Research Synthesis

Evidence for improving access to homelessness services

authored by

Christine Black and Hellene Gronda

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PURPOSE AND SCOPE

This project synthesises Australian and international research and practice evidence related to the accessibility of homelessness services. The aim of the project is to guide and inform several bodies of current policy work including service system reform and development across the specialist homelessness service system in Queensland. Specific policy development goals are:

→ To identify what makes up an accessible specialist homelessness service system for homeless people.

→ To identify elements of best practice for specialist homelessness services that are specifically funded to provide or facilitate access to the homelessness service system.

Four key research questions focus on the following:

1. How do homeless people access specialist homeless services? In particular, how do people from specific target groups access these services?

2. What barriers hinder or prevent homeless people from accessing specialist homelessness services or prevent people who are currently housed but at risk of homelessness from accessing early intervention homelessness services?

3. What are the most effective service models/approaches to specifically provide/facilitate access for homeless people or people at risk of homelessness to the service system: for example centre-based, telephone / IT platforms (e.g. websites), direct engagement (outreach), or other?

4. In addition, any further current thinking, or key messages/high-level principles around an accessible homelessness service system and specialist homelessness services that are funded specifically to provide/facilitate access to the homelessness service system.

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ACRONYMS

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AHURI	Australian Housing and Urban Research Institute
CoC	Continuums of Care (US Program)
DHS	Department of Human Services
FaHCSIA	Australian Government Department of Families, Housing, Community Services and Indigenous Affairs
HPIC	Homeless Persons Information Centre, Sydney
HUD	United States Department of Housing and Urban Development
NAHA	National Affordable Housing Agreement
NDCA	National Data Collection Agency
NPAH	National Partnership Agreement on Homelessness
SAAP	Supported Accommodation Assistance Program
SHS	Specialist homelessness services

Note:
Funding and administration of specialist homelessness services in Australia was provided from 1985 until 2008 under the Supported Accommodation Assistance Program (SAAP), and from July 2009 under the new National Partnership Agreement on Homelessness (NPAH). An interim transitional period (1 January 2009 to 30 June 2009) saw funding provided directly through the National Affordable Housing Agreement (NAHA). Throughout this report, reference to SAAP data and SAAP services from pre-July 2009 should be read as contiguous with contemporary 'specialist homelessness services' arrangements and practices.

EXECUTIVE SUMMARY

This synthesis report provides evidence about current access arrangements to homelessness services, the complex and multiple access barriers faced by people experiencing homelessness, and an overview of the different approaches, models and mechanisms used in Australia and internationally to improve access.

Despite the limitations of the existing evidence base, findings about access to services and service systems for homeless people are consistent on the following points:

→ Homeless people face significant barriers in accessing both mainstream services and specialist homelessness services, with fragmentation and complexity a key criticism of both service systems.

→ Poor visibility of existing homelessness services is a common complaint from homeless people, with a lack of knowledge of availability of services being one of the major barriers to service usage.

→ Those who are *newly homeless* are much less likely to know about available resources and services than people who have experienced homelessness either periodically or chronically.

→ The initial experience of homeless services is critical in determining service usage, with negative experiences likely to make them withdraw from active help-seeking.

→ While there are common barriers across the homeless population, there are also specific barriers and access issues faced by different target groups.

→ Given the complexity and diversity of need across the homeless population, access points must incorporate high quality assessment and referral processes to enable an adequate response to be provided.

→ Incorporating consumer perspectives into service model design and practice could assist in developing more accessible and effective services.

In the key findings (Chapter 5), the report summarises evidence from the literature about the strengths and weaknesses of different structural approaches to improving access, different access models, and different access mechanisms.

The *different structural approaches* to improving access include legislative intervention, systems integration, service integration and enhanced service models. While there is limited use internationally of legislative measures to guarantee or improve access for priority groups within the homeless population, there is significant support for reforms that combine the other three approaches: developing high level systems integration initiatives (such as in the US Opening Doors strategy involving 19 Federal agencies), better integration of responses across the homelessness service system (such as the Victorian Opening Doors framework), and enhancing accessibility of existing service models through innovative needs-adapted models (such as the establishment of 'wet' drop-in sessions in Bristol, England, aimed at engaging alcohol addicted clients excluded from other services).

In reviewing the *different access models*, it is identified that multiple or 'any door' access points continue to be the predominant model of service delivery internationally with only relatively recent adoption of alternative single access points (in the ACT) and limited or streamlined access points (in Victoria). Until there are evaluations of these two models, it is difficult to assess whether their objectives of providing improved access and outcomes will be realised. However, what is clear from the evidence is that the wide-spread multiple access point model creates significant complexity and

logistical barriers for service users. While the intention may be for clients to receive appropriate referrals from their initial point of engagement with the service system, it appears that the actual experience is generally one of confusion, feelings of exclusion and unwelcomeness when services approached are unable to provide assistance, and unnecessary complication when dealing with fragmented and inconsistent service models and practices. Therefore, it appears that efforts to streamline access points to some degree may have benefits, both for service users and for referring agencies from other service systems, if it can provide a more coordinated and well-articulated service system that makes better use of its resources at the intake/assessment point of service delivery.

Finally, a summary of *key access mechanisms* identifies the elements of success, strengths and weaknesses, and target groups that would benefit from use of commonly utilised mechanisms such as centre-based access, centralised telephone services, outreach services and online directories. The evidence points to the need for a combination of access mechanisms in order to provide the most flexible and appropriate response. It is also clear that different groups within the homeless population are better served by different mechanisms, with the most obvious example being that chronically homeless clients with complex needs are less likely to engage through a centre-based service than through a flexible outreach service. Indigenous people have also expressed a strong preference in some studies for outreach services to be provided in their communities, rather than being expected to attend formal institutionalised settings. In contrast, young people are found to prefer centre-based services, particularly where they provide a diversity of services (including immediate, practical assistance) and operate with more informal drop-in type models. The use of centralised telephone services is widespread, however limited research evidence makes it difficult to assess their effectiveness.

The report concludes with a compilation of principles that could be used to underpin the development of both a more accessible service system (Section 6.4.2), and more accessible individual services (Section 6.4.3). These essentially argue that access for clients would be improved by:

→ A more client-centred approach to service provision, including service user involvement in design and implementation of new approaches and a greater focus on respectful engagement practices by agency staff.

→ Greater visibility of homelessness services across the community.

→ Better integration and coordination between mainstream and homelessness services.

→ Low barrier entry and eligibility criteria, particularly for those with complex needs.

→ Use of system-wide streamlined or simplified intake, assessment and referral processes.

→ A combination of access mechanisms, alongside flexible and diverse service models (such as the 'one-stop shop' model), that are responsive to the needs of their specific target groups.

The evidence presented in this synthesis report provides numerous examples of how current access arrangements can be improved for the various target groups within the homeless population. The challenge remains to determine the most appropriate and effective combination of responses from the suite of options provided.

1 INTRODUCTION

1.1 Methodology

The first step in the methodology was an assessment of existing research, policy and program documentation over the past 10 years to identify how homeless people are currently accessing specialist homelessness services, the barriers that face different sub-populations of homeless people, and any good practice guides or examples from national or international sources.

The search and selection process for this review targeted both peer-reviewed articles and publications, and commissioned research undertaken for government and non-government bodies. To find research, reiterated searching utilised the following tools:

→ Academic journal databases in the housing, homelessness and related social science fields.

→ General internet searching of online policy communities and information clearinghouses (including Government departments).

→ Follow up of bibliographic references in found studies.

→ Discussion with key researchers in the homelessness field about known published and unpublished research in this field.

Search terms included combinations of the following words: homelessness, homelessness service, access, accessibility, entry point, barriers, service model, service evaluation, engagement, good practice, complex needs, young people, women, indigenous, rough sleepers, families, older people, families, children, domestic violence.

Article abstracts and report executive summaries were reviewed for an initial assessment of relevance and quality. Further searching for relevant literature occurred throughout the project. Each piece of literature was summarised and assessed for inclusion in the final synthesis.

The final report has been compiled based on the evidence found, structured around the key questions contained in the initial project brief.

1.2 Scope and quality of the evidence base

An extensive review of research and practice culminated in approximately 80 relevant studies being identified as relevant to this synthesis project. These include:

→ Journal articles, 32.

→ Reports (Government, consultants, non-government organisations), 25.

→ AHURI publications, 8.

→ Other publications (book, thesis, discussion paper, conference papers, government document, practice manual, website), 16.

The literature search focused on studies from 2000 onwards, however studies from the mid-late 1990s were also used to supplement the review.

Country breakdown

Research source country	No. of studies
Canada	3
United States	29

Australia	41
United Kingdom	6
Rest of Europe	2

The United States was identified as having the most rigorous approach to research and program evaluations in the homelessness field, with European work in this area significantly limited. Australian research was found to contain the most detailed information about service access and barriers.

Strengths, weaknesses and gaps in the literature

This synthesis project identified a significant evidence base dealing with the issue of barriers to services for people experiencing homelessness, with a strong focus on difficulties faced by those with multiple and complex needs. The priority over the last decade on ending chronic homelessness and rough sleeping in both the US and the UK has driven significant research interest in the issues facing long term or chronically homeless people. In comparison, the amount of literature directly focused on access issues for newly homeless, or those at risk of homelessness, is sparse.

There was also limited recent research evidence on the specific issue of access to specialist homelessness services. Reasons for this are posited to include the limited use of rigorous program evaluations within the homelessness field, the traditionally limited data collection systems within homelessness services (particularly internationally), and the low priority given to research on access issues compared to other aspects of homelessness (such as understanding causal factors and developing effective interventions). This lack of focus on access issues may also be driven by the fact that homelessness services have typically operated on a limited resource base compared to high levels of demand—commonly referred to as *safety net* responses—and effort has focused on demand management rather than expanding the potential client base.

However, access to mainstream service systems such as health, treatment services for drug and alcohol and mental health, and employment services was commonly addressed within the evidence base. Much of this work has been driven by an underlying interest in cost effectiveness, recognising that failure to treat underlying health issues can contribute to chronic homelessness, which in turn can result in greater costs across the service system.

While much of this information about access to mainstream services is relevant to the scope of this project, it did not provide direct evidence about the difficulties and strategies for improving access to homelessness services. The most comprehensive study directly related to homelessness services was the 2001 report by consultants Thomson Goodall Associates prepared for the Victorian Government in its development of a more integrated homelessness service system. This study was specifically aimed at addressing the problems raised by service users (and service providers) about the fragmented and complex nature of the service system, and the difficulties this raised in both accessing and navigating services—therefore directly relevant to this synthesis project.

Of particular concern was the limited availability of evidence-based program evaluations assessing the efficacy of different service models, or even the relative strengths and weaknesses of different approaches or types of access services as identified in the project brief (see Question 3). Where program evaluations have been commissioned, it appears that they are seldom made publicly available (the author has been made aware of numerous Australian program evaluations funded by

governments and individual agencies that could have informed this synthesis but that were not published for external use).

Finally, there were numerous studies found that included consumer perspectives on service delivery and use of services. This has provided a rich source of information about what makes a service accessible or approachable from a service user perspective, and is summarised as a discrete sub-section within the examination of service model/practice barriers.

2 CURRENT ACCESS ARRANGEMENTS

2.1 Introduction

There is currently no single source of information identifying or measuring access arrangements for specialist homelessness services, either in Australia or internationally. Therefore exploring the issue requires analysis of the different types of information available, an understanding of the complexity of the current service system, and the different modes and models of access points available. This section of the report outlines the services available in Australia, the most common modes and models of access, analysis of some of the Australian data available around service usage by different groups, and a summary of information about the centralised access points across each jurisdiction.

2.2 Defining 'access'

Across the literature there is no single or common definition of 'access' or 'accessibility' as it pertains to homelessness services. The range of meanings as they occur in the literature includes the following:

→ The availability of information about the existence of a particular agency or the services it offers.

→ The ability to physically access or otherwise contact an appropriate service (e.g. via phone or by attending an agency in person).

→ The receipt of some form of assistance (or referral) from an appropriate service.

This definitional issue is important in analysing the literature, as the availability of information or the ability to physically access a service doesn't necessarily mean that a person is able to receive any form of meaningful assistance from that service.

In addition, where a service has been 'accessed' by a homeless person, there is often no further details available about whether that led to an appropriate intervention, or what the outcomes may have been.

Finally, the measurement of service usage was sometimes used interchangeably with the measurement of service access. However service usage data is by its very nature only able to measure those services provided to clients who successfully gained access, not the full extent of the numbers of people who were unsuccessful in gaining access or even those who were in need but did not approach a service.

2.3 Services for people experiencing homelessness

2.3.1 Mainstream services

People experiencing homelessness typically require access to a wide range of mainstream services, including:

→ Income support or welfare services.

→ Housing—public and community housing services.

→ Primary health care services.

→ Clinical treatment services (including mental health and drug and alcohol services).

→ Employment and training services.

→ Education and early childhood services.

→ Veterans' affairs services.

→ Aged care services.

→ Immigration services—including asylum seeker and refugee systems.

→ Legal and Court service systems.

Some of these service systems provide specialised or targeted programs aimed at people who are homeless, in recognition of the additional needs they may have. However a common complaint internationally is that these mainstream services fail to adequately serve, or tailor their services, to the specific needs of people within the homeless population (Burt et al. 2010), resulting in them 'falling through the gaps' and being forced to rely on far less adequately resourced homelessness services.

The need for better coordination between mainstream and specialist homelessness services is a recurring theme throughout the Australian Government's national approach to reducing homelessness (Australian Government 2008).

2.3.2 Specialist homelessness services

Historically, homelessness services evolved primarily as a 'safety net' response to people who had fallen through the gaps in mainstream service delivery, or as the last available option where no adequate welfare services exist. Traditionally provided through the charitable sector (dominated by religious organisations), homelessness services usually comprised emergency accommodation (in the form of night shelters or refuges), material aid (such as clothes, blankets, food vouchers), and other forms of practical assistance (showers, meals, some primary health services).

Homelessness services typically developed in isolation from each other, with service models and practices focused on meeting the identified needs of particular target groups. Service models generally evolved on the basis of worker knowledge and experience and in line with the philosophical beliefs and principles of the auspicing organisation, rather than on research evidence.

It wasn't until the 1970s and 80s that governments across the UK, US, Canada and Australia began developing and funding specific homelessness policies and programs. Since that time, the articulation, documentation and evaluation of homelessness services has led to a better understanding of the service system and the difficulties service users face in accessing these services.

The literature shows that the most common means of accessing a specialist homelessness service was, and remains, a person or household in need approaching a centre-based agency to request assistance.

2.3.3 Homelessness services provided in Australia

Funding and administration of specialist homelessness services in Australia was provided from 1985 until 2008 under the Supported Accommodation Assistance Program (SAAP), and from July 2009 under the new National Partnership Agreement on Homelessness (NPAH). While there have been some minor changes to the service system under these changed arrangements, the sector has substantially maintained a similar structure and operating arrangements from SAAP to NPAH administration (AIHW 2010, p.viii). Throughout this report, reference to SAAP data and SAAP services from pre-July 2009 should be read as contiguous with the contemporary 'specialist homelessness services' arrangements and practices.

In Australia, services to assist homeless people funded under the National Partnership Agreement on Homelessness (NPAH) include:

→ Emergency supported accommodation.

→ Transitional supported accommodation.

→ Assistance to obtain and/or maintain accommodation and independent housing.

→ Financial assistance and material aid.

→ Personal support for issues including domestic violence, relationship breakdown and emotional difficulties.

→ General support and advocacy services, such as providing advice and information and advocating on behalf of clients dealing with other services.

→ Specialist services such as drug/alcohol support or intervention, health/medical services, and culturally specific services.

→ Basic support services such as meals, laundry and shower facilities, transport, and recreation activities. (AIHW 2010, p.46)

The service system has evolved since it was established under SAAP in 1985 to provide this range of services to meet the needs of specific target groups within the homeless population (see Table 1 for categories). The most recently available data identifies that over the past five years, services targeted at young people represent the greatest proportion of funded services (around 35%), with cross target/multiple/general the second largest, and services targeted at women escaping domestic violence the third largest (AIHW 2010, Table 17A.2). Adult single women have the lowest number of targeted services (2.8% or 43 services nationally).

Table 1: SAAP agencies by primary target group

| Primary target group | Unit | Proportion of SAAP agencies targeting client group | | | | |
		2004–05	2005–06	2006–07	2007–08	2008–09
Young people	%	36.4	36.0	35.4	35.4	34.3
Women escaping domestic violence	%	22.5	22.8	24.0	23.0	22.9
Cross target/multiple/ general	%	20.9	21.4	22.7	23.6	25.2
Families	%	9.3	9.2	8.4	8.3	8.6
Single men only	%	7.1	7.0	6.4	6.5	6.2
Single women only	%	3.8	3.6	3.0	3.1	2.8
Total	**%**	100.0	100.0	100.0	100.0	100.0
Total number		1,291	1,300	1,539	1,562	1,532

Source: AIHW 2010a, Table 17A.2. Totals may not add up to 100 per cent as a result of rounding.

Support periods provided by agencies roughly correlates for the primary target groups of women escaping domestic violence, families and single women (see Table 2). However there were much higher rates of support periods for clients of single adult male and cross target services than their proportionate representation in the service system and much lower rates for young people (20% of support periods compared to over 34% of agencies). Further analysis of the data shows that single adult males and females make up the two largest client groups of cross target services (38% and 19% respectively), illustrating that the primary target group categories represent only part of the picture about how people are accessing the service system (AIHW 2010a, Table 5.2). In addition, nearly 20 per cent of support periods provided by single women targeted agencies were for women with children, and single adults also represent 20% of support periods within agencies targeted at families.

Therefore, access to specialist homelessness services does not simply follow or correlate to the design and funding of the service system, but is a more complex and nuanced picture requiring detailed analysis.

Table 2: Support periods by primary target group agency

		Proportion of support periods
Primary target group	**Unit**	**2008–09**
Young people	%	20.2
Women escaping domestic violence	%	22.6
Cross target/multiple/general	%	36.0
Families	%	7.2
Single men only	%	11.2
Single women only	%	2.8
Total	**%**	100.0
Total number	**No.**	208,500

Source: AIHW 2010a, Table 17A.2.

Totals may not add up to 100 per cent as a result of rounding. Excludes accompanying children support periods

2.3.4 Common modes and models of access

Analysis of Australian and international literature demonstrates a consistency in the traditional modes of access to homelessness services. These typically comprise:

→ Centre-based services—where clients must attend an established service, either through informal drop-in visits (at day centres, soup kitchens, multi-service hubs, or individual agencies) or formal appointments with agency support workers.

→ Outreach services—either traditional models of outreach where workers visit clients in a range of settings (boarding houses, public places, caravan parks) or assertive outreach models where workers actively seek out 'hard to reach' homeless people (see Section 4.5.6 for more details on this approach).

→ Telephone contact—either directly to individual agencies or via specialist information/referral services.

→ Online information—either homelessness specific or general community services sites, and government agencies.

In Australia, centre-based services represent the overwhelming mode of delivery with the majority of agencies operating some form of supported accommodation (41% medium/long term and 32.0 per cent crisis or shorter term). Only 6.5 per cent of agencies are specifically funded to provide outreach support (n=99), and 1.2 per cent of agencies are funded to provide telephone information/referral support (n=18) (AIHW 2010, Table 17A.3—based on SAAP NDCA Administrative Data Collection).

