevent avoidable homelessness for many people in this population group. (Australian Government, 2008b, p. 42).

The Green Paper acknowledges the implications of such an approach for the homelessness workforce, and discusses workforce developments that focus:

on the skills and competencies for delivering integrated case management, service partnerships and improved health, housing, education and employment outcomes. Salaries would reflect these competencies to attract and retain high quality staff. (Australian Government, 2008b, p. 68)

In the White Paper following the Green Paper it was found that specialist services “need to be able to wrap services around their clients” which would involve “using expertise to assess all of the clients’ needs, identifying the services required, brokering these services and co-ordinating the delivery” (Australian Government, 2008c, p. 47). The White Paper also stated that “services should be funded to work with clients for as long as they need active support to maintain housing, rather than being subject to time limits on the support they provide” (p. 47). Specific policies recommended by the White Paper include:

- “no exits into homelessness” from statutory, custodial care and hospital, mental health and drug and alcohol service for people who are at high risk of homelessness. This entails “strengthening current post-release services so a person is connected to long-term (supported) housing, to education, training and employment assistance and, where required, family counselling” (p. 27); and
- new or expanded services to assist people with mental health issues to maintain their housing and participation in the community, including the Personal Helpers and Mentors program.

The New National Partnership on Homelessness will also include expanded models of integrated support to enable women and children experiencing domestic and family violence to remain at home safely, while also recognising that some women and children are at too high risk of violence within the home to do this and need a speedy transition from crisis accommodation to safe, secure long-term housing.

In relation to implications for workforce development, the White Paper states that a key

priority is to address the need for increased skills and competency in specialist homelessness services, to achieve sustainable outcomes for people with high and complex needs. The Australian Government, with state and territory governments, will consider the development of “advanced practitioners” within the awards covering employees in specialist homelessness services. However, as outlined previously, such services need to be trauma-informed, as well as providing specialist trauma services.

Implications for violence prevention and underlying social and cultural inequalities

Addressing issues of trauma will assist those who are already homeless. It can help to prevent subsequent homelessness, including that of their children. Prevention initiatives will need to not only target the general population and young people within educational institutions, but also groups most vulnerable to social exclusion, such as those in transitional housing, living in disadvantaged areas, at risk of homelessness due to family breakdown, and outside of the education system. Prevention should also involve measures to prevent the abuse of power in personal relationships and society more broadly, and to promote the respect, recognition and equal rights of certain disrespected social groups, including women (particularly poor women), children, and Indigenous people. These issues are also relevant to the social inclusion agenda.

Implications for the social inclusion and human capital agendas

The current Australian Government previously stated that its approach to social inclusion would be “underpinned by its investment in our human capital” (Gillard & Wong, 2007):

[A] framework based around investment in people and communities that deliver the right interventions, at the right time, in the right place. (Gillard & Wong, 2007, p. 5)

It was further stated that:

community and government programs which focus on investment in human capital ultimately build social capital, because by building capabilities in communities and disadvantaged groups we are reducing social isolation. (Gillard & Wong, 2007, p. 10)

Part of investing in human capital and reducing the social exclusion and isolation of people who are

homeless will often involve investing in their ability to recover from sexual trauma. Such a measure differs from commonly defined human capital issues of education and workforce participation. Recognising other much-needed primary supports for acutely disadvantaged groups, such as the episodically homeless, is fundamental to their ability to make the most of the opportunities available to them. The aim of this work is also ultimately to increase people’s overall social and economic participation.

Part of investing in human capital and reducing the social exclusion and isolation of people who are homeless will often involve investing in their ability to recover from sexual trauma.

Implications for further research

This paper has highlighted the lack of research on homelessness and sexual assault, particularly in an Australian context. Future research on this topic should include explicit attention to groups of homeless people not currently represented in Australian literature—including Indigenous homeless people, people living in rural and remote areas, and people from culturally and linguistically diverse backgrounds. Research also needs to examine and document the specific pathways to homelessness created by sexual abuse and assault, with a view to envisaging effective intervention.

Research that would deepen understanding of the ways homeless people experience sexual violence—“what meaning do they make of it in their lives? How do they understand its causes and effects?” (Goodman et al., 1997)—could also help inform models of future service provision. This could include more research into the overlap, and distinctions between the experiences, of family violence and sexual assault. For example, for those who have experienced domestic violence, to what extent has this included sexual assault, and does this create particular issues and needs?

Research (including evaluation) is needed to document successful models of care that work with people who are homeless, and could further investigate the effectiveness of trauma-informed and trauma-specialist models. Research is also needed on how social and economic participation is facilitated for people with histories of homelessness and violent trauma (e.g., modifications that may need to be made by employment services providers). Finally, research could also look at how to bring together the efforts to prevent both violence and homelessness.

Conclusion

This ACSSA Wrap has shown the significance of the issues of sexual assault and abuse to the issue of homelessness. It has described the high prevalence of sexual assault of people who are homeless, particularly of young and adult women. It has documented ways that standard homelessness “solutions” may be unsuitable for homeless people who have experienced sexual assault. It has suggested ways an explicit recognition of sexual assault could be incorporated into Australia’s new approach to homelessness. This paper has described a trauma-informed and trauma-specialist service system, with an explicit recognition for more trauma-specialist services for people who are homeless. It has also suggested that preventing homelessness needs to be more explicitly linked to preventing violence against women and children, and that these issues are also relevant to the social inclusion and human capital agendas. The successful addressing of this issue could potentially have an immense impact, particularly among young homeless people and children, and those who are most disadvantaged and entrenched in the homeless population.

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