In 2001 a key study undertaken for the Victorian Government reviewed the intake, assessment and referral practices of homelessness services internationally (Thomson Goodall 2001a). While the project was focused on the development of new assessment and referral processes, it also included a review of the most commonly used intake or access models. The two key models were described as 'single or limited points of intake' (typically involving centralised information and referral models, centralised service directories, and specialist assessment and referral models) and 'any door models' (typically incorporating multiple agencies working within networks or

clusters, maintaining broad access to the service system through multiple entry points) (Thomson Goodall 2001a, p.13).

The stated benefits of single or limited points of intake, assessment and referral were cited as:

→ 'The existence of visible and identifiable *front doors* to the service system.

→ The capacity of specialist intake services to develop a rich understanding of complex service systems.

→ Cost-efficiencies in reducing duplication, as there is no longer a requirement for all services to extend a comprehensive assessment and referral response to all people contacting the services.' (Thomson Goodall 2001b, p.11)

However, internationally it was found that most service systems used the *any door* or multiple entry point arrangements, where individuals were able to contact any agency and theoretically gain access to the broadest possible range of services through coordinated arrangements (Thomson Goodall 2001b, p.10). As well as the benefit to clients in being able to enter the service system at multiple points, and potentially preventing them from falling through the gaps, it also has the positive aspect of encouraging a diversity of agencies (including those in the mainstream) to work in collaboration and partnership to deliver the range of services required (Thomson Goodall 2001b, p.16). This was commonly achieved through various mechanisms such as:

→ Service collaboration—through development of networks, clusters, or partnership models.

→ Co-location and co-auspicing models—such as developing 'one-stop shop' multi-service centres, providing clients with a range of services in the one location.

→ Common tool models—such as the development of common intake, assessment and referral forms for data collection and case management purposes (e.g. the National SAAP Case Management Tool Kit), which allowed for consistency in approach across agencies and the benefit of being able to integrate with common information managements systems.

→ Priority models—allowing agencies across a network to allocate limited resources in an equitable manner, through a jointly agreed system of priority targets.

→ Protocols and agreements—typically formal written agreements between agencies clarifying the roles, responsibilities and relationships of each agency or service and how they would response to common client groups (Thomson Goodall 2001b, pp.15–22).

2.4 Measuring use of specialist homelessness services

Measuring rates of access to homelessness services has proven to be beyond the capacity of existing data collection and analyses in all countries reviewed in this synthesis project. The difficulty is that an accurate estimate of access rates would rely on collection of comprehensive data on the need for services, measured against the actual numbers of people provided with those services.

The Australian Productivity Commission reports annually on the performance of a whole range of government funded services, including homelessness services. Within this report they do specifically address issues of access and equity (Productivity Commission 2011, p.17.9). However its performance measures for access are limited, only reporting on the three outcomes measures of turn-away rates from the service

system, access for Indigenous clients and access for people of non-English speaking backgrounds (see Section 3.3.1 for reporting on these measures).

An analysis of data collected through the Australian Census and data from specialist homelessness services (previously under the Supported Accommodation Assistance Program (SAAP) and now the National Partnership Agreement on Homelessness (NPAH)) allows for some insight into the current use of specialist homelessness services and how it relates to estimated numbers of homeless people in the general population.

Data from the Australian 'Client Collection' can also provide some information on the question of 'how' people access specialist homelessness services, based on their source of referral/information (Q.3 on Client collection form). This identifies how they came to be a client of a homeless service, however not the mode of access (i.e. telephone, drop-in, appointment, or outreach). See following Section 2.4.2 for a breakdown of 'source of referral' data for Queensland.

2.4.1 Australia

Homelessness services data

Australia's national data collection reports on the annual use of services funded under the National Partnership Agreement on Homelessness (NPAH). Australia is reported as being a leader internationally in the national collection and reporting of homelessness data (Greenhalgh et al. 2004) through the federal government's National Data Collection Agency, run by the Australian Institute Health and Welfare. In 2008–09, this data collection reported that 323 600 periods of support were provided nationally across the service system (AIHW 2010). This represented a total of 125 800 clients provided with a service, along with 79 100 accompanying children.

The majority of clients (73%) received only one period of support in 2008–09, indicating low levels of repeat usage. However the reasons for this low repeat usage are not known: it may be because their needs were met and their homelessness resolved, or because their initial experience of the service system discouraged them from seeking further assistance. Despite the large proportion of agencies providing accommodation services, only 33 per cent of support periods involved access to accommodation with the majority of clients receiving only support (67%) (AIHW 2010, p.9)—indicating that high levels of unmet need for accommodation.

Clients received support for an average of 63 days, and the average length of stay in accommodation was 57 days (p.11). However the length of support periods for nearly a quarter of all clients was less than one day, suggesting access to the service was either an information inquiry or the provision of a basic service such as a meal, use of laundry/shower facility, or attendance at a recreational activity.

Data on unmet demand is collected bi-annually from service users, however there are limitations and exclusions in this collection, with one estimate that true unmet demand figures are around four times that of the official rate (Thompson 2007, cited in Urbis 2009, p.3). (For a full discussion of issues with Australian data collections, see Thompson 2007). It is also acknowledged by the NDCA that this reporting may underestimate the true extent of unmet needs due to the fact that a requested need must only be met once within a support period for it to be considered 'met', even where that particular type of support might be required multiple times (AIHW 2010a, p.53). However despite the limitations of this data set, the NDCA acknowledges that finding accommodation within specialist homelessness services is difficult, the current system is working to capacity and demand for accommodation is unable to be completely met (AIHW 2009, p.60).

Around 500 requests for accommodation are unmet on an average day (AIHW 2009, p.11). The most commonly reported unmet needs of clients presenting to services were housing and accommodation (32% of all unmet needs), specialist services such as counselling, psychiatric services, or culturally specific services (16%) and financial or employment services (16%) (AIHW 2010a, p.53).

ABS data

The five yearly Census data collected by the Australian Bureau of Statistics uses a *Special Enumeration Strategy* to estimate the numbers of people experiencing homelessness on a single night in the three categories of primary, secondary and tertiary homelessness. On Census night 2006 it was estimated that nearly 105 000 were experiencing homelessness, with almost 20 000 temporarily accommodated within the specialist homelessness service system (Urbis 2009, p.7).

These figures highlight that the vast majority of people experiencing homelessness are not being directly assisted with supported accommodation, even though they may have had some other form of contact and/or assistance with other needs through the SHS.

The total count represents a rate of 53 homeless persons per 10 000 in the Australian population, a rate that has remained consistent from the 2001 Census to the 2006 Census (Urbis 2009, p.5). A breakdown of the Census figures (from Chamberlain & MacKenzie 2009) shows that of the 105 000:

→ Nearly 22 000 were young people aged 12–18 years.

→ Nearly 60 000 were adults (singles and couples) without children.

→ Only 7740 (7%) were aged over 65 years.

→ The proportion of male was 56 per cent.

→ The Indigenous proportion was nearly 10 per cent.

→ The proportion of those sleeping rough or in improvised dwellings/tents was 16 375 (16%).

→ The largest proportion (45% or 46 856 people) was staying with friends or relatives.

2.4.2 Queensland

ABS data reports that on Census night 2006 there were 26 782 people experiencing homelessness across Queensland, representing 26 per cent of the national homeless population (Chamberlain & MacKenzie 2009). Compared to the national rate of 53 homeless persons per 10 000 in the population, Queensland recorded higher rates in many areas, including 56 across Brisbane City, 60 across the Sunshine Coast, 120 in Coastal Queensland, 91 in Coastal cities and 154 in rural and remote subdivisions (including a staggering 235 per 10 000 in the Mackay SD Balance).

Queensland also recorded a higher proportion of people sleeping rough (19% compared to 16% nationally) and staying with friends and relatives (49% compared to 45% nationally). Analysis of rough sleeping data from the Census also indicates that Queensland is the jurisdiction with the largest absolute number of rough sleepers (5165 out of 16 375 nationally) and has a significantly different profile to that of other jurisdictions—a rate of 12 per 10 000 in capital cities compared to 30–38 per 10 000 elsewhere and much higher rates in rural and remote areas (Australian Government 2008, p.4).

While Indigenous people made up 3.5 per cent of the Queensland population, they represented 8.1 per cent of all homeless people. They were significantly more likely to be staying in specialist homelessness accommodation representing nearly 22.0 per cent of all people in that category of homelessness on Census night.

Other comparisons with the national data show that the number of homeless aged 35 or older was significantly higher in Queensland (49% compared to 42%), and that only 12 per cent of homeless people were in SAAP accommodation on census night compared to 19 per cent nationally.

On an annual basis, data from the SAAP National Data Collection annual report 2008–09 (AIHW 2010, p.8) shows that 323 600 support periods were provided by funded homelessness services of which approximately 1/3 were support periods for accompanying children (see Table 3). In Queensland, 47 100 support periods were provided including 16 800 for accompanying children.

Table 3: Australian and Queensland support periods, 2008–09

	Client support period		Accompanying children support period		Total support	
	No.	%*	No.	%*	No.	%*
Qld	30,400	14.3	16,800	15.1	47,100	14.6
Australia	212,400		111,200		323,600	

* per cent of national figures.

Source: AIHW 2010, Table 2.2

This demonstrates that despite representing 20.0 per cent of the national population, Queensland has significantly lower rates of support periods than other jurisdictions (less than 15% of total support periods). However Queensland also received proportionally less funding than its population percentage, at only 17.8 per cent of national funding, and has only 15.4 per cent of the total number of SAAP agencies nationally (see Table 3). In comparison, Victoria with 25.0 per cent of the national population had 31.5 per cent of all client support periods SA with only 7.5 per cent of the national population recorded 11.2 per cent of all client support periods (Ref: AIHW 2010, p.8, Table 2.2). This suggests some fundamental inequities in the availability of housing and support services to people experiencing homelessness in Queensland.

Queensland also has a slightly different agency profile when compared to the national profile, with proportionally less services for young people but significantly more family services (see Table 3).

Table 4: SAAP agencies by primary target group, 2008–09

Primary target group	Proportion of SAAP agencies targeting client group		
	Australia %	Queensland %	Queensland No.
Young people	34.3	29.7	70
Cross target/multiple/general	25.2	26.3	62
Women escaping domestic violence	22.9	22.0	52
Families	8.6	14.4	34
Single men only	6.2	5.5	13
Single women only	2.8	2.1	5
Total %	100.0	100.0	100.0
Total number	1,532		236

Source: Table 2.2, AIHW 2010a and Table 2.1, AIHW 201b

NDCA data (2008–09) from the *Client Collection* can provide some information on *how* people access specialist homelessness services based on the question about their source of referral/information (Q.3 on Client collection form). However, it is not possible from this information to identify the mode of access (i.e. telephone, drop-in, appointment, outreach.). Data for Queensland was analysed to examine how the source of referral/information varied by age and gender, and for those identified as Indigenous clients (Note: data provided is from Confidential Unite Record Files (CURFs) which are non-weighted for participation or consent—therefore total client numbers are lower than the totals reported by the AIHW. It is assumed that responses from the CURFs are reflective of the broader client collection).

In 2008–09, there were 15 401 clients recorded by services (closed support periods). For 2500 of these clients, no information was available about their source of referral/information, representing the second highest response to the question (16%). As shown in Figure 1, the most common source of referral/information was 'self' (34%), followed by 'other non-government organisation' (11%) and 'other government organisation' (9%). 'Family and friends' represented 7 per cent of referrals/information, and 'telephone/crisis referral agency' represented 6 per cent. Other response rates were less than 5 per cent, with school/education institution providing the smallest number of referrals at only 1 per cent.

Figure 1: Source of referral/information, 2008–09 SAAP clients, Queensland
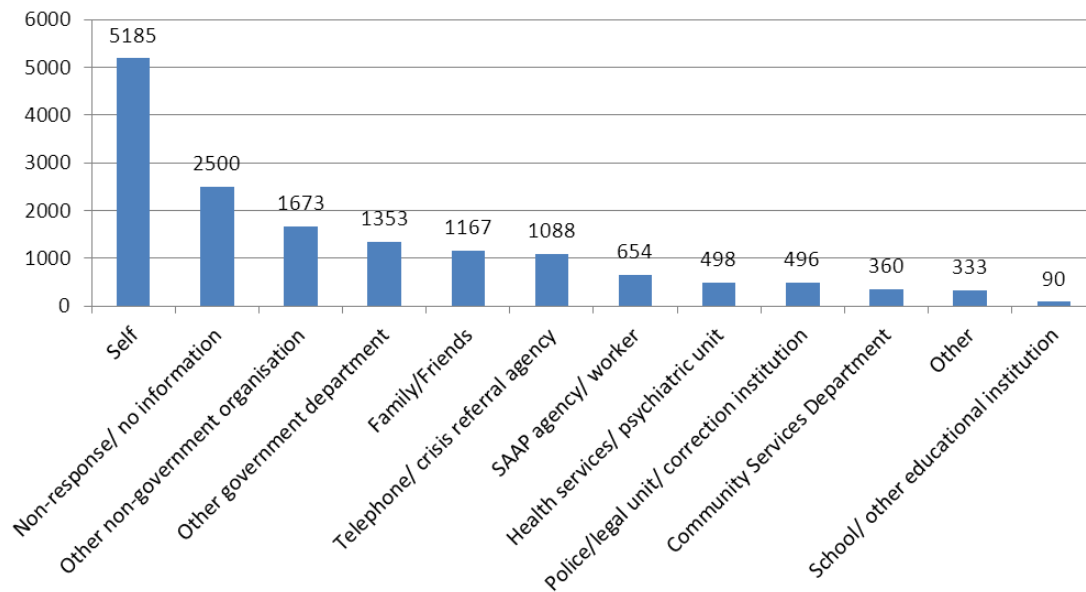
Source: 2008–09 iSAAP closed support period (CURFs) data, Department of Communities, Queensland

These patterns of referral/information source were generally consistent across different age cohorts, with the following exceptions:

→ For young people aged 15–17 (n=1480), family/friends were the second most common source, with community services also providing a higher number of referrals (7%) and school/education institution representing 4 per cent.

→ For those aged 25–45 years, telephone/crisis referral agency became the third highest source, overtaking the category of family/friends.

→ For people aged over 65 years (n=293), health services/psychiatric units were the fourth highest source of referral (at nearly 8%) and use of telephone/crisis referral agencies was much lower at only 3 per cent.

Table 2 provides a breakdown of the Queensland client data by gender, identifying that women represent nearly 54 per cent of all clients. Again the general rankings of referral/information source hold for both genders. However, telephone/crisis referral agency is a much higher source of referral/information for women, most likely explained by the dedicated hotline for women escaping domestic violence. While relatively low in numbers (n=90 for all referrals), women also make up 80 per cent of all referrals from schools/education institutions. Health services/psychiatric units are more likely to be a source of referral/information for males.

Table 5: Gender breakdown of clients, 2008–09 SAAP clients, Queensland

Source of referral	Male		Female		
	No.	%	No.	%	Total
Self	2,718	52.4	2,467	47.6	5,185
Non-response/ no information	1,313	52.5	1,187	47.5	2,500
Other non-government organisation	668	39.9	1,005	60.1	1,673
Other government department	667	49.3	686	50.7	1,353
Family/Friends	505	43.3	662	56.7	1,176
Telephone/ crisis referral agency	191	17.6	897	82.4	1,088
SAAP agency/ worker	256	39.1	398	60.9	654
Health services/ psychiatric unit	272	54.6	226	45.4	498
Police/legal unit/ correction institution	216	43.5	280	56.5	496
Community Services Department	146	40.6	214	59.4	360
Other	149	44.7	184	55.3	333
School/ other educational institution	18	20.0	72	80.0	90
Error	**1**	**25.0**	**3**	**75.0**	**4**
Total	**7,120**	**46.2**	**8,281**	**53.8**	**15,401**

Source: 2008–09 iSAAP closed support period (CURFs) data—Department of Communities, Queensland

Data for Indigenous clients (see Table 6) shows that they represent 21.1 per cent of all clients in Queensland, and women represent a higher proportion of Indigenous clients at 64 per cent (compared to 54% of all clients). The same rankings of source of referral/information are also consistent between Indigenous and non-Indigenous clients, with one major exception—the use of telephone/crisis referral agencies by Indigenous men is significantly lower than that for women (4.7% compared to 95.3%), and ranks at second last behind school/education institution. Indigenous women are also more likely than Indigenous men to be referred from SAAP agencies and school/education institutions.

Indigenous clients are more likely than non-Indigenous clients to be referred from police/legal unit/corrections institutions and community service departments, and less likely to be referred from school/education institutions, other government departments, and telephone/crisis referral agencies.

Table 6: Indigenous clients, 2008–09 SAAP clients, Queensland

Source of referral	Male		Female		Total Indigenous	% of all clients	Total
	No.	%	No.	%			
Self	471	42.0	650	58.0	1,121	21.6	5,185
Non-response/ no information	204	40.8	296	59.2	500	20.0	2,500
Other non-government organisation	100	31.3	220	68.8	320	19.1	1,673
Other government department	98	31.0	218	69.0	316	27.1	1,167
Family/Friends	87	39.4	134	60.6	221	16.3	1,353
Telephone/ crisis	9	4.7	184	95.3	193	17.7	1,088

referral agency

SAAP agency/ worker	52	34.0	101	66.0	153	30.8	496
Health services/ psychiatric unit	36	25.2	107	74.8	143	21.9	654
Police/legal unit/ correction institution	33	33.7	65	66.3	98	19.7	498
Community Services Department	34	35.4	62	64.6	96	26.7	360
Other	39	50.6	38	49.4	77	23.1	333
School/ other educational institution	4	28.6	10	71.4	14	15.6	90
Error	**0**	**0.0**	**1**	**100.0**	**1**	**25.0**	**4**
Total	**1,167**	**35.9**	**2,086**	**64.1**	**3,253**	**21.1**	**15,401**

Source: 2008–09 iSAAP closed support period (CURFs) data, Department of Communities, Queensland

2.4.3 International

Data collections in the United States and Europe have traditionally been focused at the local community and local authority level, but over the past decade there has been significant effort (particularly in the US) to improve and develop national collections.

In the US, the use of homeless management information systems (HMIS) to collect data on people using homelessness services was mandated by Congress in 2000, and is gradually being implemented in communities across the country (Culhane et al. 2007). In the UK all local authorities are required to collect data on people presenting as homeless (O'Connell 2003). Both the UK and US have invested significant effort and resources on the enumeration of rough sleepers, and responding to this target group (FEANTSA 2010, p.5), however this does not measure the extent of national usage of homeless services, or the levels of unmet need in these countries.

The 1996 US National Survey of Homeless Assistance Providers and Clients provided the basis for an estimate of chronically homeless people at between 150 000 and 250 000 (Burt & Spellman 2007, p.2.2). More than a decade later a one night Census in the US counted around 672 000 homeless people (58% of whom were staying in shelters), including around 121 000 defined as chronically homeless (Burt et al. 2010, p.1).

Across Europe the predominant model of service delivery is for local authorities to have responsibility for funding and planning services, with non-government agencies responsible for service delivery. National data collections have not been a high priority of governments to date, however it is recognised that access to homelessness services is a major problem in many European countries, with an uneven spread of services across metropolitan and rural areas, particularly in the UK and France (Busch-Geertsema 2010, p.75).

The lack of rigorous or comprehensive international data collections on homelessness services precludes the provision of comparable data to the Australian service system. However a direct comparison would in any case not be possible, given that the nature and composition of the respective service systems are significantly different.

2.5 Current access points in Australia, by jurisdiction

Another approach to exploring 'how' people currently access homelessness services in Australia is to survey access points across jurisdictions. Compiling publicly available information from each state/territory (primarily web-based) has identified a

variety of access points, primarily based on telephone access, supplemented by online service directories in some jurisdictions (see Table 7 below).

Victoria and the ACT have both recently implemented centralised access arrangements:

→ In 2008, Victoria launched a new area-based coordinated service system (Opening Doors). Clients are provided with streamlined access to the homelessness service system through a limited number of centralised intake/assessment/referral points in each of eight regions across the state, supported by a centralised statewide telephone service. The aim of these reforms was to provide better and easier access to the service system, both through specialist homelessness services and eventually through allied community services (such as health, mental health and drug and alcohol services). Documentation available includes a Framework, Service Coordination Guide and Practice Guide.

→ In 2010, the ACT established the new *First Point* service in the ACT which provides a single, centralised telephone information and intake point for all homelessness services in the Territory. This service requires that all people seeking assistance from homelessness services must enter through a single agency, representing a significantly different system to that operating in any other Australian jurisdiction.

In other jurisdictions a combination of different types of direct access and centralised telephone lines is in place. NSW and South Australia (as well as Victoria) provide dedicated youth and domestic violence telephone information services. Queensland provides a statewide telephone service as well as dedicated domestic and family violence phone service, with WA and Tasmania providing a range of different numbers based on location and determined by whether the call is during business hours or after hours. All of these telephone services are designed to complement the established service systems in each jurisdiction, rather than operate as a centralised 'front door' or intake point.

Typically government websites promote the centralised access points rather than providing details of all the individual services that are funded to provide specialist homelessness services.

Table 7: Access points by jurisdiction, Australia

NSW	**Homeless Persons Information Centre (HPIC)**
	A statewide telephone assessment and referral service for people over 18 years old, operated by the City of Sydney. This is complemented by an extended hours outreach service people in the inner city which incorporates a specialist medical and drug and alcohol services team.
	Telephone Toll Free: 1800 505 501
	7 days a week: Monday–Friday 7:00am–10:30pm
	Saturday–Sunday 9:00am–5:00pm
	DoCS Domestic Violence Line
	A statewide free-call number available 24 hours, seven days a week. The Domestic Violence Line provides telephone counselling, information and referrals (including accommodation) for people who are experiencing or have experienced domestic violence.
	Phone: 1800 656 463, TTY 1800 671 442
	Youth Emergency Accommodation Line
	Run by Yfoundations (previously the Youth Accommodation Association NSW). Service for young people 12–24 years operates Monday to Friday 9.00am–4.00pm and provides a 24 hour recorded message about vacancies for metropolitan youth crisis services. Supplemented by an online register of vacancies.
	Phone: Metro (02) 9318 1531, Rural 1800 424 830.
Vic	As part of the new Opening Doors arrangements, Victoria has a central 24 hour **1800 contact number** for people experiencing or at risk of homelessness, providing information about services available in eight catchment areas or regions around the state. Calls are automatically transferred from the central number to the closest intake service to the caller. Calls received outside business hours are redirected to the Salvation Army Crisis Service located in metropolitan Melbourne (St Kilda). http://www.housing.vic.gov.au/homelessness-and-family-violence/getting-help
	Melbourne Youth Support Service (run by Melbourne City Mission)
	A statewide telephone information and referral service for young people 16–24, operating as an extended hours access point for homeless young people.
	Monday–Friday 9.00am–8.00pm
	Saturday/Sunday/Public holidays 10.00am–6.00pm
	Phone: 03 9614 3688
	The **Women's Domestic Violence Crisis Service**
	A 24 hour phone service for women and children experiencing family violence.
	Phone: 1800 015 188 (not free for mobile phones)
	The **Salvation Army** provides a 24 hour phone service for those in the St Kilda area, and operates as a de facto statewide information and referral service for the rest of the State.
	5pm–9am
	Phone: 03 9537 7711 or 1800 627 727
Qld	**Homeless Persons Information Queensland (HPIQ)**
	Provides a toll-free service (and TTY toll-free service) that assists with housing, advice and support, and practical assistance such as where to find meals, showers and clothing. *No information available on website about hours of operation or service directory to provide direct access to local services.*
	Toll-free: 1800 474 753 (1800 HPIQLD) (toll-free within Australia from landlines)
	TTY Toll-free: 1800 010 222 (toll-free within Australia from landlines)
	dvconnect
	A dedicated domestic and family violence phone service that is also a key access point for women's refuges across Queensland. It provides free help for women, men, children and pets affected by domestic and family violence across Queensland.

	Women's line operates 24 hours, 7 days per week
	Phone: 1800 811 811
	Men's line operates from 9.00am–midnight 7 days per week
	Phone: 1800 600 636
WA	WA currently operates a statewide Homeless Advisory Service during business hours (1800 065 892) and an after-hours Crisis Care line based in Perth (08 9223 1111) with free call access for those in country areas (1800 199 008).
	As at 4 March 2011 it was noted that a directory of crisis accommodation and homelessness services is being finalised and will be available shortly, at:
	http://www.dcp.wa.gov.au/CrisisAndEmergency/Pages/CrisisHomelessnessServices.aspx
SA	SA has three specialist phone access services open varying business hours for young people, those experiencing family violence, and families along with a single out of hours phone contact (131 611).
	→ Youth, 15–25 years. Phone: 1300 306 046 or 1800 807 364.
	→ Domestic or family violence. Phone: 1300 782 200 or 1800 800 098.
	→ Families. Phone: 1800 003 308.
	Homelessness Service Provider Directory available online from South Australian Government website, listing services for: Families, Adults, Young People, Domestic or family violence, Aboriginal or Torres Strait Islander people.
Tas	The Tasmanian Department of Health and Human Services provides access to specialist homelessness services through three key access points (Access North, Access North West and Access South) which operate during business hours to provide assessment and case planning services, as well as assist with referral to emergency accommodation providers. There is also a statewide after-hours free call number for assistance with emergency accommodation.
	Phone: 1800 800 588
	Operates outside of business hours on weekdays, and on weekends and public holidays.
ACT	In 2010 the ACT launched 'First Point', a central service for people experiencing or at risk of homelessness in the ACT. It is linked to all community support service providers and is designed as a single access point to the service system. Currently operating through a 1800 number, the plan is to supplement this with a shopfront in Canberra for direct access.
	The toll-free number operates Monday–Friday 9.00am–7.00pm and Saturday 10.00am–1.00pm
	Phone: 1800 176 468 (1800 1POINT)
NT	NT Govt provides a list of SAAP service providers (Darwin and Palmerston only) on the Department of Health website

2.6 Conclusion

The evidence presented demonstrates that there are varying modes and models of access currently operating across specialist homelessness services and service systems. The most common mode of access in Australia remains centre-based visits, requiring clients to identify and approach an appropriate service that is able to meet their needs, and the most common model of access is through multiple or 'any door' access points (as opposed to single or limited intake services).

There is no single data collection or other means of measuring access rates against demand for services, with neither the ABS Census data nor the NDCA data able to accurately provide this information. However it is clear that the existing service system working at full capacity is only able to meet around 20 per cent of the accommodation needs of people experiencing homelessness in Australia.

The most useful mechanism for understanding access patterns to specialist homelessness services is the question on 'source of referral' within the NDCA data collection. It identifies that in Queensland the most common source of referral or information for those who do become clients of a homelessness service is 'self' (34%), with relatively low levels of access via telephone/crisis referral agencies (6%). There are relatively small variations by age or gender in terms of referral/information source; however there are notable variations for Indigenous compared to non-Indigenous clients including the significant under-utilisation of telephone/crisis referral agency services by Indigenous men.

3 BARRIERS TO ACCESSING SERVICES FOR HOMELESS PEOPLE

3.1 Introduction

National and international studies primarily focus on barriers for homeless people in accessing affordable housing, health and other mainstream services by homeless people, rather than barriers to specialist homelessness services (SHS). However many of the principles and lessons about barriers to mainstream services, and ways to overcome them, can be adapted for the SHS system.

In a recent study examining barriers to mainstream services in the US, it was identified that 'the type, extent and duration of services needs of different groups of homeless people varies widely', based on factors such as demographic characteristics, the length of time and patterns of homelessness experienced, and their individual causal factors (Burt et al. 2010, p.1). Similarly, the barriers faced by different groups within the homeless population can vary significantly.

The barriers faced by people who are either at risk of homelessness, or who have become homeless, can be broadly categorised as:

→ service system barriers

→ service model/practice barriers

→ individual barriers.

This section of the report will outline the common barriers faced across the three different categories of service system barriers, service model or practice barriers and individual barriers, as well as those issues identified in the literature that are specific to the following sub-populations:

→ people with complex needs, including rough sleepers and chronically homeless people

→ Indigenous people

→ young people

→ families

→ women & children escaping domestic and family violence.

3.2 Service system barriers

The literature identifies difficulties with access to the broader human or community service system as both a causal factor in homelessness, and a factor in preventing sustainable exits from homelessness. Given the complexity of need often associated with homelessness, accessing and navigating multiple service systems is generally required.

The most commonly identified service system barrier is that of capacity, or more precisely the lack of funding and other resources to meet the needs of all those requesting assistance. This limited capacity can mean that those with additional complex needs, such as people experiencing homelessness, can be placed even further at the back of the queue in preference for clients who are easier to serve and with greater perceived potential to result in a positive outcome (Burt et al. 2010). Other common barriers at a service system level include (Thomson Goodall 2001a, 2001b; Resolve Community Consulting 2006; Greenhalgh et al. 2004):

→ The large number of uncoordinated services and service systems.

→ Difficulty in clients, and service providers, negotiating access to these various service systems.

→ A lack of appropriate and readily available information about those services and service systems.

→ Inconsistent eligibility criteria and participation requirements.

→ Insufficient knowledge and training amongst staff in mainstream services around responding to homeless clients.

→ Difficulty in accessing specialist treatment services, such as drug and alcohol and mental health services.

→ Availability of stable, appropriate, safe and affordable housing.

→ Availability of appropriate emergency accommodation for people in crisis.

→ Rigid service models including eligibility criteria that excludes characteristics prevalent within the homeless population.

→ Competition for funding and other resources affecting cooperative working arrangements between service providers.

→ Increase in incidence of multiple diagnosis clients and complexity of needs.

→ Deinstitutionalisation and lack of affordable supported housing options for people with mental illness.

Overcoming systemic barriers remains a major obstacle internationally, despite significant attention paid to systems integration over the past few decades (Burt et al. 2010; Dennis et al. 1998). In a US study on improving access to mainstream services and benefits (Burt et al. 2010), it was identified that system barriers could occur in three main categories:

→ Eligibility barriers—because of their lack of stable housing and complex needs, homeless people often face additional challenges in meeting program eligibility or participation criteria.

→ Structural barriers—including transportation, discrimination, identification and documentation requirements, system interaction breakdown.

→ Capacity barriers—insufficient supply to meet demand for services, insufficient value of benefits and services, and delayed availability.

In addition, as few mainstream programs are required to collect information about the housing status of their clients, it is virtually impossible to find accurate data about the extent of their service usage by homeless people (Burt et al. 2010, p.3). However the authors cite various studies which suggest that homeless people are less likely to receive mainstream benefits and services than other low income people (p.4).

3.3 Service model/practice barriers

Access to individual services in both mainstream and homelessness services is determined through a combination of their specific service model, eligibility criteria and participation requirements. The following section outlines common barriers in both mainstream and specialist homelessness services as identified in the literature.

3.3.1 Barriers to mainstream services

Some of the common service model and practice barriers for homeless people attempting to access mainstream services include (Resolve Community Consulting 2006; Thomson Goodall 2001a; Burt et al. 2010):

→ Cost of services (including cost of transport and phone calls).

→ Eligibility criteria precluding clients without stable accommodation or with active addictions.

→ Identification and documentation requirements difficult for homeless people to meet.

→ The use of place-centred, as opposed to person-centred, services.

→ Limited opening hours or use of appointment-only access.

→ Service location making access by public transport difficult.

→ Lack of flexibility in service provision, including insufficient brokerage funds to provide flexible responses.

→ Intrusive assessment processes.

→ Long waiting times for access to appointments, and long waiting lists for services, meaning clients have moved on before engagement is established.

→ OH&S policies dictating worker practice (for example precluding outreach work).

→ Focus on throughput and unit costing encouraging services to work with less complex clients.

→ Belief that people experiencing homelessness should be accessing specialist services, rather than mainstream services.

→ Service banning for clients with challenging behaviours or history of violence.

→ Lack of communication and integration between services about common clients (sometimes due to unresolved privacy issues).

→ Reluctance to assist those clients not 'in-scope' with their particular service model or capacity.

3.3.2 Barriers to specialist homelessness services

In 2001 the Victorian Government commissioned consultants to assist in developing a new assessment and referral framework for the homelessness service system. One of the stated reasons for this work was the identified problems with a fragmented service system, resulting in difficulty of access by clients and navigation by workers in other community service systems (Thomson Goodall & Associates 2001, p.1). Findings from client consultations from the concurrent project to develop a new Victorian Homelessness Strategy (VHS) were incorporated into their work, with clients reporting the following barriers in accessing and navigating homelessness services:

→ A lack of clearly visible entry points to the homelessness service system.

→ A lack of readily available information about service options.

→ Inadequate information, or misinformation, about services.

→ Getting the 'run around' from agencies.

→ Intrusive and insensitive assessment processes.

→ Poor coordination between the large numbers of existing services (Thomson Goodall & Associates 2001, p.1, pp.17–18).

Clients reported these factors as contributing to the difficulty and stress of accessing services at a time when they were already experiencing the upheaval and instability of being homeless.

These barriers are consistently repeated across the international literature, along with the following additional factors:

→ The need to visit multiple sites to access different types of assistance.

→ Cost of service access (including transport costs and phone calls).

→ High barrier entry requirements.

→ Additional requirements to participate in and accept conditions of case planning, including participation in treatment services (drug and alcohol or mental health clinical services).

→ Long waiting times for telephone information services.

→ Use of appointment-only access (rather than drop-in or outreach models).

→ Practice of referring clients to emergency accommodation without providing appropriate support services (due to limited resources).

→ Hours of operation limited to business hours when needs are often greatest outside those hours.

→ Use of answering machines by agencies.

→ Misinformation or out of date information about other service availability.

In addition, the use of 'exclusionary practices' or service banning by homelessness agencies was identified as an issue, particularly within the Australian literature.

3.3.3 The use of 'exclusionary practices' by homelessness services

An exception to the limited number of studies specifically exploring the issue of access and barriers to specialist homelessness was the relatively large body of Australian research focused on the issue of 'exclusionary practices' or 'banning'. Four recent studies into this issue were identified:

→ NSW Ombudsman (2004) *Assisting homeless people*—the need to improve their access to accommodation and support services: Inquiry into access to, and existing from SAAP accommodation services in NSW.

→ Evolving Ways (2007) *Barriers to Access to SAAP Services*, Department of Health and Human Services, Housing Tasmania.

→ Jill Cameron & Associates and J Payton (2004) *Report on Exclusion Practice in SAAP, Identification of the mental health, alcohol and other drugs issues impacting on current practice in SAAP Services*, SAAP State Advisory Committee, Western Australia.

→ Upham, L. (2001) *Opening the debate: exploring 'exclusion' in Queensland SAAP/CAP services*, Ministerial Advisory Arrangement for the SAAP and CAP, Queensland (cited in Cameron & Payton 2004).

Exclusionary practices typically involved the provision of 'restricted services', or in some cases the refusal to allow the person access to any services. They were often found to impact people with high and complex needs, with groups most affected being:

→ affected by or dependent on drugs and/or alcohol

→ those exhibiting, currently or previously, violence and other challenging behaviours

→ those with a mental illness

→ people with disabilities (including physical, intellectual and acquired brain injury). (NSW Ombudsman 2004, p.7)

Other groups facing exclusions included: those not willing to enter into a case management plan, unwilling or unable to pay for accommodation, pregnant women, those who have been 'blacklisted' by services, those unable to meet other eligibility criteria of individual agencies (NSW Ombudsman 2004, p.8; Evolving Ways 2007, p.1).

The Tasmanian study categorised the barriers imposed by exclusions as:

→ behavioural issues

→ duty of care and OH&S issues

→ service unable to meet presenting needs

→ failure to comply with agreed case plans

→ perceived incompatibility with current client mix in the service. (Evolving Ways 2007, p.4)

Systemic issues identified in the NSW study included:

→ Concerns by SAAP providers that they were being expected to take responsibility for clients that would be more appropriately be serviced by other sectors (jurisdictional barrier setting).

→ OH&S concerns and duty of care issues toward staff, particularly related to clients exhibiting violent or challenging behaviours.

→ Limited agency resources affecting initial access, particularly related to those with high and complex needs.

→ Congregate care models cited as impacting ability to taking on clients that may not be suitable.

The NSW Ombudsman found that the 'level and nature of exclusions in SAAP are extensive', in some cases unreasonable, discriminatory and in contravention with SAAP legislation and standards (p.7). A series of recommendations were made in the report to address the issues of exclusions, including that services 'ensure that access to services is inclusive of all persons within an agreed target group … and that any exclusions are based on considered assessment of the presenting circumstances of an individual and reasonable attempts by the agency to managed identified risk'. Other mechanisms included the adoption of minimum service standards, the use of interagency protocols, training and professional development activities, and negotiation around increased resources for agencies (p.14). There was a specific recommendation that access should not be terminated on the basis of a client refusing to enter into or continue with a case management plan, and that any request for assistance should be assessed as a new request (p.19). Each of these measures is designed to assist in removing blanket bans on individuals from accessing a service, but approached within a risk management framework.

The Tasmanian study notes that while services report that the formal use of exclusions ceased in 2005, there are still restrictive service practices in place. Proposed solutions included more coordinated planning and service provision between the various service sectors responsible for clients with complex needs, both

at a policy and practice level (p.15). The NSW Ombudsman provided a series of detailed recommendations for service policy and practice change.

These studies highlight the difficulties faced by service providers in managing the needs of existing service users and those seeking access who may have challenging behaviours. This is a tension that would exist on an ongoing basis, regardless of the status of formal 'exclusions', due to the complexity of need experienced by many within the homeless population. It also highlights that service providers must find alternative ways of managing clients who present with challenging behaviours or more complex needs.

3.3.4 Consumer perspectives on service access barriers

Six studies were identified that specifically asked people experiencing homelessness their views on service delivery, including the question of barriers to services. These studies illustrate that service usage and help-seeking behaviour can be strongly influenced by a person's initial experiences of the service system, and that their coping behaviours are in part determined by the barriers and resource limitations imposed by service providers.

A 2008 study in Portland (Oregon) drew on a database of 500 transcribed interviews of service users to explore how people experiencing homelessness viewed services and providers (Hoffman & Coffey 2008). Their descriptions of interactions with staff and providers were overwhelmingly negative, with a common theme of staff using objectification and infantilisation in their treatment of service users. For many clients the response to this treatment was one of anger, followed by a conscious decision to opt of the service system 'in order to maintain a sense of dignity and self-respect' (Hoffman & Coffey 2008, p.207). The researchers argued that this should be viewed as evidence of power relations and inequities in the provider-client relationship, rather than individually pathologised. They found that very little research exists around users' experience of homelessness services; however, a better understanding of this aspect of the service system could assist in improving the understanding and development of better service responses. Examining the quality of interactions and experiences could help in understanding some of the reasons why individuals turn away from services designed to assist them (p.219).

A 2007 Canadian study explored the perceptions of homeless people around the 'welcomeness and unwelcomeness' they encountered in accessing health care providers (Wen, Hudak & Hwang 2007). Using 17 in-depth interviews, the research was designed to ascertain whether past encounters with health care providers affected attitudes toward future help-seeking. They identified that negative encounters were likely to reduce help-seeking in future, and that the perception of 'unwelcomeness' was linked to factors such as perceived discrimination, stigmatisation, and power imbalances with service providers.

This self-imposed limitation on help-seeking behaviour was also found in a 2004 study in Pennsylvania, where 225 rough sleepers were interviewed about their service needs around housing and treatment for drug addiction (Freund & Hawkins 2004). Two thirds of those interviewed believed that they would not be eligible for treatment or services because of service eligibility requirements. Some of the factors that helped form these beliefs were negative past experiences of the service system, and the knowledge that very few treatment options were linked to housing provision (p.90). A major finding was that homeless people believe there is little point in making the effort to access drug treatment services if they weren't linked to housing in an appropriate area—there was a particular concern about returning to neighbourhoods where there

was significant drug dealing activity, as they were more likely to return to their addictive behaviours if returned to those environments.

This study identified that homeless people with drug addictions have an additional level of complexity that affects their willingness or ability to access services, and that this must be recognised in the development of appropriate service responses (p.92).

Another US study also found that help-seeking behaviour was affected by experiences with the service system, particularly those experienced when first becoming homeless (O'Toole et al. 2007). A community-based survey of 230 homeless adults in Pittsburgh and Pennsylvania (USA) was undertaken in 1997 to identify the 'first-stop' access sites of clients, and to develop a better understanding of reasons for seeking assistance from those sites Findings showed that from a list of 20 possible sites, 47 per cent of respondents reported going to a soup kitchen, 31 per cent to a welfare office, 28 per cent to a detoxification centre, 26 per cent met with a homeless outreach team, 25 per cent approached a family member and 23 per cent to a hospital emergency room (p.446). Those with a chronic medical or mental health issue were more likely to access a health facility or social service agency.

The most common reason for seeking assistance was to meet an immediate need, rather than for their homelessness. It was argued that this could be explained by the 'socio-rational choice' model (Sosin & Grossman 2003) whereby clients weight up the costs and benefits of accessing services against alternative uses of their time and resources (p.451).

The authors postulate that clients' help-seeking behaviour at sites such as soup kitchens indicated a lack of confidence (or knowledge) about the broader housing, support, and clinical services that may be available. They note that 'the process of help-seeking is often overwhelmed by the need for meeting daily subsistence needs' (p.451). The authors conclude that 'targeted outreach and interventions at 'first stop' sites and the co-location of substance abuse treatment and other services may be opportunities to engage homeless persons earlier in the course of their homelessness, shortening the duration and consequences of this condition' (p.452).

In the UK, a quantitative study was undertaken to identify who uses services for the homeless, using interviews with 389 rough sleepers to understand the characteristics of the service population and implications for service planning and delivery (Fountain, Howes, Marsden & Strang 2002). It was found that 90 per cent of those interviewed had used at least one accommodation service over the previous year, despite 47 per cent having slept rough for more than six months over this period. Services most commonly used were day centres, food runs, outreach teams and cold weather shelters. When asked about the main barriers to using services, the responses included that there was too much substance abuse present, too much violence and chaos, a dislike of the food provided by food services, and not knowing where to access assistance. These responses indicate that even when faced with extremely tough conditions, service users are actively making judgements about the type and quality of services provided, with personal safety being a primary concern. The study also found that those who had been homeless for less than two years were less likely to know about homeless services than others. This led to a recommendation that services should target their information and publicity among the newly-homeless populations, as well as incorporating them into prevention strategies.

Finally, a 2008 dissertation examining the process of providing Assertive Community Treatment (ACT) to homeless people with a severe mental illness looked at the issue of relationships between clients and providers, the use of coercion and impact on quality of services (Stanhope 2008). The author argues that while there has been

extensive research on the use and structure of case management models in working with homeless people, there has been very little examination of the process of engaging and maintaining consumers in services. Using focus groups of both service users and providers, the research found that there were very different perspectives between the two groups with service users valuing the relationship with the worker for its intrinsic value, whereas providers saw the interaction as a means of meeting case plan goals. For service users, the quality of service provided was found to be associated with positive relationships. Particularly for those with tenuous connection to services, an immediate positive response to service interactions was considered to be vital to maintaining engagement. These findings identify the importance of service providers and case managers in understanding consumer perspectives in order to design and provide an effective service response.

3.4 Individual/personal barriers

Much of the literature acknowledges that while individual and personal factors can present a barrier in the use of services, these are typically of less significance than the structural and service barriers encountered. However one commonly mentioned personal barrier for people experiencing homelessness in accessing services is their capacity to do so during a period of crisis and in a state of chaos.

Other personal or individual factors commonly impacting service access include (O'Toole et al. 2007; Resolve Community Consulting 2006; Charles & Helen Schwab Foundation 2003, cited in Burt et al. 2010):

→ Lack of knowledge about services available and how to contact them.

→ Lack of identification and other documentation.

→ Lack of telephone and mailing address make it difficult to retain contact.

→ Higher likelihood of poor health, physical or psychiatric disability, substance abuse problems or criminal history.

→ Competing priorities such as obtaining food and other basics.

→ Lack of social support.

→ Difficulty in keeping appointments due to cognitive impairments or chaotic lifestyles.

→ Lack of money/resources to access services, including lack of transport.

→ Lack of skills to access services (e.g. self-confidence, communication skills).

→ Suspicion of services and lack of trust, including fear of government and bureaucracy.

→ Feeling unsafe, particularly for women who have experienced violence.

→ Disconnection from mainstream society and service systems.

Recognising and adapting service models and practices to cater for these factors, rather than expecting clients to adapt to strict service models and rules of engagement, is important in order to overcome these additional barriers.

3.5 Barriers for sub-populations

It is well-acknowledged within the literature that access to services impacts different sub-populations of people experiencing homelessness in different ways. As identified in the Thomson Goodall study, 'there is no such thing as a "typical" homeless person

or family—getting access to the service system is complicated by the need to find a service that "matches" the specific needs of each client' (Thomson Goodall 2001, p.9).

This synthesis project has focused on five specific sub-populations, determined by the depth of available literature and the specific interests of the commissioning client:

→ people with complex needs, including rough sleepers and chronically homeless

→ Indigenous people

→ young people

→ families

→ women & children escaping domestic and family violence.

The following section summarises the specific barriers identified for each of these groups from the sourced literature.

3.5.1 People with complex needs, including rough sleepers and chronically homeless

'People with complex needs' is a commonly used term for people with a dual diagnosis of mental illness and substance addiction. This group is also strongly represented in the population of rough sleepers and the chronically homeless. While these three groups are not synonymous, for the purposes of this synthesis project they are being treated together as they often overlap within the study populations.

In Australia it is estimated that rough sleepers represent only around 6.2 per cent of the overall homeless population (6500 out of 105 000 counted in the 2006 Census) (Chamberlain & MacKenzie 2008), however it is acknowledged as a group that is particularly disengaged and underserved by the existing homelessness service system. It is also important to recognise that rough sleepers commonly move in and out of different categories of homelessness, and therefore do not constitute a static or homogenous group (Parsell 2010).

The literature search identified six studies that directly addressed the issue of access to services for people with complex needs, a large proportion of these focused on rough sleepers who are typically long term or chronically homeless. The depth of literature in this particular field can be linked to the recent interest, both in Australia and internationally, on engaging 'hard to reach' populations. The establishment of the UK Rough Sleepers Strategy in 1998, and concurrent development of 'Housing First' models in the US to provide rapid access to permanent housing, have been two significant pieces of work in this field.

The additional barriers to services experienced by people with complex needs are typically attributed to the additional complexity of need and behaviours created by their interlinking issues, and the fact that there are few services specifically designed to deal with, or capable of responding to, these complexities. The following section provides summaries of six of these studies.

'Accessing housing … for chronically homeless street dwellers'—US

This longitudinal (three-year) study of 174 chronically homeless street dwellers focused on enablers and barriers to accessing long term housing, particularly for those with substance addictions (Meschede 2010). The study found that a major barrier in accessing housing services was the difficulty in retaining contact between services and highly mobile street dwellers. The high barrier model of most housing services, requiring clients to participate in lengthy addiction treatment services was also a major barrier, and for many individuals resulted in them making the active

choice to avoid homelessness services. Those most likely to exit street homelessness were high-risk women, white, older and health-insurance holders. While the researchers had hypothesised that higher exposure to medical and substance abuse services would in the long term lead to greater access to housing, this was found not to be the case, largely because suitable and affordable housing options remained out of reach for this client group. Their conclusion was that ending chronic homelessness may require the integration of housing services into the provision of health services, rather than expecting chronically homeless people to transition into long term housing as a result of their involvement with targeted health services. The authors suggest Housing First models as a preferred option, with low barrier entry stipulating that housing access and retention is not conditional on involvement in long term treatment services.

'Reaching the unreachable'—US

A recent doctoral study in the US identified that those with dual diagnosis do not fit neatly into the service eligibility criteria of most services, making them easier to turn away from increasingly under-resourced service providers (Collins 2010, p.5). The author used retrospective data from 379 client case records from a drop-in centre in suburban New York to determine which factors contributed to involvement in human service systems, and to investigate whether there were differences in service usage by those who were chronically homeless as opposed to episodically homeless. She found that 'the data contradicts the generally held belief that chronically homeless people are unwilling to seek treatment' (p.98), however they do experience greater rates of service denial and found it difficult to integrate into existing treatment systems.

Proposed solutions for overcoming these additional barriers included the development of more coordinated and more flexible services, as well as practices that are specifically designed to actively engage people who are long term or chronically homeless. The findings suggest that service development should focus on streamlining services 'to minimise the impact of categorical social welfare systems on homeless, and other marginalised, populations' (Collins 2010, p.1).

Site and service characteristics as a barrier to services

An earlier US study looking at service barriers for homeless people with a serious mental illness also found that site and service characteristics were more important than individual client characteristics in presenting barriers to service (Rosenheck & Lam 1997, p.387). In a study of 1828 clients entering the Access to Community Care and Effective Services and Supports (ACCESS) program, the researchers note that while previous research has examined the efficacy of outreach approaches in reducing barriers to service use, there has been little attention paid to the way in which service site characteristics impact on usage. The most frequent barriers cited were not knowing where to go for a service (32%), not being able to afford the service (29.5%), experiencing too much confusion, hassle or waiting times (27%) and previous denial of service (16.5%). In addition, people sleeping rough were likely to have encountered more barriers than those seen in other locations. Some of the other contributing factors to service utilisation were acknowledged as per capita funding of services, the efficiency of using those funds, and the proximity of services to areas frequented by homeless persons (Rosenheck & Lam 1997, p.389).

Organisational characteristics as a barrier to service use

Another US study looked at the interaction between individual client and organisational characteristics in determining service usage by homeless people with substance abuse and mental health issues (North et al. 2005). Using data from a

longitudinal study of 400 clients and 23 organisations, researchers looked at utilisation of services in the substance abuse, mental health and shelter sectors. The organisational characteristics used as variables in the research were number of funding sources, number of service types offered, number of paid employees and proportion of professional staff employed. The findings showed that all three sectors had unique patterns of associations between service usage and organisational characteristics, with use of shelter services positively associated with a large number of services offered and smaller service size, but negatively associated with the employment of professional staff. In contrast, service use was positively associated with larger organisations in the mental health field and with diversity of funding sources in the substance abuse field. These findings suggest that organisational characteristics do have some bearing on service utilisation, and need to be taken into consideration in service design, particularly the finding that a greater diversity services is a positive factor in shelter settings.

Difficulties in predicting service use for those with complex needs

An earlier study by this same grouping of researchers (Pollio et al. 2003) explored factors affecting service usage by homeless people with complex needs in the US. This study also found that there were different patterns of use for homelessness services than with mental health and substance use services. In a study of 396 clients, it was found that need factors were strongly associated with service access in the mental health and substance abuse sectors, closely fitting a needs-based conceptualisation of service usage (p.493). However in relation to homelessness services, it was more difficult to predict use based on need, and other factors such as race, gender, the complexity and episodic nature of homelessness and convenience of location could be more influential than for other service types. The researchers argue that this supports the need for greater cross-sector collaboration and greater amounts of outreach in order to overcome the barriers specifically faced by those needing homelessness services (p.494).

'Reaching the hard to reach'—impact of structural barriers within services

A qualitative study in the UK focused on health services the 'reaching the hard to reach' also found that it is not the individual who is necessarily difficult for services to reach, but the service system itself that may present structural barriers making it difficult for vulnerable and marginalised individuals to access what it is offering (Flanagan & Hancock 2010). In examining service provision by the Voluntary and Community Sector (VCS), the study found that additional barriers for marginalised people included previous bad experiences putting them off accessing services, complexity of navigating transport services, the limited number and range services for this client group, poor links between statutory services and the VCS services (including a lack of professional trust and respect between workers in these two sectors). In contrast, they identified factors that contributed to improved access for this group as being: trust and respect shown to clients, flexibility in service provision, working in partnership with other agencies to offer services, and user participation.

3.5.2 Indigenous people

Indigenous people are over-represented in the homeless population, making up almost 10.0 per cent of the homeless population in Australia, even though they represent only 2.4 per cent of the total population (Urbis 2009, p.8). Overcrowding, spiritual homelessness, transient homelessness, and lack of access to any stable shelter are all issues specific to this population (Urbis 2009, p.4). The issue of additional barriers in access to services is widely acknowledged throughout many generic studies on Indigenous homelessness. However it is typically only addressed

as one of many factors in understanding and responding to Indigenous homelessness, rather than as a targeted area of inquiry.

An exception is in the recent consultations with Indigenous people in Darwin as part of the process for developing a National Quality Framework for homelessness services, where service users were asked specifically about access issue (Catherine Holmes Consulting 2010). Some of the key factors in accessing services were cited as:

→ The practical or logistical challenges of going to a service.

→ The frustration associated with being referred to other agencies where the outcomes are likely to be futile.

→ The respect and kindness extended by service staff/volunteers.

→ Whether the service has the capacity to meet their basic needs.

→ The presence or absence of other Aboriginal groups and the geographical location of their camps.

There was a strong preference expressed for services to be provided on an outreach basis, bringing needed services to communities (whether remote or not) rather than expecting members of the community to come to them. Otherwise, physically gaining access to services that were well known and respected remained a major impediment to service usage.

Australian data from homelessness services in 2008–09 reported that while Indigenous people represent around 22 per cent of all accommodated SAAP clients, they represent 30 per cent of all those turned away from services (Productivity Commission 2011, p.17.14). Queensland recorded slightly higher turnaway rates for Indigenous people than the national average (Productivity Commission 2011, p.17, p.15), indicating that access for Indigenous people is a significant issue both for Queensland and within the national homelessness service system.

Some of the additional factors cited as being specific barriers for Indigenous people include:

→ Reliance on the kinship system in Indigenous populations, where families are expected to take responsibility for meeting the needs of extended relationship networks, can lead to over-crowding and high levels of secondary homelessness. (Birdsall-Jones et al. 2010)

→ Indigenous women in particular may avoid service use because of feelings of shame, stigma, lack of formal support structures, racial discrimination and inherited debt, concern about accessing services where extended family members might work, including concerns about potential confidentiality issues. (Cooper & Morris 2005; Wilson & Talbot 2010)

→ The lack of culturally appropriate or culturally sensitive services, including limited number of Indigenous staff and limited involvement from Indigenous service users in service design. (Hovane 2007)

3.5.3 Young people

Homelessness research has consistently identified young people as having different needs and presenting issues to those of the adult homeless population. The development of a dedicated youth service stream within the national Supported Accommodation Assistance Program (SAAP) also indicates an acknowledgement that young people are better served by a targeted service system. In 2008–09, 34.3 per cent of all SAAP agencies were targeted at this group (AIHW 2010).

In 2008–09, the largest age cohort of SAAP clients were 15–19 year olds (18%), the second highest were 20–24 year olds (15%), and the highest rate of use by any one age and sex group was female clients aged 15–19 years (AIHW 2010).

The following studies identify some of the specific barriers and access issues facing different groups within the youth homeless cohort.

The first is a study based on records from two specialist lesbian, gay, bisexual and transgender (LGBT) housing providers in the UK used interviews and focus groups with agency workers, and interviews with homeless LGBT young people in London and Manchester (Dunne, Prendergast & Telford 2002). It identified the invisibility of LGBT young people within the general community and within the homeless service system as a factor in them remaining invisible within service statistics. It is argued that this in turn leads to services retaining assumptions and practices around heterosexuality as a norm, therefore raising cultural barriers to their use of these services. It was found that the LGBT population can also face additional violence, bullying and discrimination within the homeless community, limiting their access (or perceived access) to shelters and hostels for young people.

An AHURI synthesis study on youth focused homelessness practice (Gronda & Foster 2009) also found that barriers to service accessibility for young people can have both practical and psycho-social elements. Young people were found to be reticent about seeking help from formal support services, and only resorting to seeking assistance (if at all) from these services once they had exhausted all help from family and friends (p.1). Reviewing a number of studies on youth homelessness practice, this AHURI report identified major accessibility issues for young people as:

→ Inflexibility of arbitrary rules and regulations (such as curfews, visitor restrictions, daytime lock-outs).

→ Significant wait times for services requested.

→ Exclusionary practices by staff.

→ Physical environment of the service.

A key finding was that newly homeless young people in particular lack knowledge and information about the service system, suggesting that youth focused practice that is specifically aimed at engaging with this population is required to increase their accessibility (p.37). Important aspects of service delivery for young people include the provision of a trusting, non-judgmental and respectful relationship with a worker. Effective interventions for young people already homeless were respectful outreach services, whereas school-based interventions were found to be effective at prevention and early intervention with homeless school students.

Physical and emotional barriers to service use were also explored in a 2008 paper providing guidelines for the opening and running a drop-in centre for homeless youth (Slesnick et al. 2008). They report that a consistently cited barrier to seeking service for this group is the inaccessibility of the location, the level of safety and belonging felt by individuals within the local community, and whether the built form of the service is inviting or not (p.729). The range of services offered can also be a factor, with drop-in centres that provide basic needs such as food, washing and cleaning facilities, and access to health care considered to be more attractive to this target group.

Finally, the circumstances faced by homeless young people in rural and regional areas present specific access issues. An AHURI report from 2006 found that young people from regional centres displayed a preference for staying in those areas rather than travelling to larger cities or towns in order to access accommodation and other

emergency services (Beer 2006). This is problematic given that support services tend to be concentrated in the larger regional centres, meaning that young people are more likely to be hidden in the secondary and tertiary homeless populations. It also found that young people tend to be unaware of available services, including benefits available through Centrelink, until after they become homeless and even then often only access them on an ad hoc basis.

3.5.4 Families

The literature is consistent in its recognition that family homelessness presents particular access difficulties because of the relatively limited number of services available for this target group. In Australia, family specific services represented only 8.6% of funded agencies, even though families are also able to access cross-target or generalist agencies and family violence services (AIHW 2010, Table 17A.2). However, families are consistently reported as having higher representation in turn-away rates for accommodation than other groups (AIHW 2009, p.13).

A recent study on family homelessness in Australia argues that homeless families have traditionally been overlooked in Australian research, although the authors state this is starting to change (Hulse, Spinney & Kolar 2010, p.2). However it found that in an analysis of US and UK literature it was possible to identify that there are significant differences in the causal factors for homelessness between families and single adults, which in turn has an impact on their help-seeking and access to services (p.3). The primary causal factor is around housing affordability and accessibility, which is also reflected in their experience when attempting to access specialist homelessness services, where finding housing that is appropriate for their family size and configuration often proves difficult. It was found that the variety of accommodation options available for families from homelessness services were typically inadequate and unsatisfactory for family life, including:

→ lack of cooking facilities

→ overcrowding

→ highly unaffordable (particularly motel and rooming house accommodation)

→ short term

→ unsafe for children (particularly in shared accommodation such as rooming houses). (Hulse et al. 2010, pp.6–10)

Another Australian study focused on family services in NSW identifies barriers to service use as including limited timeframes for support within the SAAP service model, limitations in the physical appropriateness and layout of available accommodation (such as insecure premises being unsuitable for families where domestic violence is an issue), and the general resource limitations of agencies (Brown, p.5).

One particular sub-group of families that has been identified as facing particular barriers in accessing services is single fathers and their children (Bui & Graham 2006). In 2003, single father families with children under 15 years of age represented around 11 per cent (or 55 100) of all single parent families (p.13). SAAP data from 2002–03 indicated that 1900 support periods were provided to homeless single fathers with their children, representing just 4.3 per cent of all support periods for homeless families (p.15). This Australian based study found that while the existing homelessness service system has a relatively strong focus on the needs of women headed households, there are very limited services available for men with primary caring responsibility. This lack of appropriate services represented a major barrier.

However they also had higher levels of unmet need in accessing housing and accommodation than mothers with children (40% compared to 30%), and children accompanying male parents were found to receive fewer services than those in other family groups (p.15). Reasons for this variation in service use are not clear from the available data, but may be related to the fact that women with children are more likely to be accessing family violence services, whereas men are most likely to be accessing a generalist or cross-target agency where services for children are less readily available (p.16).

Other barriers include a lack of understanding and sensitivity of workers toward their circumstances, a feeling of stigmatisation when contacting services, a sense of mistrust and wariness toward service providers, limited family and social supports, lack of information about available services for single fathers, perceived bias toward helping women-headed families, lack of male workers in the sector, and a reluctance among single fathers to initiate help-seeking (pp.37–8).

In the United States, access to educational services for children in homeless families is mandated in the McKinney Act. However the one international study on families (from the US) reviewed found that lack of knowledge by shelter staff about the basic legislative requirements around provision of services to children under the McKinney Act was an ongoing factor in limiting access. This study also identified the basic lack of shelter services for homeless children and families as the key barrier to accessing appropriate services (Hicks-Coolick, Burnside-Easton & Peters 2003).

3.5.5 Women & children escaping domestic and family violence

In Australia, services primarily targeted at women and children escaping domestic violence represent 23 per cent of all specialist homelessness services, and domestic violence is reported as the most common reason (22% of all support periods) for seeking assistance from a SAAP funded service (AIHW 2010).

The specialisation of a distinct stream of family violence services within the homelessness service system recognises the specific needs of this client group, and the barriers they would face in attempting to access generalist homelessness services. In addition to barriers faced by other families (due to lack of appropriate emergency accommodation for families with children), this sub-population faces the additional barriers related to the need for physical security measures in accommodation, and the crisis nature of incidents, often occurring outside business hours of operations (NSW Women's Refuge Working Party 2003; Moe 2007). Different groups within this sub-population are also reported to experience even greater difficulties in accessing family violence services (NSW Women's Refuge Working party 2003; Multicultural Disability Advocacy Association of NSW 2010; People with Disability Australia 2009; St. Pierre & Senn 2010; Zweig, Burt & Schlichter 2002) including:

→ Aboriginal women—strongly over-represented yet with few Indigenous specific services. Contributing factors include mistrust of government agencies, racism and discrimination, lack of aboriginal workers, inadequate networks and connections with Aboriginal specific services.

→ NESB—lack of awareness of legal rights and service options available, communication and language barriers, racism and discrimination, culturally inappropriate responses.

→ Women with a disability—research has shown that women with disabilities experience violence at higher rates than other women, but that services for this group are severely limited (PwDA 2009). Contributing factors include the lack of

accessible means of communication, lack of information in accessible formats, discriminatory and paternalistic attitudes, physical accessibility of services, limited skills of workers in assisting people with various disabilities.

→ Women with mental illness—discrimination due to behaviours associated with mental illness, lack of skilled workers.

→ Women with alcohol and drug issues—discrimination toward active substance users, lack of understanding by workers about A&OD issues.

→ Lesbians—primarily due to a lack of lesbian specific services. Factors leading to concealment of sexual orientation have an impact on help-seeking behaviour (St. Pierre & Senn 2010).

→ Women with HIV/aids/hepatitis—recognised as facing discrimination and inappropriate service responses from refuges, including denial of service.

3.6 Conclusion

Access barriers are faced at a multitude of levels, and at various stages in the help-seeking process, in attempting to access both mainstream (often preventative) services, and specialist homelessness services. Service system barriers are often linked to limited capacity and resources, and increasing demand for services.

The literature identifies that service model and practice barriers represent some of the most immediate opportunities for change, whereas the broader systemic barriers are likely to require longer term and more incremental reform opportunities. The perspectives of consumers are critical in developing a better understanding of barriers and how these impact on initial and repeat usage of homelessness services. The literature clearly identifies the importance of respectful client/worker relationships as a fundamental driver of client access and engagement.

Critically, barriers to service access must be understood in terms of the different homeless sub-populations, as each group has specific and distinct needs. The challenge for the service system is to respond to this diversity and complexity with access models and mechanisms that simplify, not compound, that complexity for clients.

4 APPROACHES TO IMPROVING SERVICE ACCESS

4.1 Introduction

In reviewing the recent literature, approaches to improving service access for people experiencing homelessness can broadly categorised as:

→ legislative intervention

→ systems integration

→ service integration

→ enhanced service models.

This section of the report will provide examples of existing initiatives under each category, with an analysis of their respective strengths and weaknesses presented in Section 5.

4.2 Legislative intervention

Examples of legislative intervention in improving access are limited (UK, Scotland and France), but illustrate a direct means of making homelessness services accountable for their access policies and procedures.

The UK introduced the 1977 Housing (Homeless Persons) Act which established a priority system for access to permanent and temporary housing, and welfare benefits (O'Connell 2003, p.161). Priority groups included families with dependent children and vulnerable single people. This effectively created a two tier system in the UK whereby those not captured within the priority system were less likely to gain access to homelessness services.

In Scotland, legislation introduced in 2001 and 2003 were designed to improve access to housing, with a goal that by 2012 all 'unintentionally' homeless households would gain the legal right to permanent accommodation (FEANTSA 2010, p.3). Even those deemed to be intentionally homeless will have the right to temporary accommodation along with support services, with the option that after 12 months their accommodation can be converted into a regular permanent leasehold.

France has also provided a legal right to housing under a 2007 Act of Parliament, requiring that 'everyone presenting at an emergency accommodation centre should be offered a long-term, adapted solution to their housing needs (FEANTSA 2010, p.6). This is being supported by a 'Housing First' approach for rough sleepers, and low barrier 'unconditional access shelters' for undocumented migrants (p.7).

4.3 Systems integration

4.3.1 Evolution of systems integration

As social welfare systems developed over the late twentieth century, governments in developed countries such as the US, UK, Canada and Australia became more involved in funding and planning of homelessness services. At the same time, the increasing visibility of homelessness, particularly in the US and UK during the 1970s and 1980s, saw the issue receive greater attention in public policy debates (O'Connell 2003, p.160). This resulted in the development of national policies around homelessness, accompanied by more formalised service system development and analysis of their effectiveness.

Recognising that homelessness services on their own would never be able to address the complexity of needs involved in resolving homelessness, efforts began in various

countries to better integrate homelessness services with other human service systems. The US has been a leader in this field, and has implemented a number of different systems integration programs and pilots that will be outlined in the next section. A paper entitled 'What do we know about systems integration and homelessness?' (Dennis, Cocozza & Steadman 1998) outlines the significant history of efforts at systems integration in the field of homelessness in the United States over the past 40 years.

In an article on the approach of a high profile systems integration program in the United States (ACCESS—Access to Community Care and Effective Services) Randolph (1995) explains the differences between service integration and systems integration:

→ 'The goal of *services integration* is to maximise an individual's use of existing resources in order to help that person achieve improved functioning, greater independence, and enhanced quality of life'—case management is an example of service integration where a case manager attempts to bring together the various services required by the one client.

→ By contrast, '*systems integration* refers to establishing linkages with agencies within a system and across multiple systems to facilitate the provision of services to individuals at the local level'—focused on 'reducing barriers, coordinating and improving existing services, and developing new programs to improve the availability, quality and comprehensiveness of services'.

Examples of systems integration include multi-agency taskforces working together to identify and address barriers, cooperative agreements and protocols for sharing or coordinating resources, creating one-stop-shops for service delivery (typically in low demand settings alongside various practical assistance and material aid).

However it is important to recognise that systems integration is not solely a concern of funders and program managers—consumers also recognise the benefits of a more integrated service system. As part of consultations for the Victorian Homelessness Strategy, clients were asked to describe what an 'ideal' service system would look like, and suggested the following (Thomson Goodall 2001a, p.18):

→ Centralised information centre.

→ One-stop shop, or central agency to provide range of services.

→ The initial contact of 1800 phone numbers.

→ Web-based database of services information.

→ Better coordination of services.

→ Practical links to assist in moving between service providers.

→ Common processes and information sharing between services to reduce the need for duplication of information provided.

→ Follow up processes once referrals are made.

The first six points all have direct relevance to the issue of access, highlighting the importance of addressing problems with the existing fragmented and complex service system from the perspective of consumers attempting to access and navigate services.

4.3.2 *Evaluating the benefits of systems integration*

Dennis et al (1998) state that 'the goals of integration are to improve access to comprehensive services and continuity of care: to reduce service duplication,

inefficiency, and costs; and to establish greater accountability' (p.2). While access to services appears to improve through a systems integration approach, there is inconsistent evidence about the direct benefits of systems integration to the long term outcome for individuals seeking care. This paper (Dennis et al.) reviews 11 different systems integration projects across the US which had varying levels of success, with the evaluation of the ACCESS program cited as providing the most comprehensive and rigorous studies of systems integration.

The ACCESS program was established in the early 1990s as a five-year demonstration project to provide better integration between all levels of government and service providers to specifically meet the needs of people who were homeless with mental illness or substance addictions. The 1990 Taskforce on Homelessness and Severe Mental Illness identified that many people in this target group faced enormous barriers in accessing services due to the many of the systemic and structural complexities within the service system—this resulted in them being even more likely to fall between the cracks than other service users (Randolph 1995).

The goal of the ACCESS program was to create 'any door' access so that a client can enter via any one of the involved services and be able to obtain all necessary supports. The program was established in 18 communities chosen across 9 states in the USA to test system reform strategies—both communities in each state were provided an equal amount of money to provide assertive outreach and case management services, but one undertook systems integration and the other was treated as a comparison community. Preliminary findings from the ACCESS evaluation showed that systems integration was able to provide greater access to housing for clients (Dennis et al. 1998, p.15), and there was evidence of overall greater access to services and significant improvement in all of the client outcome domains (Rosenheck et al. 2002, pp.963–4). However the unexpected finding was that systems integration initiatives alone could not be positively linked to the improved social and clinical outcomes achieved by clients—this was more directly linked to the concurrent use of assertive community treatment (ACT), or assertive outreach case management approaches. These findings suggest that while systems integration is an important element in improving access to services, it does not necessarily guarantee better outcomes and should be implemented in conjunction with enhanced service models aimed at the specific needs of different target groups.

Dennis et al. (1998) also conclude that systems integration can be effective in improving outcomes for clients, but only if adequate resources are committed to support implementation (p.19). Other lessons from this review include:

→ That service integration (client-level) and systems integration (administrative level) should be pursued simultaneously in order for maximum effect.

→ That service recipients must be involved in the planning and implementation of integration efforts.

→ Incremental change must be pursued in order to achieve large-scale systems change.

A review of the US Continuums of Care (CoC) initiative (Burt et al. 2002) found that few of the 25 CoCs evaluated had successfully integrated mainstream agencies and services into their locally coordinated efforts, but those that had were experiencing greater success (p.xv). Strategies adopted by those CoCs that had attempted integration with mainstream services to some extent included:

→ Appointing staff with specific responsibility for promoting systems/service integration.

→ Creating a local interagency coordinating body.

→ Having a centralised authority responsible for the homeless assistance system.

→ Co-locating mainstream and homeless-specific agencies and programs.

→ Adopting and using interagency management information systems (p.xv).

The review concluded that the CoC funding model (requiring a coordinated, community wide approach to planning and allocation of resources) had helped move toward a more integrated system of planning and program development than would otherwise have been the case. However greater emphasis on mainstream services engagement would need to be undertaken to drive this further.

In 2003 the US Department of Health and Human Services released a report, 'Ending Chronic Homelessness: Strategies for Action', that identified a number of strategies for improving access to mainstream benefits for people experiencing homelessness, including:

→ Strengthening outreach and engagement activities.

→ Simplifying application procedures.

→ Improving the eligibility review process.

→ Increasing the flexibility of funding streams.

→ Developing incentives for mainstream providers to serve people who are homeless' (Burt et al. 2010, p.6).

One of the practical initiatives from this project was the development of a computer-assisted tool, FirstStep <http://www.cms.hhs.gov/apps/firststep/index.html> that provided a streamlined way for case managers and outreach workers to more easily identify and assist clients to access appropriate benefits and services.

This work on improving access to mainstream benefits and services was followed up with another report by Burt et al. in 2010, to analyse the success of initiatives in the US to date and promote strategies that had been successful in improving access.

In responding to the identified barriers categorised as eligibility, structural and capacity barriers, the authors developed a framework of three types of mechanisms used (Burt et al. 2010, pp.11–12): *smoothing mechanisms* that are applied at 'street level' or service delivery level to make it easier to apply for or access programs and benefits, *changing mechanisms* that involve changes in policy or practice to enhance access rates, and expanding mechanisms that increase overall availability of resources to meet the needs of hard to serve client groups.

It was found that smoothing mechanisms were those most commonly used to overcome barriers and included strategies such as:

→ Providing transportation for clients to attend appointments.

→ Outreach services to hard to serve clients.

→ Co-locating mainstream workers in homeless services.

→ Creating 'one-stop shop' intake centers for homeless people, where staff from various mainstream agencies would assist in applications for benefits and services.

→ Ensuring mainstream services are conveniently situated.

→ Providing 'quick question' lines at benefit offices.

→ Providing adequate translation services on telephone access lines.

→ Computer access for clients to fill in their own application forms.

→ Training staff in homelessness services in mainstream benefits and programs application procedures.

→ Improving communication between mainstream and homeless service staff.

→ Developing strategies and procedures for ensuring that benefits for people in institutions can be reinstated immediately upon discharge (Burt et al. 2010, pp.xvii–xviii).

In addition, they found that the most successful communities were those that had implemented a strong central organising structure to implement and coordinate changes, promoting communication and collaboration between all stakeholders and ensuring the widest possible coverage of strategies to improve access (Burt et al. 2010, p.iv).

More recent developments in the US around systems integration are presented in the 2010 strategic plan, 'Opening Doors: Federal Strategic Plan to Prevent and End Homelessness' (Interagency Council on Homelessness 2010). This document presents a long term plan for improved systems integration through involvement of the 19 member agencies of the Interagency Council. It builds on the efforts of over 300 communities in the US to develop integrated homelessness plans at the local level. The integration of targeted homelessness programs with mainstream programs is a key goal of the Federal strategy in preventing homelessness, along with a joint effort on the rapid rehousing and support of people once they become homeless (Housing First approach).

Integrated responses to homelessness are also being promoted throughout Europe, with a 2010 Joint Report of the European Commission and Council on Social Protection and Social Inclusion calling on member states to 'develop integrated policies to tackle homelessness' (FEANTSA 2010, p.5). However it is not clear how far systems integration—as opposed to the use of service integration mechanisms—will be part of these integrated responses.

4.4 Service integration

As outlined above, service integration is aimed at the client level, bringing together the range of different services required to provide an improved outcome. However there is also evidence that service integration can assist in improving access to services by providing clearer entry points to the service system and removing some of the navigation and administrative barriers experienced by service users.

4.4.1 Service integration in Australia

Opening Doors—Victoria

The most comprehensive approach to service integration in Australia is the work in Victoria on the development and implementation of the *Opening Doors* Framework (DHS 2008). This was based on the earlier work of Thomson Goodall (2001) to develop a new framework for improving access to services through improving service coordination, and making 'entry points' to the homelessness system clearer for all involved. As identified in this earlier work, the two common models of access are single or limited points of intake, or the 'any door' multiple entry point arrangements. The stated benefits of single or limited points of intake, assessment and referral were cited as:

→ 'The existence of visible and identifiable "front doors" to the service system.

- The capacity of specialist intake services to develop a rich understanding of complex service systems.

- Cost-efficiencies in reducing duplication, as there is no longer a requirement for all services to extend a comprehensive assessment and referral response to all people contacting the services.' (Thomson Goodall 2001b, p.11)

It was this more streamlined approach to access chosen for the Opening Doors, despite the fact that internationally most service systems used the 'any door' or multiple entry point arrangements, where individuals were able to contact any agency and theoretically gain access to the broadest possible range of services through coordinated arrangements (Thomson Goodall 2001b, p.10).

This framework developed for Opening Doors is initially focused on improving access and coordination within the homelessness and social housing services field, but with the long term aim of incorporating other service systems such as health, mental health, drug and alcohol services (systems integration). Using a system of Local Area Service Networks (LASNs), the model is designed to provide a common initial assessment and planning response at designated entry points within each local area. This is to be backed up by a range of local services that work collaboratively to provide the necessary housing, support and other services required by each presenting client.

Principles underpinning the Opening Doors framework are:

- A consumer-focused and strengths-based approach.

- Equity of access to the resources of the homelessness service system.

- Support for skilled workers with training, supervision and efficient tools.

- Collaboration and partnerships between agencies and the Department of Human Services.

- Reasonable care to address the risks faced by each homeless person.

- Maximising the use of available homelessness resources.

In terms of improving access arrangements, the Opening Doors model has streamlined the entry points to the service system to key agencies in each local region so that clients are no longer responsible for finding the appropriate access point themselves. Assessment procedures at each entry point will determine the most appropriate service response and assist the client in accessing that service. (For a detailed summary of the project see Appendix. For a full description of the service model, see the Framework and Practice Guide handbooks available online).

This model using local area networks also recognises the significant different between service systems and integration practices in rural and metropolitan areas—earlier consultations identified and greater cooperation and coordination was already evident in rural settings, where co-location of services is also a long-standing practice (Thomson Goodall 2001a, p.20). It responds to some of the specific access issues in rural locations—such as greater geographical isolation of services, tendency to centralise services in regional centres and reduce access in outlying towns, lack of extended hours and crisis responses, and lack of specialised services available for referral—to be addressed within the local model.

Findings from the upcoming evaluation of the Opening Doors model will be of significant interest to other jurisdictions in Australia, each of which are currently undertaking various forms of systems integration.

HPIC (Homeless Persons Information Centre)—Sydney

The Homeless Persons Information Centre (HPIC) run by the City of Sydney operates as a statewide telephone assessment and referral service, providing access and active referrals to accommodation and support services. HPIC contacts around 60 metropolitan crisis accommodation services on a daily basis to update its vacancy register, and maintains a database of around 1800 government and non-government services for use in its referral process. While there are no formal protocols in place with referring agencies, the fact that the service has been in operation for 25 years means that it has strong relationships with homelessness service providers and other key services.

HPIC is aimed at single adults over the age of 18 and families, who are either currently experiencing homelessness or are at risk of homelessness. Around 80 per cent of calls to HPIC are directly from clients, and in 2007–08 HPIC received 47 236 calls for accommodation making it a large volume, statewide, highly integrated service.

HPIC provides a unique model of service integration using a centralised intake model, although people experiencing homelessness are also able to access services directly and are not limited to using the HPIC intake and assessment process in order to receive a service.

The Community Connections Program (CCP)—Victoria

The Community Connections Program (CCP) is an example of service integration across health and homelessness services in Victoria. Currently there are around 16 CCPs operating in communities across Victoria, funded through the Department of Health's Low Cost Accommodation Support program banner. The program was developed in recognition that many people with multiple or complex needs living in insecure or low-cost accommodation are very isolated and not well connected into health, housing or community services. They typically experience difficulty in accessing and navigating services, and many of them would not consider themselves eligible for specialist homelessness services, given that they would not identify as homeless.

CCP uses an assertive outreach model to proactively find, engage, assess and link these clients into the service system, using a pool of flexible funds to assist those in crisis. The program is also designed to develop greater integration of local services for this high needs client group, through active development of networks and partnerships amongst the range of service providers in the local community.

An evaluation of one CCP service (based in St. Kilda) found that the program achieved strong outcomes for its client, including improved health and quality of life, improved continuity of care and access to responsive services, and reduction in risk factors for homelessness and admission to institutions such as hospital and prison (Resolve Community Consulting 2010, p.37).

Service integration study—AHURI

Integration of homelessness, mental health and drug and alcohol services is the subject of a current study by AHURI (Flatau, Conroy, Clear & Burns 2010). In a peer reviewed study using a literature review and case studies (Haymarket Foundation in NSW, Ruah Community Services in WA and HomeGround services in Vic), this project aims to increase the understanding of ways in which these three service systems can be better integrated and coordinated to provide improved access to services and improved outcomes to people experiencing homelessness.

However the authors note that the benefits of integration for clients cannot be assumed as a given, and one of the aims of the study is to identify the potential problems (p.2). They identify that service integration does present difficulties, including additional costs, the challenge of bringing together different organisational cultures whilst maintaining goodwill, tensions between partnership arrangements and maintaining autonomy, the requirement for leadership and good management to be successful, potential dilution of specialist skills and the fact that existing funding arrangements are often inconsistent with integrated care arrangements.

Various typologies and theories of integration are reviewed (pp.1–15), as well as an overview of different approaches to the measurement of integration (p.15).

The authors claim that 'no robust evidence on the extent and effectiveness of integrated care arrangements surrounding homelessness in Australia' exists—however integration of homelessness and health services is covered in international literature (Flatau et al. p.18). In reviewing international evidence on integrated service delivery, the researchers report:

→ That a 2002 review of the ACCESS program found closer formal integration helped in improving housing outcomes for clients, but did not necessarily provide improved social or clinical outcomes (p.19)—however what did make a positive difference was the use of Assertive Community Treatment (ACT) which uses an enhanced case management approach to bring together service providers from various disciplines 'with a single leader, a common location and a shared caseload' (Rosenheck et al. 2003, p.78).

→ Supported housing models were also found to provide improved housing outcomes but not necessarily clinical outcomes (Flatau et al. pp.19–20).

→ The Community Connections Housing Continuum program (US) provides the most comprehensive single-agency integrated response (specialist mental health service), as opposed to models that merely provide coordination of various services. It included an assertive outreach approach—stable housing outcomes were achieved for 52 per cent of clients (all of whom were formerly homeless with severe mental health issues and substance abuse disorders).

→ Street to Home programs have been emphasised under the National Partnership Agreement on Homelessness, which provide examples of integrated service delivery combining Assertive Community Treatment and Support Housing models (p.26)—however at this point Australia's national mental health and drug and alcohol plans and strategies do not have a specific focus on homelessness issues or on better integration of services (p.28).

Service hubs—Queensland

A 2008 report, 'Closing Gaps and Opening Doors', provides an evaluation of homelessness service integration and coordination at three sites in Queensland (Brisbane, Townsville and Gold Coast) established as 'service hubs' (Keast et al. 2008). These service hubs were seen as providing a 'coalescing point' for clients and offering a more client-centric approach (p.34)—with the presence of alternative hub models serving different client needs was seen as a bonus and working in a complementary way to meet the diverse needs of different groups.

The Homeless Health Outreach Team was noted as an effective model as they specifically introduced access to various health services (p.31, p.35)—and the model of taking services to the clients rather than expecting them to come to the service has proved effective—'working with clients in their own locations offers an important

additional service dimension, especially to more vulnerable clients and those less willing to present to "formal" intervention sites' (p.33).

Findings related to access included that mobile service options, such as outreach, were able to provide a more client-centric model rather than the more typical agency based model (p.15). In relation to phone access, connection with clients through mobile phones has allowed better connections to maintained, particularly with the less connected clients. In addition, a free call service established through HPIQ, which allows free calls from mobiles (not all free call services allow this) has improved access to information and services—also freeing up agency resources in tracking down highly mobile clients (p.16).

The new phone access service hub—Homeless Persons Information Queensland (HPIQ)—was considered particularly important as an information point for newly homeless and vulnerable people, even though it is still in early stages (p.34). The most significant contribution to the integration process across all sites studied were the long term positive working relationships between agency workers and considered the 'glue that binds' the integration process together (p.35) In conclusion, various integration mechanisms were found to have worked effectively to improve access to services and better links between different parts of the service system, notably through the development of both place-based and space-based initiatives—indicating that multiple approaches are important rather than a single approach (p.31).

4.4.2   Service integration internationally

Boston Medical Centre ACCESS Project

A paper by Lincoln et al. (2009) describes the development and implementation of a safe haven shelter for people who are chronically homeless with severe mental illness and active addictions in Boston, Massachusetts. This integrated service was specifically designed as a 'low barrier' model for difficult to reach (and engage) clients and involved collaboration between state, local and community based organisations to establish the Advanced Clinical Capacity for Engagement, Safety and Services (ACCESS) Project in 2002.

This clinically enhanced 'safe haven' model was developed specifically for those with mental illness and substance abuse issues who had been unwilling to engage in supportive housing. An evaluation of the Safe haven model from 2005 found that they were effective in engaging and retaining residents with over half subsequently housed in permanent accommodation.

Program services at the ACCESS project were not compulsory, but consistently offered throughout the program—components included housing (for men and women) in a multi-level building with individual rooms and common areas available on each floor, outreach services, and a 24/7 clinical model of care incorporating primary health and psychiatric services. Removal of barriers was a critical part of the project, including not requiring sobriety or adherence to treatment services.

Lessons from this service integration project included (Lincoln et al. pp.489–91): the need to identify and reduce regulatory and financial barriers to the process of developing innovative programs; the need for reinterpreting policies and practices for dealing with people with mental illness, specifically examining the priority of housing as a means of stabilising their situation; the value of a Safe Haven transitional model in allowing clients the time to address some of the practical barriers to permanent housing for this high needs group, such as providing an address, having personal identification established, proof of income, access to appropriate benefits.

The authors note that the benefits of this transitional form of Safe Haven model could be considered for expansion to include more permanent housing, given that the client population are likely to require ongoing medical and other support services. They question whether this medically enhanced model might be better for people who have been living on the streets for long periods than the alternative Housing First model, which doesn't necessarily provide that additional level of care and support.

Balance of Cook County CoC, Illinois

The 2002 evaluation of US CoCs presents the 'Balance of Cook County' CoC as an example of a 'no wrong doors' model that uses a range of innovative methods for ensuring that service coordination and integration occurs behind the scenes (Burt el al. 2002, p.54, p.130). To allow for consistency of intake, assessment and referral processes, 134 agencies within the Continuum used a specifically designed information management system that would provide real-time information about available resources, as well as use a standardised online assessment format. While not yet fully live at the time of the evaluation, the plan was to incorporate other agencies in the region such as the police, libraries and other government facilities into the system. This would maximise the number of access points across the service system, as well as encourage greater coordination and collaboration between services. One of the objectives was also to provide greater capacity for accurately enumerating homelessness across the CoC, allow for longitudinal tracking of clients, undertaking needs and gaps analysis, and providing an online directory of available services (p.131). While going beyond the issue of access, this model demonstrates that an 'any door' approach can overcome the problems of service fragmentation through using other resource management tools.

Integrated health and homelessness services

There are a number of examples of integrated service models combining a range of primary care, clinical treatment (drug and alcohol and mental health) and homelessness services in the literature. These include:

→ The ACCESS (Access to Community Care and Effective Services and Support) program in the United States, designed to assess the impact of integrated systems of care on outcomes for homeless persons with a mental illness. The Assertive Community Treatment (ACT) model used involved a team of specialist mental health and homelessness support workers (and sometimes other health professionals) working from a common location. The program evaluation found that the use of ACT made a difference to clients' health, social and housing outcomes (see Section 4.3.2 for discussion of how the broader efforts of systems integration were found to be less successful).

→ Mobile Health Units in the US, funded under the Health Care for the Homeless program, designed to improve access to health care services by homeless people (Post 2007). Using an outreach model, mobile outreach services were provided by teams in specialised vehicles to identified hard-to-reach communities of homeless people. The key principles of the service were flexibility, building trust and using assertive outreach. Promoting accessibility of the service was found to be most effective through word of mouth amongst the target population, as well as the use of printed materials distributed through a range of community services.

4.5 Enhanced service models—practice examples

This section outlines service models that go outside the 'traditional' provision of centre-based service provision to meet the specific access needs of different groups of homeless people.

4.5.1 Centralised telephone services

Numerous systems internationally use telephone hotlines as a means of providing access to the largest possible number of people in need. In Australia, there are centralised telephone lines available in several States and Territories, with the Homeless Persons Information Centre (HPIC) in NSW being the longest running, most well-established and integrated with the broader service system.

The Homeless Persons Information Centre (HPIC) service provides a statewide triage-style information, assessment and referral model, where callers are able to speak directly to a trained worker who can identify the best match between their needs and those resources available that night. Callers are then linked with the individual service provider to finalise access arrangements.

A range of other models are provided in other jurisdictions (see Table 7 in Section 2 for an overview of different structural and operational arrangements).

4.5.2 Single intake, assessment and referral services

Montgomery County CoC—US

In the review of 25 high achieving Continuums of Care in the US, only one service was identified as having a single point of entry for all clients (Burt et al. 2002, p.54). The Montgomery County DHHS Crisis Center operated 24 hours a day and provided detailed clinical assessments of all clients (including screening for mental health and substance abuse issues) to ensure they received the most appropriate referrals to individual services within the CoC network. While this model was seen to be a cost-effective way of providing a professional assessment, the central physical entry point was also found to limit access to services for clients, particularly given the suburban nature of the County. Although complemented by a mobile crisis team, clients found that the logistical difficulty with travelling to a central location for case management was a drawback.

First Point service—ACT

The new 'First Point' service in the ACT follows this model of a single intake, assessment and referral service for the entire Territory. This is a major change to the previous 'any door' access model for all agencies and client groups within the service system. With the service starting as a telephone only access point but planned to expand to a physical access point (co-located with a government housing agency in Belconnen) within the first six months of operation, there is a phased transition from the old system to the new system. The street presence will include a 9.00am–5.00pm drop-in service. Eventually the plan is to integrate services from across the mainstream service system.

While the relatively small size of the Territory has been cited as a rationale for implementing this model, there are still significant transport issues likely to be encountered by some client groups, and the co-location with a government housing agency may also deter those people averse to dealing with government authorities. However, it is less than six months old, and a service evaluation is due for commencement at the end of 2011.

4.5.3 Service standards

Since 2009 Victoria has used a series of Homelessness Assistance Service Standards to support improvement of services. This requires funded agencies to be formally accredited, and to adopt a series of client service delivery standards and organisational management standards (Urbis 2009, p.22). Section 2.1 of the standards specifically addresses the issue of access to the homelessness service

system, to ensure that 'people are actively assisted to access the most appropriate service within the homelessness service system' (Department of Human Services). They require that all people approaching a funded organisation will be offered a service of some kind, with the most basic service being a screening process that would provide them with information and/or an active referral to another agency.

Using a framework of good practice signposts, the standard requires agencies to develop and document their own practice guidelines that ensure:

→ Documentation of their organisational commitment to improving access.

→ Provision of written information, in appropriate community languages, about the service system and how to access services.

→ Documentation for staff in their provision of housing information, referral and advice.

→ Up-to-date information about available services and resources is made available to other parts of the service system.

→ Ensuring that service users have timely access to assistance.

→ Processes are in place to adequately monitor the accessibility of their service to people seeking assistance (HASS, Section 2.1).

Other sections of the standards identify good practice in providing equitable access to support services (Section 3), direct service delivery to specific sub-groups within the homeless population (Section 4), and building partnerships and integrated networks with other community services (Section 5). Taken together, these standards represent a client-centred approach to service delivery within a quality improvement model (Urbis 2009, p.20).

The current project to develop a national quality framework for homelessness services will be using service standards as a means of ensuring consistency of practice across the sector, with the second options paper containing a section on access and equity standards.

4.5.4 Extended hours services

The development of extended hours services is a direct response to the concern that standard 'business hours' are not appropriate for people in crisis and whose need for assistance is often greatest overnight or on weekends. Some examples of extended hours services include:

→ The Melbourne Youth Support Service (MYSS), which operates its telephone advice, referral and placement service for young people Monday to Friday 9.00am–8.00pm and Saturday/Sunday/Public holidays 10.00am–6.00pm. The service also provides access to a range of other co-located services including regular visits from Centrelink, a youth health service, training programs and a community legal centre.

→ The Homeless Persons Information Centre (HPIC) in Sydney, which operates a telephone information, assessment and referral service from 9.00am to 10.00pm (closed 1.00pm–2.00pm) seven days a week including public holidays. This is complemented by an inner-city outreach support service.

→ A 'Homeless Service Centre' in Stockholm, Sweden, which runs a drop-in service for rough sleepers open after working hours seven days a week. The service undertakes client assessment, referrals to emergency shelter and support services. (FEANTSA 2010, p.8)

→ The St Kilda Crisis Centre in Melbourne's inner-south suburb of St Kilda provides an extended hours drop-in service seven days a week (9.00am–11.00pm), and operates the statewide after hours telephone service 24 hours a day, seven days a week.

Most jurisdictions in Australia operate dedicated 24 hour domestic violence advice and referral telephone services, and internationally this is also considered best practice given the crisis nature of domestic violence incidents. They are typically not linked though to 24 hour access refuge access, with refuge administration operating predominantly on a business-hours model.

4.5.5 Online directories—UK, US and Australia

Internationally, access to homelessness services is generally offered through a combination of telephone 'hotlines' or helplines, online information and service directories, and localised service providers.

In the UK, a comprehensive centralized information register, Homeless Link UK, is available online through Homeless UK (www.homelessuk.org) which identifies five different entry or access points to the service system:

→ Local authorities (Councils) are the central entry point for housing and homelessness services for people in 'priority need'—the online directory provides a searchable database of Councils and their housing departments for people to contact.

→ Independent advice services are available to provide advice on housing rights and homelessness—a searchable directory of these services is available online.

→ Shelter UK runs a free national housing advice helpline, available 8.00am–8.00pm weekdays and 8.00am–5.00pm on weekends.

→ Citizens Advice Bureaux across the country are able to provide advice on housing, benefits and other community services—a searchable directory of these services is available online.

→ Day centres provide shelter during the day for people experiencing homelessness, offering advice and practical assistance such as meals, showers, laundry and medical services—a searchable directory of these services is available online.

The website also provides information and links to over 200 help-lines and websites arranged under topic headlines such as domestic violence, alcohol and drugs, employment, young people, older homeless, single homeless, ex-offenders, human rights and housing rights, and LGBT issues.

In the US, the Department of Housing and Urban Development provides an online resource, The Homelessness Resource Exchange (http://www.hudhre.info/), outlining funded programs, and a facility for people seeking assistance to search for services in their local area. Access points vary significantly across jurisdictions but are typically based on access through the Continuums of Care (CoC) networks established to coordinate integrated responses in local communities (see Section 4.3.2 for further information on CoCs).

There is also a national domestic violence helpline, which provides a 24 hour advice and information service and is supported by an online directory—The Hotline.

In Australia, the InfoXchange Service Seeker is an online searchable directory providing information about 250 000 community support services and agencies available nationally, including homelessness services. It began in 1988 as a project to

establish an online accommodation register, to allow better access to emergency accommodation in Melbourne, and has grown into a much more extensive service.

While there is no centralized government online directory of homelessness services, the national peak body Homelessness Australia provides an online listing of key access points to the service system. Centrelink also provides a list of government services and payments available for people with 'accommodation, renting or homeless issues', including information about Centrelink Community Engagement Officers (CCEOs) who can provide referrals to homelessness services.

4.5.6 Assertive outreach and Housing First models

Assertive outreach is being promoted internationally as an effective way of engaging 'hard to reach' communities within the homeless population, predominantly those sleeping rough and who have been chronically homeless.

The UK's 1998 *Rough Sleepers Initiative* was one of the early examples found to be successful in using the assertive outreach approach, with a 2002 evaluation finding that the Contact and Assessment Teams (CATs) were one of the major successes of the initiative (Randall & Brown 2002). In London in 2000–01, CATs contacted 3031 people living on the streets and assisted 1679 of these into accommodation. Some of the key strategies used by CATs in helping people off the street included:

→ A focus on intensive street work, with up to three-quarters of staff time spent on the streets, compared with less than a third in some areas previously.

→ Persistence by outreach staff, with contact attempted every day with individual rough sleepers.

→ Abandoning the policy of leaving people alone who were not initially willing to engage with staff and instead contacting them as often as possible.

→ Switching from a 'social work' approach, which sought to meet a wide range of needs on the street, to a more interventionist stance aimed at the more specific goal of moving the client into accommodation, from where detailed assessment could be made and appropriate supports put in place.

→ Detailed action plans for individual clients, particularly longer-term, entrenched rough sleepers.

→ Close and coordinated work with other agencies including the police, day centres, medical services, hostels and any other service in regular touch with rough sleepers.

A new study by AHURI into assertive outreach practices (Phillips, Parsell, Seage & Memmott 2011) provides an overview of this model as it has evolved from international settings into Australian programs.

Phillips et al argue that assertive outreach is more focused than traditional outreach on engaging with homeless people as a means to ending their homelessness, often through provision of direct entry to long term housing, such as the Housing First model in the US and Street to Home programs being implemented across Australia. As well as using persistent engagement strategies, assertive outreach is also commonly delivered through service integration arrangements.

The South Australian Street to Home service established in 2005 uses 'client-focused, multidisciplinary and integrated' outreach teams linking clients to both transitional and crisis accommodation (pp.12–13). Other examples are provided of new Street to Home services in Australia, with the Way2Home service in NSW linking and outreach and support team with mental health skills, and the Street to Home service in

Melbourne being run by a homeless service in collaboration with staff from the Royal District Nursing Service (pp.10–11).

The authors note that outreach services have been used for some time in engaging young people, and with Indigenous people in public spaces, with a particular on 'return to country' objectives. The assertive outreach model offers scope for improving access to the service system for chronically homeless people, however it is noted that the success of the model is likely to in part rest on the ability of outreach teams to follow through in being able to offer tangible housing outcomes (p.31).

Another recent US study looking at the effectiveness of housing options for homeless people with complex needs and active additions (Kertesz et al. 2009), compared outcomes for clients in traditional 'linear' recovery programs with those for clients accessing low barrier Housing First models. It found that the traditional recovery programs were able to provide evidence of success in treating addictions, but not in maintaining long term housing. In contrast, Housing First was found to provide excellent housing retention outcomes, however the authors caution that there is only limited data available that can identify the breakdown of outcomes for those with chronic or active drug addictions. Researchers concluded that while Housing First does appear to be a more appropriate response, further research is required to identify outcomes for those with active addictions before declaring it a successful intervention for this sub-group.

In the evaluation of CoC programs in the US (Burt et al. 2002), the most successful outreach services were those used in combination with place-based programs (such as drop-in centres and soup kitchens). Chicago was found to have a significant outreach program, with a 24 hour crisis intervention centre including a toll-free hotline complemented by a mobile assessment and intervention service (p.58). These mobile teams could be despatched as required to provide crisis intervention, assistance with transport, or other practical forms of engagement. Through a range of cooperative agreements, homeless people were able to access the service via police station, hospital emergency rooms or other emergency facilities, and even the Transit Authority. Another innovative model was found in Broward County where an outreach team comprising a police officer and a formerly homeless person would actively seek out hard-to-reach homeless people. The approach was designed to develop a sense of trust and peer-based engagement, and was successful in bringing 1800 individual clients into contact with the service network over a two year period (p.59).

4.5.7   Other innovative approaches

A number of other innovative approaches to improving access across service systems and within homeless specific services have been identified in the literature, including:

Project Homeless Connect

Originating in San Francisco, 'Project Homeless Connect' is now a strategy adopted in over 200 communities in the US, Canada and Australia whereby local agencies come together under one roof to offer a 'one-stop shop' of consumer-focused homelessness services. The aim is to increase the profile of various services available in the local community, both amongst service users and service providers. As well as providing practical support services on the day, this forum encourages the development of partnerships and closer working arrangements between service providers. A toolkit is available from the Interagency Council on Homelessness website for agencies looking to establish Project Homeless Connect events in their local community.

Advocacy Services

Recognising that the significant barriers faced by some clients in accessing and navigating homelessness services requires more active intervention, a number of 'client advocacy' services have been developed internationally. Two of these are the [Office of Client Advocacy](#) established by the New York City Department of Homeless Services, and the Victorian Homelessness Advocacy Services run by the Council to Homeless Persons Victoria.

Both services encourage clients to try and resolve issues in the first instance with service providers directly, but where these efforts fail advocates are available to assist.

The New York Office of Client Advocacy assists clients by:

→ Providing crisis intervention for people at risk of becoming homeless.

→ Assisting clients overcome barriers to obtaining permanent housing.

→ Negotiating with other agencies and providers on behalf of the clients.

→ Helping mediate conflicts between agency staff and clients.

The Victorian Homelessness Advocacy Service (HAS) has three areas of focus: individual advocacy, secondary consultation, and training (Urbis 2009, p.25). It also includes a Peer Education Support Program that involves a reference group of homelessness service users to inform policy and practice development. One of the key roles of HAS is to provide an independent complaints process for funded homelessness services, with complaints measured against the Homelessness Assistance Service Standards mandatory for all funded services (see HAS, p.5.4.3).

Innovative European models

A 2010 report by FEANTSA aimed at providing policy-makers with a handbook for ending homelessness identifies a range of innovative approaches that work to help improve access (and outcomes) for clients (FEANTSA 2010). These examples are descriptive rather than evaluative in nature, but include:

→ 'Unconditional access shelters' in France, providing a low-barrier model specifically aimed at undocumented migrants—clients are not required to disclose personal details or information in order to gain access, which removes the significant barriers faced by this group in accessing shelter accommodation (p.7).

→ In Norway, it was found that the poor quality of existing accommodation services was acting as a barrier to people using available services, and increasing the rates of rough sleeping. The solution was the development of 'quality agreements' in temporary accommodation shelters in Norway, whereby an agreement is signed between the local authority and service providers to ensure adequate quality and basic standards are met, including the nature of equipment to provided in each room, cleaning schedules, minimum staffing levels, privacy and safety for service users (p.7).

→ Establishment of a service-user group at a homeless service in London, that meets with directors and board members every six weeks to raise client concerns and contribute to future agenda-setting for the service (p.8).

→ Piloting of 'wet' drop-in sessions in Bristol, England, aimed at engaging alcohol addicted clients who may have been excluded from other services—the model includes teams of outreach workers, drug workers, nurses and mental health workers using a joint approach to this typically hard to reach client group (p.7).

5 KEY FINDINGS

5.1 Strengths and weaknesses of different approaches

In analysing the literature, there are four primary categories covering different approaches to improving service access:

→ Legislative intervention—provides a legal right to service access for designated groups within the homeless population.

→ Systems integration—aimed at better coordination and collaboration between mainstream services and specialist homelessness services.

→ Service integration—aimed at better coordination and resource allocation within homelessness service system.

→ Enhanced service models—attempts at adapting existing services to remove barriers and improve access rates or levels for specific target groups, using a range of innovative means.

While there are no published studies evaluating the comparative effectiveness of each of these approaches, the relative strengths and weaknesses can be assessed based on various evidence and findings from the literature. However, further evaluative research is required to provide more definitive results about the overall effectiveness, and applicability in the Australian context, of each approach.

5.1.1 Legislative intervention

This approach requires a high degree of political (and therefore community) support in order to be introduced. While there is limited application of the legislative approach internationally (restricted to UK, Scotland and France) this appears to be a very direct way of guaranteeing access to services for people experiencing homelessness. However given the overwhelming demand for services and resource limitations, there is typically a requirement to create a high level of specificity in the eligibility criteria. This in effect creates a high barrier to entry and would specifically exclude certain groups within the homeless population. Therefore it may be a useful approach in prioritising groups who are currently locked out of service access or who are substantively under-served.

In the Australian context, legislative intervention mechanisms would have to occur at both the national and state level given the bi-lateral nature of the National Partnership Agreement on Homelessness. Given that different jurisdictions may have different priorities for targeting specific groups for access, this level of detail would be most appropriate to specify at the state/territory level. Further investigation of the precise mechanisms used in overseas examples, and evaluations of their effectiveness in improving access for identified target groups, would need to be undertaken before this approach could be seriously considered within the Australian context.

5.1.2 Systems integration

The evidence suggests that systems integration is recognised internationally by governments and service providers as an important component in improving service responses, including improving access. It is also identified as an important issue by homeless people as consumers attempting to access and navigate multiple service systems.

The strengths of a systems integration approach include that it must necessarily be planned and implemented from the most senior levels within government, given that it typically requires the involvement and cooperation of numerous different agencies and

funding streams. The Interagency Council on Homelessness in the US and the Australian Council on Homelessness are two examples of such an approach at a national level, with the development of homelessness strategies at the state/territory level across Australia also involving various degrees of multi-agency collaboration.

However as identified by Dennis et al. (1998), it is important that systems integration is pursued concurrently with service integration in order to gain maximum effect and that both approaches attract adequate resources to support their implementation. The ACCESS program evaluation in the US also demonstrated that systems integration alone cannot guarantee better outcomes and must be supported by the development of enhanced service models aimed at specific target populations.

Finally, the improved collaboration and improved understanding between agencies and individual workers within both mainstream and specialist homelessness services would be a significant benefit from this approach, whether applied universally or even just at the local level.

The obvious weakness of this approach is that the large scale buy-in required from the range of different responsible stakeholders represents significant challenges at both a planning and implementation level. This is further complicated by the lack of a strong evidence base from which to argue for additional resources or significantly varied practice responses, particularly within mainstream agencies. The publication of rigorous evaluations of existing 'one-stop shop' models and other integrated responses in Australia and internationally would assist in providing the evidence required to support further roll-out of such models.

5.1.3 Service integration

Service integration can occur at multiple levels, such as the statewide model implemented in Victoria (Opening Doors) and the Homeless Persons Information Centre in NSW, or at the local level through development of service hubs in Queensland.

The strengths of service integration approaches are that they can occur largely within existing resources and existing administrative/agency structures, rather than being dependent on inter-agency commitments. This allows for the development of more flexible and innovative service models and practices within an established service paradigm (such as the Supported Accommodation Assistance Program), and potentially the more effective allocation of resources within the service system. As demonstrated through the HPIC in NSW, an integrated service can incorporate different service models such as a centralised telephone assessment and referral service, online resource directories, a targeted outreach service, and collaboration with a large number of funded and unfunded agencies through the daily process of updating vacancy lists.

Service integration can also occur on a bi-lateral level between specialist homelessness services and specialist treatment services (such as the Boston Medical Centre ACCESS Project) at the local level, to provide a low barrier service for an identified group of clients. This allows for innovative and flexible service delivery, and the potential to work as a demonstration or pilot of the model prior to the broader rollout of such a program as a system-wide reform.

The weakness of a service integration approach is that it has only limited scope for achieving improved access to services without being linked to a systems integration approach. Even though not all service integration responses rely on the use of existing resources, the approach overall is more likely to be constrained because of the limited additional capacity or resources available. Finally, service integration can

be limited by the constraints and challenges of working within existing service models and frameworks—for example overcoming some of the in-built access barriers imposed by services reliant on centre-based access—without also embracing new modes of service provision. This points to the need for service integration to be pursued not only in conjunction with systems integration, but also with working to enhance existing service models.

5.1.4   Enhanced service models

The enhanced service models as outlined in Section 4.5 provide examples of innovative and 'needs-adapted' models that respond directly to the needs of their targeted homeless population. While evidence-based evaluations are only available for a limited number of these models (primarily those involving assertive outreach and Housing First models), the common theme is that service enhancements have evolved or been developed in response to identified barriers experienced by different sub-groups within the homeless population.

The advocacy services in New York and Victoria are perhaps the clearest example of service models that respond to the access and navigation difficulties of people experiencing homelessness within existing service systems. However, each of the other examples (from extended hours services, to documented service standards, to 'wet' drop-in sessions) demonstrates that innovation and flexibility can be used to overcome access barriers in different ways.

The strength of an enhanced service model approach is that it allows for maximum flexibility and responsiveness at the individual service level, allowing for the trial and evaluation of new practices and approaches to improve access. These range from the extremely low resource model of establishing a service-user group to regularly liaise with agency directors and board members at a service in London, to the much higher resources required to implement assertive outreach services for hard-to-engage clients.

5.2   Strengths and weaknesses of different access models

From across the literature it is apparent that there are three commonly used access point models: single access point, limited or streamlined access points, and multiple or 'any-door' access points. Each of these might incorporate a combination of access modes such as telephone, drop-in, centre-based appointments, and outreach services. While multiple access points are the most traditional and wide-spread model, there are some recent examples of the other two types operating in Australia and overseas. There are no comparative evaluations available that provide evidence to support one model over the others, and research of this nature would prove extremely valuable in assessing their relative strengths and weaknesses. Such research may be possible once the newly established Opening Doors in Victoria (a streamlined access system) and First Point in the ACT (a single access point) are operating at full capacity and undertake their respective evaluations.

However in the absence of detailed evaluations of each model, the following table summarises the key elements of success for each model, alongside the potential strengths and weaknesses of each.

Table 8: Access models—strengths and weaknesses

Access models	Elements of success	Key strengths	Weaknesses	Examples
Single access point	→ Proximity to transport → Co-location of multiple services → Incorporates outreach services	→ Addresses fragmentation and complexity of access → Provides specialist assessment & referral services → Potential for high profile & visibility in the community	→ Limits access for hard to reach groups → One negative experience (or exclusion) could limit further usage → Young people and DV clients may be reluctant to use	First Point (ACT) (see Section 4.5.2) Montgomery County CoC (US) (see Section 4.5.2)
Limited or streamlined access points	→ High visibility within local area → Proximity to transport → Co-location of multiple services → Incorporates outreach services	→ Concentrates assessment processes into a number of specialist services → Reduces duplication of assessments → Promotes network coordination	→ Limits access for hard to reach groups → Reliant on high level of service coordination (ongoing)	Opening Doors reforms in Victoria (see Section 4.4.1)
Multiple or 'any door' access points	→ High quality assessment & referral processes → Close collaboration and coordination with rest of service system → Incorporates outreach services	→ Client can approach closest and/or most accessible service	→ Fragmentation of service system retained → Ineffective use of resources in multiple intakes → Client may need to visit multiple services before receiving assistance → Relies on extensive knowledge of service system, and high quality assessment practices, from all workers	Current SAAP systems (except Vic and ACT). Balance of Cook County CoC (US) (see Section 4.4.2)

5.3 Evaluating key access mechanisms

The most commonly utilised access mechanisms have been identified as centre-based visits, centralised telephone services, outreach services and online directories.

Once again, in the absence of rigorous evaluations, the following table represents an assessment of the relative strengths and weaknesses of each mechanism based on available evidence from the literature.

Table 9: Evaluating key access mechanisms

Access mechanisms	Elements of success	Strengths	Weaknesses	Specific target group benefit	Good practice examples
Centre based	→ High visibility → Welcoming and respectful engagement practices → Drop-in and appointment based → Co-location of multiple services	Personalised service—capacity for in depth assessment. Ability to provide an immediate service response of some type.	Multiple access barriers. Limited use by hard to reach clients.	→ Young people → Single adults	Brisbane Homeless Centre Hub (see Section 4.4.1) Melbourne Youth Support Service (see Section 4.5.4)
Centralised telephone service	→ Well publicised at 'first-stop' sites → Adequately resourced → Free call number (including from mobiles) → Extended hours (24 hours for crisis services) → TTY and translation services → Broad coverage (statewide) → Incorporates assessment and referral triage processes	Low barrier. Single source of information—for clients and for referring agencies. Expert knowledge of service system capacity and resources centralised in a single service. Encourages communication and collaboration across agencies involved.	Low visibility, particularly for newly homeless. Limited use by specific target groups—Indigenous males, males and older people (see Section 2.4.2). Long waiting times (if not adequately resourced). Inability to provide immediate material aid/	→ People at risk of homelessness → People in crisis (particularly DV) → Rural and regional → Families	HPIC (see Sections 4.4.1 and 4.5.4)

	→ Up to date and accurate (timely) information		assistance.		
Outreach services	→ Assertive engagement practices → Extended hours → Flexible models → Co-located with place-based response → Integrated cross service systems	Low barrier. Able to focus effort on hard to reach clients. Allows persistent attempts at engagement.	Resource intensive.	→ Chronically homeless → Indigenous → Complex needs clients → Marginally housed	Street to Home (see Section 4.5.6) Chicago CoC (US) (see Section 4.5.6) Community Connections Program (Vic) (see Section 4.4.1) UK Rough Sleepers Initiative (see Section 4.5.6)
Online directories	→ Well publicised → Regularly updated → Broad coverage (state-wide or national)	Low barrier. Valuable resource for workers and referral agencies.	Low visibility. Limited evidence of use by clients.	→ People at risk of homelessness → Rural and regional (remote from services)	InfoXchange (see Section 4.5.5) Homeless Link UK (see Section 4.5.5)

5.4 Development of principles for improving access

5.4.1 Summary of key messages from the literature

Despite the limitations of the existing evidence base, the evidence about access to services and service systems for homeless people is consistent on the following points:

→ Homeless people face significant barriers in accessing both mainstream services and specialist homelessness services, with fragmentation and complexity a key criticism of both service systems.

→ Service system integration and service integration must be pursued concurrently to effectively address these barriers.

→ Both mainstream services and specialist homelessness services should focus on providing low barrier entry for people experiencing homelessness.

→ Poor visibility of existing homelessness services is a common complaint from homeless people, with a lack of knowledge of availability of services being one of the major barriers to service usage.

→ While there are common barriers across the homeless population, there are also specific barriers and access issues faced by different target groups.

→ Those who are 'newly homeless' are much less likely to know about available resources and services than people who have experienced homelessness either periodically or chronically.

→ The initial experience of homeless services is critical in determining service usage, with negative experiences likely to make them withdraw from active help-seeking.

→ There is no single access mechanism or model that is appropriate across the board, but responses must be tailored to suit the local service context and target group needs.

→ Given the complexity and diversity of need across the homeless population, access points must be accompanied by high quality assessment and referral processes to enable an adequate response to be provided.

→ Incorporating consumer perspectives into service model design and practice could assist in developing more accessible and effective services.

Based on this evidence, the following principles have been developed for improving access to both the broader service system and individual services.

5.4.2 Principles to underpin a more accessible service system

The following principles could support the development of a service system that is more accessible for people experiencing, or at risk of, homelessness:

→ Service system reforms incorporate both systems integration and service integration.

→ Service users are involved in the planning and implementation of integration efforts.

→ Create local interagency bodies to coordinate integration efforts and promote communication, coordination and collaboration across local agencies.

→ Integration and/or co-location of specialist homelessness services and mainstream services (particularly primary health and treatment services).

- → If moving away from 'any door' access, ensure high visibility and accessibility of entry point services.

- → Appropriate and accessible information (in different formats and in community languages) about services for homeless people to be readily available at 'first-stop' sites across mainstream and homelessness service systems.

- → Use of system-wide streamlined or simplified intake, assessment and referral processes.

- → Service standards to place a priority on respectful engagement and assessment practices.

- → Provision of low barrier eligibility criteria and responses at entry points, supported by referral to appropriate specialist responses.

- → Flexibility of funding and program management to allow innovation and flexibility of response at the 'street level'.

- → Increase knowledge and training of staff in mainstream services about homelessness services.

- → Increase knowledge and training of staff in homelessness services about mainstream services.

- → Provide incentives for agencies to deal with more complex clients.

- → Remove exclusionary practices and develop alternative processes for managing clients with challenging behaviours (within a risk management framework).

- → Incorporate assertive outreach approaches alongside centre-based services, focused on hard to reach clients within the target group.

- → Provide client advocacy services for service users that experience difficulty in accessing or retaining assistance from service providers.

5.4.3 Principles to underpin more accessible homelessness services

The following principles could support the development of more accessible specialist homelessness services:

- → Involve service users in the design and implementation of service responses and practices.

- → Ensure client-centred practices, including:

  1. Providing a welcoming, culturally sensitive and inclusive environment.

  2. Respectful and appropriate engagement and assessment practices.

  3. Easy to contact and physically access (via phone, online information, close to public transport, drop-in visits as well as appointment-based access).

  4. Extended opening hours (appropriate to target group).

  5. Offer services that meet both immediate and longer term needs.

  6. Low barrier access—free or cheap services, minimal eligibility requirements and conditions of continued use.

  7. Adapt service access and participation requirements to the needs of complex clients.

  8. Provide accurate and up to date information about what resources are available.

- → Ensure high visibility of services.

1. Broadly publicised across mainstream services and early intervention sites.

2. Targeted outreach and intervention at 'first stop' sites (to reach newly homeless and those at risk of homelessness).

→ Provide a diversity of services from the one site (e.g. through a 'one-stop shop') to minimise travel and other logistical barriers for clients.

→ Flexibility in service provision (requires adapting service responses to needs of specific target groups, as well as needs of individual clients).

→ Identify mechanisms and incentives for retaining contact with clients once they are engaged (particularly when they are placed on waiting lists for services).

5.5 Conclusion

This section of the report summarises evidence from the literature about the strengths and weaknesses of different structural approaches to improving access, different access models, and different access mechanisms.

Due to limitations in the evidence base, it is not possible to identify or recommend one approach or model as more effective than the others. Until there are evaluations of the more recent efforts at providing single or streamlined access points to the service system (such as in the ACT and Vic), it is difficult to assert that they provide a more effective response than the more prevalent multiple access point models in the majority of service systems worldwide.

However, what is clear from the literature is that efforts to provide tailored access mechanisms for specific target groups and needs within the homeless population has had some success in addressing known barriers. By incorporating these mechanisms, such as assertive outreach for hard to reach groups or adequately resourced centralised telephone access, access to individual services and the overall service system can be enhanced.

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APPENDIX: KEY STUDIES IN DETAIL

Burt et al, 2002, *Evaluation of Continuums of Care for Homeless People*, prepared for US Department of Housing and Urban Development, Office of Policy Development and Research, The Urban Institute, Washington.

A 2002 report for the United States Department of Housing and Urban Development evaluated the Continuums of Care program implemented nationally in 1995 (Burt et al. 20020). A Continuum of Care (CoC) community is a local or regional system for helping people who are homeless or at imminent risk of homelessness by providing a full range of housing and services designed to meet the needs of the local community. The study targeted 25 high performing CoCs across a broad geographical spread to determine the effectiveness of the CoC approach in improving outcomes and system coordination. One limitation of the study was its inability to examine truly rural services, meaning that observations were limited to metropolitan and regional areas.

The study found that across the CoCs studied, entry into homelessness service networks can be broadly described as:

→ Fragmented—where clients directly approach any service, where they may or may not receive assistance or information about other available services.

→ Centralised—where only one or a limited number of entry points to the service system exist and typically undertake some form of assessment to direct clients to the most appropriate services and resources available.

→ 'No wrong door'—where clients are able to access services via any part of the service system, including centralised intake services where these exist, and are then provided with linkages to other appropriate programs and services.

Even within a program aimed at improved coordination and integration of services, it was found that the majority (75%) of service networks still operated as 'fragmented' systems, relying on case managers within individual services to provide the linking and coordination processes for clients (p.xiv). While some CoCs did focus on engaging mainstream services in their coordination efforts, there were few examples where they had successfully been integrated into the service response.

Five of the CoCs had implemented centralised entry points, although in four cases these were only for families experiencing homelessness. The single CoC that provided centralised intake for all clients (Montgomery County, Maryland) implemented a model based on a 24 hour Crisis Centre with masters level therapists to undertaken clinical assessments, supplemented by a mobile crisis team able to respond to identified needs in the community. While the stated aim of this centralised model was to minimise the work required by clients to locate and access the right service, the evaluation found that it also placed limitations on access by requiring them to travel to a single point to connect with a worker, with both transport and cost impositions on the client (p.54).

A small number of CoCs had implemented the 'no wrong door' approach where some attempts were made to streamline access to the wider service network from agencies of first contact. This included the development of the 'Centrepoint' service in Louisiana that operated as a central intake and assessment service for the regional network, but clients were still able to access the service system through individual agencies (p.55). Long Beach, California had similar approach, using a Multi-Service Center (MSC) that provided centralised access to a range of services, however these could all be accessed individually as well (p.55). It was noted that the 'no wrong door' approach does limit the capacity to undertake full clinical assessments at each entry point, due

to the high cost of such services, potentially resulting in inappropriate referrals and less efficient use of network resources (p.60).

The study found that specific populations were more difficult to serve—chronically homeless with mental illness and/or substance abuse, youth, large families and/or families with teenage sons, and ex-offenders (xiv). However outreach services were a component in many service models, targeted at these hard to serve populations, primarily used for locating people who might otherwise not use services or even actively avoid services (p.55). The most successful outreach services were those used in combination with place-based programs (such as drop-in centres and soup kitchens).

Chicago was cited as having a significant outreach program, with a 24 hour crisis intervention center including a toll-free hotline complemented by a mobile assessment and intervention service (p.58). These mobile teams could be despatched as required to provide crisis intervention, assistance with transport, or other practical forms of engagement. Through a range of cooperative agreements, homeless people were able to access the service via police station, hospital emergency rooms or other emergency facilities, and even the Transit Authority. Another innovative model was found in Broward County where an outreach team comprising a police officer and a formerly homeless person would actively seek out hard-to-reach homeless people. The approach was designed to develop a sense of trust and peer-based engagement, and was successful in bringing 1800 individual clients into contact with the service network over a two year period (p.59).

The essential factor in successful outreach programs was found to be those with no/low-barrier programs that people could be referred to once the engagement had occurred—this recognises that chronically homeless people are often in that condition because they do not meet the higher barrier eligibility criteria of traditional service providers (p.59).

Groups that were found not to have fared well under the CoC model included those with mental illness and/or addictions, young people (particularly those under 18 and teenage mothers), families (due to the difficulty in finding appropriate accommodation placements and the additional issues associated with children's needs), and ex-offenders.

Burt et al, 2010, *Strategies for improving homeless people's access to mainstream benefits and services*, prepared for US Department of Housing and Urban Development. Available online.

This study on improving access to mainstream benefits and services was designed to examine the levels of access by people experiencing homelessness, the barriers that impede access, and mechanisms and strategies that were being used in target communities to improve access. The study used seven case-study communities across the US, and secondary analysis of data from the SAMHSA-funded Homeless Families Study (n=1110) to identify effective methods of improving access to mainstream benefits and services. The authors identified three groups of barriers (pp.10–11):

→ Eligibility barriers—because of their lack of stable housing and complex needs, homeless people often face additional challenges in meeting program eligibility or participation criteria.

→ Structural barriers—including transportation, discrimination, identification and documentation requirements, system interaction breakdown.

→ Capacity barriers—insufficient supply to meet demand for services, insufficient value of benefits and services, and delayed availability.

In identifying mechanisms used by the study communities to overcome these barriers, Burt et al developed a framework of three types of mechanisms (pp.11–12): *smoothing mechanisms* that are applied at 'street level' to make it easier to apply for or access programs and benefits, *changing mechanisms* that involve changes in policy or practice to enhance access rates, and *expanding mechanisms* that increase overall availability of resources to meet the needs of hard to serve client groups.

It was found that smoothing mechanisms were those most commonly used to overcome barriers and included strategies such as:

→ Providing transportation for clients to attend appointments.

→ Outreach services to hard to serve clients.

→ Co-locating mainstream workers in homeless services.

→ Creating 'one-stop shop' intake centers for homeless people, where staff from various mainstream agencies would assist in applications for benefits and services.

→ Ensuring mainstream services are conveniently situated.

→ Providing 'quick question' lines at benefit offices.

→ Providing adequate translation services on telephone access lines.

→ Computer access for clients to fill in their own application forms.

→ Training staff in homelessness services in mainstream benefits and programs application procedures.

→ Improving communication between mainstream and homeless service staff.

→ Developing strategies and procedures for ensuring that benefits for people in institutions can be reinstated immediately upon discharge (pp.xvii-xviii).

An important component identified in successful interventions was the ability to implement changes at the 'street level', not just at the policy or bureaucratic level (p.7).

Phillips R, Parsell C, Seage N and Memmott P, 2011, *Assertive Outreach – AHURI Positioning Paper No. 136*, AHURI Queensland Research Centre.

This Positioning Paper represents the first stage of an AHURI formative evaluation research project investigating new models of assertive outreach in Australia, with a specific focus on the applicability of this approach to help reduce rates of rough sleeping.

Assertive outreach practice is a core component of the new 'Street to Home' service models, typically espousing a Housing First approach whereby people sleeping rough are moved directly into long term, independent housing. The authors report that the success overseas of these models (Common Ground in the US, and the Rough Sleepers' Unit in the UK) have influenced the adoption of Street to Home initiatives in Australia, but that care should be taken in importing such a service delivery model from elsewhere into the local context without critical analysis (p.1). The researchers note that the model relies on the availability of secure housing, which is not currently available within the existing service system.

Traditional outreach approaches (in the homelessness field) date back to early 19th C, including provision of a wide range of material aid and support services, and were

commonly used for engaging young people gathering in public places (pp.15–16). Traditional outreach was not focused on permanently ending homelessness, but in providing assistance to those who are homeless, with some questioning whether it was in fact perpetuating homelessness in some cases. The authors note that outreach services have also been a feature of work with Indigenous people in public places, often provided by Indigenous organisations with a strong theme of 'return to country' (pp.18–19).

Three elements of assertive outreach identified as different to traditional outreach approaches (p.2):

1. A specific means to end service user's homelessness.

2. Conceptualised as part of a broader, integrated and intentional policy response that requires both a multidisciplinary team and the availability of long-term housing.

3. Persistent and aiming to work with people over the medium to long-term as a means to assist people to access housing and sustain their tenancies post-homelessness. (pp.1–2)

In addition to the traditional outreach model, assertive outreach incorporates a range of integrated services, including access to appropriate supported and intensively managed housing options. The paper provides an overview of elements and configurations in existing Australian assertive outreach models (pp.10–14):

→ NSW—Way2Home (established mid 2010) in Sydney including an outreach and support team delivered by Neami (mental health services) and a homeless health assertive outreach team delivered by St Vincent's Hospital. Based on Housing First model, although no guarantees that long-term housing will be available.

→ NSW—Newcastle establishing an assertive outreach service delivered by Baptist Community Services incorporates a legal team to help address other issues, with temporary accommodation provided as an exit to rough sleeping.

→ VIC—Street to Home established in June 2010—delivered by HomeGround in collaboration with the Royal District Nursing Service, Housing First approach but with limited permanent housing options available more likely to rely on transitional and temporary accommodation as exits.

→ QLD—to operate in Brisbane (commenced April 2010), Townsville, Cairns, Gold Coast and a yet to be announced rural location. Brisbane service being delivered by Micah (mental health agency with 14 years experience in outreach services) focused on people with most complex needs. Likely to be supported by a Common Ground type housing development.

→ SA—established Street to Home in 2005—used as an example of best practice service delivery in Commonwealth White Paper, and on which the new NPAH approach is being modelled. Housing First focus, with 'client-focused, multidisciplinary and integrated' outreach teams, with some long term housing provided but also transitional and crisis accommodation. Also a Regional Assertive Outreach Program established to target Riverland (indigenous and non-indigenous) and West Coast (indigenous focus) areas. Long term housing options limited in both locations.

→ WA—two services, Perth/Fremantle (commenced May 2010) and Kalgoorlie/Broome (Broome early 2010, Kalgoorlie yet to start) focused on Indigenous homelessness. Perth/Fremantle uses shared case management between Assertive Outreach Teams (AOTs), a Mobile Clinical Outreach Team

(MCOT) and Housing Support Workers (HSWs) to help those in crisis/transitional accommodation into permanent housing.

→ ACT—commenced early 2010 delivered by SVDP, based on a model of persistent and long-term engagement (recognising that many rough sleepers may be wary of accepting help from services) and integrated supports. Based on Adelaide S2H model.

→ NT—S2H program established however does not have an assertive outreach focus. Mission Australia's Darwin assertive outreach service is focused on public intoxication in indigenous communities—more of a health focus than housing. Other outreach includes Tangentyere Council in Alice Springs and Larrakia Nation in Darwin—different objectives and approaches. (see Indigenous section)

Themes emerging from the study to date, and that will explored further in the next stage through an empirical study and case studies, include that the assertive outreach approach is often presented as client-centred model offering choice and self-determination, and the difficulty of implementing in practice Housing First models that rely on access to stable, long-term housing (p.30).

Thomson Goodall Associates Pty Ltd, 2001, *Statewide Assessment and Referral in Homelessness Services Project Report*, Department of Human Services, Victoria.

One rich and directly relevant Australian study comes from the Victorian Assessment and Referral in Homelessness Services Project (A&RHSP) undertaken in 2001. While this project is now 10 years old, it remains the most comprehensive analysis of homelessness service systems available and has been critical to systems reform undertaken in Victoria over the past decade. The evidence from this project was used to inform the development of the Victorian *Opening Doors* framework, piloted since 2008 and with full implementation only commencing in 2010.

The project was established because of the identified problems with the existing fragmented service system, resulting in difficult of access and navigation by both people experiencing homelessness and workers in other community service systems (p.1) —at the time there were 400 potential entry points to the Victorian service system.

Specific objectives of the project were to:

→ Identify appropriate entry points and pathways to assessment and referral.

→ Develop principles for best practice in assessment and referral.

→ Develop a framework for local protocols between service providers.

→ Develop a common assessment approach by homelessness service providers (including a model assessment tool).

→ Consider the role of information technology systems for improving assessment and referral processes within the new model. (p.2)

Access to the homelessness service system was identified as involving the interlinked processes of assessment and referral (p.8). Development of the Family Violence Prevention Framework (Victoria) was already underway using an 'area service model' for family violence services to overcome the current fragmentation and difficulty in accessing that service system. The FV Framework Access model required: clear entry points, well-targeted services, comprehensive information provision, effective after-hours access and, referral and pathway protocols.

Key themes identified in the literature review for this project included:

→ The complexity of client need requiring flexible and integrated responses.

→ The importance of client-centred approaches to assessment and referral.

→ The need for an integrated service system involving both specialist and generic responses.

→ Capacity of the service system as a limiting factor in determining the availability, accessibility and visibility of services.

→ Diversity of existing service providers, and competition for resources, leading to duplication and sometimes incompatible approaches in assessment and referral (pp.12–13).

In exploring the different systems and service integration approaches in the literature review, two major categories were identified:

→ *Single or limited points of intake, assessment and/or referral models*: typically involve centralised information and referral models, centralised service directories, and specialist assessment and referral models.

→ *'Any door' models*: typically incorporate multiple agencies working within networks or clusters, maintaining broad access to the service system through multiple entry points: typically use the following approaches. (pp.13–14)

1. Service collaboration models.

2. Co-location and co-auspicing models.

3. Common tools models.

4. Priority models, linking resource allocation to common criteria.

5. Written protocols.

6. Pathways approaches.

The report identified that the model of service delivery influences the way in which a service operates as an entry point to the service system: typically outreach models provide services to clients in a range of accommodation settings, but still rely on a client contacting the service to gain access; whereas assertive outreach models actively seek out clients who would otherwise not engage with the service system— workers typically based in settings such as parks, boarding houses, days centres etc—effectively takes the 'front-door' out to places where potential clients already gather or live (p.41).

The authors argue that there is no single approach or model that would be appropriate for the entire state, but that flexible arrangements must be developed to respond to regionally and locally specific contexts (p.43). They developed a series of practice principles to support the new system, including the following principles to support access (pp.51–3):

→ Specific access arrangements are necessary for homeless people and those at risk of homelessness: including physical access, hours of operating, timeliness of response, service operations (drop-in, telephone access, other) and cultural accessibility.

→ A constructive, tailored response is provided to all people at initial contact; even where the first service approached is not able to provide direct assistance, in which case an appropriate referral must be made.

→ A response if provided to any presenting person/family, regardless of their 'region of origin'—to eliminate artificial geographic al boundaries.

→ Access is supported by service promotion and relevant service information – both to clients and other services.

Key features of the proposed 'front door' entry points to the new service system were to include:

→ High visibility.

→ Accessibility (service components to include telephone and face-to-face contact, free-call phone access, walk-in capacity with appointments available but not mandatory, staffed during business hours at a minimum but with capacity for an extended hours response, a welcoming and non-judgmental service culture, located close to public transport links).

→ Responsiveness and effectiveness mechanisms to provide flexible responses to variety of client needs.

→ Communication and links through protocol arrangements.

→ Appropriate organisational arrangements in place to support better integration across the service system, including partnership agreements, protocols, regular meetings, etc.

The report concludes with a series of recommendations and implementation issues to assist with the transition from the existing service system to the proposed new system (pp.69–72).

Thomson Goodall Associates Pty Ltd, 2001, *Statewide Assessment and Referral in Homelessness Services Project Report: Literature Review***, Department of Human Services, Victoria.**

This literature review was conducted to inform the Statewide Assessment and Referral in Homelessness Service Project (SARHSP) about systems approaches to assessment and referral in other service systems and determine the most effective approaches.

The review considers other Victorian service systems such as Primary Care (Health) and Home and Community Care (HACC) given their structural and client group similarities to the homelessness service system, and the fact that they had already commenced some service system improvements related to access, assessment and referral.

Thomson and Goodall acknowledge that some of the factors driving this project include:

→ The clear mismatch between demand for services and capacity of the service system to meet need (p.7).

→ The at times opposing philosophies and values of the various service systems responding to the multiple and complex needs of a homeless person (e.g. pathological as opposed to structural causes of homelessness).

They note that systems integration is a common approach to improved assessment and referral processes internationally—while some of these strategies involve single or centralised access points, most support an 'any door' or multiple access strategy. Single or limited points of intake, assessment and referral models are explained as involving 'a designated service or small number of services which undertake key access, assessment and referral roles on behalf o the broader service system' (p.11) —with the emphasis on linkages with other service, collaboration and building trust between agencies.

Advantages of a *single or limited intake point* are noted as: visible and easily identifiable 'front doors' to the broader service system; the capacity to develop specialist expertise at these sites; and a reduction of duplication and therefore costs across the service system (p.11). In recognising the complexity and difficulty of services required, and the difficulty in identifying available service options, it was found the centralised information and referral models are common across homelessness service systems. Extended hours telephone services are the most common model of phone call access points, with some also providing drop-in contact and access to emergency relief and other material aid support (p.12)—assessment is usually part of this process, rather than the just provision of information. The use of centralised service directories (such as InfoXchange in Victoria and UK Advice finder) were also growing in practice, generally updated more regularly online than in print (p.13).

Specialist assessment and referral models—where these functions are specifically separated from service delivery—were found more commonly in the health field (p.14).

In contrast, the '*any door models*'—where multiple agencies network or cluster together to form a complementary model of service—maintain broad access through multiple entry points, and a coordinated approach through the use of a common, agreed set of principles and/or practices. The authors argue that advantages for client include:

→ Only having to tell their story once.

→ Access to a wider range of services (including mainstream).

→ Less likelihood of 'falling through gaps' between services.

Examples include the 'Continuum of Care' model in the US, based on tri-partite model of outreach and assessment, transitional housing combined with rehabilitative services, and placement into permanent housing (p.18).

These 'any door models' also commonly include co-location and co-auspicing arrangements—requiring the development of practical and structural links between various services and programs, such as multi-purpose centres or one-stop-shops— e.g. Frontyard Youth Services in Melbourne, the St Kilda Crossroads Crisis Centre (Salvation Army), local community health centres in USA and Australia, 155 Local Community Services Centres (CLSCs) in Quebec Canada.